A Useful Management Tool for Understanding Correctional Mental Health Services

by

Robert J. Powitzky, Ph.D.

Corrections has a new challenge. With a proud history of facing formidable challenges such as prison gangs, irrational psychopathic violence, prison litigation, and ever-changing sentencing guidelines, corrections has evolved into a proud profession with the development of sophisticated management tools including management strategies for prison gangs, effective supermax technology/procedures, professional accreditation standards, quantitative custody/security classification systems, and unit-management theory.

The new challenge facing corrections today that will require that same professional ingenuity is the recent phenomenon of a dramatic increase of those persons in correctional care and custody who have some form of mental illness. This phenomenon is a widely accepted fact by professionals working in jails, courts, community corrections, probation, parole, and prisons (Sigurdson, 2000, and Pinta, 2000). However, a void continues to exist for a common sense, useful management tool - a framework - for adequately defining the problems and for engineering solutions related to the management and treatment of persons with mental illness in the correctional setting. Correctional administrators need to know how to efficiently manage their scarce resources in a manner that meets constitutional requirements. Legislators need useful information to make critical decisions for allocating those scarce tax dollars and for development of necessary oversight guidelines. Consumers and advocacy groups need to understand the nature of the problems and what is being done to address those problems. Researchers and academicians need comparable data to formulate and analyze hypotheses.

The purpose of this article is to present such a management tool to address those needs.

We still do not ask useful questions!

Legislators, advocacy groups, fiscal analysts, mental health professionals, and others frequently ask questions about mental health issues that correctional administrators find very difficult - if not impossible - to answer. The reason for the difficulty is the questions are not useful questions. One needs to know how to ask useful questions in order to get useful information. The following are three of the most common examples of frequently asked, ***non-useful*** questions:

1.   **"How many offenders have a serious mental illness?"   OR "What is the prevalence of serious mental illness in your correctional population?"**

     These seemingly straightforward questions ignore the fact that there is no widely accepted operational definition of "serious mental illness." Prevalence studies have included a wide range of definitions from a) those persons with a history of mental health treatment, to b) only those diagnosed with certain mental illnesses, to c) all mental disorders found in Axis I of the Diagnostic and Statistical Manual IV-Revised (DSM-IVR) (Ditton, 1999; Fasel and

Danesh, 2002). Several Courts have joined forces with experts and scholars to develop rational, scholarly definitions of serious mental illness (Cohen, 2000; Cohen, 2002b). In practice, these definitions still leave a wide latitude for interpretation. Also, the most quoted prevalence studies are based on 1996 offender populations, while actual current management information show those studies do not represent the recent increases in the numbers and percentages of mentally ill offenders/inmates. Another problem with these definitions is the fact they typically incorporate the concept of "adjustment to incarceration" in a problematic way. That will be discussed in the following text.

2.   **"How many inmates are diagnosed with having Schizophrenia, Bi-Polar Disorder, Major Depression?"**

What useful information does this question generate? Very little. There can be a wide range of possible management-relevant information within any diagnostic category. For example, one person with Paranoid Schizophrenia may be currently functioning quite well in society, on work release, or in the general correctional setting (witness the movie, A Beautiful Mind), while another with the same diagnosis may require intensive, acute care. In addition, this situation ignores many of the offenders/inmates who require a large percentage of correctional mental health staff resources and time. These include a) the developmentally/cognitively disabled, b) severe personality disorders with psychotic features, and c) co-occurring disorders that defy simple diagnostic categorization.

3.   **"How many inmates/offenders require outpatient, intermediate and acute levels of care?"**

This question is not useful for several reasons. First, another way to get the same answers, if given honestly, would be to ask, "How many beds are available in each level of care?" In other words, this question is too interdependent upon the resources currently available. Another problem with this question is the variation of descriptions of what constitutes each level of care. This prohibits any kind of cross-system analyses. This non-useful question also incorporates the concept of "institutional adjustment," while omitting an assessment of what treatment is needed to prepare the individual to reintegrate ("adjust") into the community when released. An extreme example of the misuse of "institutional adjustment" is evidenced in the recent supermax cases (Cohen, 2002a) where states like California, Wisconsin, and Ohio gradually lost perspective when inmates with mental illnesses were placed in a single isolation cell, which coincidentally eliminated behavioral or "institutional adjustment" problems. More subtle examples can be found in every correctional setting in the country. These include matching an inmate with a nurturing cellmate who guides and protects the ill inmate, or placing the inmate in protective custody or administrative segregation. These strategies merely teach the inmate with mental illness to be institutionalized (i.e., to "adjust") in a correctional setting, not how to live as independently as possible in the community.

What are some useful questions that need to be asked and answered?

The following are useful questions that can be answered using the management information framework proposed in this paper:

1.   **"How do you define your levels of <u>needs</u> for mental health services?"**

2.   **"How many inmates/offenders are there in each of the different levels of mental health service needs?"**

These two questions require a management information paradigm that provides:

- Clear, easy to understand criteria for classification of mental health service needs.
- Information to mental health professionals for tracking and treating their patient caseload.
- Clear, easy to understand language that is useful to the non-mental health corrections professionals.
- Information that can be translated into decisions regarding management of the individual inmates.
- Information that can be utilized in resource allocation.
- Information useful in budget planning and requests.
- Information useful to facility heads in understanding the composition of their individual facility populations.
- Information useful for inter-facility comparison for population management purposes.
- Information that does not violate the federal guidelines on confidentiality of medical information.

3.   **"What are the staffing patterns needed for each level of mental health services?"**

4.   **"What strategic management initiatives, if any, are needed to meet the mental health service needs of your correctional population?"**

5.   **"What are the trends evidenced in the data?"**

6.   **"How do the populations of other facilities within the department compare with each other?"**

7.   **"How does the mental health population of one state system compare to others?"**

8.   **"What are the most effective models for correctional mental health services?"**

<u>A Proposed Management Tool for Correctional Mental Health Services</u>

<u>Introduction</u>

As part of the Oklahoma Department of Corrections' medical services utilization management planning, it was determined a need existed for a mental health classification system that would be useful in strategic management planning. In Oklahoma, the model of correctional mental health services is a "Correctional Team Management Model." This model is based on the fact that no

mental health services can effectively treat an inmate if the other correctional disciplines are not working in harmony. Conversely, correctional managers/administrators can more effectively maintain safety and security if the mental health service providers are working in harmony with them while still providing necessary mental health care. Good correctional management begins with relevant information.

Oklahoma, like most states, has experienced a dramatic decrease in the number of state mental hospital beds in general and the elimination of in secure hospital beds in specific, with insufficient increases in community-based mental health resources. This has in turn resulted in a significant increase of Oklahomans with mental illness being provided care within the criminal justice system. In response, the Oklahoma Department of Corrections (ODOC) administration and Board of Corrections had to dramatically reallocate their scarce resources. Under the scrutiny of a federal court, in 1998, the Board of Corrections and the ODOC, with support from the governor and legislature, implemented intense efforts to meet the constitutionally mandated, medically necessary mental health needs of ODOC inmates. Mr. James Saffle, ODOC Director at the time, recruited Dr. JoAnn Ryan as Chief Medical Officer, and they set in motion the necessary improvement of mental health services as well as other medical services. The current director, Ron J. Ward has continued to support Dr. Ryan in meeting those service needs that are constitutionally required and medically necessary.

In 2000, Dr. JoAnn Ryan, Chief Medical Officer, initiated a utilization management plan for determining the medical service needs of ODOC inmates and for developing a classification system to help meet those needs in the most cost-efficient manner possible by centralizing resources according to the nature and quantity of services required.

In January 2001, the ODOC mental health services staff formed a task force to develop criteria for assessing levels of mental health service needs of the inmate population. Each proposed set of criteria was then submitted at three monthly statewide meetings of ODOC mental health staff for further refinement. Next, a few facilities were asked to do a pilot run using the proposed set of criteria. The criteria that resulted from this process were issued in a narrative paragraph format.

In November 2001, a pilot study was undertaken using the first, narrative-form version of the criteria of the classification levels. The data produced through this process was analyzed, and, with feedback from the professionals, further refinements were made to produce the criteria, presented in Table A, which were utilized in a March 2002 system-wide classification of ODOC inmates in all facilities. The major changes in the final version presented in Table A include: 1) making the wording more operational; 2) highlighting the critical items that distinguish one level from the lower level(s); 3) reinforcing those criteria that must be assessed independently of available resources; and 4) emphasizing the need for treatment that prepares for discharge rather than "institutional adjustment."

TABLE A. Mental Health Service Levels Classification System Criteria

Mental Health Levels ***

_MH-0_
- Inmates who do not fit the following criteria.

MH-A (Able)
- *History: mental health diagnosis/treatment, serious self-injurious behavior and/or suicide attempt/ideation, but not within the past 12 months.
- *Current observation of mild-to-moderate symptoms of mental illness.
- Symptoms may be acute or episodic, not chronic.
- Can be seen on outpatient basis
- Seen on self-referral or staff-referral, not on scheduled monitoring or therapy, or participates in non-prescribed scheduled psycho- educational program or therapy.
- May not currently require psychotropic medication.
- Mild to moderate adjustment problems.

MH-B (Baker)
- *Requires psychotropic medications.
- *Major diagnosis of Psychotic Disorder, Bi-Polar, or Major Depression.
- *Requires scheduled periodic to frequent clinical monitoring. **
- *Requires prescribed, scheduled treatment program or therapy (Which may not include psychotropic medication). **
- *Suicide attempts/ideation within last twelve months and/or current suicide ideation.
- *Self-injurious behavior within the last 12 months.
- Moderate adjustment and/or impulse control problems.
- Can be seen on outpatient basis.

MH-C1 (Charlie 1)
- *Requires special intermediate housing unit with intensive treatment track(s) to be able to adjust to incarceration. **
- *Adjustment dependent upon special arrangements such as administrative overrides/housing. **
- *History of cycling, sporadic or consistent non-compliance with prescribed treatment with resultant behavioral and/or mental deterioration.
- *Requires specialized intensive treatment track(s) and release planning to be able to function upon release to community. **

MH-C2 (Charlie 2)
- *Developmentally disabled and/or significant cognitive deficits
- *Requires special intermediate housing unit with intensive treatment tracks to be able to adjust to incarceration. **
- *Requires specialized intensive treatment track(s) and release planning to be able to function upon release to community. **

MH-D (Delta)
- *Due to mental illness, is a danger to self or others or is grossly impaired in ability for self-care.**
- *Requires 24 hour medical monitoring. **

*   Indicates criteria that distinguishes this level from lesser level.
**   Indicates criteria met independent of resources available.
***   Unless otherwise meets criteria for MH-Levels A-D, this classification excludes inmates seen for intake screening, transfer screening, and required segregated housing assessments.

Note: Criteria without asterisks are given to assist in differentiation from higher levels.

During development and implementation of this system, three major objections or criticisms were expressed. The first was an initial concern that this system was a replacement for the traditional Diagnostic and Statistical Manual, Revised-IV nomenclature and the corollary treatment regimes that professionals are taught in their education and training. In fact this management tool heavily relies on such training and knowledge; moreover, it helps to direct this professional framework in the most effective manner. An example is the MH-C1 criterion item, "History of cycling, sporadic, or consistent non-compliance with prescribed treatment with associated behavioral and/or mental deterioration." This criterion places inmates with a wide range of diagnoses and treatment regimens into one level of mental health service needs, because the time intensity, staffing patterns, and housing issues are similar. However, the specific treatment plan for each inmate meeting that criterion will depend on the diagnosis and treatment regimen provided by the traditional skills and knowledge of the trained clinician.

A second objection is the use of a history of mental health treatment as a criterion for inclusion in MH-A. This criterion was kept for two reasons. First, the most often-quoted prevalence studies used history of mental health treatment as a major criterion in assessing prevalence. Thus, the data collected can be useful in trend analyses, using past prevalence studies with the same criteria. Secondly, since one of the best predictors of future mental health problems is a history of mental health problems, including this inmate on the mental health caseload list as MH-A would seem useful in case of future deterioration.

A third objection actually serves to highlight one characteristic of how this proposed system differs from the traditional mindset of the clinician. Some of the clinicians involved in the testing of the final version of the criteria asked why the more "minor" diagnoses, such as Post Traumatic Stress Disorder, were not placed in MH-A rather than MH-B. We were able to use this as an excellent example of the shift in thinking required for this classification system, because the "service needs" are similar regardless of the type of medication prescribed. We discovered it takes a total of nine staff contacts (or "service units") to process a prescription: from the doctor's order, to the nurse review, to sending the order, and all the steps until the pill is actually delivered. Thus, any diagnosis of a mental illness that requires a prescription is serious enough to warrant a higher level of service.

The validity and reliability of the data collected with these criteria was supported in at least three ways. First, the assignment of mental health levels to inmates at time of intake was analyzed over a six-month period, and these summary data were consistent with the department-wide "snap-shot" reports of the numbers by level during a one-month period. Secondly, a test given at the time of training revealed a significant level of inter-rater reliability. What few mistakes did occur were usually made by classifying the inmate in a lower level of service needs, most frequently assigning a MH-C1 classification to a MH-D inmate. This trend, although not a significant one, reinforced the confidence that the data would err toward more conservative, rather than liberal, estimates of the levels of mental health service needs. Finally, the affirmative reactions of experienced correctional administrators who reviewed the data gave credence that the system was accurate and useful.

As simple as the criteria appear at first glance, experience supports the need for fairly intensive training, which involves teaching the clinician to think in terms of a mental framework different from the commonly accepted disease model of mental health assessment and treatment. In one session, clinicians were given the criteria in writing with little verbal instruction and were asked to rate various scenarios developed by a panel of experts. In the second session, they received item-by-item instructions and discussion, and they again were asked to rate the scenarios. Although both

sessions resulted in significant interrater reliability, the second session showed a significant increase in accuracy. Training is needed because this system is different from the usual disease model in at least two major ways. First, it incorporates both pathology of the inmate and type and intensity of service required. This requires the clinician to think in operational terms in addition to their usual diagnostic nomenclature. It also requires the mental health professional to assess the need for services that would prepare the inmate for reintegration into the community rather than just the inmate's "adjustment" to the particular prison facility. In our training, we found that for many clinicians, especially those with many years of clinical experience, it was difficult to shift their assessment paradigm. We also found newer staff with non-doctorate degrees were statistically less accurate.

For the purposes of this article, Table A presents the suggested generic criteria for use in any correctional system. Each system can then add to these criteria to address the specific needs of that system. For example, ODOC has a policy of random housing assignments that ordinarily requires an understandably detailed list of required steps to obtain an exemption to this policy for an individual inmate. This mental health services classification system allows an assessment of the need for an exemption at the intake assessment. Another refinement has been the distinction between a B1 and B2, which informs the population management personnel where to make facility assignments based on the mental health staffing patterns of different facilities. The future of this system will include even more refinements, such as sub-categories (e.g., suicidal history, self-injurious behavior, dual diagnoses, etc.), always taking care to retain the paradigm's simplicity and utility. Other planned uses include the development of staffing ratios and resource allocations based on the data. Useful trend analyses can now be accurately made and used in planning. In addition to clinical treatment planning, this system can be utilized in refinement of correctional management policy and procedures such as disciplinary procedures, housing/facility assignments, and program planning/assignments.

Finally, Table A should be considered a proposed framework that is a work in progress. It is expected that the generic criteria presented therein will be improved with future refinements in operational definitions and distinctions. It is also expected that each correctional agency will develop innovative ways to make the framework useful to the unique needs of that specific system.

SUMMARY

It is hoped that the correctional mental health services management tool presented in this paper will prove to be as useful to other systems of correctional mental health services as it has been to the Oklahoma Department of Corrections. After reviewing mental health classification systems from other states (including Colorado, New Jersey, Connecticut, Florida, Missouri, Ohio, California, and Texas), it is believed that the proposed levels of correctional mental health services needs classification system differs from existing systems in at least the following ways:

- The incorporation of both psychopathology and levels of mental health services.
- Levels that can be easily incorporated in intake mental health screening and modified as needed during the individuals' incarceration history.
- Criteria stated in specific behavioral and operational terminology.
- Information that can be used by both clinical and lay management correctional professionals without violating medical confidentiality.

- A framework that can be customized to meet the unique needs of the individual correctional agencies while still providing general quantitative data that can be used in national prevalence and comparative research.
- A framework independent of available resources.
- A management tool for fiscal planning and development of effective management strategies.
- Criteria for assessing treatment needs that focus on post-release reintegration rather than institutionalization.

The concept of rehabilitation of the normal offender has been debated without general resolution. We as a society cannot afford the same debate for offenders with mental illnesses or disabilities. We must provide the medically necessary care to help them reintegrate into the community. This proposed management tool with a necessary shift in paradigms should provide a framework for sound, efficient understanding of the magnitude of the problems of mental illness in corrections and for innovative solutions.

REFERENCES

Cohen, F. (2000). <u>The mentally ill inmate and the law</u>. Kingston, New Jersey: Civic Research Institute, Inc.

Cohen, F. (2002a, January/February), Supermax cases and mental health settled: Wisconsin, <u>Correctional mental health report</u>, 4, 1 & 15-16.

Cohen, F. (2002b, July/August), Mental illness defined: Jones 'el II, <u>Correctional mental health report</u>, 4, 17-18 & 32.

Ditton, P. M. (1999,July), Mental health and treatment of inmates and probationers, <u>Bureau of justice statistics special report</u>, NCJRS Pub. No. 174463.

Fazel, S. and Dansh, J. (2002), Serious mental disorder in 23,000 prisoners: A systematic review of 62 surveys, <u>The Lariat Journal</u>, 359.

Pinta, E. R. (2000, March/April), Prison mental disorder rates—what do they mean?, <u>Correctional mental health report</u>, 1, 81 & 91-92.

Sigurdson, C. (2000, December), The mad, the bad, and the abandoned: The mentally ill in jails and prisons, <u>Corrections Today</u>, 70-78.