Current Issues in State Mental Health Forensic Programs

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The major current issues facing state and local forensic mental health programs are presented in this paper. Debates over forensic patients' rights and the insanity defense are discussed, together with many administrative problems such as the pros and cons of correctional versus mental health system program control and payment incentives for treatment. The authors cite the differing goals of correctional and mental health systems, i.e., security and treatment, as reasons for difficulties in developing needed collaboration. Guidelines are suggested to address such important issues as mixing civil with criminal patients, developing units for special populations, defining patients who can respond to treatment, and follow-up after discharge.

The issues surrounding services to forensic patients are receiving increasing priority at both the local and state levels. The significant increase in the population of most state and local prisons has exacerbated concerns as to how to best evaluate and treat mentally ill persons who are involved with the criminal justice system.

The mentally ill inmate in prisons and the prisoner in mental hospitals pose serious difficulties for prison wardens and hospital administrators, respectively. Not only do these persons pose special problems related to their needs for security, but many tend to be disruptive and therefore require increased staff resources to manage their behaviors. In addition, an inmate patient may victimize more regressed mentally ill patients in mental health settings; on the other hand, within a correctional setting mentally ill persons who are passive or withdrawn may become victimized by their fellow inmates.

This paper attempts to summarize and update several of the major issues that should be considered by state and local mental health agencies as forensic mental health services are developed and improved.

Service Issues

In spite of recent increased visibility of forensic patients and attention to forensic issues, the forensic mental health

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services system in many states is still not well developed. In part, this is because of historical difficulties in coordination and collaboration between mental health and correctional agencies. This lack of development is also related to lack of resources. Unlike many mentally ill populations, forensic patients have almost no patient or program advocacy, which has led to the low priority that forensic services often have in both mental health and corrections systems. Forensic patients are all too often seen by many individuals and groups within both the mental health system and the general public as violent, antisocial, and/or undesirable persons; therefore, they are often considered less worthy of access to health and mental health services. This makes the development of an appropriate array of emergency, ambulatory, and inpatient services difficult.

In our view, several key clinical and program issues must be addressed if forensic patients are to be adequately treated in the near future:

Development of Appropriate Array of Services at Both State and Local Levels With regard to the development of forensic programs within correctional settings, it is important to recognize that state correctional institutions (SCIs) pose challenges different from those in local jails. SCIs tend to house longer term prisoners with more serious charges and convictions. Because SCIs are state operated, they usually can relate more directly to state mental health agencies. In contrast, a local jail tends to provide short-term incarceration, often houses small numbers of prisoners, and develops programs based on local need, resources, and politics. The diverse needs of local jails on one hand and the sheer size of larger state SCIs on the other make the statewide development, coordination, and oversight of programs difficult for mentally ill persons in the criminal justice system.

In our view, insufficient effort is frequently made by SCIs and local correctional officials on one hand and state mental health officials on the other to plan for and achieve agreement on the appropriate services to be developed and/or delivered. The lack of planning and coordination is related both to concerns about financing and administration (both of which are discussed later in this paper) and to the low priority/low status of forensic patients as seen by many persons in mental health and correctional systems, mental health/correctional interest groups, and the public.

Special Populations Major programmatic and administrative challenges are posed by certain subgroups of the forensic population. These include female forensic patients, juveniles, mentally retarded patients, civil patients, and persons who are not guilty by reason of insanity (NGRI) or guilty but mentally ill (GBMI). As a result of their special needs, some of these populations often require specialized treatment programs either as part of the general forensic program or, more commonly, in specially developed separate units.

Given the limited resources allocated to forensic programs in many states, development of specialized treatment programs for forensic subgroups is diffi-

cult. Specific admission and discharge standards criteria must be developed. Specialized staff must be recruited. Specific treatment programs that meet the special needs of the subgroup in question must be developed; increased numbers of staff must be allocated to programs serving especially difficult patients.

Forensic programs specifically for women, for example, must address the specialized medical and psychological problems that are common in female offenders. The specific developmental needs of adolescents must be addressed in an adolescent forensic unit. Specific behavioral interventions must be developed for mentally retarded populations. The challenges are even greater in dealing with individuals with multiple diagnoses.

General state mental hospitals which claim they are unable to manage civil patients with violent behaviors frequently are allowed to use forensic service programs which have provisions for security. Such mixing of chronic mentally ill with criminal populations confounds the issue of security and patient management and raises philosophical and legal concerns. Specific criteria need to be developed for the circumstances under which civil patients, including persons who are NGRI, should be allowed to be mixed with forensic populations.[1] In our view, a separate unit within each civil mental hospital should be established for specifically assaultive civil patients; the number of such patients should be small and the criteria for admitting such patients should be stringent. In Pennsylvania, we have also established a separate unit for the management of chronically assaultive patients on the grounds of one of our general state mental hospitals. This unit provides treatment for the chronically assaultive patients and provides consultation and assistance to other hospitals in developing programs for managing their patients with violent behavior. Only as a last resort should civil patients be committed to forensic programs and only after stringent admission criteria have been met.

Patients who are NGRI tend to require longer term care than the general forensic population. Accordingly, questions have arisen as to whether forensic services should be divided into short and longer term treatment programs to allow for more appropriate intervention with patients needing different lengths of treatment. The issue of preventive detention with NGRI patients must also be addressed.

Correctional and mental health system administrators frequently face a dilemma with regard to special populations. Patients with special needs are frequently more disruptive and the need for specialized programs, particularly within the larger states and within large correctional facilities, is often clear. However, given limited resources, decisions must often be made as to whether or not the development of the specialized unit is more important than the continued development of an array of services for the general forensic population. Factors to be considered include the state of development of the general forensic program and the pressures on mental health and correctional

agencies from internal and external forces for certain types of specialized programs.

Axis II Diagnoses A significant issue in many states is the concept of "treatability." Adult and juvenile corrections officials frequently equate antisocial, disruptive behavior with mental illness. As a result, correctional inmates whose basic disorder may be antisocial personality frequently manipulate their way into the more comfortable setting of a mental hospital forensic treatment program to avoid the harsh reality of the prison. This is a frequent complaint in Pennsylvania's forensic programs.

Historically, corrections officials often consciously or unconsciously have labeled disruptive behavior as mental illness so that disruptive inmates can be transferred out of the prison environment. On the other side, mental health administrators have too easily yielded to pressures to return mentally ill forensic patients who are disruptive and manipulative and commit antisocial acts to the criminal justice system. To help alleviate historical feelings of mutual mistrust and the "revolving door syndrome," correctional and mental health officials need to agree on a definition of mental illness that differentiates the nontreatable disruptive and antisocial inmate from other types of patients who can and should be treated by a mental health program. In addition, mental health agencies should provide assistance to correctional institution staff in developing methods of shaping and controlling behavior within the prison.

If these general issues of treatability and the revolving door syndrome are not addressed, state and local mental health programs may become flooded with individuals with limited potential for treatment who will disrupt mental health programs. Corrections, in turn, may continue to readmit patients who they believe have not been treated adequately or appropriately.

Follow-up Follow-up programs for mentally ill patients who have been involved in the criminal justice system are generally not well developed in the United States. In part, the lack of development relates to the difficulties in communication and collaboration between mental health systems and probation and parole departments. Inconsistent follow-up also results from the lack of state or local direction for assigning responsibility for treatment of forensic patients and the lack of understanding and training for probation and parole officers concerning mental illness. Many community mental health programs do not consider it their responsibility or priority to follow patients who have been involved with the criminal justice system.

It seems clear that recidivism of mental illness, as well as concomitant criminal behavior in some cases, can be reduced by adequate follow-up. Involuntary outpatient commitment as an adjunct in the follow-up of forensic patients may also be useful in states the involuntary commitment statutes of which allow for it. Accordingly, it is highly desirable for both probation/parole and the mental health agencies at the state and local level to establish policies and procedures for follow-up treat-

ment and for the provision of necessary staff training.

Quality of Service In addition to quantity of service, concerns are frequently raised about the quality of mental health services for forensic patients at both the state and local level. The oversight of quality of service is important to the success in treatment of forensic patients and to the credibility of the forensic mental health system.

Licensing of forensic programs in accordance with state standards is a useful mechanism for assuring a minimal level of quality service. In Pennsylvania, an agreement exists between the correctional and mental health state agencies that all inpatient units that are to be established in corrections will be licensed by the mental health agency. In addition, accreditation by the Joint Commission of the Accreditation of Hospitals and Medicare certification provide indications of quality of service.

In the last analysis, however, it is the day-to-day treatment practices of professionals and the adequacy of treatment review mechanisms in forensic programs which provide the best assurance of quality of service. Administrative support is necessary to assure quality care, including high standards and careful screening in hiring treatment professionals, peer review of various kinds, and provision of ongoing training related to forensic treatment issues.

We cannot overemphasize the importance of insisting on standards of high quality personnel and treatment in forensic service programs. The credibility of the entire forensic system often depends on the quality of the individuals working in it and the degree to which programs meet professional standards of care. In Pennsylvania, a specific bonus is provided for psychiatrists who work in forensic mental health settings and forensic training for mental health staff is encouraged.

Legal Issues

Involuntary Commitment Concern with civil and patient rights in the 1970s led to the passage of new State involuntary commitment laws, which applied to both civil and forensic patients.[2] These laws made three major changes in previous statutes: (1) They created a standard of "dangerousness" to self or others for involuntary commitment and treatment; (2) they established rights for patients in mental hospitals; and (3) they required due process hearings and evaluations of involuntarily committed persons at specific intervals.

Many of the protections provided by these changes in law have been extended by courts to forensic patients (e.g., *Vitek v. Jones*),[3] and, in several states, special legislative and judicial provisions have been created for the security, treatment, and discharge of forensic patients, including those found NGRI.

While some of the above changes have helped clarify legal ambiguities related to forensic patients, others continue to be debated; chief among these are patient rights and the insanity defense.

Patient Rights The rights of civil versus forensic patients and how the rights of civilly committed patients in mental

hospitals should apply to forensic programs where security is a major concern are continually being tested and evaluated. In addition, the establishment of appropriate policies on such issues as visiting, telephone access, and the screening of mail and packages are thorny practical issues related to forensic programs.

In addition, it remains unclear how the right to treatment and the right to refuse treatment decisions of courts relate to pretrial detainees and patients/persons committed for an evaluation of competency to stand trial. Can mentally ill prisoners be forced against their will to take medication for treatment of their mental illness? Should forced medication take place within a prison setting? We believe that, consistent with resolution of these issues for civil patients, the answer to these questions should be a qualified affirmative one. However, national guidelines would be helpful in assuring that forensic treatment programs are operated more consistently in these key areas. The federal protection and advocacy legislation recently passed by Congress[4] may help to shape the resolution of these issues.

The Insanity Defense Legislation in several states and at the federal level has proposed and/or finalized changes in the insanity defense. At least three states (Montana, Idaho, and Utah) have abolished the defense and other states have established new criteria for the definition of insanity that would lead to a finding of not guilty. Thirteen states have passed a guilty but mentally ill (GBMI) statute. Several national associations have taken positions on various aspects of the insanity defense. Views differ on such issues as the retention of the insanity defense, the definition of legal insanity, the appropriate disposition of patients who are NGRI, and the value of allowing GBMI pleas. This debate culminated in passage of the federal Insanity Defense Reform Act of 1984,[5] which made several changes in the insanity defense. This law eliminated the "volitional prong" of the insanity defense, created automatic commitment to a mental hospital after a finding of NGRI, limited the role of expert witnesses, shifted the burden of proof from the prosecution to the defense, and raised the level of proof to "clear and convincing evidence." The results of these changes are being closely monitored by states and the federal government to assess their impact on forensic programs.

Administrative and Funding Issues

Administrative and funding concerns and conflicts often impede progress in the planning and implementation of forensic mental health services.

Administrative Issues: Who Should Operate Forensic Mental Health Programs? For many years controversy has existed about whether a correctional or mental health agency should operate forensic programs, and states vary greatly in this regard. In some states, forensic programs are operated entirely by corrections, while in other states they are operated entirely by the mental health agency. In a few states, the responsibility is divided.

In Pennsylvania, SCIs are in the pro-

cess of taking on the responsibility within prisons for short-term psychiatric inpatient, ambulatory, and emergency treatment, while the mental health system will continue to provide longer term inpatient treatment within mental health facilities. In Pennsylvania's local jails, the responsibility rests with county corrections, with mental health providing licensing for inpatient and outpatient units.

In most states, nonsentenced persons tend to be treated by mental health agencies. In our view, this is appropriate. Some states are providing for treatment of nonsentenced persons through contract agencies rather than through state-operated programs. Sentenced persons are generally treated in one of four organizational patterns: (1) in a correctional setting where corrections provides both security and treatment; (2) in a correctional setting where corrections provides security but a mental health agency provides treatment; (3) in a mental health setting where the mental health agency provides both security and treatment; or (4) in a mental health setting where corrections provides security and the mental health agency provides treatment.

Arguments can be mustered to support both sides of the debate: treatment should take place in the correctional setting on one hand or in the mental health setting on the other. In our view, some of the major considerations favoring treatment in a correctional setting include the following: (1) due to their current priority for state funding and rapid growth, correctional departments are currently able to obtain adequate resources more easily than are most mental health programs; (2) correctional departments feel "ownership" of their own service programs; (3) correctional departments theoretically provide better security; and (4) patients do not require transfer to a separate agency and, therefore, they can receive a more consistent treatment approach with increased continuity of care. The following arguments can be made in favor of the mental health agency's operation of the treatment programs: (1) the mental health agency is more likely to develop and maintain a therapeutic environment; (2) recruitment of treatment staff is generally easier for a mental health agency; and (3) resources will most frequently be channeled to treatment rather than focusing purely on security.

In our view, the decision as to which agency is responsible should take into account the special skills of incumbents in key agency positions but more importantly should focus on the organizational structure that maximizes the likelihood that appropriate security and appropriate types, amounts, and quality of treatment will be provided. It seems to us that both mental health and correctional agencies can and should have a role in this regard. If corrections operates the mental health program, the mental health agency should license the services, otherwise help to assure that services are being provided in appropriate ways, and assist in the meeting of training needs. If the mental health agency is providing the service, corrections should provide advice, consultation, and direction on the issue of se-

curity, both at the mental health facility and in the process of transferring patients.

Funding The mechanism of payment for forensic services is an important issue that can affect the number of patients in specific service settings and the amount and types of service provided. In systems in which the amounts of funds are limited, restrictions on numbers of patients may need to be set in certain types of service settings. For example, Pennsylvania's forensic hospital beds are limited to 512 because of tight state hospital budgets and concomitant staffing restrictions. The 1966 Pennsylvania Mental Health/Mental Retardation Act[6] gives the Secretary of Public Welfare the authority to set capacities for state mental hospitals. In Pennsylvania, the two factors of limited budget and ability to set capacities allow the state mental health authority to operate forensic beds with a ceiling; this is very different from the correctional system, which must take whatever inmates are sentenced to it. The ability to set capacities is particularly important because it prevents forensic units from becoming overcrowded, a situation that could seriously compromise the effectiveness of treatment.

Similarly, specific provisions for payment for services can serve as incentives or disincentives to the use of certain kinds of forensic services. For example, Pennsylvania law requires counties of residence of convicted forensic patients to pay the first $120 per day of costs for inpatient care in a state mental hospital. Counties therefore send patients to state hospitals for inpatient treatment only when absolutely necessary. One potential beneficial effect of this payment requirement is that pressure is placed on counties to develop mental health programs in their local jails and/or to pursue arrangements for care with psychiatric units of general hospitals. In addition, at the state level, the payment requirement helps keep the demand for forensic beds to a reasonable level. However, it should be noted that considerable opposition to the payment requirement has developed in counties because of the high cost of forensic services and the drain on local resources.

Conclusion

In summary, some of the current major issues facing state and local forensic mental health programs have been discussed. While more state and local resources are necessary to address the needs of forensic patients, it is clear that much more can be done for the benefit of forensic patients through the development of clinical and programmatic guidelines, systematic plans and mechanisms for communication, and collaboration between correctional and mental health agencies. The differing goals of the two agencies make such collaboration difficult; the goal of corrections is adequate security, while the objective of mental health treatment is to help patients by relieving their mental symptoms. However, encouragement of this collaboration is needed at all levels of government, especially from officials with influence and authority in correc-

tional and mental health agencies. Through mutual commitment and willingness to work together, correctional and mental health agencies can provide a continuing improvement of forensic services to the mentally ill.

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