Title: Creating a mental health care model. (Central New York Psychiatric Center)
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Abstract:

The need for an efficient mental health care system led to the search for a mental health care model that would meet all the public's mental health needs. The Central New York Psychiatric Center was chosen as the mental health care model due to its ability to provide adequate care to inmates and its cost-effective feature. It also provides a complete line of services that could meet inmate needs. The center also features the satellite unit and parole mental health services as part of its outpatient and post-release services.

In 1976, in response to several important class action lawsuits, New York state made a historic decision by enacting legislation that transferred responsibility for the system of prison mental health care from the Department of Correctional Services to the Office of Mental Health (OMH). During the past 17 years, this system has seen dramatic increases in quality, quantity and diversity of mental health services.

The mission of the prison mental health system is clear and concise. Providing high-quality mental health services to prisons will:

* make the prisons safer for everyone who lives in, works in and visits the correctional system;

* reduce the unnecessary extremes of human suffering caused by mental illness; and

* reduce the disabling effects of mental illness so that service recipients can participate more fully in the programs, such as education and work, within each prison.

Community Mental Health Model

The basic premise of this system of care is that prisons are communities. They are places where people live and work together, with a variety of stresses. Some of these stresses are unique to each prison, others are found in most or all facilities, while still others are identical to those found in society at large. Like most communities, prisons include persons with serious mental illnesses who have both ongoing and emergency need for mental health services. Even among the general inmate population, the stresses of life can occasionally cause psychiatric crises that require mental health intervention.

Prior to 1976, New York, like many other states, relied on inpatient care as its primary mode of mental health service delivery. This approach, however, has several critical flaws. First, it limits care to a very small number of seriously mentally ill inmates, allowing little or no care for those left in the prison community. Second, inpatient hospitalization is by far the most expensive type of care, costing nearly $150,000 annually per bed in New York. Third, without mental health services in the prison community, inpatient settings often retain people long after the acute phase of their crisis, thus wasting hospital care because there is no continuity of services in the prison system. Finally, it sets up an adversarial relationship between the hospitals--whether run by corrections or mental health staff--and the prisons, each charging the other with "dumping" unwanted inmates.

No state has adequate resources to meet all of the public's mental health needs, and inmates seem never to be a top priority. It thus becomes imperative to maximize every available treatment dollar. In this light, a basic goal

of the New York system is for all inmates with serious mental health illness or in psychiatric crisis to receive all the help they need, but only the help they need. Just as in the public sector, we have adopted a community mental health model of treatment:

1. There must be a wide array of services, varying in intensity.

2. Services should be individualized, with treatment plans for every recipient on the active caseload.

3. Each person should receive the least costly, least intensive service that meets his or her needs.

4. The service system should extend as far as possible into the (prison) community, giving people mental health support in their environments.

5. The system's goals and procedures should be clear, concise and widely understood by inmates and staff.

To accomplish these goals, New York operates a psychiatric center in Marcy as well as 11 satellite units throughout the state. Since 1977, the Central New York Psychiatric Center (CNYPC), a 191-bed hospital that operates under OMH, has been a fully accredited psychiatric inpatient facility. Although its perimeter security and procedures are as stringent as any maximum security prison, within that perimeter the facility functions as a psychiatric hospital. It serves both inmates and the general public. As in most public mental health systems, stays are intended to be short (median length of stay of less than 40 days), with a focus on stabilization, symptom reduction and the acquisition of skills that will enable patients to cope with their illnesses.

Currently, the treatment philosophy of CNYPC is changing from that of a traditional acute psychiatric treatment model to a rehabilitation/recovery model that stresses the patient's personal investment in his or her own recovery. Patients are helped to learn about their own illnesses, and services are tailored to the needs, preferences and culture of each person. The satellite units operate as the outpatient service of CNYPC. Each satellite unit provides a full range of treatment services to the people who live within its catchment area. All of the satellite units are located within maximum security prisons; however, inmates in lower custody who need crisis services can be moved to satellite units on a temporary basis for assessment or until stabilized.

Satellite Unit Services

The satellite units provide a range of services to each prison cluster. These include screening and referral; crisis beds, with an average stay of less than 10 days; long-term residential treatment units called intermediate care programs; outpatient treatment, which usually includes medication and/or psychotherapy, for those living in the general population; and pre-discharge planning services for inmates about to be released or paroled.

Screening and referral. At New York's reception corrections facilities, satellite units focus on screening and follow-up evaluations of incoming inmates to determine those who are likely to have a high level of need for mental health services during their incarceration.

Reception center corrections staff--usually corrections officers, counselors or nurses--review documents, including presentence reports, to look for histories of mental health treatment, suicide attempts and so on. Anyone with such a history, or who seems confused, distraught or otherwise in distress, is referred to OMH for follow-up evaluation. This system requires a minimal level of training for corrections staff because it uses very low thresholds for referral. Almost any sign of current or past possible mental illness or distress results in referral to the next level of review. Similarly, at any time during an inmate's incarceration, he or she may be referred for evaluation, either by self-referral or referral by inmates or staff members, and for any reason.

After inmates are screened or referred as possible mental health service recipients, OMH staff conduct a follow-up review in the reception centers or satellite units. In most cases, this review results in a face-to-face meeting to discuss whether the inmate needs or wants services and the proposed requirements.

Each inmate is given a mental health service designation, which can change frequently during incarceration. This designation, in part, determines to what institution an inmate is transferred, so that at any given time those inmates most likely to need intensive services will be housed in institutions with satellite units.

Crisis beds. Each satellite unit has a crisis bed capacity of approximately 10 beds. These are for short-term placements that allow inmates to receive treatment aimed at stabilizing crises such as acute psychoses or suicide attempts. Treatment includes medication and verbal crisis-oriented therapy. Inmates also receive activity therapies such as occupational therapy. Once in a crisis bed, the inmate is evaluated to determine if he or she has stabilized (often resulting in transfer to an intermediate care program or the general prison population) or requires inpatient commitment.

Intermediate care programs (residential care). For some inmates, the general prison population can be so stressful that they are in a constant state of crisis. In 1979, New York realized that this group needed a level of service less intensive than crisis beds or inpatient hospital care, but more intensive and supportive than general population outpatient care. The intermediate care programs were created to meet this need. These interagency programs are funded through the DOCS and staffed by corrections counselors, and with clinical staff hired and supervised by OMH. These programs have been shown to reduce significantly the incidence of disruptive behaviors, such as disciplinary write-ups.

Outpatient services. Each satellite unit maintains an outpatient caseload of general population inmates who receive regular treatment, most often medication and/or psychotherapy. This level of treatment is meant to help the inmate live and work within the general prison community. Satellite unit staff provide consultation on all aspects of the prison program and security operations to help maintain a safe and secure environment for all staff and inmates.

Pre-discharge planning services. Several years ago, OMH determined that the weakest part of the service delivery system was the pre-discharge planning services for those inmates preparing for release or parole. Although this weakness was due largely to resource limitations, officials began a concentrated effort to link inmates with serious mental illness to the community's service delivery system upon release from prison. Each satellite unit now has a discharge coordinator who works closely with the Division of Parole and the state and local mental health service network.

Parole Mental Health Services

New York is continuing to develop its post-release services. Current initiatives include the pre-discharge planning process, and negotiations are under way to develop a process of Medicaid review to enable newly discharged parolees to avoid long delays in receiving needed mental health services in the community.

Another new initiative provides intensive case managers devoted exclusively to parolees with mental illness, many of whom have substance abuse disorders. This program, already successful with non-offender populations, is expected to reduce the reliance on crisis-oriented care and is designed to tailor services to the client. Experience shows that this approach significantly improves client participation in treatment. Specially trained parole officers will be assigned to work as a team with several intensive case managers, with progressive sanctions aimed at reducing technical violations by giving parole officers more choices (as opposed to revocation) for responding to episodes of treatment failure.

Mental Health System Problems

One area of constant concern in New York prisons is the special housing unit, especially the disciplinary segregation area. To maintain the safety of the entire prison, inmates with mental illness must also be held accountable to prison rules. However, segregation does not remove their mental health service needs, and for some inmates the experience of segregation is especially difficult because of their mental illness. As one response, several years ago OMH staff began making daily rounds in segregated units to identify inmates whose mental status required more intensive treatment. These inmates may be moved temporarily to treatment settings until they are stabilized.

Another problem, related to limited resources, is the state's inability to provide long-term hospital care for those relatively few inmates whose mental illness is so severe that their cycles between prison and hospital are very short and unproductive. While efforts to support these inmates in the prisons have helped, there are a few for whom longer-term inpatient care seems clearly warranted.

New York's mental health staff serve both individual inmates and the prisons themselves, working collaboratively with prison staff to ensure the best possible care. Like any community, prisons need adequate attention to the mental health needs of their residents in order to function as safe and productive institutions. By working together, with each agency contributing its expertise and respecting the expertise of others, many of the historical turf wars between treatment and security are avoided.

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