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Models of Mental Health Service Delivery to Correctional Institutions

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ABSTRACT: The mentally disordered offender falls into the "no man's land" between prison and mental health systems. A number of reasons are given to explain why mental health service to this special group is in crisis again, and to lay the base for understanding the advantages and disadvantages of five different models of service delivery. The authors conclude by favoring small psychiatric units attached to major prisons.

KEYWORDS: psychiatry, jurisprudence, prisons, mental illness

The provision of mental health service to convicted mentally disordered offenders is in crisis again [*1*]. This perennial problem has remained unsolved for a number of reasons. A principal reason underlying our lack of success (resolve?) is the basic conflict between the principles of the criminal justice system, punishment, retribution, deterrence, and rehabilitation [*2*], and the basic premise underlying the therapist/patient relationship, trust [*3*]. The practice of punishment prevents the possibility of trust formation. This basic conflict in values, in our opinion, underlies all the apparent levels of conflict. The perennial problem of the insanity defense, where law and psychiatry collide, and the deep difference between the roles of security and treatment staff in prisons, are two obvious examples of this basic difference.

Furthermore, there are a number of reasons why this crisis is apparent at this time. First, our prisons are overcrowded. There was a 34% growth in population between 1978 and 1982, straining already scarce resources. Second, the movement to deinstitutionalize the chronic mentally ill in the 1960s and 1970s has not only created "the bag lady," but crowded jails, and then prisons, with patients who used to reside in hospitals. The criminalization of the mentally ill is well documented [*4,5*]. Third, the trend towards giving longer sentences has kept prison beds full. More important, however, in this swing to the right, is the growing trend to decrease the judge's authority at the time of sentence, and to decrease the flexibility parole boards have to grant early release to selected inmates, especially those who have participated honorably in prison rehabilitation programs. Psychiatric/psychological treatment is losing credibility with the public and the parole board.

For these reasons and others, it is not surprising that recent surveys of psychopathology in

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prison populations continue to demonstrate that at any given time 20 to 25% of the inmate population experience significant, and in other circumstances, treatable symptoms of mental illness [*6–8*]. The fact that mental health services to the mentally disordered offender have been neglected for years; that most departments of corrections are understaffed compared to European staffing standards [*9*] both in custodial and mental health professionals; that in a recent survey of state correction facilities 28 states had defined standards for mental health services for the convicted and that only 16% of these complied with their standards, it is understandable that the human suffering of the mentally ill has come to the attention of the courts. While the *Wyatt v. Stickney* case [*10*] in Alabama does not offer the promise that was first sought in the court's entrance into setting standards and so forth in a psychiatric hospital, Metzner reported that 20 states are now under court order to provide mental health services. Overcrowding, environmental health conditions, the lack of medical and mental health care, and violence are the four major issues addressed by this litigation.

Given this pessimistic picture [*11*], is there any reason to believe that the current effort to address this issue will have any success? Class action suits will bring some relief [*12*]. There is also a growing emphasis and body of knowledge in correctional mental health, as attested by the scope of the papers presented in Chicago at the 8th National Conference on Correctional Health Care [*13*]. Of 40 major topic areas, 30 had a direct clinical focus. There were more than 100 separate papers presented in these topic areas. Interest and information are growing. The following will, then, review models of delivery of mental health services in prisons and discuss the advantages and disadvantages of each. It will not discuss mental health services to jails or to juveniles. It will not discuss important system issues or specific treatment approaches. We can say that there are no standards to judge effectiveness of any of these models, and that, in spite of all our efforts, recidivism rates remain unchanged.

The judgments made below arise from personal experience and from a review of surveys of psychopathology found in prison settings [*6–8*]. The first model is explained in greater detail as the basic issues of intention, administration, and separating the mentally disordered offender from other inmates are considered common to all models. Other models, then, are discussed in regard to their unique advantages. All other factors are held constant.

Models for the Disposition of Convicted Mentally Disordered Offenders

Wardlaw [*14*], in an excellent article, identifies and discusses the advantages and disadvantages of five models of mental health service to convicted mentally disordered offenders. We have followed his lead, below, in describing these models. A number of solutions have been attempted as a means of coping with the dispositional problems posed by mentally disordered prisoners. Although they are not entirely mutually exclusive, five major approaches may be broadly distinguished. These are:

(1) a centralized psychiatric prison,
(2) small psychiatric units attached to major prisons,
(3) regional forensic psychiatric centers,
(4) regional security units at psychiatric hospitals, and
(5) a centralized psychiatric security hospital.

Irregardless of model, the central problem lies in the fact that neither the prison system nor the health system want jurisdiction over the mentally disordered offender. Mentally disordered prisoners fall in a "no-man's land" and are not properly cared for by either prison or psychiatric hospitals. This situation arises principally from disagreements over what role each should play. On the whole, prisons view mentally disordered prisoners as inappropriately placed in their institutions, arguing that prisons are neither equipped nor staffed to deal with their problems. On the other hand, the mental health system generally is reluctant to deal with prisoners, particularly those who are labelled "dangerous" [*7*]. Often psychiat-

ric staff believe prisoners/patients to be merely trying to avoid the rigours of prison life and thus to be wasteful of resources and frequently disruptive to the ward routine. More seriously, they fear that the need to provide security for prisoners is diametrically opposed to the general movement toward open wards in psychiatric hospitals. Further, it is argued that a large proportion of mentally disordered offenders are, for practical purposes, untreatable, and there is thus no justification for their occupying scarce hospital beds. It is easy, therefore, to see the pressures and interests that exist in both systems to divest themselves of this problematic group.

Psychiatric Prison

A psychiatric prison seems an ideal solution to many. Hartz-Karp [*15*], in her analysis of dispositional modes, argues that the three major reasons most frequently cited for constructing psychiatric prisons are administrative efficiency, humanitarian concern, and protection of the offender and the community. It is argued that it is important to separate the mentally disordered from the criminal so that the former are "treated" and the latter are "punished." In particular, it is felt that it is inappropriate to subject the mentally disordered to a regime officially labelled as punishment. It is then argued that only in a special purpose institution will those who are mentally disordered be afforded proper treatment and not be subjected to punishment. The psychiatric prison holds the hope of dealing appropriately with mentally disordered individuals by removing them from a punishment environment and placing them in a treatment one, thus satisfying humanitarian concerns. It provides security which alleviates community fears, and it removes what is said to be a particularly difficult and often violent group from normal systems, thereby removing considerable administrative difficulties for those systems.

Further, administrative difficulties are said to be caused in prisons by the presence of the mentally disordered because facilities do not exist to segregate those who are violent, exhibit bizarre or unpredictable behavior, or are in other ways difficult (for example, refuse to work or obey orders). Proponents of a psychiatric prison accept that many of these problems have a psychological/psychiatric basis and that a treatment facility would be the most appropriate place to deal with them.

Separating the violent from the mentally disordered, who may also be violent, is another difficult issue. Often the tendency is to lump both groups together because they both cause management and administrative problems. When undifferentiated, the group with characterological pathology become a major problem to the treatment milieux whether in psychiatric prisons or mental hospitals. Accurate diagnosis in the prison is important.

The final argument advanced in favor of a psychiatric prison is that it would be an ideal protective device. Mentally disordered prisoners would be better protected from the depredations of other prisoners and the stresses of prison life (to which it is thought it is "unfair" to subject someone suffering under a mental disability) if housed in the "protective environment of a treatment facility [*16*]. Further, such persons will also be protected in the sense that the treatment offered theoretically holds out real hope of a "cure" which will eliminate mental disorder or dangerousness or both. The community also benefits. It is protected because the dangerously mentally disordered offender is housed in secure conditions and is receiving treatment that will eliminate his or her dangerousness. Of course, the ultimate benefit derived from a psychiatric prison is claimed to be when the treatment staff themselves control release decisions and can release mentally disordered prisoners only when the staff considers them "cured."

While all the above arguments stem from real concerns, the solution offered, a psychiatric prison, is based on, at best, unproven assumptions. The most important assumptions underlying psychiatric intervention are that persons whom the administration finds "difficult" (be they violent, noncommunicative, not amenable to discipline, and so forth) have psychiatric

disorders and that psychiatrists are able to provide accurate diagnosis of and treatment for these disorders. The first assumption is widely challenged and the second and third are largely disproven by an increasing number of empirical studies which show that psychiatrists are extremely poor at arriving at reliable diagnoses in court [*17*], and even should they be able to do so, there is no specific treatment that can offer any realistic chance of success for the character disordered who would be so diagnosed [*18*].

Much of the attraction of the idea of a psychiatric prison lies in the belief that psychiatry and psychology are powerful and accurate tools. The evidence suggests otherwise, however, and to be responsible we must carefully assess the claimed expertise and benefits. (Although it should be noted that the attraction of psychiatric prisons may simply be asylum, that is, getting the most disruptive inmates out of the general population, and may be considered by some prison administrators to be sufficient rationale in and of itself, regardless of their beliefs about the power of psychiatry and psychology.) Further, as Ericson [*19*] argues, while psychiatry (and, by association, psychology) is not necessarily powerful as a treatment tool, it certainly may be powerful as a control. The great danger of assigning all the difficult prisoners to one institution and making treatment personnel primarily responsible for them is that the control function may become paramount. And as Ericson also notes, "Once set in motion, programs of this nature have a tendency to act to a maximum capacity, seeking and finding a perpetual supply of subjects to tinker with."

Apart from the question of whether or not we have the treatment tools to change significantly the behavior of seriously disturbed offenders, the concept of a centralized psychiatric facility within the prison system suffers from a number of other potential disadvantages. First, it is obvious that a psychiatric prison will not be capable of dealing with all the mentally disordered individuals within the prison system. But the mere existence of such a facility could well remove the pressure to provide adequate mental health facilities for all prisoners both because of the diversion of scarce and costly resources into treatment of the most severely disturbed cases and because the physical reality of the institution is visible "proof" of something being done for the mentally disordered, thus diverting attention from the remaining problems. A second problem is that of the difficulty of involving the families or friends of the inmates in treatment as a result of the distance of a centralized facility from the areas in which many of the offenders and their families live. A decentralized system, on the other hand, at least allows the possibility of placing the offender in a facility within easy visiting distance of family and friends where it is thought that this may be of assistance in recovery from mental disorder. Finally, experience with a number of psychiatric prisons has shown that, often, there is an inherent inflexibility in the regimes in such institutions which does not seem to be present to such a degree in smaller units. The emphasis on security, in particular, often seems to pervade the thought that goes into devising programs for all offenders in the institution rather than only for those who truly require it. There often seems more willingness to experiment with innovative programs in smaller units, with large psychiatric prisons being, frequently, more rigid in their attitudes to such innovations.

Small Psychiatric Units Attached to, or Part of, Major Prisons

An alternative to a psychiatric prison, which still accepts that the prison system must bear the major responsibility for convicted mentally disordered offenders, is to disperse psychiatric units throughout the major prisons. This concept involves having a psychiatric unit either attached to, or within, a number of prisons. Such a model is seen as countering the disadvantages of a psychiatric prison (such as an excessive concern for security, the holding together of large numbers of disordered and sometimes dangerous offenders, the administrative and treatment conservativeness which seems to accompany larger institutions, and so forth), as well as offering its own advantages. The first advantage is that such a system is able to cope with a greater number of individuals within the prison system because it is not geared pri-

marily to the most severely disordered group. A unit, as well as being a secure facility for the treatment or containment of the severely disordered, should also serve the general population of its parent prison, providing day-care or out-patient type services. Having a number of such units also allows for the development of specialist services so that, for example, different units may aim to provide special programs for different problem groups. In the United States, New York State has developed a comprehensive system in this mold [*20*], and the State of North Carolina has also adopted this model, as the following mission statement indicates [*21*]:

> The North Carolina Division of Prisons has the responsibility to deliver comprehensive mental health services which will provide for the care and treatment of mentally disordered inmates. Treatment programs will contain multi-disciplinary responses designed to prevent, contain, reduce, or eliminate those conditions which contribute to the patient's mental impairment. These services will include but are not necessarily limited to: (1) patient identification and diagnosis, (2) services for the acutely ill inpatient, (3) outpatient services, (4) special programs for selected diagnostic categories (e.g. passive inadequate, mentally retarded, etc.), and (5) preventative services. There will also be a program evaluation and a staff development component as a part of the mental health program.

A formal Memorandum of Understanding exists between the North Carolina Department of Human Resources (which is responsible for the state's mental health services) and the Department of Correction, which specifies that:

> The Department of Human Resources will be responsible for service delivery for the mentally ill, the mentally retarded, or the substance abuser prior to the time they are actually committed to a state prison. Once they enter the gate of a state correctional facility, the responsibility for their treatment shifts to the Department of Corrections. When they leave prison, either through parole or by "maxing out", the responsibility reverts to the Department of Human Resources. The Memorandum of Understanding further specifies that the two agencies cooperate in every way possible to provide an orderly flow of the patient into and out of the prison system to facilitate continuity of care.

The major advantage of this sort of formal agreement is that each department knows exactly where it stands and what its responsibilities are. The existence of such an agreement, together with the provision of adequate resources to enable the Department of Correction to fulfill its mandate, eliminates the disagreement between departments, which is characteristic of many jurisdictions. More important, it eliminates the Ping-Pong game which is played as many mentally disordered offenders are shunted back and forth between hospital and prison (what one cynic has called "bus therapy").

The major disadvantages appear to be those of cost. It could be argued that many services which could be provided by the civil mental health system are unnecessarily duplicated with resultant unnecessary cost to the community. However, it could equally be argued that such duplication as does exist is a small price to pay for the advantages that such a system offers.

Regional Forensic Psychiatric Centers

In Canada, one solution to the disposition problem has been the establishment of regional forensic psychiatric centers which have a mandate to cater exclusively to mentally disordered offenders [*22*]. In Canada, these centers are under the control of the federal prison authorities, but other models envisage control being vested in the mental health authorities on a joint service. There are a number of possible ways of organizing such centers. To set them apart from the psychiatric prison model, some examples would seek to offer a comprehensive forensic service to both convicted and unconvicted mentally disordered offenders. Thus, such a unit would provide long-term accommodation, short-term care for those on temporary transfer from a hospital or a prison, out-patient services for probationers/parolees and

possible prisoners, and assessment and diagnostic services for the courts (including facilities to hold remandees for psychiatric observation and report).

The advantages seen in this model center on the presumed expertise that would be gained by having a large, comprehensive service-delivery agency capable of dealing with the problems of both prisons and mental hospitals. The disadvantages come from having to accommodate such a mixture of problem types and security levels. It is argued that, in the final analysis, the security needs of the dangerous, mentally disordered offenders could easily come to dominate, thus reducing many of the benefits which might otherwise flow from such a facility.

Regional Secure Units in Psychiatric Hospitals

The British solution to the problem of hospitals being unwilling to accept certain groups of mentally disordered offenders, either from the courts or from prison, was to build a number of regional medium secure units within the confines of psychiatric hospitals. These units are designed to take only those offenders who the medical staff consider as having a good chance of responding to treatment. They accept patients from the hospitals as well as from prisons, and thus such units are not exclusively for offenders but rather, for those who need more control than is considered appropriate in a normal psychiatric setting. The criteria for admission to one such unit (the Wessex Interim Secure Unit) are as follows [*23*]:

(a) An agreement between the relevant doctors and staff that the patient is both mentally disordered and should be treated in hospital.
(b) The patient's behavior is too difficult or dangerous for him (or her) to be managed in an ordinary psychiatric ward, but is not so difficult or dangerous that he/she requires the high security of a Special Hospital.
(c) The patient is either legally detained (e.g. by court order using the Mental Health Act) or is willing to stay as an "informal" patient, or as a condition of probation.

It is obvious that while the concept of such units, firmly in the civil mental health system, could have merit, it is only a very limited solution to the problem of where to locate the mentally disordered offender. Because of the limits on security and the criterion of treatability, such units exclude a large number of potential inmates (that is, the dangerous and the "untreatable").

A Centralized Psychiatric Security Hospital

The model of having a large, secure institution within the mental health system to cater for the dangerous mentally ill has been adopted all over the world, but has been the subject of intense criticism over the last few years. Such institutions (for example, the British Special Hospitals such as Broadmoor or maximum security hospitals such as Atascadero in California) usually cater for both civil and criminal patients. On the whole, they have been justly criticized for an overconcern with security, fostering institutionalization, and being conservative and inward looking [*24*]. They are frequently overcrowded and lack any real attempt at treatment. Security and control usually take precedence over all. Apart from the negative effects of the institutions themselves, the psychiatric security system, with its emphasis on security, is an inappropriate place to treat many sorts of mentally disordered offenders. But, if ordinary psychiatric hospitals are unwilling to take prison patients, many end up, inappropriately, in security hospitals—often with negative impacts on their chances of recovery or rehabilitation [*25*]. Thus, the presence of such a facility either means that it contains inappropriate patients or that these individuals may remain untreated in the prison system. Some complementary institution is still necessary.

Conclusion

In our opinion, small psychiatric units attached to major prisons with dual management have the most to offer. Prison and mental health expertise is required at the administrative level to ensure that both security and treatment needs are met. Small units are less entrenched in excessive security. They offer a greater level of trust, better staff communication, and the possibility of specialization. Where morale is good, they even offer the potential of a rewarding career to the mental health professionals who would choose to work in this subspeciality.

References

[1] In Brief *Jails: Intergovernmental Dimensions of a Local Problem,* Advisory Commission of Intergovernmental Relations, Washington, DC 20575.

[2] Cavender, G., "Justice, Sanctioning, and the Justice Model," *Criminology,* Vol. 22, No. 2, May 1984, pp. 203-213.

[3] Maier, G. J., "Therapy in Prisons," in *Rage, Hate, Assault and Other Forms of Violence.* D. J. Madden, and J. R. Lion, Spectrum Publications, Inc., New York, 1976.

[4] Steadman, H. F., Cocozza, J. J., and Melich, M. E., "Explaining the Increased Arrest Rate Among Mental Patients: The Changing Clientele of State Hospitals," *American Journal of Psychiatry,* Vol. 135, No. 7, July 1978, pp. 816-820.

[5] Sosowsky, L., "Explaining the Increased Arrest Rate Among Mental Patients: A Cautionary Note," *American Journal of Psychiatry,* Vol. 137, No. 12, Dec. 1980, pp. 1602-1605.

[6] Metzner, J. L., "Evaluation of a Prison Mental Health System in Litigation," presented at the Fifteenth Annual Meeting of the American Academy of Psychiatry and the Law, 27 Oct. 1984.

[7] Gunn, J., Robertson, G., Dell, S., and Way, C., *Psychiatric Aspects of Imprisonment,* Academic Press, New York, 1978.

[8] McKay, H. B., Jayewardene, C. H. S., and Reedie, P. B., "The Effects of Long-Term Incarceration and a Proposed Strategy for Future Research," Minister of Supply and Services, Ottawa, Canada, 1979.

[9] Ward, D., "Inmate Rights and Prisons Reform in Sweden and Denmark," *Journal of Criminal Law, Criminology and Police Science,* Vol. 63, No. 2, 1972, pp. 240-255.

[10] Stickney, S. B., "Problems in Implementing the Right to Treatment in Alabama. The *Wyatt vs Stickney Case,*" *Hospital Community Psychiatry,* Vol. 25, No. 7, July 1974, pp. 453-460.

[11] Maier, G. J., "Relationship Security: The Dynamics of Keepers and Kept," *Journal of Forensic Sciences,* Vol. 31, No. 2, April 1986, pp. 603-608.

[12] Isele, W., *Constitutional Issues of the Prisoners' Right to Health Care,* American Medical Association, Chicago, 1980.

[13] Brochure, *Eighth National Conference on Correctional Health Care,* 1984.

[14] Wardlaw, G., "Models for the Custody of Mentally Disordered Offenders," *International Journal Law and Psychiatry,* Vol. 6, No. 2, 1983, pp. 159-176.

[15] Hartz-Karp, J., *The Mentally Ill Within the Criminal Justice System.* Research and Information Series No. 19, Western Australian Department of Corrections, 1979.

[16] Kittri, N., *The Right To Be Different: Deviance and Enforced Therapy,* Penguin Books, New York, 1971.

[17] Bartholomew, A. A. and Milte, K. L., "The Reliability and Validity of Psychiatric Diagnoses in Courts of Law," *Australian Law Journal,* Vol. 50, No. 9, Sept. 1976, pp. 450-458.

[18] West, D. J., Ed., *Psychopathic Offenders,* (papers presented to the Cropwood Round-Table Conference), University of Cambridge, Institute of Criminology, Cambridge, 1968.

[19] Ericson, R. V., "Psychiatrists in Prison: On Admitting Professional Tinkers into a Tinker's Paradise," *Chitty's Law Journal,* Vol. 22, No. 1, 1974, pp. 29-33.

[20] Wright, J. B., "Mental Health Services in Correctional Settings," in *A Report to Governor Hugh L. Carey on the Insanity Defense in New York,* State of New York Department of Mental Hygiene, 17 Feb. 1978, pp. 119-130.

[21] Kiel, R. A., "Mental Health for the Convicted Offender: A Model That Works," *Corrections Today,* Vol. 43, No. 1, 1981, pp. 20-27.

[22] Arboleda-Florez, J., "Forensic Psychiatry Services in Canada. Strengths and Weaknesses," *International Journal of Law and Psychiatry,* Vol. 4, No. 3-4, 1981, pp. 391-399.

[23] Faulk, M., "Mentally Disordered Offenders in an Interim Regional Secure Unit," *Criminal Law Review,* Vol. 17, No. 6, Nov. 1979, pp. 686-695.

[24] Gostin, L. O., *A Human Condition. The Law Relating to Mentally Abnormal Offenders: Observations, Analysis and Proposals for Reform,* MIND (National Association for Mental Health), London, 1977.
[25] Bluglass, R., "Advances in Forensic Psychiatry in England and Wales," *International Journal of Law and Psychiatry,* Vol. 4, No. 1-2, 1981, pp. 199-212.

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