Analysis and Commentary

Anatomy of a Prison Commission

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Although the epidemiology of mental disorders in the prison system has been investigated in the past, delivery of health services to prison inmates has not received similar scrutiny. Members of a state prison commission describe the process by which they developed their assessment of health care delivery. A model is offered for defining such a mission, selecting standards against which to test prison health services, choosing a testable focus, refining a valid and reliable methodology, and piloting the result.

In January 1994, a group of inmates at the Massachusetts maximum security prison at Cedar Junction brought a class action suit against state officials in the Departments of Corrections (DOC) and Mental Health (DMH). The plaintiffs, confined to the prison's Department Disciplinary Unit (DDU), challenged the "unlawful and inhumane conditions" of their confinement, alleged violation of their constitutional and statutory rights, and asserted inadequate psychiatric screening, monitoring, and treatment as well as inadequate medical treatment. Citing a section of the Massachusetts general laws,[1] the plaintiffs based their complaint against the Department of Mental Health on a statute requiring the DMH to supervise the periodic mental, medical, and dental examination of inmates in segregated units.

Segregated units in the DOC are used for disciplinary purposes, after assaults or other disruptive incidents, for protective custody, or for isolation during a pending investigation. In addition to the DDU, the DOC contains eight segregation units among its facilities. Inmates generally remain segregated fewer than 30 days, with the exception of the DDU, to which inmates may be "sentenced" for up to 10 years. DMH had conducted inspections of treatment services in prison segregation units through the 1980s before ending its formal oversight. The DOC, meanwhile, had purchased health care services for its inmates from a health service delivery company (HSDC) with national experience in correctional health care. The

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plaintiffs asserted that the absence of DMH supervision of health services violated statutory requirements.

This article examines the decision-making process followed by the commission appointed by DMH during the pending litigation to assess health service delivery to segregated units.* We present the process followed by the commission in interpreting their mission, selecting a focus, choosing a methodology, and piloting the result. Our intent is to offer a model to correctional systems nationwide that have an interest in valid and reliable assessment of health service delivery. Although the epidemiology of mental illness in correctional settings has been investigated in the past[2] and is reviewed by Metzner elsewhere in this issue,[3] evaluation of the *provision* of health services has not been attempted nor has the process of arriving at such an evaluation been described. We hope that description of this review process spurs a discussion of standards to be followed in other jurisdictions committed to objective assessment of state-provided services and advances the discussion of appropriate health care for prison inmates. Analysis of the data derived from this investigation will be presented upon its completion.

Interpreting the Mission

In response to the inmates' suit, the Commissioner of Mental Health appointed a private consultant to perform a systematic review of health service delivery to all segregated units. The consultant's review consisted of site visits to each prison, medical record and policy review, interviews of administrative staff, and interviews of selected inmates. The methodology was not designed to generate strict judgments of statistical power or significance, but a number of observations were reported to DMH. Although the consultant found that good quality health care was being provided to segregated inmates, all inmates interviewed complained of inadequate services and a lack of privacy. Suggestions by the consultant that privacy and confidentiality were areas deserving continued examination led to further site visitation by the DMH Medical Director and discussions with senior DOC staff. The DMH consequently appointed four members to a commission charged with assessing segregated units in greater depth. The commission included a forensic psychiatrist with a full-time academic appointment, a senior social worker from the DMH administrative staff who had participated in the review process during the 1980s, a nursing consultant to DMH with experience in staffing and accreditation, and a DMH attorney-social worker. The latter member of the commission was reassigned shortly to another office and replaced by a psychiatrist with prior experience in policy analysis.

The DMH through its Office of General Counsel further suggested a set of minimal requirements to assure its compliance with the statutory language. These included recommendations for site visitation, medical record review, interviews with prisoners and staff, as well as a review of DOC and HSDC policies,

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procedures, and internal auditing mechanisms. The suggestions followed the model of previous reviews and appeared to offer a potential duplication of extant oversight mechanisms within the DOC and HSDC. However, the commission chose not to focus on accreditation standards for correctional institutions or on private contracting arrangements, nor did it wish to encompass such a broad scope. Indeed the prisons were already accredited by the National Commission on Correctional Health Care (NCCHC), an accrediting body for provision of health care in correctional systems. Where the commission did offer expertise was in clinical and ethical standards of practice within the health professions, as well as in methodologies for assessing those standards. Furthermore, it was unclear whether the DMH had authority to require DOC to conform its practices to the recommendations of the commission, suggesting that the review might best be held to objective standards external to the correctional system. In fact, even the health service contractor was held to standards established by NCCHC.

Rather than reassess whether health care delivery to segregated units met established accreditation criteria, the commission chose a set of alternative criteria more in keeping with its clinical expertise. The team adapted the 1989 American Psychiatric Association's (APA) Task Force Report on Psychiatric Service in Jails and Prisons,[4] a report that both assumed accreditation by NCCHC and set a "community" standard for delivery of health services to inmates. The APA Task Force Report took a "pragmatic" approach to offering health services in prison settings and acknowledged the constraint of scarce resources. Focusing on the services necessary to provide *adequate* rather than *minimal* care, the APA task force chose their standard to "reflect the necessary level of acceptable services," while recognizing the difficult environment in which the services must be delivered. Ultimately, the standard of care applied was that of care available within an average community. The DMH commission, recognizing the fluid nature of health care availability in any community, used this construct to apply standards of care as they would to any clinical case presented for treatment (i.e., whether psychiatric, medical, or dental). The manner in which policies and procedures for segregated units facilitated usual care (e.g., triage, coherent treatment, appropriate record-keeping) and approximated epidemiologic needs within the prison were considered the ultimate target for the review.

Moreover, the commission recognized the need for review as an ongoing process that could be reshaped by changes in any of a series of complex systems (i.e., administrative, legal, political). Far from being a one-time assessment of health service delivery, the commission would design a model for future review teams, recommendations for improvement if needed, and a methodology for assessing changes over time.

Choosing a Focus

Having chosen an interpretation of mission and having set a community standard against which to assess health care

delivery, the commission began focusing the assessment. Literature review and consultation with national figures in prison health services comprised the next stage of the commission's deliberations.

The prevalence of psychiatric disorders in prison populations had been an area of some scrutiny over the past years[2, 5] and would serve as a benchmark for deciding what questions regarding psychiatric or medical treatment were appropriate. Prevalence of inmate psychiatric disorders in the 8 to 19 percent range and life-time substance abuse prevalence over 60 percent raised the questions of how and when prisoners received services as well as whether competent, appropriate care was available. Potential questions that the commission could track included the presence and success of screening methods and follow-up, the presence and compliance with documented treatment plans and goals, and the presence of elements of informed consent. It was also not clear from previous studies whether inmates were aware of available health resources or whether their reports of services received matched official accounts. When combined with the APA guidelines regarding adequate diagnosis and follow-up, adequate and confidential medical records, properly prescribed medications and other treatments, adequate numbers of trained personnel, and adequate policies and resources for crisis management, acute care, and transfer, a formidable array of services presented themselves for assessment.

Rather than commit to detailed evaluations of each individual element, the commission took a two-tiered approach. First, a methodology would be developed to parallel the APA guidelines, ascertaining whether broad policy constructs existed and were implemented in the care of patients in general. Second, more detail would be sought through a focused survey of areas of specific interest (e.g., appropriate triage, adequate screening and follow-up, accurate documentation). In this way, areas inherently problematic to a system influenced by security responsibilities, attempts at manipulation, and limited resources could be addressed more directly. Questions of how and when prisoners received specific services would make up the more targeted assessment.

Refining the Methodology

Having focused the assessment conceptually into general and specific categories, the commission turned to developing a methodology. A comprehensive checklist evaluating compliance with APA guidelines provided an easily implemented tool for assessing breadth of policies and procedures. The checklist would track not only the existence of appropriate policies but also implementation in medical charts. If a policy existed for a physical or mental status screen, for example, the screen should appear in individual medical charts. Furthermore, using an individual's treatment plan as a *de facto* research protocol, the review team could answer fundamental questions concerning whether the treatment plan was initiated, completed, and explained. An inmate survey instrument corroborated against other sources could supply the detail absent from the checklist and elicit

further information in areas of interest. A statistician would assist in sampling strategies.

Ultimately, two checklists and a survey were generated. The first checklist would be distributed to senior administrative staff at each prison to assure the existence of appropriate policies. The original intent to compare policies at different prisons was ultimately rendered moot when it became clear that the HSDC applied the same policies system-wide. Their single policy manual provided the background for assessing the familiarity of administrative staff with their own procedures and measuring discrepant reports from each of approximately two dozen administrators chosen for the checklist. The administrators were to be chosen on the basis of seniority and availability, beginning with the superintendent or deputy at each site and including medical or psychiatric directors. Two or three administrators would be surveyed at each site to achieve an adequate sample for descriptive measures of familiarity with their own policies.

A second checklist, nearly identical to the first, assessed implementation of policies as documented in the medical records of each site. The commission planned to review a random sample of charts of those inmates who had received a health-related service. This approach could then test both the adequacy of documentation as well as the compliance with modified APA standards.

A survey of inmates who had received health services completed the review. An informed consent introduction assured inmates that information would and could not be traced to them, that their demographic information would not appear in any form that could identify them, that the review team was in no way affiliated with the correctional system, and that they need not participate. To test the potential over-endorsement of problems, the survey was rationally synthesized to compare inmate self-report to verifiable elements of the medical record. Inmates would then be questioned about basic elements of their screening, treatment, and follow-up. Twenty questions intended to consume 5 to 10 minutes were constructed to elicit simple yes/no responses regarding whether inmates actually had received a physical screen, mental status exam, orientation information, and the like. Their latest interaction with the health care system was then reviewed, with date, recommendations, length of time to response, site, and privacy assessed against the medical record. An open-ended question regarding desired changes within the system was included in an attempt to identify common themes among the respondents. A Likert scale satisfaction question was also included as a comparison with prior reviews, although this was not intended as a valid commentary on the ultimate questions to be addressed by the commission. A system-wide sample size of 100 to 120 inmates was deemed adequate to fit both the time constraints of day-long prison visits and to represent fully 20 percent of all inmates in segregated units. Similar percentages of inmates from each prison would be surveyed to attenuate site-specific biases.

Piloting the Evaluation

With the assessment now focused on the mechanics of service delivery and a methodology selected for determining its adequacy, the commission chose a site to pilot its efforts. At a medium security prison with a relatively small segregation unit, the commission arranged for a tour and meetings with senior prison staff. Clarification of health care delivery policies, description of the prison health system as a whole, and introduction to the medical record comprised the initial agenda. Senior administrative staff described their respective divisions (i.e., superintendent, health service delivery company liaison, medical director, psychiatric director, nursing director) and commented on the checklist instruments item by item. Commission members were instructed on where corroboration for checklist items could be found in medical charts and guided through both charts and policy manuals by staff members who were present throughout the day.

As commission members grew familiar with the prison health system, arrangements were made to meet with segregated inmates. Members of the team requested that they meet collectively with individual inmates to pilot the survey instrument. The review team also required a setting that would be both secure and private. A library with a glass door was available: guards could remain in view of the shackled inmate without overhearing comments or complaints. Elements of coercion would be minimized as much as is possible in this setting, with the potential benefit of a review of prison health care considered by the commission to outweigh the possible intimidation of inmates by the interview.

The manner in which inmates were selected also raised the question of confidentiality. Segregated inmates had to be identified to consent to an interview. However, personal identifiers would not be used on the surveys and only cumulative data would be presented at the conclusion of the review. Prison health officials could legitimately identify inmates who had needed medical services and who could therefore be asked to participate in the review process. Guards then approached inmates in their cells to determine whether they would speak with a reviewer. Initial description of reviewers as "psychiatrists" or officials from "mental health" led to some immediate refusals until guards were asked to modify their approach and ask simply whether inmates would speak with reviewers interested in their views on health care delivery. The consent process proceeded from there.

Inmates were then interviewed by the collective commission, with reviewers taking turns administering the informed consent introduction and the survey. Discussion among team members following each interview led to refinement of interview techniques, scripted response to digressions, and minor changes in the instrument itself. Surveys were coded only by location and number (i.e., prison name-respondent 1, prison name-respondent 2, etc.) with specific complaints retained only so that they might be categorized at the conclusion of the systemic review.

At the conclusion of the day-long re-

view process, prison administrators were offered a feedback session to identify themes that may have become evident throughout the review or to answer questions regarding methodology. Members of the commission offered information both on the history of the review process as well as explication of the standards used to achieve its mission.

With a broader understanding of the system to be assessed, as well as an appreciation of the unique requirements of prison health care, the commission was prepared for the body of its work.

Conclusion

Development of a model for reviewing health care delivery to correctional systems raises conceptual and methodological questions that have not been addressed in a systematic fashion by the health professions. Recognizing the unique constraints on administrative and clinical colleagues in these settings is prologue to any such evaluative endeavor. Difficult patients with compound problems and substantial motivation to overuse or misuse the correctional health system can strain an institution with significant security responsibilities. Providing an objective mechanism for assessing application of the health professions' expertise in these challenging settings would appear both socially redeeming and eminently pragmatic.

Use of a community standard for assessment of correctional health care grounds the process in a language and culture that is accessible to all practitioners and permits collegial, reliable exchanges of information. This respect for the usual standard of clinical care maintains the integrity both of the medical professions and of the unique settings in which their standard may be applied. Adapting this standard to a methodology that is valid and reproducible consequently offers the opportunity for advancement of health care outcomes in general and correctional health care in particular. Whether the methodology ultimately takes the form envisioned here is secondary to establishing a consistent process for this kind of review.

References

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