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MONITORING THE QUALITY AND UTILIZATION OF MENTAL HEALTH SERVICES IN CORRECTIONAL FACILITIES

Clarence J. Sundram, J.D.*

INTRODUCTION

Explosive growth in the population of seriously mentally ill inmates in prisons has created new demands for mental health services. Increased public expenditures for such services require increased accountability. This article identifies essential elements of an adequate system of mental health care in a correctional environment. It describes the common areas of vulnerability when the adequacy of correctional mental health services is challenged in court. It proffers several arguments in favor of a proactive program of monitoring the adequacy of mental health services in correctional facilities. Finally, the paper suggests specific areas and methods for monitoring both by internal quality assurance or quality improvement programs and by external bodies, including court-monitoring bodies.

Much has been written about the dramatic transformation of correctional institutions housing a rapidly growing population of inmates with serious mental illnesses and other mental disorders. This transformation has been traced to a number of changes in laws, policies, and practices of public mental health systems regarding civil commitment, a significant reduction in bed capacity in state psychiatric hospitals, and lack of adequate development of a range of community support programs.[1] Another contributing factor is the rapid rise in the overall prison population and concomitant overcrowding, which increases tensions in prisons and causes more mental illnesses than previously existed.[2] Recent studies suggest that 6 percent to 15 percent of persons in city and county jails and 10 percent to 15 percent of persons in state prisons have severe mental illness.[3] Another 15 percent to 20 percent will require some psychiatric intervention during

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1 E. Fuller Torrey, *Editorial: Jails and Prisons—America's New Mental Hospitals*, 85 AM. J. OF PUB. HEALTH 1611-13 (1995); H. Richard Lamb & Linda E. Weinberger, *Persons with Severe Mental Illness in Jails and Prisons*, 49 PSYCHIATRIC SERVICES 4 (1998); E. FULLER TORREY ET AL., CRIMINALIZING THE SERIOUSLY MENTALLY ILL: THE ABUSE OF JAILS AS MENTAL HOSPITALS (Public Citizen Health Research Group, 1992).

2 TERRANCE THORNBERRY ET AL., OVERCROWDING IN AMERICAN PRISONS: POLICY IMPLICATIONS OF DOUBLE-BUNKING SINGLE CELLS (1982).

3 Richard L. Elliott, *Evaluating The Quality Of Correctional Mental Health Services: An Approach To Surveying A Correctional Mental Health System*, 15 BEHAV. SCI. & L. 427-39 (1997).

their term of confinement.[4] Female inmates display symptoms of serious mental illness in significantly higher proportion than males.[5]

The changing population in prisons and jails creates a dramatically different mission for these institutions, one that they have been historically ill-prepared to implement. Penal institutions typically have not had the physical facilities, staff, training, and clinical resources to meet the needs of the seriously mentally ill population they are currently called upon to serve. Yet the courts have made it abundantly clear that these institutions are legally and constitutionally required to develop a capacity to provide adequate mental health services for the inmates in their custody.[6] More precisely, they cannot be "deliberately indifferent" to "serious medical needs" of inmates, including the need for mental health treatment.[7] In meeting these needs, institutions cannot rely on psychotropic medications alone, but need to develop a full range of mental health services to meet the foreseeable needs of the seriously mentally ill inmates in their custody.[8]

To aid in implementing appropriate services, a number of professional organizations have promulgated standards and guidelines describing the critical elements of professionally adequate mental health services in correctional facilities. Organizations which have published standards for mental health services include the American Psychiatric Association,[9] the American Public Health Association,[10] the American Correctional Association,[11] the National Commission on Correctional Health Care,[12] the American Bar Association[13] and the United Na-

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4 Jeffrey L. Metzner, *Guidelines for Psychiatric Services in Prison*, 3 CRIM. BEHAV. & MENTAL HEALTH 252-67 (1993).

5 Henry J. Steadman, *Estimating Mental Health Needs and Service Utilization among Prison Inmates*, 19 BULL. AM. ACAD. PSYCHIATRY & L. 297-307 (1991).

6 Estelle v. Gamble, 429 U.S. 97 (1976).

7 Farmer v. Brennan, 511 U.S. 825 (1994).

8 Madrid v. Gomez, 889 F. Supp. 1146, 1218 (N.D. Cal. 1995); Balla v. Idaho State Bd. of Corr., 595 F. Supp. 1558 (D. Idaho 1984); Casey v. Lewis, 834 F. Supp. 1477 (D. Ariz. 1993); Cody v. Hillard, 599 F. Supp. 1025 (D.S.D. 1984), *aff'd in part, rev'd in part*, 830 F.2d 912 (8th Cir. 1987); Langley v. Coughlin, 715 F. Supp. 522 (S.D.N.Y. 1989), *aff'd*, 888 F.2d 252 (2d Cir. 1989).

9 AMERICAN PSYCHIATRIC ASSOCIATION, GUIDELINES FOR PSYCHIATRIC SERVICES IN JAILS AND PRISONS (Psychiatric Services, Jails And Prisons Task Force Report No. 29, 1989) [hereinafter APA GUIDELINES].

10 AMERICAN PUBLIC HEALTH ASSOCIATION, STANDARDS FOR HEALTH SERVICES IN CORRECTIONAL INSTITUTIONS (1986) [hereinafter APHA STANDARDS].

11 AMERICAN CORRECTIONAL ASSOCIATION & COMMISSION ON ACCREDITATION FOR CORRECTIONS, STANDARDS FOR ADULT CORRECTIONAL INSTITUTIONS (3d ed. 1990) [hereinafter ACA STANDARDS].

12 NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE, POSITION STATEMENT: MENTAL HEALTH SERVICES IN CORRECTIONAL SETTINGS (1992) [hereinafter NCCH POSITION STATEMENT]; STANDARDS FOR HEALTH SERVICES IN PRISONS (1997).

13 AMERICAN BAR ASSOCIATION, CRIMINAL JUSTICE MENTAL HEALTH STANDARDS (1984) (hereinafter ABA STANDARDS).

tions.[14] Standards have also been promulgated for federal correctional facilities.[15] The key provisions of these standards and guidelines, as well as several others, are summarized in a very useful manual by the Advocacy Training/Technical Assistance Center.[16]

A general caveat applies to the statements in this paper. Correctional facilities vary greatly in their size, mix of inmates, the scope of the mental health programs they deliver, average length of an inmate's stay, and specific mission. The state laws, policies, and regulations governing psychiatric care differ in significant respects in different jurisdictions.[17] Thus, the suggestions that follow should be viewed as a menu from which correctional officials and others can select items appropriate to their programs, regulatory environment, and needs.

I. An Adequate System of Correctional Mental Health Services

Professor Jeffrey L. Metzner has identified the following six types of services that an adequate system of mental health care must provide:

- Crisis intervention for short-term treatment, usually in an infirmary for less than ten days;
- Acute care, usually in an inpatient, hospital-type facility;
- Chronic care, including special needs housing for those unable to function in the general population but not needing hospitalization;
- Outpatient services;
- Consultation; and
- Discharge/transfer planning.[18]

Viewed from the perspective of the judicial system, Professor Fred Cohen has distilled the core elements of a mental health program that meets constitutional requirements[19] to include at least the following six components identified in the landmark case of *Ruiz v. Estelle*:[20]

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14 Standard Minimum Rules for the Treatment of Prisoners: *Resolution of the First United Nations Conference on the Prevention of Crime and the Treatment of Offenders*, E.S.C. Res. 663C, U.N. ESCOR, 24th Sess., Supp. No. 1, at 11, U.N. Doc. A/Conf/611 (1955), amended by E.S.C. Res. 2076, U.N. ESCOR, 62nd Sess., Supp. No. 1, at 35, U.N. Doc. E/5988 (1977).

15 United States Department of Justice, Federal Standards for Prisons and Jails (1980) [hereinafter Federal Standards].

16 Advocacy Training/Technical Assistance Center, Mental Health Services in Prisons and Jails (1998).

17 Ira K. Packer, *Privatized Managed-Care and Forensic Mental Health Services*, 26 J. Am. Acad. Psychiatry & L. 123-29 (1998).

18 Jeffrey L. Metzner, *An Introduction to Correctional Psychiatry, Part III*, 26 J. Am. Acad. Psychiatry & L. 107-15 (1998).

19 Fred Cohen, The Mentally Disordered Inmate and the Law 2-8 (Civic Research Institute ed., 1998).

20 503 F. Supp. 1265 (S.D. Tex. 1980), *aff'd in part* and *rev'd in part*, 679 F.2d 1115 (5th Cir. 1982).

- A systematic program for screening and evaluating inmates in order to identify those who require mental health treatment:
- Treatment that is more than simply segregating and closely supervising inmate patients;
- Trained mental health professionals, in sufficient numbers to identify and treat in an individualized manner those inmates suffering from treatable serious mental disorders;
- Complete, accurate and confidential records of the mental health treatment provided;
- Prescription and administration of psychotropic medications by qualified staff in a manner that complies with prevailing professional standards; and
- A program for identification, treatment and supervision of inmates with suicidal tendencies.

There is no general constitutional right to recreational, vocational or rehabilitative programs in prison.[21] Courts that have reviewed the adequacy of correctional mental health programs, however, have found several types of programs to be essential, including access to inpatient and outpatient mental health treatment, suicide prevention programs, and individual and group therapy programs to address issues such as anger control and stress management. The purposes of such forms of treatment, along with access to psychotropic medications, include stabilizing the symptoms of mental illness, relieving suffering, and providing inmates with the tools to cope with their mental illness in the prison environment.

II. MOST COMMONLY FOUND PROBLEMS IN CORRECTIONAL MENTAL HEALTH PROGRAMS

The most common problems in the delivery of mental health services identified by courts and studies of various correctional systems fall into three categories: diagnosis, treatment, and record-keeping.

1. Diagnosis: Identifying and responding to indications of mental illness

A number of courts have recognized the following situations or incidents as indicating problems in diagnosing mental illness among inmates:

- The failure to diagnose a serious mental condition upon intake;[22]
- The failure to respond to a known psychiatric history upon intake;[23]

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21 Madrid v. Gomez, 503 F. Supp. 1265, 1262 (N.D. Cal. 1995).

22 *See, e.g.,* Coleman v. Wilson, 912 F. Supp. 1282 (E.D. Cal. 1995); *see also* Madrid v. Gomez, 889 F. Supp. 1146, 1218 (N.D. Cal. 1995); Balla v. Idaho State Bd. of Corr., 595 F. Supp. 1558 (D. Idaho 1984); *Casey*, 834 F. Supp. 1447; *Cody*, 599 F. Supp. 1025; Langley v. Coughlin, 715 F. Supp. 522 (S.D.N.Y. 1989), *aff'd*, 888 F.2d 252 (2d Cir. 1989); *Ruiz*, 503 F. Supp. 1265; Dunn v. Voinovich, No. CI-93-0166 (S.D. Ohio 1995) (consent decree on file with author) discussed in FRED COHEN, THE MENTALLY DISORDERED INMATE AND THE LAW, *supra* note 19, at 7-39-7-41.

23 *See, e.g., Langley*, 715 F .Supp. 522.

- Finding persons with untreated mental illness in segregation or on disciplinary status;[24]
- The failure to respond to bizarre behavior and consider a diagnosis of mental illness;[25]
- The failure to train corrections officers in recognizing the signs of serious mental illness;[26]

Clearly, identification of prisoners' mental illnesses is but the first step. Diagnosis simply lays the foundation for the next obligation, which is to provide access to timely, adequate, and appropriate treatment.

2. Treatment: Access to timely, adequate and appropriate treatment

Among the aspects of mental health treatment which the courts have found to be constitutionally inadequate are the following:

- The lack of mental health treatment other than medications;[27]
- The use of medications without adequate professional involvement and monitoring;[28]
- The failure to provide for involuntary administration of psychotropic medications when clinically indicated;[29]
- The lack of access to mental health professionals in a crisis, or in sufficient numbers to provide treatment to the treatable inmates with serious mental disorders;[30]
- The failure to have an adequate program of suicide prevention;[31] and
- Prolonged delays in access to treatment, during which the inmate's condition substantially deteriorates or the inmate experiences needless suffering.[32]

3. Record keeping: Adequate and reliable record keeping

In all institutions, responsibility for medical and mental health treatment is shared by many professional and paraprofessional staff members, across three

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24 *Id.; see also Madrid*, 503 F. Supp. 1265; *Coleman*, 912 F. Supp. 1282; Dunn v. Voinovich, *supra* note 22.

25 *See, e.g., Langley*, 715 F. Supp. 522; JAMES R. P. OGLOFF ET AL, *Screening, Assessment and Identification of Services for Mentally Ill Offenders, in* MENTAL ILLNESS IN AMERICA'S PRISONS 61, 64 (Henry J. Steadman & Joseph J. Coccozza eds. 1993).

26 *See, e.g., Coleman*, 912 F. Supp. 1282.

27 *See, e.g.,* note 8 *supra.*

28 *See, e.g.,* Lightfoot v. Walker, 486 F. Supp. 504 (S.D. Ill. 1980); *see also Madrid*, 503 F. Supp. 1265; *Coleman*, 912 F. Supp. 1282; *Casey,* 834 F. Supp. 1477.

29 *See, e.g., Madrid*, 503 F. Supp. 1265; *Coleman*, 912 F. Supp. 1282.

30 *Id.*; *see also* Balla v. Idaho State Bd. of Corr., 595 F. Supp. 1558 (D. Idaho 1984); *Ruiz*, 503 F. Supp. 1265; *Lightfoot*, 486 F. Supp. 504.

31 *See, e.g.,* FRED COHEN, LIABILITY FOR CUSTODIAL SUICIDE: THE INFORMATION BASE REQUIREMENTS (Jail Suicide Update no. 4, 1-11, 1992).

32 *See, e.g., Madrid*, 503 F. Supp. 1265; *Coleman*, 912 F. Supp. 1282.

shifts daily. Thus, record keeping is an essential component of the system of care to ensure that all responsible persons have access to necessary information. Problems with record keeping include:

- The failure to keep adequate records of medical and mental health treatment;[33]
- The lack of continuity of care;[34]
- The failure to communicate essential information between mental health staff and corrections officers;[35]
- The failure to transfer necessary information about inmates' mental health needs and prescriptions upon transfer to a new institution or residential setting;[36] and
- The failure to make adequate provisions for treatment and care upon discharge.[37]

III WHY EXAMINE CORRECTIONAL MENTAL HEALTH SERVICES?

State and local governments have sharply increased expenditures for mental health services in correctional facilities over the last few years. This expansion of governmental responsibilities and expenditures for services inevitably and correctly creates concern over the manner in which public funds are being spent. Whether the services are delivered by employees of a correctional facility, by contract with a governmental mental health agency or with a private entity, the rise in expenditures brings heightened attention to the results or outcomes produced by these expenditures. Government managers and leaders must be conscious of the environment of accountability that now permeates government service systems.[38]

The sharp rise in governmental expenditures for correctional mental health services is a function of combined pressures. One source of pressure is class action lawsuits – filed in about half the states – challenging the adequacy of mental health services in correctional facilities. Another source of pressure on state and local governments is individual damage actions brought when inmates suffer serious harm due to lack of treatment. A third source of pressure is the weight of professional opinion as represented in the standards and guidelines promulgated by various professional organizations.

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33 *Id.*; *see also Ruiz*, 503 F. Supp. 1265; *Cody*, 599 F. Supp. 1025; *Langley*, 715 F. Supp. 522.

34 *See, e.g.*, Burks v. Teasdale, 492 F. Supp. 650, 676 (W.D. Mo. 1980); *See also* Consent Decree, Dunn v. Voinovich, *supra* note 22; APA GUIDELINES § D.4.b (2).

35 *See, e.g.*, NCCH POSITION STATEMENT, P-53 at 68.

36 *See, e.g.*, Arnold v. Lewis, 803 F. Supp. 246 (D. Ariz. 1992); *see also Madrid*, 503 F. Supp. 1265; *Coleman*, 912 F. Supp. 1282.

37 APA GUIDELINES § D.4.b (1)(2).

38 DAVID OSBORNE & TED A. GAEBLER, REINVENTING GOVERNMENT (1992).

Correctional institutions are unlikely to be targets of class action institutional reform lawsuits if they have identified critical mental health needs, organized their resources to meet their legal obligations, and developed reliable methods of monitoring to identify and correct any deficiencies that occur. The more clearly it can be demonstrated that a service system recognizes its legal obligations and has a process for internal monitoring of its compliance with such obligations, the less often courts will find it necessary to intervene.[39] Even if they do, the scope of the intervention is likely to be narrower and less intrusive. Conversely, the failure to monitor effectively often leads to seriously deficient conditions, which in turn has led to major class actions over conditions. Class action lawsuits severely tax judicial resources during the litigation phase, as well as during judicial supervision of long-term implementation of remedial measures. Having a system of monitoring may help to identify and correct service problems before they become legal problems. Furthermore, if the system is already involved in litigation over the adequacy of mental health services, a court will usually require the implementation of such a monitoring system as a condition for termination of judicial supervision.[40]

Quality assurance programs are recommended by many of the standard-setting professional organizations, and these professional opinions urging the adoption of some organized method of monitoring mental health services are making their way into judicial opinions. For example, the APA principles state:

> Each facility or each administrative authority should have prepared a quality assurance plan that describes the mission and goals of the mental health services delivery system, the means by which these goals are to be achieved, and the means of evaluation of these objectives.[41]

In two cases involving the California prison system, the courts made pointed reference to the absence of functioning quality assurance programs. In *Madrid v. Gomez,* the district court clarified the functions of these programs:

> [A] Quality Assurance program is designed to enable a medical institution or department to review, on an ongoing basis, staff medical decisions and practices in order to assess whether corrective measures are necessary or appropriate. Such a program is considered 'standard practice' in virtually every health care facility in the country and is considered a 'fundamental part' of a health care operation . . . . Failure to institute quality control

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39 Association for Retarded Citizens of N. D. v. Schafer, 872 F. Supp. 689, 709 (D.N.D. 1995).

40 *See* Joseph A. v. New Mexico Dep't of Human Services, 69 F.3d 1081 (10th Cir. 1995); Powell v. Coughlin, 953 F. 2d 744 (2d Cir. 1991); Celestineo v. Singletary, 147 F.R.D. 258 (M.D. Fla. 1993).

41 APA GUIDELINES, § B.2. a

procedures has had predictable consequences: grossly inadequate care is neither disciplined nor redressed.[42]

In *Coleman v. Wilson*, the court found the absence of a quality assurance program to be evidence of "deliberate indifference" to the inmates' need for mental health services, and stated that "the development of a quality assurance program is an appropriate remedy for constitutional deficiencies in the delivery of prison health care."[43] The next part describes and analyses the elements of a quality assurance program.

IV. RECOMMENDATIONS FOR MONITORING THE ADEQUACY OF MENTAL HEALTH SERVICES IN A CORRECTIONAL SYSTEM

In designing a monitoring process, it is useful to separate the structural aspects of a system from its actual performance in achieving the desired outcomes for mentally disordered inmates. A determination of adequacy requires a consideration of four distinct areas of structure and outcome assessment:

- Policies and procedures;
- People — adequate numbers of staff with appropriate qualifications;
- Places — adequate space for programs and housing; and
- Performance — how people implement the policies and procedures and utilize the available resources to deliver timely, appropriate and quality services.

The first three areas are all structural. They reveal whether the conditions exist that would permit delivery of timely, adequate, and appropriate mental health services, but not whether such services are actually being provided. In the substantial absence of these conditions, however, one can reasonably conclude that the facility is unlikely to be able to deliver timely, adequate, and appropriate mental health services. The last area, performance, requires a more direct examination of the actual delivery of mental health services to inmates with serious mental disorders.

A. *Structural Issues*

The following are the three specific types of structural issues to be considered: Policies and procedure, people, and places.

1. Policies & Procedures

Adopting and implementing essential policies and procedures creates a framework to guide staff in implementing a mental health program. These policies and procedures should be comprehensive enough to give specific guidance to staff

42 889 F. Supp. at 1209.

43 *Coleman*, 912 F. Supp. at 1308.

regarding the issues addressed by the policy in question. Of course, it is essential that staff be adequately trained to properly implement the policies. The following list of basic policies is drawn from a comprehensive consent decree in the case of *Dunn v. Voinovich.*[44] It includes:

1. Mental health screening by trained staff[45] to identify inmates with possible mental health problems for further evaluation and linkage to treatment if needed;[46]
2. Mental health classification to identify inmates for different levels of service and security;[47]
3. Mental health services orientation for inmates,[48] in a language they can understand, to make them aware of how to access mental health services;
4. Treatment planning and delivery which addresses the need for individualized treatment plans and services;[49]
5. Medication prescription and administration,[50] including informed consent;[51]
6. Involuntary medication for inmates with serious mental illness who pose a danger to themselves or others;[52]
7. Suicide prevention;[53]
8. Physical restraints and seclusion/isolation;[54]
9. Segregation rounds by mental health professionals to check on the condition of inmates who may display symptoms of mental disorders in segregation units;[55]
10. Record-keeping, including confidentiality of medical and mental health records and information;[56]

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44 *See supra* note 22.

45 ACA STANDARDS §§ 3-4345, 3-4349; APA GUIDELINES §§ D.1.a. (2), D.1.b. (1)(c); § 5.16.

46 APA GUIDELINES §§ C.1.b.(1)(c), D.1. (b)(1)(a); ACA STANDARDS § 3-4343; NCCH POSITION STATEMENT, P-32 at p. 41; FED STANDARDS § 5.15.

47 ACA STANDARDS § 3-4282, at 95; ACA STANDARDS § 2-4129 (1994 Supp. P. 43); FRED COHEN, *supra* note 19.

48 FED STANDARDS § 5.18.

49 ACA STANDARDS § 3-4355 at 12; APA GUIDELINES § F.5 at 11-12; § D.3.a.5 at 30; NCCH POSITION STATEMENT, P-50 at 61.

50 ACA STANDARDS § 3-4342 at 114; APA GUIDELINES § D.3.a. & b. at 30; § F.5.c. at 13; APHA STANDARDS, at 40; NCCH POSITION STATEMENT, P-24 at 26; P-30 at 24.

51 APA GUIDELINES § D.2; NCCH POSITION STATEMENT § P-64 at 77.

52 NCCH POSITION STATEMENT, P-67 at 79.

53 ACA STANDARDS § 3-4364 at 123; NCCH POSITION STATEMENT § P-54 at 65; APHA STANDARDS at 38.

54 ACA STANDARDS § 2-4312 (1994 Supp.) at 53; APA GUIDELINES § F.5.d. at 13-14; NCCH POSITION STATEMENT P-66 at 78; APHA STANDARDS at 41.

55 NCCH POSITION STATEMENT P-43 at 51.

56 APA GUIDELINES § E.2. at 8-9; ACA STANDARDS § 3-4377 at 127; NCCH POSITION STATEMENT P-60, P-61 at 72; APHA STANDARDS at 45-46.

11. Transfer of seriously mentally ill inmates to other facilities or to a psychiatric hospital;[57] and
12. Discharge from caseload.[58]

2. People

The second structural issue is the need for an adequate and appropriately trained staff. This includes hiring and deploying a sufficient number of service providers in various disciplines (e.g., psychiatrists, psychologists, nurses, social workers, etc.) to provide adequate mental health services. There are no fixed staff ratios that are universally applicable to all types of correctional facilities. Rather, the number and type of staff required will depend upon the qualifications and training of the staff, the scope of the mental health program being provided and needed, the organization of mental health service delivery, and the duration of confinement.[59]

For example, Way and colleagues conducted a national survey of all 50 states and the District of Columbia, gathering information about the staffing of every public forensic hospital in the United States.[60] They reported a national mean of 1.3 direct patient care staff, with a range from .35 to 4.0 direct care staff per patient.[61] Condelli reported that a typical intermediate care unit (i.e., a unit for inmates with serious mental disorders who have difficulty coping in the general prison population) in the New York Department of Corrections serves 60 inmates and is staffed by a .5 full-time equivalent (FTE) psychiatrist and three to five other full-time mental health professionals (psychologists, nurses, social workers, or occupational/recreational therapists).[62]

In *Dunn v. Voinovich,*[63] the consent decree, which involved prison mental health services provided by the Ohio Department of Rehabilitation and Correction, specified mandatory staffing levels based on a total prison population of 40,253 inmates. The decree required a total of 246.5 FTE mental health staff to be allocated solely for the provision of mental health services mandated by the decree. This number specifically included 25.5 FTE psychiatrists, with the remaining staff to be allocated to different disciplines according to the professional judg-

57 ABA STANDARDS § 7-10.2(b) at 510; ACA STANDARDS § 3-4360 at 121; APA GUIDELINES § D.4.a, b. at 31; NCCH POSITION STATEMENT P-33 at 41-42.

58 APA GUIDELINES § D.4.a. & b. at 31.

59 ACA STANDARDS § 3-4050 at 14; APA GUIDELINES § B.2.b. at 6; NCCH POSITION STATEMENT, P-20, P-21 at 23-24.

60 B.B. Way, et al., *Staffing of Forensic Inpatient Services in the United States*, 41 HOSP. & CMTY. PSYCHIATRY 172-74.

61 *Id.*

62 W.S. Condelli et al., *Intermediate Care programs for Inmates with Psychiatric Disorders*, 22 BULL. AM. ACAD. PSYCHIATRY & L. 63-70 (1994).

63 No. CI-93-0166 (S.D. Ohio, 1995), discussed in FRED COHEN, THE MENTALLY DISORDERED INMATE AND THE LAW, *supra* note 19, at Appendix D-5.

ment of correctional officials. These staffing numbers do not include security and support staff, but relate solely to the provision of mental health treatment.

The issue of staffing also includes providing effective training for mental health staff and correctional officers to equip them to perform their expected duties and to implement the policies and procedures.[64] One measure of the effectiveness of training will be revealed in an examination of the performance of various duties, as described more fully in section B.

3. Places

The final structural issue is the provision of adequate numbers of beds and program spaces for inmates with a need for differing levels of mental health services. In long-term correctional facilities, this will require having specific areas for crisis stabilization, acute treatment, specialized housing, and space for operating therapeutic programs. In the *Dunn v. Voinovich* consent decree, for a total prison population of 40,253 inmates, the state of Ohio agreed to provide 120 inpatient psychiatric hospital beds for male patients and 11 for female patients. An additional 710 residential beds for seriously mentally ill inmates were to be allocated between crisis beds and "residential treatment units" or specialized housing and programming areas for such inmates.[65]

B. *Performance Issues*

The actual performance issues can be considered by examining the six functional areas described below. The content of the monitoring of each of these areas should be drawn from what is required by the policies described earlier or from prevailing professional standards.

1. Access to Services

This concept includes several distinct areas of operations of a correctional facility, including:

1. *Reception screening.* This is a process of trained observation and structured inquiry designed to identify those inmates who may have mental disorders and to refer them for further evaluation and appropriate placement within the correctional facility.
2. *Mental Health Evaluation.* This is a function performed by mental health professionals, and, if the evaluation results in a diagnosis of mental illness, it should lead to the development of an individualized treatment plan.

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64 ACA Standards § 3-4082 at 24; APHA Standards at 38; NCCH Position Statement, P-20, P-21, P-23 at 23-25.

65 *See supra* note 22.

3. *Segregation rounds.* The rounds are intended to ensure that inmates are not kept in segregation solely due to mental illness, and that when mentally-ill inmates are placed in segregation, they are kept there for the minimum time necessary and continue to receive treatment and protection. Segregation rounds should be done by properly trained mental health professionals at least weekly and documented in clinical records.
4. *Self-referrals by inmates.* Is there evidence that inmates know how to access mental health services?
5. *Correction Officer Referrals.* Is there evidence that correction officers know how to recognize the signs and symptoms of mental illness and to make referrals to mental health staff?

2. DIAGNOSIS, EMERGENCY CARE, TREATMENT PLANNING & TREATMENT

This area of examination is the heart of the mental health program.

1. *Individualized treatment plans.* Are there appropriate clinical diagnoses reflected in individualized written treatment plans developed by interdisciplinary teams and periodically reviewed with the inmate's participation and consent?
2. *Crisis Intervention Services.* Is there effective and timely availability of appropriate professionals in a crisis and access to a full range of crisis services?
3. *Psychotropic Medications.* This area examines the most widespread form of treatment and covers such issues as whether medications are prescribed on the basis of a bona fide clinical diagnosis and not for punishment or control; whether medications are administered by qualified nurses and periodically monitored for effectiveness, side effects, and polypharmacy; whether appropriate lab tests are done and recorded; and whether the formulary provides for access to the full range of medications that are safe and effective for the treatment of mental illness, including the newer generation of medications. Informed consent is required except in narrowly defined emergencies.[66]
4. *Individual & group therapy programs* (e.g., anger control, stress management, sexual dysfunction and victimization, substance abuse, etc.) Are these available and provided by qualified staff?
5. *Hospitalization/transfers.* Is there ready access to hospitalization when this is the least restrictive environment for appropriate treatment of the inmate's condition? Is the rationale for hospitalization or transfer adequately documented?

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66 Washington v. Harper, 494 U.S. 210 (1990).

3. High Risk/High Volume Restrictive Interventions

   1. *Restraints/seclusion/isolation.* Are these interventions used in compliance with policies and professional standards?
   2. *Involuntary Medications.* Are involuntary medications administered in compliance with policy supported by adequate rationales and administered only in a hospital or residential treatment unit?
   3. *Crisis bed placement.* Is there an appropriate clinical rationale for placements, 24-hour nursing coverage and a length of stay less than ten days for such placements?
   4. *Segregation.* Is there involvement of mental health professionals in the decision-making process leading to disciplinary placement of inmates with mental illness in segregation units? Such involvement is usually necessary to ensure that inmates are not being punished for behaviors that are the product of untreated mental illness.[67]

4. Actual and Potential Harm

   1. *Suicides, suicide attempts.* Is there an effective program to identify potentially suicidal inmates, availability of safe cells, communication between mental health and corrections officers, effective intervention in suicide attempts, and timely access to emergency medical care?
   2. *Abuse/neglect incidents, injuries, self-abuse, mutilations, fires, deaths and other incidents of harm.* Are these reported and investigated in compliance with policies? Are appropriate preventive and corrective measures implemented as a result of such investigations?
   3. *Use of force by corrections officers.* Are these incidents reported and investigated to assure compliance with policies? Are appropriate preventive and corrective measures implemented as a result of such investigations?

5. Conditions of Confinement

   1. *Least restrictive environment.* Are mentally ill inmates kept in the prison general population unless individualized clinical rationales are in the record? Are mentally ill inmates, except for those hospitalized, integrated with non-mentally ill inmates for meals/recreation?
   2. *Out of cell time.* Do mentally ill inmates get the same amount of out-of-cell time as non-mentally ill inmates unless there is an individualized clinical rationale?
   3. *Reasonable accommodation.* Are reasonable accommodations made in prison educational and vocational programs to enable inmates with mental illness to participate in such programs? Do they actually participate in such

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67 *Casey*, 834 F. Supp. at 1550.

programs in approximately the same proportion as their representation in the prison population?[68]

6. Transfer/Discharge from Caseload

Mentally ill inmates should not be discharged from the caseload solely due to the failure to comply with treatment, but must meet discharge criteria as set forth in the treatment plan. In cases of substantial noncompliance with treatment, it would be advisable to explore the inmate's reasons for noncompliance and consider revisions to the treatment plan based on such a discussion. As with nonforensic patients, discharge planning and linkage to follow-up services are essential components of adequate and appropriate mental health services. Just as intake screening is intended to ensure that the system of mental health services does not break down at the front door, discharge planning is intended to ensure that the responsibility is not abdicated at the back door.

C. *Utilization Review*

Adequate monitoring of correctional mental health services requires periodic review of service utilization. Utilization review is a systematic way of examining whether available resources are being used in a cost-effective and clinically appropriate manner to achieve the desired outcomes. The concept of utilization review includes examining the following:

- *Over-utilization* of services, which wastes scarce resources (e.g., excessively long inpatient hospitalization);
- *Underutilization* of services (e.g., the prescription of medications at below therapeutic levels or the failure to prescribe them at all when clinically indicated), which is also wasteful of resources because such underutilization does not produced the desired clinical effect and may lead to the use of more expensive resources and restrictive measures such as crisis beds, segregation, or inpatient hospitalization.
- *Inefficient utilization* (e.g., a one-day hospitalization which is likely to be either too brief to do any good or unnecessary in the first place); and
- *Inappropriate utilization* (e.g., placing seriously mentally ill inmates in segregation because of behaviors which are the product of untreated mental illness).

In a correctional context, given the usual scarcity of resources, a system-wide retrospective review is an appropriate starting point, enabling a system to develop baseline information about mental health service delivery. As a reliable

68 *See* Americans with Disabilities Act of 1990 (ADA). 42 U.S.C. § 12101 et seq. (2000); Pennsylvania Dep't of Corr. v. Yeskey, 524 U.S. 206 (1998) (applying ADA to correctional settings); PAULA N. RUBIN & SUSAN W. MCCAMPBELL, THE AMERICANS WITH DISABILITIES ACT AND CRIMINAL JUSTICE: MENTAL DISABILITIES AND CORRECTIONS (Sept. 1995).

picture emerges, the system can consider whether the data suggest patterns of over-utilization or underutilization of services in specific facilities or programs, and determine whether other approaches such as concurrent review or prior authorization are needed to bring practice into line with expected norms.[69] The process of collecting data is likely to reveal that there are specific facilities or clinicians whose patterns of diagnosis and treatment deviate significantly from the norms one would expect with the population and in the particular facility. The detection of such significant deviations should prompt further inquiry to determine the appropriateness of clinical practices.

The data required for an effective utilization review program can be designed into a management information system. The management information system should include:

(1) Continual collection of objective performance data of the type described above, as well as other data believed to be useful for management purposes.
(2) Regular aggregation and analysis of performance data and reporting to clinical managers. The most common failing of many information systems, especially in public institutions, is that data are not used for any discernible purpose. This creates a vicious cycle in which staff soon stop being careful in collecting and reporting the data, making the system unreliable, leading to further reluctance to use it for decision-making, and further discouraging care in data collection and reporting.
(3) Regular provision of comparative performance data to each institution to help in their performance improvement activities. Such data provide an impetus for change, particularly for those who have ranked poorly among their peers.
(4) Identification of trends and patterns that may call for more focused attention either system-wide or at individual institutions. It is important to emphasize that the data be used as the start of an inquiry about clinical appropriateness, not as a rigid measure from which conclusive judgments are to be formed.[70]

What are some of the indicators to examine?

For outcome assessment, there are generically two types of indicators: indicators of clinical outcomes and indicators of utilization of resources. Management information systems are generally more proficient at identifying and collecting

69 G.L. Tischler, *Utilization Management of Mental Health Services by Private Third Parties,* 47 AM. J. PSYCHIATRY 967-73 (1990); Kenneth G. Terkelsen et al., *Development of Clinical Methods for Utilization Review in Psychiatric Day Treatment,* J. MENTAL HEALTH ADMIN. 298-313 (1994).

70 Linda O. Prager, *Standards Challenge Rigid Uses of Utilization Guides,* 41 Am. Med. News 8 n.28 (1998).

data about resource utilization, as such data are often necessary to develop and justify budget requests, and are more easily obtained. There has generally been less of an emphasis on collecting data about clinical outcomes.

Indicators of clinical outcomes include

(1) Increased ability to function in prison, as determined by:

- Movement of mentally ill inmates through the level system;
- Better management of environmental stress by mentally ill inmates;
- Increased socialization and leisure activities;
- Increased participation in work, vocational and educational activities; and
- Increased medication compliance and participation in other treatment activities.

(2) Reduced harm and attempts, measured by:

- Reduced suicide attempts and gestures;
- Reduced self-abuse and mutilation;
- Reduced incidents, infractions, and discipline; and
- Reduced impulsive behaviors.

(3) Symptom reduction and increased well-being as reported by the inmates themselves or by corrections staff.

In order for such clinical outcome data to be useful, it is necessary that baselines be established and that such data be collected regularly over a period of time to assess changes in performance and conditions.

Utilization review also requires access to reliable sources of the data. One of the primary sources of data is the clinical record. A minimally adequate clinical record would include at least the following:

- A written plan of individualized treatment;
- Notes of physical and mental exams;
- A medical and mental health history;
- Medication records including laboratory tests and evaluations;
- Evidence of periodic tests for tardive dyskinesia and other side effects of medications;
- Regular progress notes; and
- Organization of the file for easy use by many different staff persons.

CONCLUSION

Monitoring the quality and utilization of mental health services in correctional facilities can help an agency assess how well it is meeting its own expectations for the delivery of timely, adequate, appropriate, and cost-effective mental health

services.[71] Each organization must determine its goals and establish its expectations. While there are thresholds below which one cannot perform without legal peril,[72] there is a great deal of room for judgment about what is appropriate care. This is a judgment that each agency must make with the help of its clinicians.

An effective program of monitoring the quality and utilization of mental health services will not only assist correctional facilities in continually improving the quality and cost-effectiveness of their programs, but also should sharply reduce the risk of exposure to individual and systemic lawsuits challenging the adequacy of mental health services.

71 C.D. Naylor, *Editorial: What is Appropriate Care?* 338 N. ENG. J. MED. 1918-20 (1998); Am. Ass'n of Correctional Psychologists, *Standards for Psychological Services in Adult Jails and Prisons,* 7 CRIM. JUSTICE & BEHAV. 81, § 09 at 92, § 40 at 113 (1980); Grubbs v. Bradley, 821 F. Supp. 496, 500 (M.D. Tenn. 1993).

72 E.g., a finding of "deliberate indifference" to inmates "serious medical needs," constitutes a violation of the Eighth Amendment's prohibition of cruel and unusual punishment. *See, e.g., Coleman,* 912 F. Supp. at 1298, (quoting Wilson v. Seiter, 501 U.S. 294, 297 (1991)) (quoting Estelle v. Gamble, 429 U.S. 97, 106 (1976)).