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Mental Health and Corrections: Towards a Working Partnership

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ABSTRACT: This paper describes the development of mental health services to the courts and correction facilities in the City of New York. The origins, structure, and functions of the interagency New York City Task Force on Prison Mental Health Services are explained. The Task Force's role in the development, promulgation, and implementation of the Minimum Standards for Mental Health Services in New York City Correctional Facilities are outlined. These standards, enacted by the New York City Board of Correction, are described and discussed.

KEYWORDS: psychiatry, jurisprudence, prisons, mental illness

The New York City correctional system is the largest local correctional system in the United States today. With 13 institutions and a capacity of almost 13 000 (in 1986), the management and provision of mental health services is a Herculean task at best (see Table 1). No single agency has overall responsibility for the so-called system of services. Instead, mental health care has been provided under the jurisdiction of several city agencies.

The Service System

There are two levels in the system: the actual providers of on-site services and the administrative overhead agencies, which act as conduits of city funds and monitor the delivery of services to ensure compliance with contractual and organizational standards. The overhead agencies are the Departments of Mental Health, Mental Retardation, and Alcoholism Services (hereafter known as the Department of Mental Health), the Department of Health, the Department of Correction, and the Health and Hospitals Corporation. The service providers are the Health Department's Office of Prison Health Services, the Health and Hospitals Corporation's municipal hospitals (Bellevue, Kings County, and Elmhurst), and Montefiore Hospital and Medical Center, a private voluntary hospital under contract to the City of New York. Table 2 outlines the major actors in the system and their responsibilities as of 1984.

Rikers Island, an isolated bit of land in the East River, is the focal point of the New York City correctional system. There are seven institutions on Rikers Island, and six other facilities spread amongst the City's boroughs, for a total of 13 separate correction commands

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TABLE 1—*Population of N.Y.C. correctional facilities: November 1986.*

	Males		Females	
	No.	%	No.	%
Adult detainees	8 053	58	628	5
Adolescent detainees	1 688	12	89	0.6
Adult sentenced	2 557	19	206	1.5
Adolescent sentenced	584	4	28	0.2
Total	12 882	93	951	7
Grand total		13 833	100%	

(Table 3). Treatment for medical and psychiatric problems is provided at each major institution. More seriously mentally ill inmates are transferred to the centrally located Mental Health Center on Rikers Island, or to the infirmary known as Rikers Island Hospital. The most disturbed inmates, those in need of hospitalization, are transferred to psychiatric prison wards at Bellevue and Kings County Hospitals (male defendants) and Elmhurst Hospital (females).

Diagnostic services for the courts and the Department of Probation are provided on-site in the borough court houses by the Court Psychiatric Clinics, under the auspices of the Department of Mental Health (Manhattan), Bronx Lebanon Hospital (a voluntary hospital under contract to the City) in the Bronx, and the Health and Hospitals Corporation through Kings County Hospital in Brooklyn, Queens, and Staten Island.

The Prison Mental Health Task Force

Over the course of time, all of the participants in this somewhat disjointed system have evolved legislative, administrative, and interpersonal procedures for working together. One of these is the Prison Mental Health Task Force.

In June 1979, the Board of Correction, a watchdog agency empowered by the New York City Charter and whose mission it is to oversee the operations and evaluate the performance of the Department of Correction, held public hearings on the issue of mental health services in the jails. The concept of what was to later become the Prison Mental Health Task Force evolved from what was learned at these sessions. The earliest meetings, held in the autumn of 1979, brought together representatives of most of the major actors in the system.

At that time, the State of New York, in need of additional prison beds for sentenced inmates, had offered to purchase the Rikers Island complex from the City. Additional or expanded local jails would then be constructed in the five boroughs, and the entire correctional system would be decentralized. The impact of this on the organization of treatment services became the focus of discussion, with the goal of developing a unified plan for the provision of health and mental health services in the New York City correctional system, and of obtaining input into the planning process for the Rikers Island transfer.

Working towards this common objective gave those people involved a much needed chance to get to know one another better. In fact, the information gap was so great that the first job of the Task Force was simply to define and describe the then current system of services. As participants who were actual program managers described the activities, personnel, and resources of their units, it became apparent that these meetings were long overdue, and had an inherent value of their own in improving inter- and intra-agency communication. Representatives of other service delivery agencies were invited to participate. Several goals for the prison mental health system were proposed: the prevention of suicide; the minimization of management/behavior problems; the diagnosis, detection, and treatment of

TABLE 2—*1984 service delivery.*

Funding	Administration	Service Provider	Services	Institution
NYC Dept. of Mental Health, Mental Retardation, and Alcoholism Svcs. (Psychiatric Svcs.)	Dept. of Health	Prison Health Services and Prison Mental Health	medical and psychiatric	Bronx House of Det. Queens House of Det. Brooklyn House of Det. Brooklyn Corr. Fac. Rikers Isl. Hosp. Mental Health Ctr.
N.Y.C. Dept. of Health (Medical Svcs.)		Prison Mental Health	psychiatric only	A.R.D.C.[a] A.M.K.C. H.D.M C.I.F.M. C.I.F.W.
	Montefiore Hosp. and Medical Center	Montefiore/Rikers Island Health Services	medical only	A.R.D.C. A.M.K.C. H.D.M. C.I.F.M. C.I.F.W.
			medical and psych.	Manhattan House
Health and Hospitals Corp. (Med. Svs.)	Health & Hospitals Corp.	Kings County Hosp.	medical and psych.	(inpatient services)
		Bellevue Hosp.	medical and psych.	(inpatient services)
Dept. of Mental Health (Psych. Svs.)		Elmhurst Hosp.	medical and psych.	(inpatient services)
		Kings County Hosp.	psych. outpatient	Brooklyn Court Clinic
Dept. of Mental Health	Dept. of Mental Health	Forensic Psychiatry Clinic	psych. outpatient	Manh. Court Clinic
		Family Court M.H. Services	psych. outpatient	Family Court Clinics
	Bronx Lebanon Hosp.	Bronx Lebanon Hosp.	psych. outpatient	Bronx Court Clinic

[a]See Table 3 for full names.

TABLE 3—*Facilities of the N.Y.C. Department of Correction.*

Institution	Census 22 Oct. 1986
Rikers Island facilities:	
Anna M. Kross Correctional Center (AMKC)	2 318
Adolescent Reception and Detention Center (ARDC)	1 832
House of Detention for Men (HDM)	1 200
North Facility	1 188
Correctional Institution for Men (CIFM)	2 083
Correctional Institution for Women (CIFW)	1 622
Rikers Island Hospital	60
Manhattan facilities:	
Manhattan House of Detention (the Tombs)	421
Bronx facilities:	
Bronx House of Detention	413
Hart Island	29
Brooklyn facilities:	
Brooklyn House of Detention	755
Brooklyn Correctional Facility (the Brig)	825
Queens facility:	
Queens House of Detention	502
Total	13 248

mental disorder; the prevention of acute episodes and decompensation; and the improvement of staff morale.

In early 1980, the New York City Board of Estimate, responding to public pressure against having sentenced prisoners housed so close to home, rejected the proposed State acquisition of Rikers Island. The Prison Mental Health Task Force proceeded under its own momentum with its information sharing and problem solving activities. Issues that were discussed over the years include: the Department of Correction's suicide prevention program utilizing specially trained inmates as suicide observation aides, program planning for the newly opened Manhattan House of Detention (the Tombs), confidentiality problems relating to communication between services, aftercare for mentally disturbed inmates, and the care and treatment of acquired immunodeficiency syndrome (AIDS) patients in the system. A directory was developed with names, addresses, and phone numbers of all participants. In response to discussion of the need for staff development, two conferences were held, bringing line staff and interested outside parties together on the subjects of psychotropic medication and confidentiality.

The Standards

Staff of the Board of Correction, in its ongoing role of overseeing the prison system, continued to work with the Task Force towards the development of guidelines for the provision of adequate mental health services to the prison system.

Conceptually, once agreement was reached among the major actors in the system (the Departments of Correction, Health, and Mental Health), the Board would promulgate these

guidelines as the Minimum Standards for Mental Health Services. Once approved by the Board, these standards would be binding on the City of New York.

The process of developing the standards, and of obtaining an agreement about their contents, took four years. The standards were promulgated in January of 1985, and began to take effect in February of that year.

The basic service goals of the standards have remained constant over the years. As published in the final document, they are:

(1) crisis intervention and the management of acute psychiatric episodes,
(2) suicide prevention,
(3) stabilization of mental illness and the alleviation of psychological deterioration in the prison setting, and
(d) elective therapy services and preventive treatment where resources permit.

The standards are then broken down into eight major sections: Identification and Detection, Diagnosis and Referral, Treatment, Medication, Restraints and Seclusion, Confidentiality, Coordination, and Variances.

Identification and Detection includes a special screening for mental and emotional disorders for every inmate entering the system within the first 24 h of arrival. Available mental health services are described to the inmates, along with procedures for obtaining access to these services. Training for Department of Correction and Medical Services staff is mandated and must include the recognition of symptoms of mental illness, substance abuse, reactions to psychotropic medication, and signs of developmental disability. Staff must also be trained in the handling of mental health emergencies, suicide prevention, and basic first aid and cardiopulmonary resuscitation (CPR). The Department of Correction's Suicide Observation Aide program is made a part of the standards, with trained inmates paid for their services and receiving periodic performance evaluations.

Procedures for Diagnosis and Referral address the need for prompt access to services at all times. Twenty-four-hour access to emergency psychiatric care is mandated, and the Correction Department is given some responsibilities in ensuring that requests for care are transmitted promptly to mental health services staff and that inmates are escorted to mental health services areas promptly.

In the area of Treatment, special attention is to be given to those inmates who may be suicidal, developmentally disabled, or alcohol or drug abusers. Staffing patterns and space requirements are to be developed by the Departments of Health, Mental Health, and Correction. Special housing areas are mandated for inmates in need of close supervision for mental or emotional disorder. Dormitory space must be provided for potentially suicidal inmates. Each inmate in mental observation (MO) housing must have a written, individual treatment plan, which should include more than just the provision of medication. Special provisions for the developmentally disabled individual include the immediate notification of the court by the Department of Correction if mental health services determines that an inmate's developmental disability makes it clinically contraindicated that the inmate be housed in a correctional facility. Finally, inmates have the right to refuse treatment except in emergency situations, and informed consent is required before mental health treatment may be administered.

Guidelines for Medication stipulate that it shall not be used solely as a method of restraint or control, but only as one facet of a treatment plan. Prescription, dispensing, administration, and review will be covered in procedures to be developed. Likewise, Restraints and Seclusion shall not be used as a substitute for treatment or as punishment, and are strictly controlled and limited to a maximum of 4 h. After that time, if an inmate remains too agitated to be released from restraints, he or she must be moved to a municipal hospital prison ward.

Confidentiality of mental health records is considered essential to effective treatment,

even in the jail setting. Mental health services staff are required, however, to notify Department of Correction staff if an inmate is considered to be suicidal, homicidal, posing a clear danger of injury to self or others, presenting a clear and immediate risk of escape or riot, or requiring transfer for mental health reasons.

The standards call for the institutionalization of interagency Coordination. The representatives of mental health services, correction services, and health services (including nursing staff) are required to hold formal monthly meetings on the delivery of mental health services. Inmates who the Department of Correction feels are in need of punitive segregation, and who have a history of mental or emotional problems, must be seen by mental health services staff. Mental health services will be given an annual formal evaluation for quality, effectiveness, and level of performance by the Department of Mental Health.

Finally, guidelines for requesting Variances from either implementation dates or specific manner of implementation are delineated in the standards. The standards must be implemented; it is the form and not the standard itself which may be varied by the Board.

Implementation

Implementation of the standards was scheduled to take place over an approximately ten-month period, with services being phased in gradually over that time. The City of New York has committed an additional $2.3 million for Prison Mental Health Services in the first fiscal year (1 July 1984–30 June 1985). In fiscal 1985, the funding for this program was $5.15 million. The bulk of this funding was allocated through a service delivery contract with the Montefiore Hospital and Medical Center.

In the past, health and mental health services were provided in the correction system by both Montefiore and Prison Health/Mental Health Services. Prison Mental Health operated psychiatric services at all facilities on Rikers Island. Medical clinics at these facilities were operated by Montefiore, with the exception of the Rikers Island Mental Health Center and Rikers Island Hospital (at these two facilities, medical care was provided through Prison Health Services). In the boroughs, Prison Health/Mental Health furnished both medical and mental health services to the houses of detention, again with one exception. At the new Manhattan House of Detention, both medical and psychiatric care were furnished by Montefiore staff.

The new contract has rearranged this system. In each institution, all services, both medical and psychiatric, are delivered by a single-service provider. On Rikers Island, that is Montefiore Health and Mental Health Services. In the borough houses of detention it will be Prison Health/Mental Health. The Manhattan House and the Rikers Island Hospital and Mental Health Center are still the exceptions; their services will remain as before (Table 4).

The Montefiore program will use this integrated service approach to maximize services to inmates. The plan is based upon internal coordination of medical and mental health services within each institution, and gives medical, nursing, and administrative supervisors the responsibility for the integration of these services. Staff of the medical unit are on the premises of Rikers Island facilities 24 h a day, seven days a week, and provide mental health screening for all new inmates and emergency care if necessary. Medical staff refer to mental health staff all patients with a history of mental illness, past suicide attempts, or abnormal mental status. The program also encourage referrals from staff of the Department of Correction.

Mental health staff are in the institutions generally from 8 a.m. to 11 p.m., seven days a week. Efforts will be made to provide individual, group, and family therapy services to inmates whenever possible. The Mental Observation Areas (MOAs) are used for inmates who are too ill for general population housing, but not in need of intensive psychiatric monitoring. In these areas, mental health staff work closely with Department of Correction staff, who are assigned to the areas on a permanent basis and who receive special training in psychiatric observation skills from the Montefiore staff. Discharge planning is provided, includ-

TABLE 4—*1985 service delivery.*

Funding	Administration	Service Provider	Services	Institution
N.Y.C. Dept. of Mental Health, Mental Retardation, and Alcoholism Svs. (psychiatric svs.)	Dept. of Health	Prison Health Services and Prison Mental Health	medical and psychiatric	Bronx House of Det. Queens House of Det. Brooklyn House of Det. Brooklyn C.F. Rikers Isl. Hosp. Mental Health Ctr.
N.Y.C. Dept. of Health (medical svs.)	Montefiore Hosp. and Medical Center	Montefiore/Rikers Island Health Services	medical and psychiatric	A.R.D.C. A.M.K.C. H.D.M. C.I.F.M. C.I.F.W. Manhattan House

ing attention to interinstitutional transfers within correction, communication with mental health staff of the State Department of Correction, and referrals to community-based agencies.

The program emphasizes the need to develop and nurture liaisons among the various agencies involved in service delivery in the correction system. Montefiore will maintain ongoing communication with Prison Health Services, the Health and Hospitals Corporation, and the Department of Correction. To quote the Montefiore Proposal:

> Adequate systems of referral and followup and establishment of collegial professional relationships are essential so that continuity of patient care will be maintained.

The Prison Mental Health Service, which had been stretched thin trying to provide services to eleven major correctional institutions, has also been the recipient of funds for additional staffing. The program consolidated its personnel and, like Montefiore, began to coordinate medical and psychiatric services. The focus of the reorganization is to provide more intensive services, with particular attention to the Rikers Island Mental Health Center. That facility is used as a referral resource for the entire system for patients who require more supervision than can be adequately provided in the Mental Observation Areas, but who are not necessarily in need of hospitalization. The Mental Health Center and the Rikers Island Hospital, which houses individuals who are also behavior/management problems, are the intermediate stages of care in the treatment system. Special emphasis is placed on the referral, admission, and discharge procedures for these institutions.

The hospital based services have not been affected by the standards, since they are already in compliance with more elaborate types of regulatory guidelines (Joint Commission on Accreditation of Hospitals [JCAH], for one). They continue to provide treatment and diagnostic services to inmates who are so mentally ill as to require care in a hospital setting, for as long as such hospitalization is necessary. Referrals to the hospitals come from Prison Mental Health Services, the Montefiore Mental Health Services, and directly from the courts.

Conclusion

Now that the Minimum Standards for Mental Health Services are being implemented, the individual members of the Prison Mental Health Task Force have become understandably occupied with their own internal problems and needs to conform to the standards. The initial goal of the development of a unified plan for the provision of comprehensive health and mental health services to inmates of the New York City Correctional System seems to have been accomplished. Monitoring the effectiveness of the plan is now the responsibility of the administrative overhead agencies, the Departments of Mental Health, Health, and Correction. The subsidiary goal of getting to know each other better has certainly been accomplished over the course of several years of meetings.

The members of the Task Force are now turning their attention to other issues. Some of the subjects under consideration are planning for the discharge of mentally disabled inmates, alternatives to incarceration, and the impact of the standards on the hospital based services. Although the standards are in place at last, the Task Force will continue to meet to facilitate the free flow of information among the agencies concerned with providing comprehensive care and treatment in the New York City jails.

Bibliography

Brutsche, R. L., "Medical Standards for Corrections: A Status Report," *Corrections Today*, July-Aug. 1979.

"A Federal Strategy is Needed to Help Improve Medical and Dental Care in Prisons and Jails," Report of the U.S. General Accounting Office, 22 Dec. 1978.

Harness, J. K., "Comment: Correctional Health Care," *Advance,* University of Michigan Medical School, Winter 1984.

Jails: Intergovernmental Dimensions of a Local Problem, Federal Advisory Commission on Intergovernmental Relations, May 1984.

Lamb, H. R., Schock, R., Chen, P. W., and Gross, B., "Psychiatric Needs in Local Jails: Emergency Issues," *American Journal of Psychiatry,* Vol. 141, No. 6, June 1984.

Otero, R. F., McNally, D., and Powitzky, R., "Mental Health Services in Adult Correctional Systems," *Corrections Today,* Jan.-Feb. 1981.

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