

Managed Behavioral Healthcare in Correctional Settings

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This paper alerts practitioners and administrators in correctional healthcare settings to a variety of issues of concern when advising or negotiating with state or county governments on the provision of managed behavioral healthcare. The participation of the mental health practitioner or administrator involved in determining the quality and appropriateness of behavioral managed care contractual services is an essential component of an overall healthcare service in a correctional setting. Several crucial elements are outlined relative to correctional settings, including the interface between custody and treatment providers, crisis intervention for incoming detainees or inmates, and provision of services for longer term "no parole" inmates in correctional settings. A number of considerations are reviewed, including (1) staffing, (2) drug formularies, (3) levels of service, and (4) "hidden costs," that may influence contractual negotiations as well as service provision by managed behavioral healthcare companies in correctional settings.

The concerns about managed care in the general community have generated more inches of print in most newsletters and journal publications than perhaps any other topic in recent years. While the general public and the courts are beginning to realize the pros and cons of managed care, there is another population that has been more affected by managed care on an individual and systems basis than perhaps any other. This population con-

sists of detainees and inmates residing in various departments of correction throughout the United States. The movement toward management of healthcare in correctional facilities has followed a wave of privatizing many previously state-run activities. The buzzwords for such privatization have included "public/private partnerships," "reinventing government," "reengineering government," "seamless" provision of services, and "urgent and emergent services." Additionally, this movement has been at a time when state and federal court rulings have mandated the delivery of healthcare in prisons, based on the "deliberate indifference" standard as supported by the "equal

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protection” or “cruel or unusual punishment” amendments of the U.S. Constitution.¹ Such rulings require inmates to receive “healthcare,” but they do not necessarily require that care to meet community standards, physician standards, or other measures of quality of healthcare. Indeed, these rulings require there not be “deliberate indifference,” that is, active avoidance of assessment or treatment regarding the provision of healthcare. Metzner has provided an excellent description of effective ways to design quality and appropriate behavioral healthcare systems in correctional settings.² The current paper focuses on negotiating such a system with a managed care provider.

There are several mega-managed care companies that have the “inside track” on bidding on state contracts. They have a national presence and are able to bid contracts based not only on their substantial resources but also on their knowledge of practices in various states. Their knowledge of these practices allows them to bid on contracts with an enhanced information base to determine which states may have the greatest likelihood for the necessary provision of services and maintenance of the “profit margin.” Some managed care companies are quite adept at providing general medical care, but have a great deal of difficulty in establishing behavioral healthcare. This has given rise to behavioral health managed care companies, which subsequently subcontract with the healthcare provider to provide behavioral health services. Other important subcontractors for the general healthcare provider are the pharmacy subcontractors who are responsible for the

provision of drugs for patient populations.

The behavioral healthcare subcontracting providers typically approach the main contractor, or in some instances the state, with the intention of providing low cost healthcare. Those of us working in correctional environments are quick to realize that the provision of general medical healthcare is relatively straightforward. The areas that are most problematic for the general managed healthcare provider for medical care have to do with catastrophic illness, longer-term hospitalization, and the use and cost of protease inhibitors for HIV disease. However, in the behavioral health or mental health area, the provision of healthcare is complex within correctional settings. One reason for this is the mandate within corrections systems to “maintain order.” Several actions influence the orderly management of correctional facilities.

The ratio of prison correctional officers to inmates is usually disproportionately low, particularly in older prisons that do not have electronic and other means of surveillance as well as protections from escapes through controversial, lethal or sublethal, prison fences. This situation exists because budgetary reduction advocates have not kept pace with the increasing numbers of inmates per prison or with technological advances. Additionally, the hierarchy within correctional settings for correctional officers and the opportunity for advancement to higher rank typically includes working a number of different posts. The mental health tiers are limited to one post. Correctional officers are encouraged by their own system to rotate

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posts for greater experience and potential promotion and subsequently do not spend any more time on the mental health tier than on other posts. This practice does not allow for consistency in assignment of correctional officers to mental health tiers, which contributes to various complications involving training of officers to interface with mental health practitioners and mentally ill inmates.

A second factor in correctional settings that is reflective of the complexities of providing services is the higher rates of suicide in these settings. The rate of suicide in jails is nine times the national average. As a number of studies have shown, successful suicides are most likely to occur in the first 24 hours of incarceration.³ A second high incidence of suicide attempts occurs after the denial of release on bail or parole. Such statistics certainly support anecdotal evidence that when someone is denied their freedom, initially or subsequently by judicial process, the likelihood of acute depressive episodes and suicidal behavior is greatest.

A third factor, longer sentences and "no parole" mandates, affects management in long-term housing facilities. The management of individuals who may have cyclical bipolar disorder, inconsistent signs and symptoms of psychotic disorders, and major depressive disorders may become difficult "chronic care" problems in a correctional environment. Additionally, individuals with severe anxiety disorders and/or panic disorder, particularly when coupled with a history of long-term illicit substance abuse, become treatment and custodial challenges. Added to this is a fairly large percentage

of individuals who have personality disorders characterized by self-mutilating and/or disruptive behavior, including borderline personality disorder, narcissistic personality disorder, and paranoid personality disorder. These "top three" personality disorders require a great deal of attention from the custodial staff because when an individual "cuts," "hangs up," or "drops (swallows)," the custodial response is to control that behavior and to eliminate its presence from the environment. From a custodial point of view, many officers and correctional administrators believe such behavior is indicative of mental illness. From a clinical point of view, many healthcare providers believe these behaviors are examples of manipulative behavior designed to achieve a change in status (i.e., movement from one facility to another or from one security level to another), to achieve other interactive goals (telephone calls to family members, visitations from family members, and/or letters from family or legislative supporters to influence a lesser sentence or other placement), or to avoid internal stressors (old debts to other inmates or "beefs" with other inmates or correctional officers).

Managed Behavioral Healthcare Considerations

Given such difficulties in management, the role of managed care organizations, particularly the behavioral healthcare component, becomes very important to the overall management and success of the system. There are key decision points at which mental health professionals, par-

ticularly psychiatrists, should be involved in the negotiation of state contracts with managed care companies. Traditionally, these contracts are negotiated by contract administrators, legal representatives of the department, and general medical providers. They typically do not include mental health professionals at the "front door" but frequently require mental health professional assistance after the contract has been implemented. A review of the practices in a number of states as well as the author's own experience identify several key areas in which mental health practitioner involvement is crucial. These areas are identified as follows:

Staffing At pre-bid and bid contract negotiation levels, a determination of the number of hours, qualifications, and level of service to be provided by mental health practitioners is crucial. In correctional settings, a number of contracts have allowed for a "mental health professional," which is an ambiguously defined position, to make a number of key decisions including diagnosis and treatment directives. Additionally, the number of psychiatric hours for provision of service is usually grossly underestimated, and it includes flexibility in the scheduling of hours worked such that psychiatrists are frequently assigned in the evenings, on weekends, or at times when the rest of the mental health service staff is not on duty. This often creates a breakdown in communication, resulting in service or documentation errors and inconsistencies.

Drug Formulary As a second issue within any pre-bid and bidding conferences, an up-to-date formulary is necessary. Frequently, behavioral managed

care companies request, as a part of their bidding process, the current formulary. If the current formulary is outdated, that is, does not have any selective serotonin reuptake inhibitor (SSRIs) or the newer antipsychotics (such as Depakote as a primary treatment for bipolar disorder) and other medications that are reflective of the current community standard for psychiatric practice, managed care companies and their pharmacy subcontractors quickly respond to this by bidding very low dollar amounts, because they do not have to provide for medications that may still be under patent. This becomes a management nightmare when individuals come into the correctional facilities on such medications and/or are transferred to the psychiatric inpatient component (whether that is a part of corrections or a part of the mental health system component in the state), then are returned to correctional environments that can not provide the same medication without nonformulary approval. Here again lies another important point: who has the authority for nonformulary approval? If this authority is in the hands of the behavioral or general managed care component, such approval may not be forthcoming when clinically indicated because the approval process typically is governed by a non-psychiatrist.

Level-of-Service Requirements: The "Urgent and Emergent Care" Dilemma

A number of state governments have seen their responsibility as providing only urgent or emergent healthcare for prison and jail populations, particularly for pre-trial detainees. The National Commission on Correctional Health Care standards⁴

and the American Psychiatric Association guidelines⁵ are reflective of a concept very much like emergency room care rather than urgent and emergent care. This distinction is crucial in contract negotiations and the provision of services because to nonclinicians urgent and emergent care typically means only that care which is absolutely necessary and is intended only to meet the deliberate indifference standard. The argument that correctional facilities are not hospitals does not take into account the population that is typically coming into correctional environments. This population is usually overly represented by individuals who have not had health or mental health care and who may be impoverished and lack good nutritional, hygienic, and other supports. Thus, they require more, not less, attention to their mental health, dental health, and other health-related needs. Those who negotiate "by the numbers" for the state or the contractor are not particularly sensitive to these considerations and require clinical direction to more appropriately estimate the needs of the populations they are receiving.

I have been involved in semantic discussions in which individuals have suggested that the detainee or inmate does not "belong" to the Department until there is some judicial ruling. In my opinion, the detainee or inmate "belongs" to the Department when they are unable to walk out of the door whenever they might choose. This would be very consistent with involuntary commitment of an individual to a mental hospital, and therefore, the responsibility of treatment staff is increased rather than decreased. Should any

of us go to a "quack" on the street, that responsibility is ours as individuals for not appropriately checking out the credentials or qualifications of the person from whom we seek services. Conversely, if we are unable to leave an environment, the responsibility for appropriate and quality services becomes that of those who control the environment rather than solely our own as individuals.

Other Costs Related to Healthcare Finally, there are "hidden costs" that are typically not part of a managed care contract but are borne by the state. These hidden costs are extremely important in the overall management of budget, as well as the designation of service provision.

Staff Qualifications There are contracts that do not require particular practitioner designations for specific services such that masters-level psychologists are responsible for diagnosis and treatment, bachelors-level social workers are responsible for social services with minimal supervision, and general physicians are responsible for involuntary commitment based on mental illness. These are generally not reflective of either the community standard or the best practice of healthcare delivery for individuals with mental illness. Therefore, the classifications of staff providing services must be scrutinized carefully to determine whether the proper level of qualifications are being supplied by the contract or may subsequently be required, necessitating an increase in contractual or state costs.

Hospitalization Many contracts do require the contractors to pay for transfers to general hospitals but do not require the

contractor to pay for transfer to state psychiatric facilities. This practice does not encourage the contractor to utilize medication such as resperidone or olanzapine, which may cost several hundred dollars per month, because the contractor does not have to bear the cost of hospitalization, which may cost several hundred dollars per day. A number of contracts call for the cost of hospitalization to be borne by the state if hospitalization is required within a certain time period, typically 72 hours after intake to a correctional facility. This is a particularly remarkable feature in that it encourages the contractor to identify individuals who may require hospitalization quickly and then to transfer them to a hospital before the burden of payment falls upon the contractor. Careful monitoring of appropriateness of hospitalization is required to assure that this practice is not abused.

Cost of Materials, Supplies, and Overtime Particularly for individuals who may have significant mental illness and are engaged in destructive activities when not stabilized, the costs for destruction of property (usually toilets and/or items that may be destroyed through flooding of tiers or burning of mattresses) are not covered by the contractor. Similarly, overtime costs for officers who may be injured by individuals with active mental illness is not borne by the contractor but by the state. When coupled with the provision of antiquated medication interventions, this cost can become enormous for the state.

Psychotropic Medications This area has perhaps the most immediate impact upon the treatment and management of

individual detainees and inmates. The provision of appropriate psychotropic medications in a timely manner, without extensive administrative review due to nonformulary medication approval requirements, is crucial to any contract negotiations. Substitutions of generic medications, including medications that are not approved for such substitutions (Depakene for Depakote, for example), may be done by pharmacy providers who are not well monitored. Similarly, the provision of "watch take" procedures may be manipulated in such a way as to change the *vehicle* of administration (for example, placing pills in liquids to be taken by inmates, rather than providing medications that come in liquid form but are more costly). Failure to provide all vehicles of administration, including injectable and depot forms, without nonformulary approval is another cost-saving mechanism (although frequently not clinically appropriate) should the original contract not be specific in this regard. Unless addressed in the initial negotiations, the general contractor and pharmacy subcontractor will typically request a contract modification and additional remuneration to provide medications or forms of medications that should have been included in the original contract.

Appropriate "watch take" precautions require participation of staff to provide medication and to observe the proper ingestion by inmates. The practice of providing "blister packs" of a day's medication to inmates with psychiatric disabilities and relying on their judgement for compliance contributes to the hoarding of medications, which may then con-

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tribute to noncompliance by some inmates and trading of medication by others.

Conclusion

The considerations and recommendations represented in this article are reflective of years of experience in state mental health and state correctional facilities. The trend toward privatization of healthcare in such facilities, in the opinion of this author, will only increase. These issues must be addressed by clinicians to appropriately advise their state governments of the apparent short-term monetary savings and the long-term consequences of inappropriate and unknowledgeable contract negotiations and to better

achieve effective and quality managed behavioral healthcare systems in correctional environments.

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