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Chronically Mentally Ill Inmates: The Wrong Concept for the Right Services

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In 1980, James and his colleagues published the first empirical prevalence study of psychiatric morbidity among prison inmates (James, Gregory, Jones, & Rundell, 1980). Prior to that landmark study of 246 sentenced felons in Oklahoma, the scant literature on prison mental health was dominated by concerned clinical reflections (Halleck, 1967) and rare empirical forays (Toch, 1975), all of which concluded that (a) many prisoners were in need of mental health intervention, (b) this group was a grossly underserved population, and (c) the mental health professions ought to be doing something to alleviate their suffering.

At approximately the same time as the James study, the legal system was in ferment with landmark litigation establishing a right to mental health services for prison inmates, by applying the "necessaries" doctrine of Anglo-American common law to the eighth amendment prohibition against cruel and unusual punishment. This doctrine asserts that when a person is taken prisoner, the jurisdiction owes that person necessities such as food, clothing, shelter, and medical care for the course of that incarceration. In 1976, the United States Supreme Court in *Estelle v. Gamble* (1976) established a right to treatment for prison inmates, at least for serious medical ailments, and adopted deliberate indifference as the minimal Constitutional standard for providing medical care in prison. One year later, in *Bowring v. Godwin* (1977), psychiatric and psychological services were held to be as "necessary" as other medical services (see Cohen, 1985).

As some empirical work was beginning to appear and while important legal decisions were emerging, prison populations in the U.S. were exploding. In the 15 years between 1971 and 1986, the number of inmates in U.S. state and federal prisons increased by 176% from 198,061 to 546,659. The two largest annual increases in the 60-year history of the Bureau of Justice Statistics National Prison Statistics Program occurred in 1982 and in 1986. As these dramatic increases were occurring, the pressures they were producing were evident in many forms, up to and including prison riots. In Texas, for example, from

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1968–1978, the prison population doubled while housing increased only 30%. The resultant crowding was associated with increased rates of suicide, violent deaths, and disciplinary incidents (McCain, Cox, & Paulus, 1980).

Armed with new case law and faced with burgeoning prison populations, mental health professionals began to be called upon more and more frequently to respond to prison management problems. As they answered these calls in small numbers, questions began to be posed as to how many were needed, what services they should be providing, and how much they were going to cost. These issues were, and are, often couched in terms of "How many chronically mentally ill people do we have and what do we need to do to minimally meet their needs?"

That the question of the mental health service needs of prison inmates would become framed in terms of the "chronically mentally ill" reflects the transfer to the corrections environment of one of the core concepts in the generic mental health planning literature that emerged in the post-deinstitutionalization era in the U.S.

Debates about the ultimate wisdom of deinstitutionalization have focused heavily on "the chronically mentally ill" as its victims. In order to focus community-based services on those most in need, planners of community mental health services increasingly relied on the concept of the chronically mentally ill (CMI) to target scarce public mental health services (U.S. Department of Health and Human Services, 1981). It is crucial to understand that this designation of a person as "chronically mentally ill" is predominantly based on a *history* of mental illness, usually indicated by a long history of inpatient treatment in public mental hospitals. More recently, it was expanded to include simply a long history of disturbed behavior, but in neither case did the designation reflect anything about the current needs of the person.

As a result of the centrality of the CMI concept in mental health planning, many of the community services that were developed in the 1970s and 1980s were static and inflexible. While the needs of the person suffering from mental illness may have changed frequently, and while those grouped as CMI included a clinically heterogeneous collection of people, the services developed tended to be "pre-packaged." They were put in place and it was up to the client to fit into the program. Then, when clients proved reluctant to participate, there were labeled as "treatment resistant." Only lately have these ideas begun to be reshaped in the general mental health arena. Currently, the trend is toward development of programs which are more responsive and acceptable to patients, according to their own perceived needs (Surles & McGurrin, 1987).

Unfortunately, no such reshaping has yet found its way into programs for mentally ill inmates. In fact, only lately, as its limited utility in the broader community was becoming apparent, has the concept of CMI found its way into correctional mental health programs. And, as we will see below, this concept is even more inappropriate for planning mental health services in prisons and jails than it is in the generic public mental health system.

The major problem for the concept of "chronicity" in the prison is that since the history of mental illness that is used to define someone as "chronic" usually occurred in the community or in state psychiatric centers, there is no reason to assume that the person would have the same strengths *or* weaknesses while

incarcerated. For example, some mentally ill individuals have a great deal of trouble managing the essentials of life in an unstructured community setting. They have difficulty arranging for rent, food stamps, entitlements, transportation, and so on. They have trouble avoiding nuisance or even criminal behavior during unstructured leisure time; and since they have trouble finding and keeping jobs, they often have nothing *but* leisure time. Yet none of the above problems occur in prison. Food, clothing, shelter, and structure are provided to all inmates.

At the same time, mentally ill inmates tend to encounter a whole range of brand new problems in prison, to which they may be especially susceptible due to their mental illness. Examples here include such things as predatory inmates, avoiding disciplinary infractions, visits, and authority problems. What all this points to is the need to more aggressively pursue the research and planning directions James and his colleagues took in their 1980 article; that is, to develop a current picture of inmate dysfunction from which appropriate services can be developed. This does not mean simply measuring the distribution of DSM-III-R diagnoses among a population of inmates. What it does mean is creating an in-depth behaviorally based profile of what makes an inmate unable to function in prison, and then determining what services are required to address these deficits.

In the next section, we describe New York's approach to these problems, an approach which has proven useful in planning for services there and which focuses not on a history of hospitalization but rather on the current clinical needs of inmates in the prisons in which they live.

Overview of NYS Approach

Since 1977, mental health services to incarcerated felons in the state of New York have been provided by the State Office of Mental Health (OMH). These services include a fully accredited free-standing psychiatric center, as well as a unique system of "community (prison) mental health centers" within 15 of the state's large prisons. Obviously, as a "tenant" of these prisons, the OMH relies on the cooperation of the State Department of Correctional Services (DOCS), which bears the ultimate responsibility for the more than 50,000 sentenced felons in New York.

There are three core principles upon which OMH prison mental health services in New York State have been based: (a) To mitigate the disabling effects of psychiatric illness which prevent inmates from fully participating in the positive aspects of the correctional environment (e.g. educational and vocational programs); (b) to relieve the unnecessary extremes of human suffering; and (c) to help make the prison a safer place for both inmates and staff.

These principles are founded on the belief that no mental health program in prison is likely to directly cause an inmate to stop recidivating upon eventual release, but the *absence* of necessary treatment could preclude the inmate from learning the skills necessary to carry out a personal decision to change lifestyle. Each principle is focused on current situations. While an inmate's psychiatric history may be one predictor of how he or she may handle the rigors of prison life, it is certainly not dispositive. In planning services to meet the mission that

is articulated by the above principles, it is necessary to have data on just what disabilities and distresses currently exist among the inmate population in their actual environments.

In the absence of reliable data of current disabilities, a number of myths are impossible to contradict. For example, in reviewing OMH budget proposals to expand prison mental health services, officials of state regulatory agencies suggested that the frequency of findings of incompetence to stand trial would effectively serve as a screen to prevent the majority of seriously mentally ill defendants from being sentenced to prison. OMH responded by explaining that the low threshold required to establish competency to stand trial was one which could often be met by seriously mentally ill defendants; but there were no data to support or refute this claim. The regulatory agencies also argued that what little data did exist had limited applicability to New York, where the prison mental health system was more extensive than in other states. Again, OMH had only anecdotal data to offer in response. Finally, it was suggested that since the mentally ill in prison were already "institutionalized," there was little need for specialized mental health services. The implication was that the only compelling needs of mentally ill persons were for food and housing, needs which were automatically met by the prison itself. In order to effectively refute these and other hypotheses, data on the functional and behavioral consequences of mental illness in prison would be necessary.

Thus, it became clear that in order to succeed in lobbying both within OMH and with state regulatory agencies such as the Governor's Division of the Budget, the Bureau of Forensic Services would need to develop data not merely on the prevalence of mental illness in prison, but also on the functional disabilities that were precluding these inmates from successfully handling even this highly controlled environment.

Method

The details of the methods we employed are reported elsewhere (Steadman, Fabisiak, Dvoskin, & Holohean, 1987). Here we will give just an overview of the approach, highlight some key findings, and show the weakness of the CMI concept in planning mental health services for the prison environment.

Surveys were completed by prison staff in May 1986 for a 9.4% sample of the 36,144 inmates in the New York State prison system at that time. In addition to a randomly selected sample from the general population, we surveyed all of the inmates who were living in special mental health units. We then weighted the data in order to achieve an accurate representation of the total prison population. A three-part form was completed for each of the 3684 sampled inmates. The first part was completed by prison health care staff to document physical problems that had been treated. The second part was the core assessment tool that was completed by correctional counselors. This portion comprised a wide range of behavioral items focusing on inmates' behavior in the last 30 days. These items were adapted from a survey form used in New York State psychiatric centers for periodic surveys that had been developed from the Nurses Observation Survey for Inpatient Evaluation (NOSIE) (Honigfeld, Gillis, & Klett, 1966).

The third survey component was completed by mental health service staff on those inmates who had received any mental health services in the prior year. These data allowed careful analysis of both functional deficits that would require intervention as well as service utilization patterns.

Results

The data displayed in Figure 1 represent our major conclusions about the distribution of psychiatric disorder that produce dysfunctional behavior in prisons.

Our assessment was that 5% of the 36,144 inmates were severely psychiatrically disabled and another 10% were significantly psychiatrically disabled. In addition to measures of psychiatric disability, we also had indicators of functional disability (e.g., personal appearance, stealing, hoarding). While the data do not allow a clear interpretation of the underlying causes of these functional disabilities, such causes likely include retardation and other developmental disabilities, head injuries, and mental illness. When the functionally disabled inmates are added to those with psychiatric disabilities, we found a total of 8% with severe disabilities and 16% with significant disability. This group, numbering nearly one-quarter of all the prison inmates, would seem to be those for whom some sort of mental health services are indicated.

Service Planning Applications

Given that these summary measures of disability can be broken down into component subscales such as depression, confusion, disrupton-agitation, social affect, personal appearance, and stealing/hoarding, and even into individual items, this type of data allows precise estimates of the size of any group to be targeted for services. For example, if a program were to be designed for inmates who have been violent in the past 30 days, who had psychotic symptoms complicated by reduced social affect, who were under 35 years of age, and who had a remaining sentence of six months or more, our data set could determine how many of such inmates were in the prison system. With this need estimate, plus projected lengths of stay for the hypothetical inpatient program, the number of beds or service units required to meet the needs could be accurately assessed. Further, the geographic areas in which these needs might be greatest could also be determined.

The value of such specific information about the characteristics of inmates in need of mental health care is not limited to planning services. In defending litigation, such information can be crucial. For example, in *Wellman v. Faulkner* (1983), the court ruled that "an impenetrable language barrier between doctor and patient can readily lead to misdiagnoses and therefore unnecessary pain and suffering" (p. 272). As a follow-up to our needs assessment survey, we looked at service utilization patterns among severely disabled prisoners (Steadman, Dvoskin, & Holohean, 1989). We found that blacks and hispanics were, in fact, significantly underserved. In response, the Bureau of Forensic Services began an aggressive new recruitment campaign aimed at minority clinicians, plus Spanish language training for existing staff within the OMH prison

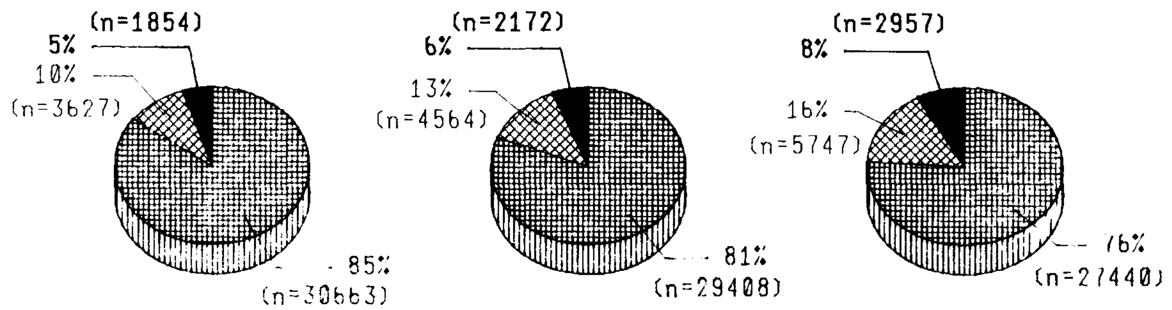

FIGURE 1. Extent of psychiatric and functional disability in the New York State prison population.

mental health units, and cultural sensitivity training of satellite unit chiefs. Thus, if challenged in court, OMH would be able to document efforts to identify and alleviate gaps in service.

None of the potential planning applications rely in any way on the concept of chronic mental illness. At issue is the current functioning of an inmate in the prison. If that functioning is compromised by psychiatric symptomatology, then some type of mental health intervention is called for. Whether the person has a long or recent history of mental hospitalization is but one factor to be considered in developing an individualized treatment plan. However, when the issue is planning for an entire system's needs, the single factor of chronicity has little utility. From the inmate's perspective of doing his or her time as humanely as possible and from the correctional staff's (front line officers or upper level administrators) perspective, the dominant concern is what dysfunctional, disruptive behavior is currently being displayed and what intervention is suggested for its amelioration. The approach we have recently taken to measuring these disabilities would seem to be responsive to both of these sets of needs.

As New York's Office of Mental Health and Department of Correctional Services collaboratively plan to meet the service needs of our continually expanding prison population, the data from the survey described as well as other studies currently in progress will allow us to continue to shape a prison mental health system which is true to its mission and is responsive to the needs of inmates and administrators alike.

Discussion

Obviously, one yardstick that any state must use in planning its mental health service delivery system within the prison system is the likely ability of that system to withstand hostile litigation. Such litigation will focus on the state's constitutional duty not to impose cruel and unusual punishment as well as its attention or inattention to the observable consequences of mental illness. In this article, we have argued that a history of chronicity, while perhaps relevant for individual treatment plans, is infinitely less important for system-wide program planning than a clear picture of *current* disability and its consequences.

This approach to planning and resource acquisition has already proven successful, resulting in significant increases in the prison mental health service delivery system in New York. As New York's prison population continues to grow, these data will continue to be useful in justifying the necessary corresponding growth in mental health resources. Similar principles will be applied to planning services for parolees. Research is already in the planning stages that will assess the specific service needs of mentally ill parolees in New York, as well as the extent to which they are able to access the existing mental health system.

In planning services, the kinds and numbers of programs and professionals are most effectively developed when they are based on accurate data on the current needs of the population at risk. The approach we used in New York State appears to meet these planning needs and seems to have very general applicability to federal, state, municipal, and county correctional and mental health systems.

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