FEATURE

In this second part of a two-part article, the authors present a rationale for the delivery of mental health services in prison, and their version of a community mental health model for such services. In an appendix, they present some specific items from their participation in major litigation involving the Utah Department of Corrections for the benefit of those readers who seek even more concrete guidance than is provided in their general formulation of a program. In the May-June issue, the authors established the legal foundation for an inmate's right to mental health treatment, analyzed questions related to how the obligation to treat may arise, and addressed the basic legal concepts of "serious medical needs" and "deliberate indifference." *See p. 339.*

Inmates With Mental Disorders: A Guide to Law and Practice

By Fred Cohen and Joel Dvoskin*

V. Existing Professional Standards

Many professional organizations have model rules or standards to guide policy in this and related areas. None of these models, including those promulgated by the American Bar Association,[79] the American Psychiatric Association,[80] the American Public Health Association,[81] and the American Correctional Association,[82] is both specific enough and on point to be sufficient for our purposes.

What follows is what none of the existing standards, model rules, or guidelines attempts to do: a service delivery model for prison-based mental health programs based on the legal predicates just discussed. Standards are not the equivalent of legal minima and, indeed, should not be. They should point the way, seek reform, or simply seek the best for the troubled individuals on whose behalf they speak. Our effort is to establish the law and then to provide a blueprint for compliance.

If this were a treatise, and if we actually were designing a prison mental health system, our treatise-plan would also consider in detail such matters as administrative structure and organization, a working definition of serious mental disorder, an array of treatment modalities, training, confidentiality, transfer, forced medication, and similar items.

What must be stressed is that the courts do not mandate any particular service delivery model and, indeed, rarely express even a preference. Eighth Amendment standards for prisons and due process standards for jails focus on outcomes – for example, the reduction of needless suffering, and untrammeled access to needed services. The choice of where to provide such services; preferences on the types of education or training of staff; preferences as to the various professionally endorsed treatment modalities; and preferences as to administrative structure and process, remain a "local option."

What follows is a model which, if adequately staffed and implemented, is well above constitutional mandates. We also believe our model to be cost efficient and desirable from the standpoint of both staff and inmates.

VI. Advocacy and Rationale for Service Delivery

There are three overriding reasons for providing *mental health* treatment within a prison environment, and together they provide an appropriate mission statement for any prison mental health system:

1. to reduce the disabling effects of serious mental illness in order to maximize each inmate's ability to participate in rehabilitative programs within the prison if he or she so chooses;

2. to reduce the needless extremes of human suffering caused by mental illness;

3. to help keep the prison safer for staff, inmates, volunteers, and visitors.

These three goals can provide a common ground for all the divergent interest groups competing for attention in correctional mental health. These interest groups can be grouped into four categories:

1. Legal advocates (i.e., the plaintiff bar).

2. Correctional management.

3. Inmate advocacy organizations.

4. Mental health professionals.

The first group, the plaintiff bar, obviously has an interest in prison mental health services. Class action litigation has been one major source of improved correctional mental

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health services. But, it has not been the only source.

Correctional administrators and managers are often strong advocates for increased resources for mental health services within prisons. As our experience in Utah showed, in addition to any altruistic motives for such support, these administrators have ample pragmatic bases to support such a position. First, there is a significant likelihood that inadequate mental health care will lead to aggressive and successful litigation both against the state Department of Corrections and the individual prison's administration. Aside from any consequences of a verdict against the state, the litigation process itself consumes a tremendous amount of staff time, and distracts the superintendent's attention away from the day to day management of a safe prison. Often, class action suits lead to tremendous anxiety on the part of staff at all levels, and to disruption of the prison environment as a progression of expert witnesses repeatedly tour the facility. Line staff may be asked to testify and, since this often is their first courtroom experience, their anxiety is understandable. Depositions, interrogatories, and production of documents can take hours or even days, and require additional time to be reviewed and corrected. Finally, lengthy appeals can be costly and create even more uncertainty and anxiety.

In addition to the costs of litigation, prison administrators and security staff often support mental health service improvements out of a belief that the absence of such services is deleterious to the working environment and leads to increased staff stress, burnout, cynicism, and absenteeism. Further, untreated inmates with mental illnesses are more likely to be involved in serious disciplinary infractions,[83] including assaults on staff and other inmates, as well as being the victims themselves of serious violence at the hands of more predatory inmates.

There certainly was a time when it was arguable that the mere *presence* of mental health services would lead to a higher concentration of inmates with mental illnesses in a given prison.[84] In many states, e.g., New York, California, Massachusetts, the psychiatric facility to which inmates were transferred accepted such transfers for quite long lengths of stay, often for the duration of each inmate's incarceration. However, litigation in the early 1970s dramatically increased the constitutional minima for psychiatric inpatient care,[85] either leading to the closure of facilities completely,[86] or raising the cost of care dramatically. Thus, while it was possible in 1976 to permanently remove as many as 10% of the inmates from the general prison population to a so-called "hospital," to do so now in a constitutionally adequate inpatient setting would result in enormous additional expense, multiplying the cost of each inmate's care more than four-fold.[87] Further, as we will discuss below, the courts have never required the permanent removal from prison of any inmate with mental illness, and to do so would not only leave the problem unresolved, it would result in a great deal of expensive, unnecessary inpatient care.[88]

The current reality, as was alluded to earlier, is that prisons have a large relatively predictable number of inmates with severe mental illnesses.[89] Administrators are thus faced with the choice of housing these inmates with adequate services, or attempting to house them without adequate services, at least until the plaintiffs' lawyers come calling. Not surprisingly, they are increasingly choosing the former.

The third group, inmate advocates, often pursues its objectives in the legal arena. In several states, this is done by state-funded legal advocacy agencies which serve inmates as their exclusive clients. State watchdog agencies, as part of their overall mandate to monitor prison conditions, have conducted studies of prison health and mental health care, complete with recommendations for improvements in service.[90] Other sources of advocacy have included inmate advocacy organizations,[91] ex-inmates, the inmates themselves, and even the media.

Two advocacy groups bear special mention. The Forensic Network of the National Alliance for the Mentally Ill (NAMI), and the National Coalition for the Mentally Ill in the Criminal Justice System,[92] have worked tirelessly to bring attention to inmates with serious mental illnesses. These two organizations have sought, wherever possible, to remove prisoners with mental illness from prison altogether, and for those who remain, they have sought improvements in the quality and quantity of mental health services available within the prisons.

A fourth group is made up of the professional staff who provide prison mental health services, along with their respective professional organizations. These organizations have been responsible for the creation and promulgation of a number of sets of standards for prison or correctional mental health care.[93] What these standards have in common is that each represents an attempt to establish benchmarks, which, if implemented, would generally upgrade the quality and quantity of such care. Professional staff also will often urge administrators to seek additional funding and staffing to provide inmates with access to a wider range of services.

Given these varying interests, and in the absence of any judicial mandates to implement a particular service delivery model, it is not surprising that there is not as yet any clear, nationally accepted model either for the mission of prison mental health services, the organizational models by which they can best be delivered, or the standards by which such services can be evaluated.

The overriding value of the mission statement proposed at the beginning of this section is to unite the four divergent interest groups described above. Where the traditional divisions between prison security staff and program staff still exist, we argue such divisions are both shortsighted and counterproductive. The presence of effective mental health services within a prison is as valuable to the prison staff as it is to the inmates who live there.

While our proposed mission statement includes reference to restorative care, reduction of human suffering, and the safety of the prison environment, it may come as a surprise to some readers that reduction of criminal recidivism is not to be found within our mission statement. While the reduction of criminal recidivism may in fact be possible through *correctional* rehabilitative programs, as asserted by Gendreau and others,[94] we are aware of little or no credible evidence that *psychiatric* programs in prison have any direct relationship to reducing criminal recidivism. [95] Further, as noted earlier in our discussion of the legal bases for mental health treatment in prison, courts have not required treatment which focuses on the attainment of goals outside the institutional environment. Rather, as the need for treatment stems from actual physical custody, so the focus of that treatment need not include objectives outside the custodial environment.

On the other hand, it would be wrong to assume that mental health programs within the prison have *no* effect on recidivism. If, as Gendreau asserts, correctional programs can indeed lower recidivism, then it follows that treatment which allows inmates with mental illness to more fully participate in correctional programs could indirectly improve the chances that individual inmates will take advantage of those programs and thus improve their chances of a successful return to the free world.[96]

Finally, let us be clear that the above discussion relates only to constitutional minima. Policymakers in any jurisdiction are free to decide, for example, that they wish to provide additional psychiatric care to meet their own goals. Nevertheless, before any jurisdiction invests in such additional goals, the jurisdiction must first meet the federal constitutional minima outlined above.[97] For those who are seeking constitutional compliance, economy, and some reasonable hope for success, we have prepared the model which follows.

VII. The Community Mental Health Model in Prisons

No matter how stressful, a prison is a community to the people who live and work within its walls. For this reason, it is useful to conceive of prison mental health in the context of providing a "Community Mental Health System" for each prison. The most important goal of this "community" system is that inmates receive all the care they need, but *only* the care they need. Systems can thus significantly reduce their reliance on very expensive inpatient care by providing far less expensive treatment alternatives within the prisons themselves. This approach not only saves money, it will allow more inmates to be served with each treatment dollar, improving both the quality and the quantity of care provided to the inmates.

Severe mental illnesses, such as schizophrenia, are almost always cyclical and somewhat episodic in nature.[98] The needs of inmates with severe mental illnesses will vary greatly over time, as will the severity of their mental illness and the level of functional disability. Even persons with the most serious mental illness, whether in prison or in the free world, will only need inpatient care during those periods of acute exacerbation of their illness. As the technology of mental health service delivery has improved, we are finding that we are able to maintain more and more persons with serious mental illnesses in their own communities – even prisons – without resorting to inpatient care, which is both quite expensive and often limits a person's other opportunities for the duration of such care. Thus, while brief inpatient stays were once derisively referred to as 'a "revolving door," they are, in fact, a much more effective and efficient way of providing psychiatric care.[99]

One issue which needs to be addressed is the auspice under which prison mental health services should be administered. Observers are divided as to whether departments of mental health or corrections are better able to deliver mental health services to inmates.[100] A compelling case could be made either for or against a variety of administrative arrangements. While a full discussion of administrative, fiscal, and clinical auspices is beyond the scope of this paper, a few important principles will be provided here.

First, which agency is better able to deliver the necessary fiscal resources? The answer to this question will vary from state to state and over time. Equally important is each agency's organizational commitment to the mental health needs of offenders. That is, a mental health department which does not care about inmates is just as bad as a prison system which does not care about mental illness. The best scenario is the one in which both mental health and corrections agencies and staff collaborate administratively and clinically in providing quality mental health services to inmates in a cost-effective manner.

The essential types of prison mental health services listed below are analogous to those offered in any community mental health service delivery system.[101]

1. *Screening and triage.* The national literature suggests that at least 15% of a population of convicted felons are likely to have serious or significant psychiatric problems.[102] Thus, any prison must be able to screen incoming inmates in order to identify those who need further assessment, mental health care, and/or special housing in a therapeutic environment. The most efficient way to do this is to make it part of the normal reception and classification process. This first level screening can be carried out by a variety of different staff, including nurses or correctional officers.

For this to work, it is important to maintain a very low threshold for referral to a mental health clinician for follow-up evaluation. Any history of psychiatric disability or inpatient care, any history of suicide attempts, any currently observable unusual behaviors or the appearance of depression – in short, any indicator at all –

should lead to a referral for further evaluation.

A low threshold supports the use of trained line staff, such as correctional officers or nurses, rather than more highly trained mental health clinicians, to perform this screening. Of course, the line staff should receive some training in what to look for, how to write behaviorally specific referrals (i.e., "What exactly did you observe that led you to question this inmate's mental status?"), and how to access the facility's mental health resources. The screening results should also be simply, clearly, and legibly documented, and reasonably standardized. That is, whether or not someone receives a follow-up evaluation should not be idiosyncratic to who was on duty, but should be reasonably predictable based on the types of services available and the threshold for receiving them.

2. *Follow-up evaluations.* Those inmates whose observable behaviors or reported history suggest the possible need for mental health intervention, should be referred to qualified mental health clinicians for follow-up evaluations. These evaluations should be timely and responsive to the referral questions raised. They also should result in practical treatment recommendations within the prison setting. Finally, in general, follow-up evaluations should be accomplished by staff who have achieved at least the masters or doctoral level in a recognized mental health profession such as psychology, psychiatric nursing, social work, or medicine.

Given the higher cost of psychiatric services and the frequent problems in recruitment, it often makes sense to have psychiatrists perform only those follow-up evaluations where there is a clear likelihood that psychotropic medications need to be considered.

3. *Crisis intervention services.* Despite the most diligent screening efforts, there are a variety of reasons that inmates will pass undetected through screens, only to appear later with emergent mental health problems. First, no screen is perfect, and some mental illnesses are marked by symptoms which are very subtle or easily hidden by the patient. Second, an inmate may enter prison with a mental illness in remission, only to later experience an exacerbation of that mental illness. Third, prison can be very stressful, and some mental health problems, such as depression or anxiety disorders, can be reactive to these stresses. Finally, we should note that many inmates enter prison as very young adults, frequently prior to the onset of serious mental illnesses such as schizophrenia.

For all these reasons, crisis intervention services should be accessible to all inmates. A timely and adequate response to crises can prevent inmates from deteriorating into more serious mental illnesses. The crisis service should include the same type of screening and triage as noted above, and should include some referral access to psychotropic medication,[103] supportive psychotherapy, as well as the other modalities and care options listed below. Finally, it is important to remember that the competent response to any crisis includes reasonable steps to decrease the chances that the crisis will recur.

4. *Crisis beds.* Many acute mental illnesses can be successfully treated and resolved if there is access to immediate, adequate, and appropriate psychiatric care. Inpatient hospitalization frequently can be avoided through the use of crisis beds, where patients experiencing acute suicidal depressions, acute exacerbations of psychosis, severe adjustment reactions, panic attacks, or any other psychiatric crisis, can receive care within the prison setting, at significantly less expense than inpatient hospitalization. These beds need to remain accessible, and thus require short-term (usually less than 10 days) aggressive intervention aimed at symptom reduction and stabilization, followed by transfer to more or less intensive care, as appropriate.

5. *Longer term residential treatment units (RTUs) or Intermediate Care Programs (ICPs).* Inmates with severe mental illness often have difficulty dealing with the stresses of prison as outlined above, and are especially vulnerable to the more predatory inmates in the general prison population. Like community residences in the free world, similar settings in prison have been shown to dramatically improve the quality of life for inmates with mental illnesses, while adding to the safety of the prison environment. A recent study in New York demonstrates that, at least for some inmates with serious mental illnesses, the ICPs reduce psychiatric crises, disciplinary violations, suicide attempts, and hospital transfers, by creating a psychologically (and perhaps physically) safer environment.[104]

In addition to being housed in a safer environment than the general prison population, this program should have some form of significant therapeutic programming, including psycho-educational and behavior modification components. Patients should be given information about their illness, the medications they may need in order to function, and even "how to do time" more successfully.

Three different kinds of inmates will find their way into these longer term residential programs. First, there is the "halfway in" inmate, who will use this setting to avoid inpatient commitment by removing himself for a time from the stresses of the general population. Second is the "halfway out" inmate who, after an inpatient stay, will use this option as a "decompression chamber" prior to returning to the general population. For these two groups, the program will be transitional and should have a widely varied length of stay, often more than six months. Finally, there is the "chronic" patient, whose placement in this program may represent the highest level of functioning he or she is ever likely to achieve in prison.

For several reasons, we do not recommend treating these three groups separately. First, it is often impossible to determine *a priori* who will and who will not be able to make this transition. Second, it is important to try moving inmates to less intensive treatment settings or to less secure prisons several times prior to "giving up" on their chances of ever leaving the program. Finally, in our

experience, a mix of patients with a variety of skills and levels of strength and impairment can enrich the treatment milieu.

The ICP inmates will function in many ways like members of a therapeutic community. There will be daily community meetings, and patients will be encouraged to participate in as many therapeutic activities as staff deem appropriate. Some ICP inmates will be progressively returned to the general population, perhaps by programming in general population during the day and sleeping in ICP for a transition period. By heavily programming these inmates, the program will be less attractive to lazy inmates who are looking to "kick back" by feigning mental illness.

6. *Outpatient clinic services.* Many inmates with mental illness or psychological problems are able to function adequately in the general prison population if they are provided with supportive services. These services include psychotropic medication, various types of individual and group psychotherapy, and case management, i.e., advocacy, information, support, and advice. In addition, certain inmates with serious mental illness or those in psychiatric crisis may also require special "outreach" services which deal with specific characteristics of their prison experience, their mental illness, or their life experience. Examples of these special populations include combat veterans, adult survivors of childhood physical or sexual abuse, victims of physical or sexual assault in prison, or inmates housed for long periods in disciplinary segregation.

This last group bears special mention. There is no more difficult dilemma in prison than the management of inmates with mental illness who, out of greed or anger (and not because of their mental illness), assault staff or other inmates. Good correctional management and the state's compelling interest in keeping the prison safe, require that there be clear and public consequences for such acts; the lack of such consequences may have grave effects on staff and inmate morale, in addition to endangering the safety of the prison. It also may be counter-therapeutic to imply to inmates that having a mental illness excuses any and all violence or disciplinary violations.

On the other hand, some inmates with mental illness find segregation so unpleasant and anxiety provoking that they will go to extreme lengths, including suicide, to force the system to move them out of segregation. Further, their response to segregation may truly and severely exacerbate their pre-existing mental illness. While there is no easy answer to this dilemma, it is at the very least a sensible step to provide on-site and regular mental health coverage to such units, to allow for ongoing assessment and support for inmates who may legitimately have trouble tolerating "hole" time, and temporary removal from segregation when appropriate.

7. *Inpatient services.* Certainly, for some inmates with serious mental illness, there will be periods of acute psychosis where no treatment short of intensive inpatient psychiatric hospitalization will be adequate. If all other aspects listed herein are in place, these stays can be few, far between, and of generally short (usually less than 60 days) duration. New York, for example, has been able to meet the inpatient needs of more than 60,000 inmates with only 191 inpatient psychiatric beds, thanks to the state's continuum of care within the prisons, and a median inpatient length of stay of approximately 35 to 50 days.

In order for a state's inpatient service to pass constitutional muster, there is no general requirement that the facility be accredited. In the context of civil psychiatric centers, however, it has been held that accreditation by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) is presumptive of constitutionally adequate care.[105] Thus, any state seeking to insulate itself from prison mental health litigation would be wise to seek such accreditation for its psychiatric inpatient facility.

8. *Consultation services.* Mental health staff in a prison can provide a valuable service by consulting with the prison's management team, including advice about particularly stressful practices and changes in the prison routine which might improve morale or reduce stress on vulnerable inmates.

The presence of an effective mental health team within a prison may have a variety of other subtle salutary effects on the institutional environment. For example, security staff may find mental health professionals useful in dealing with their own stress, or in suggesting alternative management strategies for dealing with the small number of especially problematic inmates for whom normal disciplinary strategies may be ineffective.

A second type of consultative service is the mental health staff's active participation in the pre-service and in-service training of correctional officers and program staff. Brief videotapes can also be shown in the daily briefings which occur prior to each shift, to provide in-service training at very low expense. In both cases, the training must include: how to recognize the early signs and symptoms of serious mental illness and suicide; the nature and effects of various psychotropic medications; and the nature of mental health services at the prison, as well as when and how to make referrals to those services.

In concluding our discussion of the rationale and a model for the delivery of prison mental health services, we again stress that we have not mentioned some important matters, including adequacy of medical records, details on making rounds, and aversive or other behavioral therapies.

VIII. Conclusion

There can be no doubt that the prison or jail custodian has a legal obligation to provide access to mental health services for the inmate with a serious mental disorder. The courts give such systems a wide range of discretion in how to provide such services, preferences on treatment sites and modalities, and service delivery models.

There is, of course, no discretion to do nothing. We have provided both the outline and some detail on a community mental health model that promises to work, to be cost effective, and which provides the framework for a constitutionally acceptable service delivery system.

Prison systems may conduct self-examinations and decide if they are in compliance, or they may wait until the lawyers call; and call they will. We understand that political considerations may at times dictate awaiting a lawsuit before inmates receive the services they require. We also understand how much more expensive in time and money it is to resolve these matters in the shadow of the courthouse.

Endnotes

79. American Bar Association's Criminal Justice Mental Health Standards (1989). Standard 7-9.7 states that services should be available for offenders who are mentally ill and those with severe mental illnesses should be in mental health facilities.

80. "Psychiatric Services in Jail and Prisons: Report of the Task Force on Psychiatric Services in Jails and Prisons" (Task Force Report No. 29, Am. Psychiatric Ass'n, 1989) [hereinafter "Am. Psych. Report'], does not address mental disorders, serious medical needs, or deliberate indifference.

81. Standards for Health Services in Correctional Institutions (2d ed. 1986) does not address mental health specifically.

82. Standards for Adult Correctional Institutions (3d ed. 1990) are inherently general, especially for mental health services.

83. H. Toch & K. Adams, *The Disturbed Violent Offender*, Yale Univ. Press, 1989. W. Condelli, J. Dvoskin and H. Holanchock, "Evaluation of New York State Intermediate Care Programs for Mentally Ill Prisoners" (unpublished manuscript 1991).

84. Indeed, superintendents in several states have privately admitted to Dr. Dvoskin exactly that rationale for opposing the placement of mental health programs in their prisons.

85. *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971), 334 F. Supp. 1341 (M.D. Ala. 1972), 344 F. Supp. 373 (M.D. Ala. 1972), 344 F. Supp. 387 M.D. Ala. 1972), *aff'd sub nom.* 503 F.2d 1305 (5th Cir. 1974). For an excellent discussion of the effects of *Wyatt see*, M. Perlin, *Mental Disability Law: Civil and Criminal*, vol. 2, at 29-71, The Michie Co., 1989. Although *Wyatt* involved civil patients, it has applicability to all facilities treating involuntary mental patients.

86. *Negron v. Ward*, 458 F. Supp. 748 (S.D.N.Y. 1978), a 1974 class action suit, led to legislation which transferred responsibility for inpatient treatment of prisoners with mental illnesses to the N.Y. State Department of Mental Hygiene, and required that Matteawan State Hospital be closed, to be replaced by a short-term inpatient facility at Central New York Psychiatric Center.

87. As an example, consider the approximate $82 per day cost of maintaining a general population inmate in New York to the more than $350 per day inpatient cost for the same inmate at Central New York Psychiatric Center. James Newton, Personal Communication.

88. In 1980, the Supreme Court made such transfers more difficult by requiring procedural due process. *Vitek v. Jones* 445 U.S. 480 (1980), 4 MDLR 92.

89. *See, e.g.*, H.J. Steadman, S. Fabisiak, J.A. Dvoskin, and E. Holohean, "A Survey of Mental Disability Among State Prison Inmates," 38 *Hosp. & Community Psychiatry* 1086 (1987).

90. *State Correctional Facility Health Services: A Systemwide Perspective*, New York State Commission on Correction, 1984.

91. D. Steelman, *The Mentally Impaired in New York's Prisons*, Correctional Ass'n of New York, 1987.

92. The National Coalition for the Mentally Ill in the Criminal Justice System, for example, held a large congressional briefing to encourage Congress to pay more attention to persons with mental illnesses in local jails (Jan. 16, 1991).

93. A partial list of standards published by professional organizations includes the following: American Association of Correctional Psychologists, *Standards for Psychology Services in Adult Jails and Prisons*, Beverly Hills: Sage (1980); American Psychiatric Association, *Psychiatric Services in Jails and Prisons: Report on the Task Force on Psychiatric Services in Jails and Prisons*, Washington: A.P.A. (1989); American Public Health Association; American Medical Association. *See also* Section V, *supra.*

94. P. Gendreau and R. Ross, "Revivification of rehabilitation: Evidence from the eighties." 4 *Just. Q.* 349-408 (1987); D.A. Andrews, J. Bonta, and R.D. Hoge, "Classification for effective rehabilitation: Rediscovering psychology," *Crim. Just. & Behav.*, Vol. 17, No. 1, at 19-52 (1990).

95. *See, e.g.*, G. Harris, M. Rice and C. Cormier, "Psychopathy and Violent Recidivism," *L. & Hum. Behav.*, Vol. 15, No. 6 (1991).

96. Indeed, if the focus of judicial decisions in this area had been external to the prison, then one would expect that there would be at least *some* discussion of the legal need for continuity of care. Yet, no important legal decision in this area has been found which even discusses such a requirement. F.T. Cullen and P. Gendreau, "The Effectiveness of Correctional Rehabilitation," in L. Goodstein and D.L. MacKenzie (eds.) *The American Prison: Issues in Research Policy*, New York: Plenum (1989); P. Gendreau and R. Ross, "Revivification of rehabilitation: Evidence from the eighties," *supra* note 94.

97. *See also* M. Perlin, "State Constitutions and Statutes as Sources of Rights for the Mentally Disabled: The Last Frontier," 20 Loy. L.A.L. Rev. 1249 (1987), who argues persuasively that state courts are the emerging locus of right to treatment litigation.

98. For an easily readable look at the predictable course of schizophrenia, *see* E.F. Torrey, *Surviving Schizophrenia: A Family Manual*, New York: Harper & Row (1983).

99. For an overview of the emerging paradigm for successful treatment of persons with serious mental illness, *see* W. Anthony, M. Cohen, and M. Farkas, *Psychiatric Rehabilitation*, Boston: Center for Psychiatric Rehabilitation (1990).

100. Metzner, Fryer, and Usery, "Prison Mental Health Services: Results of a national survey of standards, resources, administrative structure, and litigation," 35 J. of Forensic Sci. 433 (1990).

101. For a discussion of many of these essential services as they relate to local jails, *see* J. Dvoskin, "Jail-based mental health services," in H. Steadman (ed.) *Jail Diversion for the Mentally Ill: Breaking Through the Barriers.* National Institute of Corrections and National Coalition for the Mentally Ill in the Criminal Justice System (1990).

102. H. Steadman, S. Fabisiak, J. Dvoskin, and E. Holohean, "A Survey of Mental Disability Among State Prison Inmates," *supra* note 89. *See also* Appendix, *infra.*

104. W.S. Condelli, J.A. Dvoskin, and H. Holanchock, "Effects of Intermediate Care Programs on Serious Behavior Problems of Inmates with Mental Disorders," (unpublished manuscript).

105. *See, e.g., Pedroza v. Bryant*, 677 P.2d 166 (Wash. Sup. Ct. 1984).

APPENDIX

What follows is an edited version of a plan the authors devised for the Utah State Prison System (USP). This system had about 3,000 inmates at the time, and all the prison facilities involved in the litigation are in close proximity. We caution readers to view this Appendix simply as an illustration of what a working plan for services may look like.

General Approach to Mission of Mental Health Services

Adequate mental health professionals and other appropriate staff must be employed so that: (a) all inmates entering the USP system are adequately screened for signs of mental illness; (b) when such signs or symptoms are observed, a more thorough evaluation shall be performed by a person who is qualified by training and experience to provide diagnostic, rehabilitative, or therapeutic services to persons with mental illness. Generally, this will require at least a Masters or Doctoral degree in a mental health profession; (c) where so indicated, an individual treatment plan will be developed for the inmate with complete and regular charting to take place thereafter; and (d) a variety of services and levels of care shall be available thereafter to such inmate.

Serious Mental Illness Defined

Inmates who have a serious mental illness are constitutionally entitled to such mental health care as will avoid or reduce needless suffering. The USP adopted the following definition of serious mental illness: "a substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life."

Treatment Modalities

The USP, using a multidisciplinary approach, shall incorporate the best professional judgment of qualified mental health professionals in the continuance of existing programs and in the creation of new programs and physical facilities.

It is imperative that security and medical staff who observe inmates on a 24-hour basis have an opportunity for input to the treatment team at all stages of the treatment process. Such input will include not only security issues, but specific behavioral observations which are necessary to help prescribe and assess the effects of treatment.

Reception and Orientation: Screening

Within 24 hours of arrival, each inmate will be screened for mental illness, psychiatric crisis, withdrawal from alcohol or drugs, and suicide risk. The screening process will have the following elements: (a) adequately trained staff, either correction, medical, or mental health, will complete the screening; (b) a standard protocol will be utilized to avoid an idiosyncratic process where the identification of mental illness depends upon which screener is on duty; (c) any indication of either past or current mental illness or psychiatric crisis must result in referral for more extensive evaluation; and (d) the results of the screening must be clearly and legibly documented and be available to those responsible for medical and psychiatric care, housing assignments, liaison to outside agencies, and similar decisions.

Follow-up Evaluations

When an inmate is identified through the screening process or by referral as likely to need further evaluation or treatment, such inmate will be seen within 72 hours by a mental health professional. The evaluation must be adequate to answer the question posed by the referral and to make relevant treatment decisions, according to the best professional judgment of the evaluator.

When an inmate is identified at this stage as requiring mental health services, then the appropriate service shall be made available as rapidly as the condition or diagnosis dictates based on the judgment of the appropriate mental health professionals.

Training

Because medical and correctional staff interact with each other and members of either group may be called upon to identify and initially deal with inmates with mental illnesses, such staff will receive special pre-service, followed by regular in-service. Training will include: (a) recognition of signs and symptoms of mental illness in the inmate population; (b) recognition of signs and symptoms of chemical dependence and withdrawal therefrom; (c) recognition of adverse reactions to psychotropic medication; (d) recognition of mental retardation; (e) recognition of mental health emergencies and specific instructions on contacting the appropriate professional care provider and other appropriate action; (f) suicide potential and prevention; and (g) precise instructions on procedures for mental health referrals.

All such training shall be made a matter of record and such records shall indicate the individual's attendance and the course content.

Referral to Mental Health Services: Orientation

As a basic part of the inmate's initial reception and orientation to the USP, each inmate shall receive written material, prepared in non-technical, fully descriptive language, which explains precisely what mental health services are available at any unit or site within the USP. Such written material will be explained in a verbal session conducted by a trained staff member. Special attention shall be devoted to resolving problems associated with language barriers to understanding the written and spoken material. The objective here is to be certain that every inmate understands what mental health services exist and exactly how to gain access to such service.

Referral System

Referral is the process by which an inmate, having been initially identified or self-identified as possibly in need of mental health services, is provided with the opportunity for appropriate mental health evaluation or, in a crisis, the most expeditious means for gaining access to appropriate mental health services. Thereafter, inmates may be referred for mental health evaluation by any staff member. The staff member making the referral shall complete the "Habilitative Services General Referral Form," which is forwarded to the inmates' social worker. The social worker shall then forward the form to the relevant services administrator or provider. Inmates shall be evaluated and services provided as quickly and as efficiently as the particular condition, including the need for crisis responses, calls for in the professional judgment of appropriate staff.

Needs Assessment

Inmates who may not have had the full benefit of the enhanced screening, evaluation, and access to the appropriate mental health services shall be actively sought out, identified, and provided with access to such services as are appropriate. The USP shall ask that both corrections staff and mental health professional staff identify inmates who may have a serious mental illness and need appropriate services; staff also shall broadly disseminate, by way of written, posted notice, and verbally, the significant details of the mental health programs created herein and explain clearly how to gain access to such programs.

Mental Health Services: General

Recognizing that severe mental illness is nearly always cyclical and episodic in nature, the treatment needs of inmates with mental illnesses will vary with their diagnosis, behavior, and prognosis; and will vary with the individual over time. To meet these varied diagnosis and treatment needs, the USP will provide adequate mental health services designed for: (a) follow-up evaluations; (b) crisis intervention; (c) crisis beds; (d) longer-term residential care; (e) outpatient clinic services; and (f) inpatient services.

Professional Independence: Separation of Functions

Mental health professionals who participate in administrative decisionmaking processes such as, but not limited to, parole and furlough, should not be the mental health professionals involved in the treatment or counseling of inmates.

Staffing

Defendants agree to staff the USP mental health services with: 1 Unit chief; 3 Psychiatrists; 5 Psychologists (Ph.D. level); 4 MSW's; 1 Psychiatric Nurse Supervisor (MSN); 6 RN's, 2 day, 2 night, 2 evening; 2 Clerical staff; and 4 Activities therapists.

Evening and weekend coverage will be provided on-site on a rotating basis by psychology and social work staff. Psychiatric coverage for this time frame may be provided on an on-call basis. Night coverage will be provided via telephone on an on-call basis with on-site consultation when necessary by all mental health professional staff.

The mental health resources agreed to herein, and especially the staffing of mental health programs and the provision of the variety of mental health services, is based on a USP population of 3,000 inmates. The defendants hereby agree that significant increases or decreases in said population shall require either a commensurate increase, or allow a commensurate decrease, in the agreed upon mental health program staff and the requisite mental health services.

Crisis Intervention

Inmates must have speedy and easy access to crisis services. Crisis services may be initiated by any type or form of referral and include the following service modalities: (a) psychotropic medications; (b) special management precautions – may involve one-to-one measures, special housing options, constant observations, or other appropriate observation procedures; (c) verbal counseling, which may range from psychotherapy approaches to simply providing information or support; (d) alcohol and drug detoxification services; (e) consultation services to correctional staff on the handling of inmates who experience crisis; and (f) adequate documentation and communication to relevant others. Finally, competent resolution of any crisis will include some attention to prevention of a reoccurrence.

Crisis Beds

The state agrees to provide a minimum of 28 crisis beds, which will include the following features: (a) adequate numbers of trained staff to deal with inmates who may be acutely suicidal, dangerous to others, or otherwise experiencing a severe mental health crisis; (b) a physically safe environment with large vision panels in individual rooms, or dormitories where several suicidal patients can be observed by one staff member; (c) a minimum of 5 hours per day of out-of-cell structured activity, except where documented as clinically contraindicated; and (d) inmates generally will remain on this unit only for a brief period of time, usually less than 14 days.

Longer-term Residential Beds

For inmates who are unable to function in general population due to serious mental illness, the state will provide 50 longer term residential beds, which will serve 3 different populations: (a) "Halfway in" - inmates for whom transfer to this less stressful therapeutic setting will prevent an inpatient hospitalization; (b) "Halfway out" - inmates returning from inpatient hospitalizations who require a "decompression chamber" prior to returning to the general population; and (c) Inmates who are never able to adapt to general population and who will likely remain in this setting for the duration of their prison sentence.

The longer term residential setting will have the following features: (a) An environment in which inmates are protected from predatory inmates; (b) A full day of therapeutic programming, to include psychoeducational, behavioral and psychiatric rehabilitative components; (c) Inmates will be taught something about their mental illness, the medications they are being prescribed, and "how to do time" more successfully; and (d) Daily community meetings, along a "therapeutic community" model.

Out-patient Clinic Services

Many inmates with mental illness or serious psychological problems are still able to function adequately and safely in the general population if provided with adequate support. These support services may include psychotropic medication, various types of individual and group psychotherapy, and case management (i.e., support, advocacy, information, advice). Maintenance of inmates in the setting appropriate for their security status shall be considered a very important aspect of this entire mental health program.

High Security Inmates

Inmates in high security areas (i.e., segregation) may require special attention from mental health staff in order to achieve early identification of acute exacerbations of mental illness or psychiatric crisis. The state will provide at least 2 hours per day of on-site mental health professional staff in such units. While treatment needs may require the temporary movement of such inmates into mental health treatment settings, the classification and housing location of all inmates remains the responsibility of the security staff.

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