REPORT OF THE CORRECTION / MENTAL HEALTH TASK FORCE

"THE CARE AND TREATMENT OF MENTALLY ILL INMATES"

Pennsylvania
1981

A STUDY OF MENTALLY ILL ADULT INMATES IN PENNSYLVANIA 1980-1981

Issued by

The Correction/Mental Health
Task Force

August 1981

COMMONWEALTH OF PENNSYLVANIA

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CORRECTION/MENTAL HEALTH

TASK FORCE

August, 1981

Dear Friends and Colleagues:

It is with great optimism that the members of the Task Force release this report on mentally-ill inmates presently housed in Pennsylvania's overcrowded prisons.

The success of this group in reaching a concensus on recommendations is the result of the hard work and helpful suggestions of many individuals. Representatives with divergent views on many of the issues discussed by the Task Force recognized the critical need to identify and recommend solutions relative to the treatment of mentally-ill inmates.

Continued agency support and cooperation is expected as the Bureau of Correction, the Office of Mental Health and other public and private groups join to implement the recommendations described in this report.

The assistance and cooperation of those who participated in this research and discussion process has been greatly appreciated.

Respectfully yours,

Ian H. Lennox
Chairperson

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FORWARD

In Pennsylvania, as elsewhere, two custodial service systems exist side by side, the involuntary mental health treatment system, consisting primarily of the state hospitals; and corrections, consisting of the state penitentiaries and county jails.

With significant frequency, a prison inmate's needs may overlap both systems and require treatment for mental illness as well as correctional security. Moreover, the current overcrowding in prisons is known to cause a sharp rise in the incidence and intensity of such illness among the inmate population.

As a result, the question of how best to deal with the dual demands placed on each of these systems has become increasingly, if not critically important.

At present, mental health treatment, with a few exceptions, is not available in prison, either state or local. Instead, when an inmate's mental condition has seriously deteriorated, efforts are made to transfer him to a state hospital. Not only are the transfer proceedings cumbersome and often ineffectual - there is a severe shortage of hospital beds for forensic patients - but the hospitals have found these cases, once admitted, to be resistant and unmanageable.

In short, the mentally ill inmate has proved to be difficult and inconvenient for both systems, corrections and mental health. Each, in turn, for a variety of reasons, has not provided the services ordinarily associated with the other, and in the past, each has argued that it is ill-suited to accomodate the needs of the mentally ill inmate.

Corrections has said that a prison is not a hospital and that an inmate should not and could not be treated for mental illness in prison. Just as strenuously, the hospitals have contended that they were not jails and that untreatable criminals, identified as mentally ill, were committed to hospitals as mental health patients. Much needed hospital beds, they claimed, were inappropriately and unnecessarily used. Prior to this Task Force, with some important exceptions, neither system undertook to meet and resolve these issues head on but has chosen, rather, to circumvent them.

The Task Force was acutely aware that mental health treatment for inmates could no longer be put off or ignored. Instead, the realistic issues to be considered were, where should

programs. It is much cheaper and faster and, as a consequence, much more effective, than transfer to a state hospital. It also comports with the mandates of Pennsylvania's mental health laws.

Through the efforts of the Task Force, a crucial and extremely important agreement in principle was obtained between the Bureau of Correction and the Office of Mental Health to divide treatment for mentally ill inmates between emergency treatment in prison and long term or nonemergency treatment in the hospital. The Task Force emphasizes that this is the first time such an agreement has been reached between these two service systems and, in the light of past history, it is of unparalleled forensic importance in Pennsylvania. Both have agreed to cooperate in designing a program for mental health treatment in correctional institutions, state and county, and to work toward its implementation and ongoing administration.

The proper administration of treatment programs for the mentally ill inmate, whether in prison or in the hospital is essential. Close supervision is necessary to keep track of those difficult cases that, so far, have fit into neither system, to assist in obtaining compliance with the laws and regulations pertaining to corrections and mental health, and responsible advocacy is needed to obtain secure treatment resources. At the optimum, the Task Force considered and would recommend an Office of Forensic Administration within the Attorney General's Office, the purpose of which would be to make these systems responsible and accountable.

As a secondary position, recognizing the improbability that such an office would be established, the recommendation is a collaborative effort between the Bureau of Correction and the Office of Mental Health, as well as other organizations and agencies, in which the responsible "contact" staff would be designated to administer and coordinate the work of forensic services.

In recommending specific legislative and administrative changes, the Task Force has dealt with the problems noted in the report of the House of Representatives Crime and Corrections subcommittee entitled "The Joint Staff Task Force Report on Mental Health Services and Facilities in State Correctional Institutions" and issues identified during discussions among correctional, mental health, judicial and legislative representatives.

The Task Force recommendations, when enacted into law and/or implemented by administrators, will improve the Correction/Mental Health system and shorten the delay documented in the court processing and transfer of inmates from correctional to mental health treatment systems. However, the Office of

treatment be afforded, by whom, at whose cost, and according to what standards? Further, what kind of administration, supervision, and accountability would make sense and be workable? Sometimes, a hospital clerk could not even decipher the committing judge's signatures, so as to know to whom to send the report of evaluation. Sometimes, an inmate would have tried to destroy himself but would be denied immediate hospitalization because of various legal procedural requirements, such as a hearing after 72 hours. No one in either system was in a position to rectify any of these difficulties.

The Task Force eventually concluded that emergency mental health treatment should be administered in prison and long term treatment in the hospital. It defined emergency treatment consistent with the provisions of existing commitment law, the Pennsylvania Mental Health Procedures Act of 1976, as amended, Act 143, which provides a five-day emergency commitment, and a 20-day extension, or 25 days altogether, as the outside limits of an emergency. It agreed that if, during this period, the emergency nature of the mental illness developed into a less treatable, more permanent problem, the prison could immediately seek a full, long term hospital commitment. As to all of these recommendations, the Task Force was guided by the opinions and advice of its mental health and legal experts and authorities.

The Task Force considered the following:

1. Because of the high cost of forensic patient beds, it is unlikely that the present limited number in state hospitals, a total of 418, will be increased in the foreseeable future, even though there well may be a growing and much greater need.

2. Transferring an inmate from prison to a hospital necessarily involves administrative proceedings at both ends, secure transportation and security provisions in the hospital, and many delays in obtaining treatment. The door is also opened to inmate malingering. Clinical or hospital security differs from correctional security and their parameters are often difficult to reconcile. From a practical standpoint, many factors, including cost, argue strongly in favor of treatment in prison.

3. The delays in effectuating a prison to hospital transfer, often several weeks, result in inmates being kept in segregated prison units. Mental health treatment can and should be provided during such intervals.

4. In a substantial number of cases, inmates undergoing a mental health emergency or crisis can be treated in prison, much the same as a person confined to his home could be treated in the community, and with such treatment, a commitment to a state hospital could be obviated. This has been demonstrated in the Philadelphia and Bucks County Prison mental health treatment

Mental Health, the Bureau of Correction and other agencies will be unable to implement most aspects of the proposed changes unless additional funding is requested and provided. For example, recommendation #3 requires the Office of Mental Health to accept without delay persons involuntarily court committed to mental health facilities. This and other recommendations can not be achieved when state prisons, state operated forensic mental health units and county jails are at or over 100% capacity. Procedures must be instituted to ensure that those acutely in need of institutional placement receive adequate service.

Although an immediate expansion of service is needed, it is recognized that at the present time little can be done to immediately provide quality mental health care for the persons decompensating in Pennsylvania's prisons and thereby add significantly to the management problems of correction service administrators. However, planning must begin and incremental improvements are strongly recommended. Otherwise, serious, if not disastrous consequences can be expected.

Members of the Task Force advocate continued work on the problems and solutions described in this report by the Bureau of Correction, the Division of Forensic Services and the Bureau of Community Programs of the Office of Mental Health, the Pennsylvania Conference of State Trial Judges, the Pennsylvania Mental Health Association and other groups. Because of the serious and complex implications of the problems discussed in this report, funding shortages should not be a reason for maintaining the status quo. Rather, the documented need for funds should provide a challenge to those responsible for developing and managing adequate, timely and appropriate mental health treatment services for inmates.

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EXECUTIVE SUMMARY

PROJECT DESCRIPTION

The 22 member Correction/Mental Health Task Force was appointed in September 1980 by Attorney General Harvey J. Bartle III, with Ian H. Lennox as chairman. The members were selected from individuals with expertise in the development and operation of forensic mental health programs.

Following consultation with Attorney General Bartle; Secretary of the Department of Public Welfare, Helen B. O'Bannon; Commissioner of the Bureau of Correction, Ronald J. Marks; and Representatives D. Michael Fisher and Joseph Rhodes of the Pennsylvania House of Representatives, the Citizens Crime Commission sought financial support from the Pennsylvania Commission on Crime and Delinquency. This funding enabled the Citizens Crime Commission to ascertain specific problems in the delivery of mental health service to inmates in state and county correctional institutions and to provide staff services to the Task Force. Critical issues identified included:

1. The shortage of available mental health facilities to meet the treatment and security needs of inmates referred to courts for processing as per Act 143 (July 9, 1976) as amended by Act 324 (November 22, 1978) which will be referred to as the Mental Health Procedures Act;

2. Problems in court processing and delays in transfer of inmates in need of mental health services from the Bureau of Correction to forensic mental health programs;

3. Problems facing county correctional administrators in handling inmates in need of mental health services;

4. The inadequacy of Bureau of Correction programs that provide mental health services to inmates; and

5. The dangerous conditions that develop in prisons when inmate overcrowding and inadequate mental health treatment programming are allowed to occur.

PROJECT GOALS AND ACTIVITIES

The Attorney General asked the Task Force to develop within six months an action plan and implementation strategy to improve the delivery of mental health treatment services to inmates in state and county operated correctional institutions. Task Force recommendations listed in this final report will, if undertaken, accomplish that goal. The proposed plan requires an expenditure of approximately $3.9 million to improve staff. Capital funds will be required to provide emergency mental health treatment services within Bureau of Correction facilities. Additional resources are needed for county correctional mental health programs which will in the long term result in a more effective and cheaper system of mental health treatment for inmates.

At the first meeting of the Task Force on November 10, 1980, three subcommittees were appointed to address specific problem issues.

Facilities Subcommittee

The Facilities Subcommittee, chaired by Dr. Melvin Heller, focused on problems identified within the state system and surveyed problem issues at the local level.

Subsequently, the subcommittee visited forensic programs in five neighboring states and toured four Pennsylvania facilities including Farview State Hospital, the Regional Medium Security Forensic Unit at Norristown, Holmesburg's Mental Health Unit, and a new forensic mental health program developed at the Allegheny County Prison.

Following agreement that additional resources were needed to provide mental health services to inmates within Bureau of Correction institutions, the subcommittee developed the model of an emergency mental health treatment program that could be incorporated at the state level.

Legal/Legislative Subcommittee

The Subcommittee, chaired by Judge Edmund V. Ludwig, met on six occasions to examine the findings of a report on mental health services in Pennsylvania state correctional institutions completed in 1980 for the Crime and Corrections Subcommittee of the Pennsylvania House of Representatives. In addition, the Subcommittee reviewed the 1977 report of the Governor's Task Force on Maximum Security Psychiatric Care as well as examining other information.

The Subcommittee agreed upon specific recommendations for improving sections of the Mental Health Procedures Act and

recommended the formation of an inter-agency committee to work toward the development of a comprehensive system of mental health and treatment services for inmates.

Research Subcommittee

The Research Subcommittee, chaired by Mr. Arther Wallenstein, developed information to describe and quantify the problems presented to corrections administrators by inmates who require mental health services.

A questionnaire requesting information on the number of mentally ill offenders in county jails and state prisons in Pennsylvania was circulated. The Subcommittee served as a clearinghouse for information from research studies completed in Pennsylvania and other states. Finally, the circumstances resulting in an inmate's commitment to the mental health system was reviewed to determine, if possible, what preventive services offered by the correctional facility would have avoided the transfer from one system to another.

Other Task Force Activities

The Task Force defined a mentally ill inmate as "a person identified by correction or mental health staff who is unable to participate in regular prison/jail programs or activiites and who requires mental health treatment services." This includes those persons committable and in need of services as defined in the Mental Health Procedures Act as well as those unable to function in correctional programs due to their mental disability, but not committable for treatment in mental health operated facilities.

During the winter of 1980-81, the Task Force addressed the problem of time delays in the completion of commitment procedures under the Mental Health Procedures Act, the inappropriate use of limited medium and maximum security forensic units for non-criminal cases, the need for the Division of Forensic Services of the Office of Mental Health to establish policy and provide leadership to counties attempting to meet the treatment needs of mentally ill inmates, and the importance of continued and increased inter-agency cooperation between the Office of Mental Health and the Bureau of Correction. The Task Force commended the two agencies on their cooperative efforts and stressed the importance of promptly reviewing security requirements of patients at Farview State Hospital and the transfer of inappropriate placements to medium or non-secure mental health operated institutions.

Other issues addressed by the Task Force and referred to subcommittees for further review included:

1. The need for standards to guide the development of mental health treatment programs for inmates in state and local correctional programs.

2. The plan by which Task Force recommendations should be implemented and monitored.

3. Estimated costs of expanding mental health treatment programs operated by the Bureau of Correction.

SUMMARY OF MAJOR TASK FORCE RECOMMENDATIONS

At the final meetings of the Task Force on May 6, 1981 and June 17, 1981, recommendations were approved. Many are based on the principle stated in the MH/MR Act of 1966, 50 P.S. section 4201 that the Department of Public Welfare through the county MH/MR administrator must "provide within the State the availability and equitable provision of adequate mental health and mental retardation services for all persons who need them, regardless of religion, race, color, national origin, settlement residence or economic or social status."

The availability of resources affects the Department of Public Welfare's capability to address the legislative mandate. However, the scope of the problem defined in this report clearly indicates that prison overcrowding in Pennsylvania, the substantial number of inmates who require mental health services, and the disruptive impact of that population on the management of correctional programs necessitates the expansion of mental health treatment services in correctional institutions and in forensic mental health facilities.

A. RECOMMENDATIONS RELATING TO THE IMPROVEMENT OF MENTAL HEALTH SERVICES TO INMATES

Recommendation 1

Scope of the Problem

Additional treatment services managed by the Office of Mental Health Division of Forensic Services and expanded Bureau of Correction emergency mental health treatment facilities are required to meet the mental health treatment needs of the 912 inmates, or 6.0 percent of the total state and county correctional population, who are unable to participate in correctional programs due to their mental disability.* Management systems at the county and state levels must:

- Ensure the expeditious processing of inmates referred under the Mental Health Procedures Act;

- Ensure that the limited number of residential forensic treatment beds (418) operated within the Department's forensic system are used for mentally ill persons who have been charged with a crime and/or are serving sentence; and,

- Ensure that mental health services available to residents of the community are made available to jail inmates. It is recommended that the Office of Mental Health initially focus attention on the twenty-nine Pennsylvania counties that report dissatisfaction with existing community mental health service delivery systems. Moreover, the Office of Mental Health should initiate a process with counties for the purpose of developing a policy ensuring that appropriate mental health services available to residents of the community are made available to jail inmates.

Recommendation 2

a. Legislative Action

Legislative clarification of the Commonwealth's policy concerning the delivery of mental health services to inmates is required. As a matter of legislative intent and policy, it is recommended that state and county operated correctional institutions should develop or expand mental health treatment services intended, wherever possible, to allow an inmate to receive emergency mental health treatment services in prison.

*See page 34

The development of these services should reduce the frequency of transfer to state operated mental health forensic units.

b. Administrative Action

To fulfill the legislative mandate, the Bureau of Correction's and/or the Office of Mental Health's minimum mental health standards for state prisons and county jails should be based on the standards approved by the United States Department of Justice and ensure that each correctional institution in the Commonwealth has:

- Written policy and procedure that requires the screening and referral of cases involving mentally ill or retarded inmates whose adaptation to the correctional environment is significantly impaired. Moreover, staff charged with custodial and program responsibility are to be trained regarding the recognition of symptoms regarding mental health illness and retardation;

- Written procedures describing the process involved when petitioning an inmate under the Mental Health Procedures Act;

- Specialized programs for inmates not committable under the Mental Health Procedures Act, but who are unable to participate in correctional programs due to their mental illness;

- Written treatment plans for each inmate requiring close psychiatric and psychological supervision. The mental health treatment plan shall include directions to medical and non-medical treatment personnel regarding their role in the care, supervision and treatment of these inmates;

- Separate living units and/or specially trained staff whose services are secured either by contract or direct employment to treat inmates who exhibit severe mental health or mental retardation problems; and

- Sufficient resources and cooperative agreements with mental health agencies to provide prompt treatment for mentally ill inmates.

Recommendation 3. Amending the Mental Health Procedures Act

a. Definition of Treatment Facility

Section 103 - Scope of the Act

The definition of facility listed in Section 103 should be expanded to include mental health facilities within county jails and state prisons on the list of institutions that may be licensed to provide and/or operate emergency in-patient mental health treatment services.

b. Treatment for Mentally-ill Female Inmates

Section 105 - Treatment Facilities

This section should be amended to specify that the Department of Public Welfare shall provide adequate secure mental health treatment services for women charged with or convicted of a crime. This addition should not prohibit the treatment of women in existing or future facilities operated by the Department. It is included to emphasize the fact that at the present time there are no state operated forensic mental health treatment facilities for females.

c. Clarification of the Role of the Mental Health Review Officer

Section 109(a) - Mental Health Review Officer

Section 109(a) should be amended to authorize that a mental health review officer shall have the power to certify and order involuntary treatment under sections 304, 305 and 306 of this Act. This authority will enable the handling of cases heard by eliminating the review and approval of a common pleas court judge unless the person made subject to treatment then petitions the court for review as per section 109(b).

Section 302(d)(3) - Involuntary Emergency Examination

An addition should be made to this section to allow a 304 petition to be filed in cases where the emergency provisions of the Mental Health Procedures Act no longer apply, extended emergency care as per section 303 is not indicated, but there is a need for involuntary commitment pursuant to section 304 of the Act. This change will allow the initiation of a 304 petition following certification under section 302.

Section 303 (h)(2) - Extended Involuntary Emergency Treatment

Section 303(h)(2) should be amended to read: a judge or mental health review officer orders involuntary treatment pursuant to section 304.

Section 304(a)(1) - Court Ordered Involuntary Treatment

In order to reduce delay in the court's handling of cases, this section of the Act should be expanded to note that court

ordered involuntary treatment may be ordered by the authorized mental health review officer.

d. The Transfer of Jurisdiction

Section 304(b)(1) - Court Ordered Involuntary Treatment

This section of the Mental Health Procedures Act should be amended to ensure that the petition shall be filed in the Court of Common Pleas in the county where the person for whom treatment is sought resides.

Excepting that where the person is serving sentence, in which case:

- The mental health petition shall be filed in the Court of Common Pleas in the county of confinement and;
- A copy of the petition shall be forwarded to the Court of Common Pleas of the sentencing county. That Court shall within seventy-two hours after receipt of the petition choose to hear the case within ten days; or
- Approve of the mental health proceedings to be conducted in the county of confinement

e. The Scheduling of Hearings and Transfer

Section 304(c)(5) - Court Ordered Involuntary Treatment

This section of the Mental Health Procedures Act should be amended to read as follows: Upon a determination that petitions set forth such reasonable cause, the court shall appoint an attorney to represent the person and set a date for hearing and conduct the hearing as soon as practicable, but in no case longer than ten days. The attorney shall represent the person unless it shall appear that he can afford, and desires to have private representation.

Section 304(e)(8) - Court Ordered Involuntary Treatment

This section of the Mental Health Procedures Act should be added to provide that the transfer of the persons to a state operated facility pursuant to this section shall be carried out without delay unless otherwise directed by the Court.

Section 304(f) - Court Ordered Involuntary Treatment

This section of the Mental Health Procedures Act should be amended to add the following language: the Department shall accept for admission without delay all persons committed by order of the court or mental health administrator to a state mental health facility pursuant to this section.

B. RECOMMENDATIONS RELATING TO THE DEVELOPMENT OF EMERGENCY MENTAL HEALTH TREATMENT PROGRAMS IN PENNSYLVANIA BUREAU OF CORRECTION OPERATED INSTITUTIONS

Recommendation 4

Programs should be available to provide emergency mental health treatment services to inmates at Graterford, Muncy, Rockview, Huntingdon, Dallas, Camp Hill and Pittsburgh. If for administrative or logistical reasons it is not feasible to initiate such programs, then larger mental health programs should be developed in geographic areas where professional staff are available. The Bureau of Correction should plan and develop mental health programs as described by the Facilities Subcommittee and, where possible, contract with a professional mental health hospital or agency to provide the service.

During the planning process, the Bureau of Correction may identify alternative strategies that will result in the development of adequate mental health treatment services for inmates. Moreover, it may be necessary to phase in the development of emergency mental health treatment units in a planned sequence or on a regional basis. Thus, although the Task Force recommends that separate units in the state's major institutions are required to provide a continuum of mental health treatment services for inmates, it is recognized that factors discovered following the submission of this report must be considered prior to the proposed expansion of services. Administrative agencies and mental health program administrators require flexibility and broad decision making authority when assigned the difficult task of managing emergency mental health treatment units within state correctional institutions. Specific recommendations of the Task Force should not constrain that flexibility.

Recommendation 5

Funding requested by the Bureau of Correction for contracted or other services, additional staff and facility renovation should seriously be considered by the Governor's Office of Budget and Administration and by the Pennsylvania State Legislature. It is estimated that emergency mental health services can be provided to inmates in state correctional institutions at a yearly cost of about $518,000 per emergency mental health unit for staff services in 1982-83. Additional funds will be required for facility renovation, operating costs and supplies. It is anticipated that first year costs for each correction/mental health unit may exceed the estimated figure due to salary and renovation cost increases that occur prior to the submission of budget requests.

Regulatory/Licensing Process

Inmates in state operated correctional facilities should have access to mental health services available to residents of the community. Since the Department of Public Welfare's standards for approval of mental health facilities should be at least as stringent as those of the Joint Commission for Accreditation of Hospitals (Act 143 - July 9, 1976 - as amended), the Task Force recommends that each mental health unit operating in Bureau of Correction institutions should be at a level of care that conforms to regulations promulgated by D.P.W. Regulations should require that annual reports and evaluations are conducted and that appropriate corrective action is taken as indicated by the institution's governing authority.

Specific correction/mental health regulations should ensure the uniform operation and licensing of programs for mentally ill inmates in state and local correctional facilities. Regulations drafted in conjunction with the Bureau of Correction should be submitted to the Inter-agency Coordination Committee for review and comment. Following public dissemination and discussion, during which time the Office of Mental Health shall seek the approval of the Bureau of Correction, the regulations shall be promulgated by the Department of Public Welfare. Examples of items to be included in regulations are:

1. Treatment goals of mental health/correction programs;
2. Definition of terms, including mentally ill inmate, emergency treatment, in-patient service, out-patient service, mental health facility, correctional facility;
3. Legal base for the promulgation of regulations;
4. Governing authority;
5. General program requirements to include: program staffing requirements; client treatment and planning; service/treatment description, including in-patient services, out-patient services, right to refuse treatment guidelines, continuity of care guidelines;
6. Annual program planning process;
7. Record systems; and,
8. The involvement of community systems in programs operated by the specialized mental health treatment facility.

Regulations should be used by the Office of Mental Health to approve emergency mental health treatment facilities operating within institutions under the administrative control of the Bureau of Correction or county authorities.

Recommendation 6

An inter-agency agreement of cooperation should be developed by the Bureau of Correction and the Office of Mental Health, with the Inter-Agency Coordinating Committee having responsibility for assisting in the development of specific language contained in the inter-agency agreement.

The preamble of the inter-agency agreement may take the following form:

> WHEREAS the general statutes of Pennsylvania do not in all cases clearly define specific responsibilities for the delivery of mental health and mental retardation intervention to convicted offenders and, whereas many of these clients are served by both the Office of Mental Health and the Bureau of Correction during some phase of the treatment continuum; and whereas it is recognized that the prevalence of mental illness and mental retardation is significant for clients of the Bureau of Correction; it is therefore evident that formal agreement between the Commissioner of Correction and the Deputy Secretary of the Office of Mental Health is necessary to facilitate the delivery of mental health and mental retardation services to clients of the Bureau.

Other elements of the inter-agency agreement should include specifics as to the process used when transferring inmates from the state correctional system to facilities operated by the Office of Mental Health. Administrators of each agency should be responsible for coordinating aspects of the joint system and those responsibilities should be clearly defined. In addition, common behavioral profiles, which may identify inmates potentially in need of Office of Mental Health services, legal procedures to be followed when petitioning individuals to courts for transfer to the mental health system, and other factors required to facilitate the continuity of client care, should be included in the agreement.

C. RECOMMENDATIONS RELATING TO THE DEVELOPMENT OF MENTAL HEALTH TREATMENT SERVICES FOR INMATES IN COUNTY OPERATED CORRECTIONAL INSTITUTIONS

Recommendation 7

Since inmates in county correctional facilities have a right to receive a continuum of mental health treatment services consistent

with security requirements, and since at the present time the state of Pennsylvania funds 90 percent of mandated mental health treatment services at the county level and counties contribute 10 percent, then the same reimbursement should apply to the additional expenditure of resources by counties in order for local correctional facilities to meet minimum forensic mental health jail standards. Coordination in the delivery of mental health services can be achieved through the cooperative effort of local correctional and mental health administrators with assistance from the Office of Mental Health and the Bureau of Correction.

Recommendation 8

Improved service planning and implementation for local correctional institutions should include:

- The development of forensic mental health regulations for the licensing of emergency mental health treatment facilities in local correction institutions;

- A requirement that each county agency complete a forensic mental health service description as part of the yearly MH/MR plan. The description must meet minimum standards and service requirements established by the Office of Mental Health (see program descriptions listed in Appendix E.);

- An approved county policy stating that a continuum of mental health services must be available to persons held in all county correctional institutions. Services available to the general public but consistent with the security needs of inmates should be described in the policy;

- A directive from the Office of Mental Health that a portion of each county's MH/MR appropriation be spent on the implementation of the County Plan for Forensic Mental Health Services, to ensure that all minimum service requirements are met. An alternative approach could involve the joint development by counties and the Office of Mental Health of a detailed request for additional funds required to provide forensic mental health services identified in the county mental health service description; and,

- The monitoring of county planning efforts to ensure that the forensic mental health service description section is responsive to the needs of the local jail. It is suggested that the forensic mental health section of the plan be initialled by both the mental health administrator and the correctional administrator (warden/sheriff-warden). This will ensure ongoing collaboration between the two departments.

Recommendation 9

When an improved forensic mental health services system is in operation and monitoring reports issued by the Office of Mental Health indicate that the system of processing, screening, diagnosing and treating mentally ill inmates is functioning smoothly, then an assessment should be made to ascertain the need for additional Office of Mental Health operated secure forensic programs for mentally ill male or female inmates.

The Office of Mental Health should amend the existing five year plan to expand bed space and local service delivery capabilities in accord with population projections for both state and county correctional facilities. Forensic mental health facility (bed space) projections should be developed with the assistance of the Bureau of Correction, county correctional representatives, and groups such as the Pennsylvania Commission on Crime and Delinquency, which has produced detailed prison population projections. The projection of bed space needs should be completed within six months following the submission of this task force's report and presented to the Deputy Secretary of the Office of Mental Health and to the Commissioner of Correction for review.

The population projection study/need assessment should ensure:

- All 418 beds currently in service in Department of Public Welfare forensic mental health programs serve mentally ill persons charged with a crime and/or serving a sentence;

- All patients who do not conform to the above guideline have been transferred. It is the policy of the Office of Mental Health that forensic mental health units should not be used for non-dangerous geriatric patients and that non-maximum security prisoners/patients be transferred from Farview State Hospital to alternate facilities; and,

- The Office of Mental Health has reported to the Secretary of Welfare that all non-forensic mental health patients have been removed from forensic mental health units and that only appropriate cases are being admitted.

The Office of Mental Health should then plan programs and request resources that expand available forensic mental health services at the state and local level to meet identified mental health treatment needs of inmates.

D. RECOMMENDATIONS RELATING TO THE NEED FOR INTER-AGENCY COORDINATION AND MONITORING OF THE "FORENSIC MENTAL HEALTH SERVICES SYSTEM"

Recommendation 10

In order to continue the effort initiated by the Correction/Mental Health Task Force and to monitor the implementation of the Task Force's recommendations, an Inter-agency Coordination Committee should be established initially for a two year period.

It is proposed that this Inter-agency Coordination Committee be jointly established by the Commissioner of the Bureau of Correction, the Deputy Secretary of the Department of Public Welfare's Office of Mental Health and by the President of the Pennsylvania Conference of State Trial Judges and include representives of the Pennsylvania Commission on Crime and Delinquency, county mental health agencies and county correctional institutions. The existence of this committee should be endorsed by the Office of the General Counsel of the Governor and staffed cooperatively by participating agencies.

The functions of the independent Farview State Hospital Review Committee recently proposed by Governor Thornburgh should be expanded so that the strategy proposed to ease the overcrowding at Farview applies to all forensic mental health service facilities.

Examples of activities to be assigned to the Inter-agency Correction/Mental Health Coordination Committee include:

- The review of reports completed by the Office of Mental Health committees established to ascertain that patients are retained in the forensic mental health services system no longer than is medically necessary, nor returned prematurely to correctional or other institutions;

- The responsibility for advocating the implementation of recommendations developed by the Correction/Mental Health Task Force;

- The review of regulations developed cooperatively by the Office of Mental Health and the Bureau of Correction. Recommended revision of those regulations will be provided to agencies; and,

- The responsibility for advocating the use of management information systems to help administrative agencies in planning budgets and to ensure that an adequate number of professional staff provide quality services within correctional and mental health facilities.

The Corrections/Mental Health Task Force commends the Office of Mental Health and the Bureau of Correction on improved working relationships and cooperative efforts. Cooperation among state agencies, county agencies, academic mental health training resources, and other groups is a key element in the planning, management and delivery of adequate mental health services to inmates. The creation of the Inter-agency Coordination Committee should effectively maintain a high level of interaction with minimal cost to the Commonwealth.

APPENDICES

Recommendations listed in Subcommittee reports are provided for the reader's information.

Approved Task Force recommendations are included in the Executive Summary of this report.

APPENDIX A

REPORT OF THE

FACILITIES SUBCOMMITTEE

Chairperson, Dr. Melvin Heller

Members: Dr. Ray Belford
Mr. Robert Lerner
Mr. Gerald McEntee
Dr. Martin Myers
Dr. Herbert Thomas

I. INTRODUCTION

The Subcommittee was assigned the task of visiting forensic mental health units in Pennsylvania and neighboring states to identify factors essential to the successful operation of programs serving mentally ill offenders.

At the county level, the problem of providing mental health services to inmates varies so extensively that program "models" can only be considered within the context of the existing community conditions. Counties that have actively sought to provide mental health services to inmates in local correctional facilities have generally found a way to accomplish that end. At the present time, at least four major (2nd, 3rd or 4th class) Pennsylvania counties have appointed "forensic mental health task forces" to seek ways of improving the care of mentally ill, but non-commitable county prisoners.

II. SUBCOMMITTEE ACTIVITIES

At the initial meeting of the Task Force on November 10, 1980, Dr. Ray Belford described the limited resources that the Bureau of Correction has to deal with increasing numbers of persons who are unable to participate in correctional programs due to their mental disability. Although the number of inmates transferred from state correctional to mental health systems is small, about 2.0 percent of the Bureau's total population, or 160 persons per year, other inmates have mental health problems which substantially disrupt residents and correctional staff. No correctional programs now exist for this population.

Increased commitment of inmates to forensic mental health institutions has reduced the availability of bed space in those facilities. In the first nine months of 1980, 117 inmates

were transferred from the Bureau to mental health forensic units, but 117 were returned from those same facilities. In 1980 the total number of transfers reached 160 as compared to 94 transferred in the period September 1976 to December 1977. The legal and administrative constraints documented by the Joint Task Force Report on "Mental Health Services in Pennsylvania State Correctional Institutions" have resulted in an increase in the number of mentally disabled inmates residing in the state correctional system. The problem is compounded by the fact that increased numbers of mentally ill persons have been committed to prisons, rather than mental hospitals due to "tightening procedures for involuntary mental health hospitalization." (Steadman, 1981)

Limited treatment resources are a problem for the Office of Mental Health and for the Bureau of Correction. The Bureau's budget of $100 million in 1980-81 covers the cost of housing about 8,000 inmates in nine state institutions. The average yearly cost per inmate is approximately $12,500. The Office of Mental Health provides forensic mental health services to a maximum of 418 patients on a budget in 1980-81 of about $24.6 million. The average yearly cost is about $59,000 per patient.

While recognizing that treatment is expensive, one objective of the Subcommittee was to describe a mental health treatment program model that would increase the Bureau of Correction's capability of serving mentally disabled inmates at a reasonable cost.

The Facilities Subcommittee visited forensic mental health programs in five states and toured Pennsylvania's forensic mental health facilities, including those at Farview State Hospital, Norristown State Hospital, Holmesburg Prison and the Allegheny County Prison. The Subcommittee agreed that state correctional institutions should provide:

1. A limited number of mental health treatment and secure observation rooms to provide short-term care for inmates requiring separation from the general prison population.

2. Out-patient care with psychiatric and social work components. This should include a supportive mental health program for those unable to participate in prison activities due to mental illness.

Further, the Subcommittee planned to coordinate activities with representatives of the Bureau of Correction, Office of Mental Health and legislative staff members to outline the type and cost of mental health treatment programs to be developed by the Bureau.

Subsequently, a staffing pattern was developed and distributed to the Office of Mental Health and the staff of legislative representatives on the Task Force for review and comment. Dr. Melvin Heller, Dr. Ray Belford, Dr. Martin Myers and Dr. Herbert Thomas were instrumental in the conceptualization and design of the proposed mental health programs and in the review of program models identified in Pennsylvania and the nation.

At a subsequent meeting, the Subcommittee agreed that the Bureau can best meet the needs of mentally ill inmates after completing an assessment of the individuals' needs and then choosing from the following alternatives the appropriate treatment choice:

1. Severely mentally ill inmates should be promptly transferred to forensic mental health facilities operated by the Office of Mental Health - Division of Forensic Services.

2. Mentally ill inmates who require short-term observation and treatment for their mental disability should receive primary mental health care services within the prison. Resources, including professional staff, expanded facilities and the authority to contract for professional services are required to ensure the availability of basic mental health care services.

III. CRITICAL MENTAL HEALTH/CORRECTION PROGRAM ELEMENTS

As established by the Task Force, there exist in the population of state correctional institutions persons who are mentally ill but not involuntarily commitable under the Mental Health Procedures Act. In some respects the situation is analogous to the need for correctional institutions to provide basic medical care to those inmates exhibiting symptoms of a short-term medical illness. Inmates may on occasion require basic medical and/or mental health services and it is the institution's responsibility to provide primary treatment services on a timely basis.

The program model described in this report can be developed and managed in several ways. During visitations, Subcommittee members observed programs operated by civil service employees hired by state and local governments, as well as mental health treatment units staffed by professionals under contract to the administrative agency. Services provided in Bureau of Correction institutions should combine the strengths of both management approaches. Flexibility is essential to allow administrators to address staffing needs by combining, for example, contracted professional services

with public employees hired under civil service and union guidelines.

The following staffing model for Bureau of Correction emergency mental health programs is designed to accomplish several objectives:

1. To provide emergency mental health services in individual cells for acutely mentally ill inmates requiring intensive staff supervision. Some persons assigned to these secure rooms will require transfer to programs operated by the Office of Mental Health as per the Mental Health Procedures Act. Involuntary emergency treatment as per sections 302 and 303 of the Mental Health Procedures Act may be provided by the corrections based program. Extended involuntary treatment (section 304) should be provided by Office of Mental Health facilities.

2. To provide a mental health treatment area for those inmates who cannot be treated in the general prison population but are not severely mentally disabled and involuntarily commitable as per the Mental Health Procedures Act. It is expected that the voluntary provisions of the Mental Health Procedures Act will be utilized to authorize placement in these residential areas.

3. To provide additional out-patient services to inmates interested in and in need of treatment who are stable enough to maintain residence within the general inmate population.

4. To provide supportive activities to individuals participating in each of the mental health treatment components.

It is proposed that specialized units should be established at: Graterford, Muncy, Dallas, Rockview, Pittsburgh, Huntingdon, Camp Hill.

The cost of program planning, facility renovation, development and implementation could be included in a single budget request by the Bureau, phased in over several years. In either case, the development of the mental health areas is a critical element in the Task Force's proposal to improve the delivery of services to mentally ill inmates.

It is recommended that a mental health service unit be developed in or near the medical area for each 1000 inmates in a correctional facility. Thus, Graterford would require two units, Muncy would require one-half of a unit and five other institutions would require a single unit.

AREA AND STAFFING MODEL

(to serve 1000 Inmates)

Area Requirements

-- eight individual mental health observation rooms
-- one 10 to 15 bed area reflecting modern treatment design and with private sleeping quarters
-- one day room/recreation room
-- one interview/group counseling room
-- adequate staff office/counseling space
-- access to recreation facilities, craft shop, library, education programs, dietary facilities, etc.

Proposed Staffing Pattern (To serve 1000 Inmates)

-- two or more psychiatric consultants providing a total of no less than 24 hours per week and 24 hour on-call services
-- one licensed Ph.D. clinical psychologist
-- two psychological service associates, preferably with a master's degree
-- two correctional counselors to provide treatment planning and service coordination
-- one correctional counselor (2-10 shift)
-- five nurses (to provide full daily coverage)
-- six correctional security officers (to provide 24 hour coverage plus double staffing on the day shift)
-- one clerk steno
-- one clerk typist

TOTAL - 21 additional Bureau of Correction staff per unit

Since it is proposed that 7.5 units should be developed, a total of at least 157 staff would be required to provide basic programs to mentally ill inmates.

The Task Force advises the development of these emergency mental health units to provide a continuum of readily accessible services in state correctional institutions. When developed, these services will ease the transition of inmates between forensic mental health and correctional systems. In addition, they should prevent the decompensation of some inmates by providing outpatient services and day treatment services not now available in the prison setting.

In keeping with the intent of the Mental Health Procedures Act, services should be available to the inmate within the correctional institution of residence.

However, other alternatives to this approach may be identified during the Bureau of Correction's planning process. Moreover, the limited availability of fiscal and/or professional resources may dictate a multi-phase implementation process. The Task Force suggests that state facilities with the highest population, i.e., Graterford, be given priority consideration, if units are developed sequentially and not all in a single fiscal year.

ESTIMATED YEARLY COSTS FOR THE EXPANSION OF MENTAL HEALTH PROGRAMS IN STATE CORRECTIONAL INSTITUTIONS

The Bureau of Correction was asked to provide the Task Force with an estimate of the yearly cost of staffing such programs. An estimated cost is included for the renovation of areas within the prison to house the mental health program. Final renovation estimates would be developed following an on-site engineering study to be completed by the Bureau and may exceed estimates.

A. Staffing Qualifications and Estimated Costs

1. Psychiatric Consultation

Board certified psychiatrists will be paid at the rate of $60/hour for 28 hours per week, 52 weeks per year		$ 87,360.00

2. Psychologist - Ph.D. Licensed $ 24,632.00

3. Psychological Service Associates (2)

Master's level - Licensed $19,794 each X 2		$ 39,588.00

4. Correctional Counselors

Civil service minimum education and experience qualifications for a correctional counselor I and II apply $18,567 each X 3	$ 55,701.00	
Plus shift differential	700.00	$ 56,401.00

5. Nurses

$15,570 each X 5	$ 77,850.00	
Plus shift differential	2,100.00	$ 79,950.00

6. a. Correctional Officers (I)

$14,940 each X 5	$ 74,700.00	
Plus shift differential	2,100.00	$ 76,800.00

b. Correctional Officers (II)

$16,292 each X 1	$ 16,292.00

7. Clerk Steno	$ 12,500.00
8. Clerk Typist	$ 12,100.00
TOTAL STAFF SALARIES	$405,629.00
B. Personnel Benefits	$111,547.00

C. Renovation Estimate

Construction at each institution will be required to establish an adequate treatment area for the mental health program.

TOTAL STAFF SALARY COSTS	$405,629.00
TOTAL STAFF BENEFIT COSTS	$111,547.00
TOTAL STAFF COSTS PER UNIT	$517,176.00

Plus Construction Costs

It is recommended that 7.5 mental health programs should be developed in correctional institutions to treat an estimated 423 inmates unable to participate in correctional programs due to their mental illness. The total first year cost for staffing and benefits is estimated to be $517,176 per unit. If 7.5 units are in fact developed, approximately $3,878,820 will be required for staff.

The average yearly cost of treating a mentally ill inmate in the correctional setting would be about $9,170 plus the cost of renovating and other correctional support services, i.e., laundry, dietary, general prison security, etc.

One time construction/renovation costs for the units will require capital improvement funds. A facilities study is being conducted by the Bureau of Correction to estimate these costs.

APPENDIX B

REPORT OF THE RESEARCH SUBCOMMITTEE

Chairperson, Mr. Arthur Wallenstein

Members: Dr. Vincent Berger, Mr. Rendell Davis, Dr. Alexander Hawkins, Mrs. Marilynn Kanenson, Dr. Gerald Massaro, Daniel B. Michie, Jr., Esq.

I. INTRODUCTION

The Subcommittee agreed that, before valid recommendations for improving mental health service delivery to inmates in state and local prisons could be developed, reliable estimates of the size of that population were required. Second, there was the need to review research studies completed in the period 1975-1980 pertaining to the treatment needs of mentally ill inmates. Information to be examined included a report completed by the Pennsylvania House of Representatives Subcommittee on Crime and Corrections entitled "The Joint Staff Task Force Report on Mental Health Services and Facilities in State Correctional Institutions," November 1980. The Subcommittee agreed to investigate issues relating to the process of committing inmates to mental health facilities operated by the Department of Public Welfare's Office of Mental Health and to review management procedures in effect at those facilities.

The following report of the Subcommittee includes a description of activities completed and information obtained from state correctional administrators, local mental health administrators and local correctional administrators.

II. A STATISTICAL REPORT ON THE NUMBER OF MENTALLY ILL INMATES IN STATE AND COUNTY CORRECTIONAL FACILITIES

At the initial meeting of the Subcommittee, members agreed that a questionnaire should be distributed to all administrative officers of state and county correctional facilities. At the county level, jail administrators and county mental health administrators would be asked to jointly respond. Meetings were held with Bureau of Correction Commissioner Ronald J. Marks and Department of Public Welfare Office of Mental Health Deputy Secretary Scott Nelson to solicit their approval of a cooperative

research project that would provide quantitative information on the number of mentally ill inmates in state and local correctional facilities and promote discussion between county administrators responsible for the handling of mentally ill inmates at the local level.

There are nine state-operated correctional facilities administered by the Pennsylvania Bureau of Correction and sixty-six jails operated by sixty-four Pennsylvania counties. Philadelphia has three county-operated jail facilities, and three counties in the state do not operate jails. In this report, data from county and state systems is presented separately. All state and county data was developed by questioning correctional facility administrators and mental health administrators about the composition of the prison population on the date that the questionnaire was completed. Statistical information on this population is not regularly reported or compiled by any state or local agency at the present time.

Although it is impossible to exactly compare this research project with those completed in other states, a 1978 study in New York State found that between five and six percent of New York's 61,000 county and state inmates were severely mentally ill and in need of in-patient or out-patient mental health services as provided by the New York State Division of Forensic Services. Those results correlate closely with the findings of this Subcommittee. Copies of the covering letter and questionnaire are provided as an attachment to this report.

TABLE 1

Correctional Facilities
Capacity and Population (Winter 1980-81)

	STATE		COUNTY		TOTAL	
	Current Population	Capacity	Current Population	Capacity	Current Population	Capacity
Male	7,442	7,947	7,344	7,190	14,786	15,137
Female	230	285	329	482	558	767
Total	7,672	8,232	7,673	7,672	15,345	15,904

Narrative

Sixty-three of sixty-seven counties reported that facilities for males are operating at 102 percent of capacity, with prison overcrowding the greatest problem faced by jail administrators. It is most serious for male offenders in Philadelphia (130 percent), Chester (174 percent), Dauphin (104 percent), Lehigh (113 percent), Bucks (112 percent), and Montgomery (146 percent).

State correctional superintendents reported in December 1980 that about 150 usable cells remained available for housing inmates. However, state prison capacity for males will be reached by May 1981 as the result of a ruling by a three-judge panel in Philadelphia directing Philadelphia prison officials to reduce population at the City's three prisons.

TABLE 2

Inmates Petitioned For Court Review
As Per The Mental Health Procedures Act As Amended

	STATE		COUNTY		TOTAL	
	Number Awaiting		Number Awaiting		Number Awaiting	
	Hearing	Transfer	Hearing	Transfer	Hearing	Transfer
Petition 302	0	0	2	3	2	3
Petition 304	6	10	21	20	27	30
Petition 407	3	1	7	2	10	3
TOTAL	9	11	30	25	39	36

Narrative

A total of 75 of 15,345 or 0.49 percent of the inmates in state and county correctional programs were awaiting hearing (39) on a petition alleging the need for involuntary or voluntary

mental health services or were awaiting transfer (36) to a mental health treatment facility.

In cases involving state inmates, the "1980 Joint Staff Task Force Report" found that it usually takes 21 days from the time a petition is submitted until a court hearing is completed. Actual transfer to a mental health forensic unit may require an additional 7 to 14 days.

TABLE 3

Female Inmates
In Need of Mental Health Services

	State and County
Awaiting hearing or transfer as per the Mental Health Procedures Act	5
In need of placement, but legal procedures not yet initiated	10
Unable to participate in the correctional programs due to mental illness	26 (20 in Philadelphia)
TOTAL	41

Narrative

Forty-one of 558 (7.4%) female inmates were determined to be in need of mental health treatment services. In addition to the 41 female inmates listed, Muncy State Correctional Facility reported that 25 inmates in residence have extensive mental health problems, but symptoms are in remission.

Muncy State Correctional Institution does not have comprehensive mental health treatment services available for female inmates and no forensic mental health units are maintained by the Office of Mental Health to serve female inmates referred by correctional programs.

TABLE 4

The Number of Male and Female Inmates
Considered by Respondents
to be Commitable Under
The Mental Health Procedures Act

	STATE	COUNTY	TOTAL
Believed to be dangerous to others	24	43	67
Believed to be dangerous to themselves	49	45	94
Unable to care for themselves	20	45	65
TOTAL	93	113	226

Narrative

Two-hundred twenty-six inmates or 1.5 percent of those in state and county correctional institutions may exhibit behavior serious enough to warrant commitment as per the Mental Health Procedures Act.. However, because of limited treatment resources in correctional or mental health systems, only the most acutely mentally ill inmates are so committed. Philadelphia respondents estimated that the Mental Health Procedures Act might apply to ten inmates in addition to those already awaiting hearing (10) or transfer (2) to forensic mental health programs. Many counties, including Erie, Berks, Blair and York, reported that a high number of inmates should be petitioned and were in need of mental health treatment, but the limited availability of forensic resources precluded the initiation of the involuntary transfer process.

TABLE 5

Estimated Number of Individuals not Committable
But Unable to Participate in Correctional Programs
Due to Mental Illness

STATE	COUNTY	TOTAL
310 (4.0%)	301 (3.9%)	611 (4.0%)

About 4.0 percent of the male and female inmates in state and county correctional facilities are unable to participate in correctional programs due to their mental illness.

Narrative

Based on responses from 63 of Pennsylvania's 67 counties and the nine superintendents of Pennsylvania Bureau of Correction facilities, it is estimated that at a randomly selected point in time, 0.5 percent of the inmate population is awaiting a M.H.P.A. hearing or transfer to a forensic mental health unit; 1.5 percent may be commitable under the Act but has not been petitioned to court; and 4.0 percent is not commitable, but is unable to participate in the correctional program due to mental illness.

Thus, a total of about 912 inmates or 6.0 percent of the inmate population can be termed mentally ill and in need of mental health treatment services.

Other Issues Identified by Correctional and Mental Health Administrators

Administrators reported that M.H.P.A. processing delays are not as severe locally as at the state level. The average time required by the county to complete processing was reported to be four to six days for a 302 commitment, four to eight days for a 304 commitment and eight to twelve days for a 407 commitment.

For comparison the average time required for processing inmates in state facilities under the Mental Health Procedures Act was reported to be:

1 - 10 days for 302 commitments;
7 - 35 days for 304 commitments; and
10 - 90 days for 407 commitments.

When asked whether local plans for delivering forensic mental health services to inmates were adequate, 25 county administrators said yes and 29 said no. Nine stated that some services

were available, but additional forensic mental health services were needed. Four counties did not respond.

In response to the question, "List in rank order the five most serious issues or problems confronting prison/jai administrators in the Commonwealth," the following list was developed:

1. The most critical problem stated by correctional administrators related to the overcrowding in prisons and jails. Serious safety problems within prisons stem from overcrowded conditions and inadequate physical plants.

2. A general lack of fiscal resources to ensure the hiring of qualified staff, in-service staff training, physical plant improvement, and specialized treatment units ranked second.

3. Problems relating to the care and handling of mentally ill offenders ranked as the third most critical issue. Although the solution of the problem is related to issues 1 and 2, it includes:

   a. Serious delays in the transfer process to mental health forensic units;

   b. The lack of secure care mental health facilities operated by the Office of Mental Health;

   c. The absence of mental health treatment resources for females; and

   d. The inadequacy of transition procedures and follow-up services to provide clients with supportive mental health treatment services upon return to the correctional facility.

4. Legal problems, including the court's strict interpretation of the Mental Health Procedures Act and delays in the hearing process.

5. Other problem issues identified by correctional administrators included:

   a. The lack of coordination with local mental health agencies;

   b. Interference from outside groups concerned about specific aspects of the prison environment;

   c. The shortage of jobs and vocational training opportunities for inmates; and

MENTAL HEALTH/CORRECTIONS COUNTY FACILITIES - TABLE 6

FACILITY	POPULATION		MAXIMUM POPULATION		AWAITING 302		AWAITING 304		AWAITING 407		NEED COMMITMENT			PROCESS TIME 302		PROCESS TIME 304		PROCESS TIME 407		TOTAL PROCESSING TIME			Unable To Participate		Are Mental Health Services Adequate?	
	Male	Female	Male	Female	Transfer	Hearing	Transfer	Hearing	Transfer	Hearing	Dangerous To Others	Dangerous To Self	Unable To Care For Self	Transfer	Hearing	Transfer	Hearing	Transfer	Hearing	302	304	407	Male	Female	Yes	No
ADAMS	46		37											1	1	N/A	N/A	N/A	N/A	1			3		X	
ALLEGHENY	470	30	470	30										1	1	5	14	N/A	N/A	1	19		50	1		?
ARMSTRONG	15	1	21	4											1	?	10			1	10-?				X	
BEAVER	69	6	72	6								6		7-14	7-14	7-14	7-14	7-14	7-14	14-28	14-28	14-28	6			X
BEDFORD	22		22										2										2			X
BERKS	188	18	260	22			3			1	5	6	4	1	1	1	3	1	3	2	4	4				X
BLAIR	96	9	50	12			2	1		1	5	5	7	N/A	N/A	11	11	N/A	N/A		22		11	1		X
BRADFORD	19	0	36	0																			1			X
BUCKS	145	9	129	7	1							1		1	N/A	1-7	1-5	1-30		1	2-12	1-30	6	1	X	
BUTLER	23	4	37	6	1									1	1	1	1	1	1	2	2	2				X
CAMBRIA	85	1	150	8													3		3	1	3	3			X	
CAMERON	5		5											15		15	3	30	14							X
CARBON	22		50	3																						
CENTRE	32	1	42	2			1	1					1	N/A	N/A	1-2	3-5	1-2	3-5		4-7	4-7	5		X	
CHESTER	304		175					3		1	1	2	6	1-3	1-3	14-28	14-28	14-28	14-28	2-6	28-56	28-56	19			X
CLARION	20		26	6			1	1				1				3	3	10	7	1	3	17				X
CLEARFIELD	70		64							3	1			10	3-5	10	3-5	N/A	N/A	13-15	13-15					X
CLINTON	21		32										1	3-5	3-5								1			X
COLUMBIA																										
SUBTOTAL	1652	79	1678	106	2		7	6		6	12	21	21										104	3	5	11

FACILITY	POPULATION		MAXIMUM POPULATION		AWAITING						NEED COMMITMENT			PROCESS TIME						TOTAL PROCESSING TIME			Unable To Participate		Are Mental Health Services Adequate?	
					302		304		407					302		304		407							Yes	No
	Male	Female	Male	Female	Transfer	Hearing	Transfer	Hearing	Transfer	Hearing	Dangerous To Others	Dangerous To Self	Unable To Care For Self	Transfer	Hearing	Transfer	Hearing	Transfer	Hearing	302	304	407	Male	Female		
CRAWFORD	63		61	6							1	1	1			1	2-4	1	3-5	1	3-6	4-6				X
CUMBERLAND	70	3	85	10			1						1						1-14	?	?	?	1			X
DAUPHIN	239	25	230	30			1				5		3	1	1-2	14-21	7	14-21	7-14					1		X
DELAWARE	342	16	388	20				1			1			1-30	1-4	2-30	2								X	
ELK	6	19													3-4	3-4	3-4	3-4	3-4	3-4	6-8	6-8			X	
ERIE	202	8	190	16				2			6	5	3	N/A	N/A	1-30	2-3	N/A	N/A		3-33					X
FAYETTE																										
FOREST (No Jail)	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		
FRANKLIN	72	6	61	6										3	3	15	7	N/A	N/A	6	22		6			X
FULTON (No Jail)	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		
GREENE	9		27	2												1-5	1-5				2-10				X	
HUNTINGDON	17		25	1										1		1-3	3-5	1-3	1-3	1	4-8	2-6			X	
INDIANA	30	4	46	6					1					1	1	2	7	N/A	N/A	2	9				X	
JEFFERSON	12		15																							X
JUNIATA	10		20								1	1		1	1-5	1	3-20	1	3-90	2-6	4-21	4-90				X
LACKAWANNA	103		130	20											1		3	N/A	N/A	1	3					X
LANCASTER	213	9	260	16					1							1-30	7-10	1-30	2-3	1	8-40	3-33	6	2	X	
LAWRENCE	42		60	10								1			3								2		X	
LEBANON	116	3	142	8	1						1	1				N/A	N/A	N/A	N/A	1					X	
SUBTOTAL	3198	172	3418	257	3		9	9	2	6	27	31	29										119	6	13	19

FACILITY	POPULATION		MAXIMUM POPULATION		AWAITING						NEED COMMITMENT			PROCESS TIME						TOTAL PROCESSING TIME			Unable To Participate		Are Mental Health Services Adequate?	
					302		304		407					302		304		407								
	Male	Female	Male	Female	Transfer	Hearing	Transfer	Hearing	Transfer	Hearing	Dangerous To Others	Dangerous To Self	Unable To Care For Self	Transfer	Hearing	Transfer	Hearing	Transfer	Hearing	302	304	407	Male	Female	Yes	No
LEHIGH	189	10	167	12							1	3	2			1-2	7	N/A	N/A	1	8-9				X	
LUZERNE	173	9	241	10			2	1					1	N/A	N/A	1	1-2	14	10		2-3	24	15	3		X
LYCOMING	61	3	65	4												3-5	5	20	28	1	3-10	38	1			X
MC KEAN	23	1	44	8			1							1	3-4	1	3-4	1	3-4	4-5	4-5	4-5			X	
MERCER	44		56	4							4	1	1	1	1	2-10	1	2	1				6		X	
MIFFLIN	26	4	45	5			1				2	2	1	1	2	1	2	1	2						X	
MONROE	20		20	1										1	1	1	1	1	1	2	2	2			X	
MONTGOMERY	266		182				2	5			1	1		1	1	14-60	3-7						18			
MONTOUR	26		33												7		14		14							
NORTHAMPTON	183	6	200	7										1	1	2	7	N/A	N/A	2	9		12			X
NORTHUMBERLAND	68	1	91	3												1	3	1	3	1	4	4			X	
PERRY	6		12											1	N/A	2	8	2	10-14	1	10	12-16	2			X
PHILADELPHIA	2522	92	1950	130		2	2	8			1	4	5	1		5		10	10				100	20	X	
PIKE																										
POTTER	13	1	14																	3-4						?
SCHUYLKILL	75	1	90	5				1								3	25	N/A	N/A	1	28					X
SNYDER	13		4											5	3	N/A	N/A	N/A	N/A						X	
SOMERSET	27		33											2	2	3	5	3	5	4	8	8				X
SULLIVAH (No Jail)	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		
SUBTOTAL	6933	300	6665	446	3	2	17	24	2	6	36	42	39										273	29	21	25

FACILITY	POPULATION		MAXIMUM POPULATION		AWAITING 302		AWAITING 304		AWAITING 407		NEED COMMITMENT			PROCESS TIME 302		PROCESS TIME 304		PROCESS TIME 407		TOTAL PROCESSING TIME			Unable To Participate		Are Mental Health Services Adequate?	
	Male	Female	Male	Female	Transfer	Hearing	Transfer	Hearing	Transfer	Hearing	Dangerous To Others	Dangerous To Self	Unable To Care For Self	Transfer	Hearing	Transfer	Hearing	Transfer	Hearing	302	304	407	Male	Female	Yes	No
SUSQUEHANNA	14		21											1-2	1-2	14	5	14	5	2-4	5-14	5-14			X	
TIOGA													1													
UNION	10		19												1		2	N/A	N/A	1	2				X	
VENANGO	28	3	28	3											5	N/A	N/A	N/A	N/A	5					X	
WARREN	35		50											1	5	1-2	3-5	2-3	5	6	4-7	7-8				X
WESTMORELAND	45	5	58	4					1	1	1	2	1		5	20	5	1	7	5	25	8				X
WYOMING	8		10											1						1					X	
YORK	190	16	195	20				6			7	1	5	25	14	N/A	N/A	N/A	N/A	39						X
WAYNE	10		24	4											1	N/A	N/A	N/A	N/A	1					X	
WASHINGTON	71	5	103	5										1		3	14	3	14	1	17	17			.	X
TOTAL	7344	329	7173	482	3	2	17	30	3	7	44	45	45							4-6	4-8	8-17	273	29	26	29

MENTAL HEALTH/CORRECTIONS STATE FACILITIES - TABLE 7

FACILITY	POPULATION		MAXIMUM POPULATION		AWAITING 302		AWAITING 304		AWAITING 407		NEED COMMITMENT			PROCESS TIME 302		PROCESS TIME 304		PROCESS TIME 407		TOTAL PROCESSING TIME			Unable To Participate		Are Mental Health Services Adequate?	
	Male	Female	Male	Female	Transfer	Hearing	Transfer	Hearing	Transfer	Hearing	Dangerous To Others	Dangerous To Self	Unable To Care For Self	Transfer	Hearing	Transfer	Hearing	Transfer	Hearing	302	304	407	Male	Female	Yes	No
CAMP HILL	1112		1414						1	1	15	25	10	N/A	N/A	7-10	3-90	N/A	N/A		10-100		35			X
DALLAS	961		995				2					1	1	1		35	17	N/A	N/A	1	17-35		25			X
GRATERFORD	1852		1864				4	5			2	3	4	?		3	7-10	N/A	N/A	?	10-13		120			
GREENSBURG	235		184											N/A	N/A	5	5-7	N/A	N/A		5-12		3			X
HUNTINGDON	1089		1165				2	1		2	2		1	N/A	N/A	3	7				7-10	90	27			X
MERCER	172		180								1	1		5	5	5	5	5	5	10	10	10	10			
MUNCY	18	230	25	285							2	3	1	1	1	7	6	N/A	N/A	1	13					
PITTSBURGH	1052		1140				2				2	13	3	N/A	N/A	10	1	N/A	N/A		11		50			
ROCKVIEW	951		980									3		N/A	N/A	5	2	N/A	N/A		7		40			
TOTAL	7442	230	7947	285			10	6	1	3	24	49	20							1-10	7-35	10-90	310		26	4

d. The absence of an overall philosophy of corrections in Pennsylvania or objective management and organizational models for correctional programs.

The respondents voiced concern about the problems of mentally ill inmates, but generally had greater concern about basic problems affecting the entire prison population.

Tables 6 and 7 present data received from each county and state operated correctional facility.

III. DISCUSSION

A. Local County Planning and Programs for Forensic Services

Based on information received from sixty-four Pennsylvania counties, the prison or jail is the focal point for local correctional services. The availability and quality of services to respond to mental health problems at the local level is deficient and counties from one end of Pennsylvania to the other are critical of existing services and believe that additional service capabilities are needed in light of the tremendous demand for crisis intervention, evaluation, diagnostic screening, and related mental health program tasks. Jail populations in Pennsylvania are rising dramatically and as the county jail becomes more crowded it is anticipated that inmates will require more mental health services. (Steadman, 1981)

The Office of Mental Health has required counties to prepare a forensic mental health services plan as part of the overall county MH/MR plan in past years. This planning requirement was dropped in 1980-81 and there has been little incentive for counties to explore and develop meaningful forensic mental health programs in the absence of state funding incentives. Prisoners in the local jail have not been an effective advocacy group and, except in isolated jurisdictions, citizens groups have not been active in urging the creation of responsive mental health programs for pre-trial petitioners and sentenced inmates. It is apparent that the availability of forensic services has, in most counties, been an afterthought or an addendum to the larger county MH/MR master plan. Moreover, most institutional administrations have not been aggressive in requesting an expansion of mental health services within the correctional setting.

The Research Subcommittee in reviewing differences between county jails and state correctional facilities found that, while about six percent of the state inmates experience serious mental health problems, the state system does not confront the large number of crisis cases committed for short periods to local

prisons. Studies of and interviews with correctional administrators reveal that crisis intervention services are frequently required at the local prison. It is not surprising that the need for mental health crisis intervention services and responsive mental health commitment procedures is most pronounced at the local level due to the high number of intakes, the rapid turnover in population, and the general scarcity of mental health treatment resources in the correctional setting. Simply, the initial shock of incarceration and separation from the community causes the greatest stress to the inmate at the time of commitment to the prison. In addition, up to 40 percent of the pre-trial population in local jails may turn over within 24 to 48 hours, which indicates the great volume of persons processed by the local criminal justice system and highlights the need for the timely provision of mental health services at the local level.

County Comment on Mental Health Services and County Forensic Plans

Of the Pennsylvania counties responding to the Task Force questionnaire, 29 (56%) are not satisfied with the level of forensic mental health services and believe that the county plan for serving inmates in the jail is not acceptable. Some counties report that there is no county plan for delivering forensic mental health services to inmates. Some jails respond on a crisis management basis only when mental health emergencies arise. At the present time there are no state standards to guide the development of forensic services at the county level and county mental health administrators are not aware of what should be done in response to the needs of inmates in local correctional facilities.

Aggregate data do not adequately reflect the urgency of the problem. The seriousness associated with the lack of planning and service delivery becomes clearer when the size of the counties expressing dissatisfaction is reviewed. The 18 third and fourth class counties include most of the population centers in Pennsylvania. Among this group expressing dissatisfaction with the delivery of mental health services to inmates are: Berks, Chester, Erie, Luzerne, Westmoreland and York counties. Fourth class counties responding with dissatisfaction include Beaver, Cumberland, Dauphin, Lackawanna, Northampton, Schuylkill and Washington.

Twelve of the 16 (75%) responding third and fourth class counties found the forensic mental health services plan to be inadequate to meet identified needs. The counties account for a significant number of pre-trial admissions and an increasing number of sentenced offenders who are committed to the local county correctional facility.

Correctional administrators report that the jail is becoming a "dumping ground" for mentally disturbed persons who do not receive adequate social services in the community. Many district justices have noted that pre-trial prisoners are committed to the county jail because local courts have few alternatives when police and/or citizens insist that they be removed from the streets. Not only is the social policy decision seen by correctional administrators as inappropriate, but after the commitment to jail the correctional facility does not possess the service delivery capability to respond to the inmate's mental health problem. The problem identified in Pennsylvania counties has been substantiated in several other states by Dr. Henry Steadman and his associates the National Institute of Corrections' study of county prisons.

Correctional administrators perceive mental health Base Service Units to be unresponsive to inmate mental health problems within the county jail. Base Service Units in turn cite a lack of resources and the existence of more pressing public priorities as a reason for not providing appropriate services. Jails have often operated beyond the pale of any mental health planning and administrators in both disciplines admit that improved communication is needed.

Many Pennsylvania counties operate small detention facilities and, while the number housed is not statistically significant, the needs of the inmates in human terms are as important as those in the larger facilities. Over 60 percent of the sixth, seventh and eighth class counties express dissatisfaction with the county plan for forensic mental health services. These jails are often without the professional help found in larger communities. Lack of services to inmates in some instances reflects the lack of mental health services available to the general community.

Counties which report adequate services rely upon the Mental Health Base Service Units. Some smaller counties note that there is sometimes disagreement between correctional and mental health agencies regarding the nature and extent of help required. The jail is often confronted with interagency policy disputes when a prisoner is incarcerated. Mental health commitment procedures are either cumbersome or not applicable and interim services are often not available to handle the problem created by the presence of violent, suicidal or mentally incompetent persons in the county prison. Weekend and evening emergency mental health resources are spotty and numerous instances have been recounted in which sheriffs and wardens were obliged to handle serious mental health situations without professional assistance.

Since outpatient services are not generally provided by Base Service Units to inmates in county jails, third and fourth

class county administrators are frustrated in their attempts to secure mental health aid for inmates who have not exhibited "commitable behavior". Prevention and treatment services are generally not addressed in county forensic mental health plans and few jails report the availability of assistance other than crisis intervention.

Relationship Between Lack of Prevention Services and Crisis Cases

In most Pennsylvania counties forensic mental health service plans for the local jail include only a plan for response to a significant crisis which generally is defined in terms of Act 143 and relates to acts considered to be dangerous to self, dangerous to others, and behavior which indicates an inability to care for self. Services are initiated after the fact when jails are reporting that assistance is needed to prevent many of the acts which ultimately lead to commitment or which are potentially destructive to the disturbed inmate, to other inmates or staff within the local jails.

As jails are forced to accept mentally ill inmates, the lack of community-based mental health services becomes increasingly important. If services are not expanded, serious institutional management problems can be expected. County plans have not been responsive to these issues and state level mental health policy guidelines have been silent about the appropriate local response or treatment standards for local correctional programs.

Jail administrators do not want their facilities to become psychiatric hospitals or treatment centers for chronic and acute cases; however, it is increasingly recognized that the commitment process will not provide adequate or cost effective treatment for seriously disturbed persons who are committed to local correctional facilities. Jail administrators express frustration about their inability to control three key elements to this situation:

1. Incarceration of mentally disturbed persons in local county jails, which is the product of a social policy decision to remove mentally ill persons from large mental health hospitals;

2. Inability to place persons in a treatment setting in a uniformly expeditious and efficient manner; and,

3. Lack of resources to respond to the problems of the mentally disturbed persons who are committed to county correctional facilities.

Jails throughout Pennsylvania report that mental health services are narrowly defined by the Mental Health Procedures Act. Many jails cannot secure help unless section 302, 394 or 407

commitment procedures are initiated. Mental health services at the local level are often linked to the commitment process and this is perhaps where the problem exists. County plans, when developed, have focused on portions of the state statute, but not on the broader correctional/mental health problem. When a person is placed in a county facility because of mental health problems or when minor criminal behavior is significantly linked to mental disability but commitment to a mental health forensic unit is not the proper response, a range of short-term mental health treatment services to maintain the individual in the community may be needed. It is precisely these programs which are excluded from county plans and which are not available to the local jail.

Reliance on the Mental Health Procedures Act to define inmates in need of mental health services obscures the broader concept of mental health care. Experience has shown that when services are made available to non-acute cases exhibiting certain pathologies the likelihood of severe disturbance is reduced and commitment may be avoided. When services in the jail are not available, the prisoner's condition may deteriorate and a significant management/behavior/housing problem at the county jail may develop.

Forensic Mental Health Services in Larger Pennsylvania Counties

Larger counties report diversified services although the extent of the assistance available generally cannot handle the needs of the inmate population. Administrators of larger county jails recognize the need to provide crisis intervention, diagnosis and treatment services though emphasis is often directed toward the cases that may warrant commitment.

Counties reporting satisfaction with local mental health services rely on the Mental Health Base Service Unit to provide such assistance. Some Base Service units only provide the minimum services required for commitment procedures under Act 143. In some instances inmates must be taken from the prison to a local hospital because the commitment process cannot or will not be completed inside the prison.

In some counties, Base Service units provide inmates with mental health treatment through contracting with outside psychiatrists, clinical psychologists, or psychiatric social workers. The relationship between the prison and the Base Service unit may be cooperative and productive or it may be characterized by conflict over how mental health services are provided. Each county seems to operate differently, and neither standards nor required minimum levels of service exist. Base Service units with a special interest in forensic mental health do provide a full range of crisis intervention and treatment services to the prison population. This situation, however, is clearly the exception as the reports received from sixty-three counties indicate.

The Contracting Model for Mental Health Services With a Private Provider Organization

This model provides for a contractual relationship between the county or the local mental health/mental retardation department and a local mental health service provider with the Base Service Unit no longer responsible for providing services for the prison population. This strategy is used in only a few counties: Philadelphia (Hahnemann Hospital), Bucks County (Correctional Psychological Services). In each case the provider agrees to ensure a specific range of services and programs. These have been effective when the provider includes crisis intervention, diagnosis and treatment services. Funding may come from state mental health/mental retardation allocations or, in the case of Bucks County, from the county's tax revenues. General fund allocations are rare because few counties in Pennsylvania are sufficiently committed to providing forensic mental health care for prisoners. The private provider model is best used in areas where professional forensic experts are available in numbers sufficient to provide a full range of services. It is the model highly recommended by the Research Subcommittee.

B. State Prison Planning and Programs for Forensic Mental Health Services

The Research Committee reviewed information provided in questionnaires from each of the nine (9) state correctional facilities. It is immediately apparent that the quality and availability of services in state correctional institutions does not conform to any standardized program of services. The availability of resources is not dependent on the size of the institution or the program design. Some large maximum security institutions have a reasonably diversified mental health program while others do not. Highly programmed regional facilities may report little or non-existent mental health program capability within their facility. It appears that the availability of mental health services within the state system reflects the history of the individual institution, the historical commitment or personal commitment of individual administrators toward providing a mental health program, the availability of resources and the priority of mental health services as an operational program within the institution. In the past there has not been a standardized program or a basic minimum set of services that must be provided within each state correctional facility.

Several of the large maximum security institutions reflect the lack of planning for the delivery of forensic mental health services resulting in little or no significant capability for responding to anything other than immediate crisis situations. Services of one degree or another appear to be available for inmates who meet one of the three provisions of involuntary

commitment under Act 143. Each state institution has established an informal/formal procedure for responding to the commitment process but it appears that there is a lack of standardization as reflected in the negative comments of many administrators about the difficulty in carrying out the commitment process.

Systematic Planning and Program Monitoring

The Office of Mental Health does not require that state correctional institutions develop a plan for forensic mental health services in contrast to such a requirement for the counties. This may relate to the different funding streams that are involved in providing the resources for forensic mental health services as currently the Office of Mental Health, Department of Welfare, is not responsible for funding any of the mental health services in state correctional institutions.

The absence of systematic planning requirements hinders institutional administrators as they have few guidelines from which to plan an institutional program. There exists a divergence of opinion on how to develop a program within an institutional setting as well as what services to be provided and how these can be made available to inmates with mental health difficulties. Those differences need to be resolved.

Resource Allocation for Forensic Mental Health Services

The lack of a systematic planning requirement is reflected in the staffing patterns for forensic mental health services at state institutions. Service availability must in great measure reflect professional staff capabilities and the staffing patterns at institutions vary substantially depending upon the commitment of a particular institution toward providing the services and the resources available. It is apparent that because there are no minimum service levels, each institution must make policy decisions about the number of staff that are to provide mental health services under current budgets. Some state institutions do provide significant programs such as those existing at Pittsburg and Rockview. However, in most institutions treatment is generally limited to crisis cases, the commitment process and some counseling. In each instance the state institutions have requested additional resources.

The Commitment Process

The difficulty or lack of difficulty associated with committing under Act 143 varies widely from institution to institution. Some indicated it was virtually impossible to complete 302 Emergency Commitments and that commitments thus were limited to Sections 304 and 407 of the Act. Several institutions indicated that a considerable period of time passed before a person could be transferred to a state hospital after the commitment was

completed. This may reflect bureaucratic difficulties as well as the lack of bed space in state hospitals. Institutions do not have sufficiently qualified staff to maintain these individuals for any length of time after the commitment had been made. Correctional administrators were emphatic that the time lag between the completion of the commitment hearing and the transfer must be reduced. This will require a revision of Act 143 to provide for the immediate transfer of persons who have been legally committed. Because of the lack of systematic planning and the absence of minimum requirements, mental health services in prisons are often directed to the commitment process rather than to providing services on an out-patient basis to less ill inmates.

Out-Patient Services Within State Facilities

Virtually every state institution reported that professionally trained forensic mental health staff were not available to provide a systematic out-patient program to work with inmates who have mental health problems but who do not require extended commitment to a mental health facility. This group can present significant management problems within state facilities and may develop into crisis cases unless on-going assistance can be provided.

The importance of providing out-patient service increases as institutional populations escalate. An appropriate out-patient program within each state institution will require a substantially expanded staff of clinicians who are competent to work within a correctional environment. Such out-patient programs service those who are not able to participate in regular institutional programming because of their mental health difficulties as well as those who, while participating with the general population, still need mental health services in order to maintain an appropriate attitude during their incarceration.

Overcrowding and Expanded Mental Health Problems

Resolving the problem in state facilities involves upgrading of services for the current inmate population as well as planning for the future. In May, 1981, the Bureau of Correction announced that limited multiple occupancy celling would begin at state facilities. Over the next four years, it appears that state prison populations will continue to grow and if mandatory sentencing should be enacted, still additional persons will spend longer periods of incarceration.

The crisis will come not only from the increased numbers who will be incarcerated but from the housing densities that will result from multiple occupancy celling. The literature provides ample proof that more inmates will exhibit the symptoms

of mental illness as they are forced to live in closer proximity with their fellows. Both the perception and the reality of an increasingly crowded environment will demand that more out-patient services be made available to assist inmates who may already have mental health problems in responding to the stress of overcrowded conditions.

M E M O R A N D U M

November 26, 1980

TO: All County MH/MR Coordinators
All County/State Correctional Administrators

FROM: Dr. Scott H. Nelson
Office of Mental Health

Commissioner Ronald J. Marks
Bureau of Correction

Ian H. Lennox, Chairperson
Mental Health/Corrections Task Force

CREATION OF THE MENTAL HEALTH/CORRECTIONS TASK FORCE

We are writing to you regarding a project to review the mental health needs of inmates in the state and county correctional system in the Commonwealth of Pennsylvania. The Citizens Crime Commission of Philadelphia has received a grant from the Pennsylvania Commission on Crime and Delinquency, and over the next six months an intensive review will be made of the mental health needs of persons incarcerated in Pennsylvania facilities. A task force appointed by Attorney General Harvey Bartle, III is composed of persons representing state corrections, mental health, local/county corrections, members of the Legislature, members of the judiciary, mental health practitioners, and interested citizens. This task force will review the current situation and develop policy recommendations to be presented to the Attorney General concerning mental health services and the correctional system.

We ask that you assist in this statewide project and respond as promptly as possible to the enclosed questionnaire, which was developed by a subcommittee of the Attorney General's Task Force.

QUESTIONNAIRE ON MENTALLY ILL INMATES

IN STATE AND COUNTY CORRECTIONAL FACILITIES

One aspect of this review is to determine the number of persons currently incarcerated in Pennsylvania who require various types of mental health services. Attached is a questionnaire developed by the Mental Health/Corrections Task Force which is to be completed jointly by the mental health administrator and the prison administrator in each county. The same questionnaire will be completed by state correctional administrators and will provide basic data concerning the number of persons in need of services and their distribution in the state. The questionnaire should be completed as soon as possible and should be returned no later than December 10, 1980. If you have any questions regarding the questionnaire, they should be directed to David McCorkle, Citizens Crime Commission, Harrisburg Office, P.O. Box 1129, Harrisburg, PA 17108 (telephone 717 233-2141).

COOPERATION BETWEEN MENTAL HEALTH AND CORRECTIONS

It is recognized that any thoughtful approach to this problem must involve extensive cooperation between the appropriate mental health and correctional agencies. The Mental Health/Corrections Task Force hopes to foster this type of cooperative working relationship and the completion of this questionnaire should be considered a joint venture between the local county correctional facility and the county mental health/mental retardation agency. The directors should ensure that the questionnaire is jointly prepared and signed by a representative of the respective agency as part of this cooperative undertaking.

Your assistance with this project will ensure accurate data collection and will assist in the preparation of stronger and increasingly valid policy recommendations. We thank you for your cooperation in this matter.

PLEASE NOTE: Reference is made in this questionnaire to the Mental Health Procedures Act of 1976 (Act 143 as amended by Act 324 of 1978).

MENTAL HEALTH/CORRECTIONS TASK FORCE

RESEARCH SUBCOMMITTEE

Mr. Arthur M. Wallenstein, Chairperson
Dr. Vincent F. Berger
Mr. Rendell A. Davis
Dr. Alexander A. Hawkins
Mrs. Marilyn R. Kanenson
Dr. Gerard N. Massaro
Daniel B. Michie, Esq.

1. Name of facility _____

	Male	Female
2. Population on the date questionnaire is completed	_____	_____
3. Maximum capacity	_____	_____
4. How many persons now in your prison/jail found by the court or mental health administrator to require hospitalization in a state mental health facility are awaiting transfer as per Act 143? 302 commitments?	_____	_____
304 commitments?	_____	_____
407 commitments?	_____	_____
Other commitments?	_____	_____
5. How many persons now in your facility are awaiting a hearing or disposition of an Act 143... 302 petition?	_____	_____
304 petition?	_____	_____
407 voluntary transfer?	_____	_____
Other?	_____	_____
6. How many persons whom you believe are in need of commitment for mental health services as defined under the provisions of Act 143 are: Dangerous to others?	_____	_____
Suicidal or dangerous to self?	_____	_____
Unable to care for self?	_____	_____

7a. Describe the process involved when a person is involuntarily committed from your correctional facility to a facility operated by the Office of Mental Health.

b. About how long does it usually take for a mental health commitment to be completed?

302 -- _____ days to hearing _____ days to transfer

304 -- _____ days to hearing _____ days to transfer

407 -- _____ days to hearing _____ days to transfer

	Male	Female
8. How many persons not included in questions 1-7 cannot participate in regular activities or programs at your facility due to their mental/emotional problems?	_____	_____

9. Is the county plan for delivering forensic services to inmates adequately addressing the problem in your county? Describe your response.

10. What facilities or service provisions exist in the prison/jail for treating mentally ill offenders? Please describe.

11. Describe specialized staff members assigned to treat mentally ill offenders in your prison. This may include psychiatrists, psychologists or counseling staff. Please describe each category of specialized staff and list the hours per week of service provided by each.

12. List in rank order the five most serious issues or problems confronting prison/jail administrators in the Commonwealth.

This questionnaire was completed by:

Mental Health Representative: _____
Name and Title

Corrections Representative: _____
Name and Title

Only one response per county is requested. Mail in the enclosed envelope to the Citizens Crime Commission, P.O. Box 1129, Harrisburg, PA 17108.

Please call collect to Mr. David McCorkle at 717 233-2141 if you have questions regarding this questionnaire. Your assistance in this matter is appreciated.

APPENDIX C

REPORT OF THE

LEGAL/LEGISLATIVE SUBCOMMITTEE

Chairperson, Judge Edmund V. Ludwig

Members:
Judge Paul A. Dandridge
Senator D. Michael Fisher
Senator Philip Price, Jr.
Representative Lois Hagarty
Representative John F. White, Jr.
John Uhler, Esq.
Mr. Sam McClea
Robert Wolf, Esq.
Sherree Sturgis, Esq.

Assisting the Subcommittee were:

Ms. Kathy Clupper
Administrative Assistant, Representative John White

Mr. Anthony DeLuca
Assistant District Attorney, York County

Ms. Roberta Kearney, Research Analyst
Senator D. Michael Fisher

Ms. Mary Levy
Administrative Assistant, Robert Wolf, Esq.

Ms. Mindy Morrison
Research Analyst, Representative Lois Hagarty

Mr. Robert Moser
Administrative Assistant, Senator Philip Price

Mr. Dean Phillips
Law Clerk, Hon. Edmund V. Ludwig

I. INTRODUCTION

The Subcommittee reviewed laws from several neighboring states and assessed the applicability of portions of those laws to the Pennsylvania situation. In addition, a report completed for the Pennsylvania House of Representatives Subcommittee on Crime and Corrections entitled "The Joint Staff Task Force Report on Mental Health Services and Facilities in State Correctional Institutions" was recommended by Representatives D. Michael Fisher and Joseph Rhodes, Jr. to the Legal/Legislative Subcommittee for analysis. Other research studies reviewed by the Subcommittee included "A Plan for Forensic Mental Health Services in

Pennsylvania" (1977) prepared by Governor Shapp's Task Force on Maximum Security Psychiatric Care.

In addition, the Subcommittee studied correctional standards completed by the American Corrections Association, by the federal office of the attorney general, and by the American Medical Association, as well as reviewed a report by the General Accounting Office entitled "Jail Inmates' Mental Health Care Neglected; State and Federal Attention Needed."

Information gained from prior research activities, a review of current plans for improvement in correctional and mental health systems and an analysis of recent federal court cases relating to the care of mentally ill inmates was reviewed and serves as the basis of the recommendations presented in this report. Finally, the Legal/Legislative Subcommittee proposed the creation of an interagency committee to facilitate implementation of Task Force recommendations.

The Subcommittee observed that the prompt provision of appropriate mental health treatment services to inmates in state and local correctional facilities should result in the decreased use of expensive in-patient forensic mental health hospital units. A fiscal analysis was reviewed by Subcommittee members containing the estimate that a full range of mental health services can be provided to inmates in the state correctional system at the cost of approximately $45 per inmate per day as compared to the average cost of $161 per day for in-patient mental health hospitalization services delivered by the Office of Mental Health. The mental health service proposed for state correctional programs would provide a range of services including out-patient counseling and in-patient emergency residential services. Only in-patient residential programs now are provided in the mental health facilities.

Subcommittee Activities

It was agreed that in order to ensure the development of adequate mental health delivery systems in state and local correctional facilities, the legislature should act to establish a policy framework so that the Bureau of Correction and the Office of Mental Health could develop regulations for the operation of forensic mental health programs. Moreover, the group agreed that Bureau of Correction programs were not adequately staffed nor were there enough facilities available to provide special housing and treatment for inmates requiring mental health services. The Subcommittee concurred with the conclusion of the Governor's Task Force on Maximum Security Psychiatric Care that "A prison should be considered as part of the general community with a concomitant need for mental health services." Prisoners should be afforded within the correctional setting, the mandated services such as emergency and crisis intervention, diagnosis and evaluation, consultation, education and treatment which are available to the

non-prison mentally ill population. Finally, they agreed that improvements were required in the management and coordination systems linking the Department of Public Welfare's Office of Mental Health and the Bureau of Correction.

The Subcommittee noted that fiscal constraints will affect the implementation of standards and that the fiscal impact of recommendations would have an impact on the extent to which service delivery could be improved. It discussed specific changes required in the Mental Health Procedures Act to eliminate processing delays of persons residing in correctional programs who required treatment in forensic mental health facilities. Other issues discussed related to the lack of mental health treatment services for female offenders and the need for a strategy for the implementation of Subcommittee and Task Force recommendations.

The Subcommittee then addressed problems confronted by the Bureau of Correction when inmates are petitioned to courts under the Mental Health Procedures Act. The Subcommittee reviewed and approved specific legislative language intended to amend the Mental Health Procedures Act and to eliminate processing delays.

Major issues identified and addressed included:

1. The need for legislatively enacted policy guidelines defining a framework for the expansion of mental health services to inmates;

2. The need for minimum standards and regulations to ensure the availability of basic mental health treatment services in state and local prisons;

3. The need to eliminate processing delays currently experienced when inmates are petitioned to courts under the Mental Health Procedures Act;

4. The need for improved forensic mental health services for female offenders; and

5. The need to ensure the implementation of state and county program improvements in the delivery of services to mentally ill inmates.

The following are the specific Subcommittee recommendations:

1. In order to continue the efforts initiated by the Attorney General's Mental Health/Corrections Task Force and to oversee the implementation of the Task Force's resolutions and recommendations, an inter-agency mental health/corrections coordination committee should be established.

Pennsylvania" (1977) prepared by Governor Shapp's Task Force on Maximum Security Psychiatric Care.

In addition, the Subcommittee studied correctional standards completed by the American Corrections Association, by the federal office of the attorney general, and by the American Medical Association, as well as reviewed a report by the General Accounting Office entitled "Jail Inmates' Mental Health Care Neglected; State and Federal Attention Needed."

Information gained from prior research activities, a review of current plans for improvement in correctional and mental health systems and an analysis of recent federal court cases relating to the care of mentally ill inmates was reviewed and serves as the basis of the recommendations presented in this report. Finally, the Legal/Legislative Subcommittee proposed the creation of an interagency committee to facilitate implementation of Task Force recommendations.

The Subcommittee observed that the prompt provision of appropriate mental health treatment services to inmates in state and local correctional facilities should result in the decreased use of expensive in-patient forensic mental health hospital units. A fiscal analysis was reviewed by Subcommittee members containing the estimate that a full range of mental health services can be provided to inmates in the state correctional system at the cost of approximately $45 per inmate per day as compared to the average cost of $161 per day for in-patient mental health hospitalization services delivered by the Office of Mental Health. The mental health service proposed for state correctional programs would provide a range of services including out-patient counseling and in-patient emergency residential services. Only in-patient residential programs now are provided in the mental health facilities.

Subcommittee Activities

It was agreed that in order to ensure the development of adequate mental health delivery systems in state and local correctional facilities, the legislature should act to establish a policy framework so that the Bureau of Correction and the Office of Mental Health could develop regulations for the operation of forensic mental health programs. Moreover, the group agreed that Bureau of Correction programs were not adequately staffed nor were there enough facilities available to provide special housing and treatment for inmates requiring mental health services. The Subcommittee concurred with the conclusion of the Governor's Task Force on Maximum Security Psychiatric Care that "A prison should be considered as part of the general community with a concomitant need for mental health services." Prisoners should be afforded within the correctional setting, the mandated services such as emergency and crisis intervention, diagnosis and evaluation, consultation, education and treatment which are available to the

non-prison mentally ill population. Finally, they agreed that improvements were required in the management and coordination systems linking the Department of Public Welfare's Office of Mental Health and the Bureau of Correction.

The Subcommittee noted that fiscal constraints will affect the implementation of standards and that the fiscal impact of recommendations would have an impact on the extent to which service delivery could be improved. It discussed specific changes required in the Mental Health Procedures Act to eliminate processing delays of persons residing in correctional programs who required treatment in forensic mental health facilities. Other issues discussed related to the lack of mental health treatment services for female offenders and the need for a strategy for the implementation of Subcommittee and Task Force recommendations.

The Subcommittee then addressed problems confronted by the Bureau of Correction when inmates are petitioned to courts under the Mental Health Procedures Act. The Subcommittee reviewed and approved specific legislative language intended to amend the Mental Health Procedures Act and to eliminate processing delays.

Major issues identified and addressed included:

1. The need for legislatively enacted policy guidelines defining a framework for the expansion of mental health services to inmates;

2. The need for minimum standards and regulations to ensure the availability of basic mental health treatment services in state and local prisons;

3. The need to eliminate processing delays currently experienced when inmates are petitioned to courts under the Mental Health Procedures Act;

4. The need for improved forensic mental health services for female offenders; and

5. The need to ensure the implementation of state and county program improvements in the delivery of services to mentally ill inmates.

The following are the specific Subcommittee recommendations:

1. In order to continue the efforts initiated by the Attorney General's Mental Health/Corrections Task Force and to oversee the implementation of the Task Force's resolutions and recommendations, an inter-agency mental health/corrections coordination committee should be established.

It is proposed that this inter-agency coordination committee be jointly established by the Commissioner of the Bureau of Correction, the Deputy Secretary of the Department of Public Welfare's Office of Mental Health and by the President of the State Conference of Trial Judges. The existence of this committee should be endorsed by the Office of the General Counsel of the Governor and staffed cooperatively by participating agencies.

Moreover, functions of the independent Farview Review Committee proposed by Governor Thornburgh, should be included in the duties assigned to the Inter-Agency Coordination Committee to ensure that the strategy proposed to ease the overcrowding at Farview be expanded to include the entire forensic mental health services system.

Examples of activities to be assigned to the Inter-Agency Mental Health/Corrections Coordination Committee include:

1. Reviewing clients referred and committed to forensic units operated by the Office of Mental Health to ascertain that commitments are appropriate and that patients are retained no longer than is medically necessary;

2. Advocating the implementation of recommendations developed by the Attorney General's Mental Health/Corrections Task Force;

3. Identifying the type of psychiatric treatment required by offenders confined in state and local correctional facilities;

4. Reviewing regulations jointly developed by the Bureau of Correction and the Office of Mental Health;

5. Advocating and/or overseeing the development and use of management information systems to help in planning budget forecasting and to ensure that an adequate number of professional staff provide quality services within correctional and mental health facilities; and

6. Continuing activities initiated by the Task Force to the extent that data on mental health needs of inmates in Pennsylvania can be used to project the numbers of persons who require mental health treatment in a secure facility, as well as developing an annual report on the delivery of mental health services to inmates.

2. To clarify the Commonwealth's policy concerning the delivery of mental health services to inmates, minimum mental health standards for state prisons and county jails in Pennsylvania

should be established by the Pennsylvania State Legislature. Minimum standards should be promulgated to ensure that each jail and state prison in the Commonwealth has:

1. Initiated treatment efforts intended wherever possible to allow an inmate to remain in prison and thereby not require transfer to a state operated mental health forensic unit;

2. Written policy and procedure that requires the screening and referral of cases involving mentally ill or retarded inmates whose adaptation to the correctional environment is significantly impaired. Moreover, staff charged with custodial and program responsibility are to be trained to recognize mental illness and retardation;

3. Written procedures describing the process involved when petitioning an inmate to court under the Mental Health Procedures Act;

4. Specialized programs for inmates not committable, but who are unable to participate in correctional programs due to their mental illness;

5. Written individualized treatment plan for each inmate who requires close psychiatric and psychological supervision, to include directions to medical and nonmedical treatment personnel regarding their role in the care, supervision and treatment of these inmates; and

6. Separate living units and/or specially trained staff secured either by contract or direct employment to treat inmates who exhibit severe mental health or mental retardation problems.

It is further recommended that the minimum mental health standards as listed should be included in Senate Bill 579 and House Bill 680 which propose the development of a Department of Corrections in Pennsylvania.

3. The legislature should direct that specific regulations should be promulgated by the Office of Mental Health to ensure the uniform operation of programs for mentally ill inmates in state and local correctional facilities. Legislation should require that regulations be drafted by the Office of Mental Health, reviewed by the Inter-Agency Coordination Committee and approved by the Bureau of Correction. The regulations should then be promulgated by the Secretary of the Department of Public Welfare.

Examples of items to be included in the regulations, which will be implemented within twelve months of the passage of enabling legislation include:

1. Service goals of mental health/corrections programs;

2. Definition of terms, including mentally ill inmate, emergency treatment, in-patient service, out-patient service, mental health facility, correctional facility;

3. Legal base for the promulgation of regulation;

4. Governing authority;

5. General program requirements to include: program staffing requirements, client treatment and planning, service/treatment description, including in-patient services, out-patient services, right to refuse treatment guidelines, continuity of care guidelines;

6. Annual program planning process;

7. Record systems; and

8. The involvement of community systems in programs operated by the specialized mental health treatment facility.

Such regulations shall be used to approve mental health treatment facilities operating within institutions under the administrative control of the Bureau of Correction. At a minimum, each of these facilities should provide emergency care, special housing, and treatment for mentally ill inmates awaiting hearing or transfer as per the Mental Health Procedures Act. Counseling and other out-patient services for mentally disturbed inmates should be provided.

4. An inter-agency agreement of cooperation should be developed by the Bureau of Correction and the Office of Mental Health, and the Inter-Agency Coordinating Committee should have responsibility for assisting in the development of specific language contained in the inter-agency agreement.

The preamble of the inter-agency agreement could take the following form:

> "Whereas the general statutes of Pennsylvania do not in all cases clearly define specific responsibilities for the delivery of mental health and mental retardation intervention to convicted offenders and, whereas many of these clients are served by both the Office of Mental Health and the Bureau of Correction during some phase of the treatment continuum; and whereas it is recognized that the prevalence of mental illness and mental retardation is significant for clients of the Bureau of Correction; it is therefore evident that formal agreement between the Commissioner of Correction and the Deputy Secretary of the Office of Mental Health is necessary to facilitate the delivery of mental health and mental retardation services to clients of the Bureau."

Other elements of the inter-agency agreement should include specifics as to the process used when transferring inmates from the state correctional system to mental health facilities. Administrators of each agency should be responsible for coordinating aspects of the joint system and those responsibilities should be clearly defined. In addition, common behavioral profiles, which may identify inmates potentially in need of mental health services, legal procedures to be followed when petitioning individuals to courts for transfer to the mental health system, and other factors required to facilitate the continuity of client care, should be included in the agreement.

5. The review of studies completed by the staff of the Pennsylvania State Legislature and in 1977 by the Governor's Task Force on Maximum Security Psychiatric Care underscores a need to improve the delivery of mental health services to female inmates.

Specific service improvements include:

1. The expansion of mental health treatment services at Muncy State Correctional Institution; and

2. The improved delivery of mental health services to females in county jails.

Moreover, the Subcommittee recommends further investigation of this critical issue by the Division of Forensic Services to determine what additional services are required in Pennsylvania to meet the treatment needs of mentally ill female offenders.

6. Since inmates in county correctional facilities have a right to receive a full range of mental health treatment services, and since at the present time the state of Pennsylvania funds 90 percent of mandated mental health treatment services at the county level and counties contribute 10 percent, then the same reimbursement should apply to the additional expenditure of resources by counties in order for local correctional facilities to meet minimum mental health jail standards. Coordination in the delivery of mental health services must be achieved by the

cooperative efforts of local correctional and mental health administrators. The Office of Mental Health should notify counties of this policy.

7. Recommendations Amending the Mental Health Procedures Act

1. Section 103

Section 103 should include county jails, city jails, and state prisons on the list of institutions that may provide and/or operate emergency in-patient mental health treatment services.

2. Section 105

This section should ensure that the Department of Public Welfare shall provide adequate secure mental health treatment services for women charged with or convicted of a crime. This section shall not prohibit the treatment of women in currently existing or future facilities operated by the Department.

3. Section 109 (a).

Section 109 (a) should ensure that mental health review officers shall have the power to certify and order involuntary treatment under sections 304, 305 and 306 of this act.

4. Section 302 (d)(3)

This section should permit a continuation of mental health treatment in cases where a determination is made that the emergency provisions of the Mental Health Procedures Act no longer apply, but that there is a need to order and provide for involuntary treatment not to exceed 90 days pursuant to Section 304 of this act as entered by a mental health review officer.

5. Section 303 (h)(2)

Section 303 (h)(2) should permit a judge or mental health review officer to order involuntary treatment pursuant to Section 304.

6. Section 304 (a)(1)

This section should permit court ordered involuntary treatments to be initiated by the authorized mental health review officer.

7. Section 304 (b)(1)

This section should permit that the petition shall be filed in the Court of Common Pleas in the county where the person for whom treatment is sought resides. Excepting that where the person is serving sentence, the jurisdiction shall be exercised by the court of the sentencing county and upon request of the court of jurisdiction shall be transferred to the court where the person is confined.

8. Section 304 (c)(5)

This section should read as follows: Upon a determination that petitions set forth such reasonable cause, the court shall appoint an attorney to represent the person and set a date for hearing and conduct the hearing as soon as is practicable, but in no case longer than ten days. The attorney shall represent the person unless it shall appear that he can afford, and desires to have private representation.

9. Section 304 (e)(8)

Section 304 (e)(8) should permit the transfer of the persons to a state operated facility pursuant to this to be carried out without delay unless otherwise directed by the court.

10. Section 304 (f)

This section should be amended to ensure that the Department shall accept for admission without delay all persons committed to a state mental health facility pursuant to this section.

8. A mental retardation procedures act is needed to better define the procedures required to identify and treat the needs of mentally retarded persons.

This recommendation hopefully will lead to the differentiation of persons of mental health treatment due to retardation and those requiring treatment for other forms of mental illness. The recommendation is based in part on the findings of a team of mental retardation professionals who analyzed the population housed at Farview State Hospital in 1979. It was noted that due to the high number of individuals residing at Farview who exhibited mental and intellectual deficiencies, the need for a specialized mental retardation program existed. "The results of this review strongly support the need for a highly structured setting that provides intensive, prescriptive programming for

mentally retarded persons. This need is especially evident for clients who are either adjudicated offenders or highly aggressive/assaultive. No element of the current mental retardation residential services system addresses this need; thus, emphasizing the importance of assessing the need for such a service on a statewide basis and then taking steps to either modify existing settings or developing new ones. It is recommended that the Office of Mental Retardation establish a mechanism to study this need and to recommend means for establishing services that are appropriate to meet the programmatic needs of mentally retarded persons who also require secure settings."

Since to this date mentally retarded/sentenced offenders included in the population at Farview are not receiving treatment for their specific mental illness, it is the Subcommittee's intent to provide an alternative mechanism to provide services to this population.

The draft recommendations were discussed, revised and included in the report of the full Task Force.

Conclusion

If implemented, it is anticipated that the recommendations of the Subcommittee will:

1. Ensure that limited and expensive Office of Mental Health forensic hospitals that provide mental health treatment in maximum and medium security settings will serve appropriately committed offenders on a timely basis;

2. Provide improved emergency mental health treatment services in correctional facilities and thereby reduce the occurrence of transfer of inmates to mental health facilities; and

3. Encourage community based mental health programs to better address the needs of inmates in local correctional programs within the serious constraint of limited fiscal resources.

On June 12, during a meeting attended by Commissioner Marks and Dr. Nelson, the Subcommittee agreed on the need to develop mental health programs in state correctional facilities to provide emergency and extended emergency involuntary treatment services as per sections 302 and 303 of the Mental Health Procedures Act. Specific recommendations concerning the regulation and licensing of those programs and other issues are the basis of final recommendations approved by the Task Force.

APPENDIX D

RESOURCE MATERIAL

Resource List

During the study of mentally ill inmates housed in state and local correctional facilities, a list of informational resources will be maintained. Examples of resources used to date are listed below.

1. The American Medical Association - the Chicago based association, has recently developed "Standards for Psychiatric Services in Jails and Prisons." Copies of the Standards are available upon request.

2. Dr. Alvin Groupe, an official of the California State Department of Health, commissioned a study in 1976 to ascertain the need for an availability of mental health services for inmates. That study was completed by Arthur Bolton Associates, and has been requested, but not received as of November 10, 1980.

3. Mr. Henry Steadman - Research Foundation, New York Department of Mental Hygiene. Mr. Steadman is the project director for a recently funded review to determine the adequacy of mental health services provided to inmates of state correctional facilities in New York.

4. The National Institute of Mental Health located in Bethesda, Maryland has been contacted and informed of our Pennsylvania project.

5. An article entitled "Providing Mental Health Services to Jail Inmates - Legal Prospectives" written by Richard G. Singer has been requested. This project was funded by the Western Interstate Commission for Higher Education, located in Boulder, Colorado.

6. Many journal articles have been written on the issue, including one completed by Dr. Charles E. Smith entitled "Psychiatry in Corrections: A Viewpoint." This article appeared in the Mississippi Law Journal, Volume 45, No. 3, pp. 675-683 and will be reviewed by staff. Please forward to David McCorkle any other journal articles that you feel are important and warrant our review.

7. The National Institute for Criminal Justice Research has been asked to review the available literature pertaining to our topic and forward abstracts of that information to staff. Copies of all information listed on this and following pages are available upon request.

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Bibliography

Reports and Research Studies

1. "Report to the Governor: Proposed Use of Farview State Hospital as a State Correctional Institution", Department of Justice, Bureau of Correction. March 15, 1978.

This document was prepared by the Bureau of Correction at the request of the Governor following a three month task force review within the Bureau. Specific recommendations were made as to how Farview could be converted into a usable prison, operated by the Bureau of Correction. Specifically, the report recommends that two separate facilities be developed at the Farview site. First, it was recommended that buildings at Farview State Hospital would be converted for use as a state correctional institution and would house up to 510 mentally ill offenders in all categories of sentences. Second, it was proposed that a state regional correctional facility, administered by the Bureau, would be developed on the same site to house up to 240 adult males from a 17 county area in the northeastern part of Pennsylvania. Sentences at the regional facility would be between six months and two years in length.

Total cost to rennovate Farview for the purposes listed above, was estimated at $24 million.

2. "Myths and Realities About Crime". U.S. Department of Justice-LEAA HV6789U56, 197H.

This non-technical presentation of criminal justice statistics presents a unique view of statistics from the national Prisoners Statistics Program and the National Crime Survey. For example, the booklet analyzes the myth that "the typical person who commits a crime is either unemployed or on welfare." Findings from a survey of state prison inmates found that during a month prior to their arrest, 62% were employed full time and that only 3% had derived their main source of income during the year prior to their arrest from welfare payments. This is interesting information for speech making.

3. "A Governor's Guide to Criminal Justice." National Governor's Association.

This 40-page booklet describes in some detail the intricacies of the criminal justice system, and presents strategies for implementing improvements. The document was prepared for a recent Governor's conference and stresses the need for planning and coordination among the agencies involved in the treatment and supervision of criminals.

4. "A Plan for Forensic Mental Health Services in Pennsylvania." A Report of the Governor's Task Force on Maximum Security Psychiatric Care - Judge Paul A. Dandridge, chairman.

This report developed at the request of Governor Milton J. Shapp, analyzed the existing mental health services in Pennsylvania, held public hearings on the issue, reviewed forensic mental health services in 12 other states, and finally, made specific recommendations concerning the need for improved forensic mental services in Pennsylvania. Recommendations included the need to establish a comprehensive forensic mental service system in Pennsylvania and that Farview should be closed. A copy of this report has been provided for each member of our new task force, and should serve as the basis of the activities of this group.

5. "National Jail Resource Study." Draft Report, 1975.

This report details the process established for reviewing programs in 118 jails in 48 states. A wide range of data was collected, detailing services provided by jails. The important aspect of this study for our purposes is that extensive data collection instruments are included in the report.

6. "Final Report - The State/County Correctional Institution Relationship." Pennsylvania Department of Justice. 1972.

This report described a planning project instituted to clarify and define relationships among state and county correctional institutions. The report recommended the additional state involvement in program development at the local level and stressed the need for standards detailing the type and quality of services to be required. Moreover, the report recommended that the Bureau of Correction, the Department of Public Welfare, and the Court establish procedures that would enable county jails to quickly dispose of inappropriately confined individuals. (Emotionally disturbed people better served by mental hospitals)

7. "Security Issues in Pennsylvania State Prisons" - A report developed by the Citizens Crime Commission of Philadelphia, March 1980.

Prompted by outbreaks of prison violence in other states and specifically the escape of two convicted murderers from Farview State Hospital in March of 1980, the Citizens Crime Commission conducted a review of security issues in Pennsylvania prisons.

8. "Patuxent Institution" - A report issued by the Bulletin of American Academy of Psychiatry and the Law. Volume V, No. 2, 1977.

The structure of Maryland's forensic mental health services system and specifically the treatment program provided by Patuxent Institution are analyzed in depth. The latter includes a cost effectiveness study of Patuxent, a review of recidivism among Patuxent inmates, and a critique and evaluation of Patuxent Institution.

This evaluation and report on the Patuxent Institution serves also as a review of the ability to achieve the "rehabilitative ideal" within a prison for secure care setting. The controversy surrounding Patuxent involves the finding that an individual was a "defective delinquent" and in need of treatment services provided at the institution. Once a person was assigned this legal label, it was up to the treatment staff at the facility to determine the optimum time at which release should be granted. This indeterminant sentence and the control of treatment staff over the release decision was abolished in 1978 when new legislation was enacted. -

9. "Improving the Delivery of Services to Pennsylvania's Mentally Disabled." Pennsylvania Mental Health, Inc. May 1973.

This review of services to the mentally disabled includes sections on citizen participation, the importance of joint community/institutional planning, and specific principles for the development of a mental health/mental disabilities service system. The latter focuses on recommendations for the integration of state and county mental health services and for the coordination of mental health/mental retardation services with other human service agencies.

10. "Report and Recommendations of the Task Force on Mental Health Planning for Children and Youth." Final Report, April 1979.

This task force assigned by Governor Shapp fulfills one recommendation of the study entitled "A Plan for Forensic Mental Health Services in Pennsylvania." An intensive investigation and

needs assessment was completed by the Department of Public Welfare's Office of Mental Health and planning recommendations are clearly stated to improve the delivery of mental health services for children and youth in the Commonwealth.

11. "A Survey - Central Pennsylvania Correctional Facilities Task Force."

This survey lists the information compiled by a group of central region counties in the early 1970's. The information collected at county prisons was used to ascertain the need for the construction of a regional correctional facility. The final report of this group is also available for review.

12. "Special Report - Psychiatric Services - County Prison System." Temple Universit Unit in Law and Psychiatric, April 1975.

This special report completed by Dr. Melvin Heller, describes the organization and treatment program operating in the Philadelphia County Prison System. The report stressing the need to maintain and expand the availability of services within prisons, is documented in this report and two appendices entitled "Annual Report of the State Maximum Security Forensic Diagnostic Hospital at Holmesburg Prison" and "Annual Report Division of Psychiatry - Philadelphia Prisons for the Fiscal Year 1974." The need for expanded resources to provide forensic services within the prison setting is extensively documented in this report.

Articles

1. Wilson, Rob, "The Mentally Ill Offender," Corrections Magazine, Volume VI, No. 1, February 1980.

This article deals in some detail with the problem of treating mentally ill inmates in a correctional setting. Programs in several states including Ohio, California, and Michigan are described. National experts are interviewed, and individual cases are described, but solutions are not presented.

2. Blackmore, John, "Human Potential Therapies Behind Bars," Corrections Magazine, Volume IV, No. 4, December 1978.

This article describes various therapies, including transcendental meditation, Erhard's Seminar Training, reality therapy, and transactional analysis.

3. Wallenstein, Arthur M., "Chillon Castle Revisited or Removing the Mote Surrounding American Jails." The Prison Journal, Volume LIX, No. 1, 1979.

This essay, which was originally prepared as a review of three texts written on the issue of correctional management, presents the problems of overcrowding and understaffed prisons from a historical and administrative prospective. The role of the local jail in the community is reviewed with the result being a clear recommendation for increased community involvement in the problems of prisons and the needs of offenders.

4. The Philadelphia Inquirer and other Pennsylvania papers have repeatedly printed stories based on problems at Farview Institution. A file of those specific incidents is available upon request.

5. Smith, Jeffrey, R., "The Criminal Insanity Defense is Placed on Trial in New York." Science, Volume 119, March 1978.

This article centers on the moves in New York to abolish the insanity defense. The article reviews the history of the insanity defense of the M'Naghten rule and its application in highly publicized cases including the "Son of Sam" murders and the Patricia Hurst case. One psychiatrist notes that "a judge, a high school student, or a jury is better at predicting dangerousness than a psychiatrist." The positions of the National District Attorneys Association, Governor Carey, and others is described in the article.

6. Dogin, Henry S. "More Programs are Needed for Mentally Retarded Offenders." Justice Assistance News, U.S. Department of Justice, Volume I, No. 5.

This article by the former director of the Office of Justice Assistance, Research and Statistics, notes the problems of mentally retarded individuals who are trapped in the criminal justice system. The article points out that as many as 15% of the nation's total prison population (500,000) may be mentally retarded. If that figure is accurate, Mr. Dogin suggests that alternative forms of treatment would be more meaningful than incarceration.

7. Santamour, Miles; West, Bernadette, "The Mentally Retarded Offender and Corrections." National Institute of Law Enforcement and Criminal Justice, August 1977.

This document produced by the National Institute of Law Enforcement and Criminal Justice presents clinical and legal

definitions of retardation and criminal behavior. Moreover, it notes the state of the art of providing services to this population and develops guidelines for planning and implementing programs for retarded offenders.

Standards and Other Information

1. Press Release - September 7, 1978. "Governor Shapp's Plan to Replace Farview."

Governor Shapp released a plan for the replacement of Farview State Hospital with two new forensic treatment programs. The first program to be located on the grounds of Norristown State Hospital would have served 100 males and 20 females. The Governor stated that "We expect to draw on the best thinking nationally to design the facility with every possible security consideration as well as building in the latest treatment concepts." The second program to be developed in western Pennsylvania on the grounds of WarrendaleYouth Development Center would have provided 60 beds for males and 15 for females. Total cost for both programs was estimated at approximately $20 million.

2. "Medical and Health Care in Jails, Prisons, and Other Correctional Facilities." Prepared by the American Bar Association in conjunction with the American Medical Association, November 1973.

Although the standards primarily deal with medical and health care services, there is a single article on mental health programs developed in the San Francisco area. In March 1973, the criminal justice unit as part of the Northeast Community Mental Health Services Center, was established to coordinate the delivery of mental health services to prisoners incarcerated in local jails. The main contribution of the criminal justice unit has been to establish and solidify relationships between prisoners and community treatment facilities. An update of this program will be requested for the purposes of our task force.

3. Heller, Melvin S. M.D., Unpublished report entitled "Clinical Forensic Survey of Farview State Hospital." April-May 1980.

This psychiatric review of the residents of Farview State Hospital presents a picture of the reason for commitment and the current functioning of Farview residents. The report also notes specifically problems observed by the author at Farview State Hospital and remedies for those problems.

4. "Jail Inspection and Standards Systems in Illinois and South Carolina: An Operational Profile Handbook." American Bar Association - Commission of Correctional Facilities and Services. April 1974.

This volume is an extensive list of standards applied during the review of Correctional programs in South Carolina and Illinois.

5. "An American Archipelago - The Federal Bureau of Prisons." A speech presented by Mr. William Nagel to the National Institute on Crime & Delinquency. June 1974.

Mr. Nagel describes in this brief presentation the role of the Federal Bureau of Prisons in the past century. Moreover, the report criticizes the Bureau's master plan and the proposal to greatly increase the number of prisons operated by the Federal government without reviewing the effect of sentencing and parole policies on prison populations.

6. "Corrections - Standard and Goals Comparison Project." Pennsylvania Joint Council, 1974.

As a followup to the national standards developed by the Task Force on Corrections of the National Advisory Commission on Criminal Justice Standards and Goals, the Pennsylvania Joint Council took a project of developing a correctional standards for state and local facilities in Pennsylvania. The volume has an extensive chapter (15) on research and development information and statistics. This section of the report may be helpful in designing a research methodology for the study of mentally ill prisoners in state and local facilities.

7. Unpublished Report - "The Care and Treatment of Inmates With Mental Health Problems in the Bureau of Correction." Prepared by Peter F. Tripodi for the Pennsylvania Bureau of Correction, February 1976.

This report describes the availability of services to care for mentally ill inmates and describes the number of psychotic inmates handled by the Bureau of Correction in 1975. Other concerns addressed in this report are the use o chemotherapy in the correctional setting and the length of time quired to transfer a client from the Bureau to the Office of Menta Health. This study was developed to present information to the Commissioner of Correction for future decision making.

In general it was found that although the problem is a different one, the solution may come only through the development of specialized mental health treatment units within the Bureau of Correction and improved coordination of activities with the Office of Mental Health.

8. The Mental Health and Retardation Act of 1966. 50 P.S. 4201, October 20, 1966.

9. The Mental Health Procedures Act 143. 50 P.S. 7301, 1976.

10. "A Compendium of Services for Adults." The Pennsylvania Board of Public Welfare, 1978.

This summary of all departments of public welfare services provided to individuals aged 18 and over in the Commonwealth, is an organizational, fiscal, and program review of the Department of Public Welfare. This report complements an earlier one entitled "Compendium of Services for Children and Youth" which was completed in 1977 by the State Board.

APPENDIX E

ALLEGHENY COUNTY JAIL
MENTAL HEALTH PROGRAM

I. BACKGROUND

The Mental Health Program at the Allegheny County Jail was established in response to the Federal Court order of April 17, 1980 in which action was brought challenging the mental health treatment given to inmates of the County Jail. The Mental Health Program, which consists of a Screening Unit and a Mental Health Unit, was established in order to provide appropriate services for mentally ill inmates.

Mental health services in jails can vary greatly from "vigorous" treatment approaches to "maintain and manage" approaches. Since the jail is not a mental health facility, it is appropriate that the mental health services in the Allegheny County jail be limited to: (1) identification of inmates with mental problems, (2) treatment of emergency psychiatric problems, (3) transfer of the more serious mentally ill to mental hospitals, (4) supportive care for inmates with mental illness who can tolerate population, and (5) protection and care in a Mental Health Unit for inmates with mental illness who can not tolerate population. (Population refers to the part of the jail where inmates are not segregated.)

II. DESCRIPTION OF SERVICES

The Mental Health Program consists of two units, a Reception/Screening Unit and a Mental Health Unit. The Reception/Screening Unit is for Screening, Identification and Classification of all new inmates. All new admittees to the jail are evaluated for physical, mental and security status. They are housed in the Reception/Screening Unit so that those who cannot cope with population are not taken advantage of during the screening process. They are observed for a minimum of 48 hours. This amount of time is essential because a significant number of inmates with mental illness decompensate between the first and second day of confinement.

During the 48 hour period, they are oriented by a counselor to the jail procedure. After the screening process is completed, the inmate is assigned to the appropriate part of the jail: the hospital, the Mental Health Unit, population, juvenile block, security range, or protective range. Examples of individuals who might need secure or protective custody are: high risk rape or assault individuals, State evidence informants and those requesting lock up.

The Mental Health Unit is for inmates who have serious

mental illness and require protection, observation and/or monitoring. It is also for those inmates who have been committed to a mental institution and are awaiting transfer.

Inmates may be referred to the Mental Health Unit from the Reception/Screening Unit or may be referred from any part of the jail. Inmates in the Mental Health Unit receive care which includes: individual or group counseling, psychiatric evaluation, medication, segregation,and,if necessary, commitment to a psychiatric hospital. Those inmates who have significant physical illnesses are referred to the jail hospital, (for example in the case of drug detoxification.)

Mental Health Unit patients may remain in the Mental Health Unit until trial, until they are released, or until commitment (if the individual is committed). If the Mental Health Unit patient is assessed to be able to function in population, he is sent or returned to population.

The Mental Health Program works closely with the Behavior Clinic to expedite commitments. The Mental Health Program handles the 302 emergency commitments and refers the 304 commitments to the Behavior Clinic.

III. STAFF

The Mental Health Program has 23 staff members, 4 of whom are part-time.

The Screening Unit has a capacity of 63 cells. Evaluations of inmates in the Screening Unit is done by a staff of 5 counselors and a psychologist. The Mental Health Unit has a capacity of 20 cells. 24 hour coverage of the unit is provided by a nursing staff of 7. Three part-time psychiatrists provide diagnosis and maintenance care for the patients in the program.

CONTINUED

1 OF 2

HOLMESBURG
MENTAL HEALTH TREATMENT PROGRAM

I. BACKGROUND

In the Fall of 1977, the Department of Mental Health Sciences of the Hahnemann Medical College and Hospital drafted a proposal for a contract with the City of Philadelphia, Office of Mental Health/Mental Retardation Services, to organize and operate a comprehensive mental health service for the Philadelphia County Prison System. At the time, a review of the literature concerning the mental health status of prisoners indicated that no reliable data were available on which to base a projected staffing pattern - reports of the prevalence of mental illness ranged from 4% to 40%, and in each instance the studies were clearly and seriously flawed. The proposal used 15% as an estimate of the prevalence of mental illness requiring treatment, and indeed the unit at the Philadelphia Prison does provide treatment to about 15% of all inmates admitted, but it was clear from the outset that the figure was grossly inaccurate. In 1979 a research proposal for a systematic descriptive study of the mental health status of detainees was submitted to the Pennsylvania Commission on Crime and Delinquency and was approved and funded at a level of just over $85,000.00. Data were collected through the Winter of 1979 and the Spring and Summer of 1980.

Some of the reasons for the inconstancy in the published data concerning mental illness among prisoners appear to be related to the homogenization of the populations of the mentally ill ("the mad") and of the prisoners ("the bad") which has been taking place at an accelerating pace since World War II. On the one hand, commitment laws in virtually every jurisdiction in the country have been increasingly tightened and have demanded clear and present demonstrations of dangerous behavior as a prerequisite for involuntary hospitalization. As a result, mental illness has been "criminalized" - i.e., numbers of non-dangerous mentally ill persons who refuse hospitalization but who are utterly unmanageable by their families and communities are arrested for trespassing, malicious mischief, etc., as a last resort when their bizarre behaviors become intolerable. On the other hand, a variety of behaviors formerly dealt with by the police and by the courts have been decriminalized - e.g., public drunkenness now results in the "patient" being brought to the Emergency Room of a hospital. Other factors surely also have been involved in the admixture of what were formerly more clearly discrete populations into a growing middle group of the "mad-bad".

II. DESCRIPTION OF SERVICES

The 64 bed psychiatric unit is staffed by 74 security officers, 23 psychiatric and practical nurses, 6 full time MSW's, 3 full time psychiatrists, 5 part time psychiatrists, 7 inmate attendants, 3 creative art persons and 2 psychologists. Security and nursing personnel are paid directly by the City of Philadelphia while others are employed under a $1.3 million contract to the Hahnemann Hospital. The program services about 2,600 outpatient and 500 in-patient or partial hospitalization clients per year. Dr. Guy noted that about 3,590 of the 25,000 yearly admissions to Holmesburg Prison have serious mental health problems and 1,090 have a history of institutional psychiatric care.

The treatment provided is short term/crisis intervention and those inmates returning to the community are referred to community based mental health centers. Inmates remaining at Holmesburg or sentenced to another correctional facility are referred to available services.

Inmates are transferred from the cellblocks at Holmesburg into the hospital program following a 302 hearing held at its institution. After a period of treatment which averages 18 days, inmates are moved to a special "halfway" cellblock and then to the general population.

A key to the program's successful development is the professional training and consulting relationships maintained with the Hahnemann Hospital and teaching complex.

In addition to this psychiatric unit, 25 medical beds are maintained in the newly constructed (1978) facility. The average daily cost for the facility is calculated as follows:

a. Service contract with Hahnemann	$1.3 million
b. Security services provided by the City of Philadelphia (includes guards, nursing and dietary staff)	$1.5 million
c. Building cost - $10 million for construction amortized over 20 years	$ .5 million
	$3.3 million

Total psychiatric beds - 64

Approximate cost per bed per day - $141

About 120 transfers are made each year from Holmesburg to the Philadelphia State Hospital under the provisions of Section 304 of Act 143. In addition, approximately 150 inmates at Holmesburg cannot participate or function adequately in the prison routine because of severe mental health problems.

BUCKS COUNTY
FORENSIC MENTAL HEALTH SERVICES PROGRAM

I. BACKGROUND

The mental health needs of the Bucks County correctional and judicial system are currently being met by the Correctional Psychological Service (CPS). CPS is a recently formed division of Court Psychological Services, Inc., a non-profit corporation devoted to consultation, training, and research in the psycho-legal interface. CPS is a professional psychiatric/psychological evaluative and treatment program composed of one licensed doctoral level psychologist, one unlicensed doctoral level psychologist, one board eligible psychiatrist, and one secretary. In addition, CPS employs psychiatric/psychological consultants on an hourly basis as needed. Both salaried psychologists work 32 hours per week, while the salaried psychiatrist is employed 15 hours per week. The allocated consultant time is 16 hours per month, and the secretary is employed full time.

From 1973 until the end of 1978, the psychiatric/psychological requirements of the local correctional and judicial systems were met by a professional evaluative and treatment program entitled the "Court Diagnostic and Treatment Service". At the end of 1978, CPS was formed and Bucks County contracted with Court Psychological Services, Inc. to continue the work of the Court Diagnostic and Treatment Service through CPS. The staff of CPS had all been previously associated with the Court Diagnostic and Treatment Service. As was the case with the Court Diagnostic and Treatment Service, CPS was housed in the basement human services corridor of the Bucks County Prison and in the Mental Health Office of the Bucks County Rehabilitation Center. Similarly, since almost all of the equipment and supplies employed by the Court Diagnostic and Treatment Service had been purchased with government funds, CPS was able to inherit these materials. Consequently, CPS was able to continue the psychiatric/psychological services of its predecessor with a minimum degree of difficulty and with little or no interruption in the provision of services.

Using the above Department of Corrections facilities and the main office of Court Psychological Services, Inc. at 16 North Franklin Street, Suite 100A, Doylestown, PA., CPS currently performs a wide range of mental health/mental retardation services for the Bucks County correctional and judicial systems. These services may be grouped under the following four major categories:

II. DESCRIPTION OF SERVICES

(1) Emergency Psychiatric Services and Crisis Intervention

CPS provides 24 hour a day, seven days a week emergency psychiatric consultation to the Department of Corrections, the Bucks County judiciary, and related agencies. These services include emergency voluntary and involuntary commitments, and the prescribing of emergency psychotropic medications.

(2) Psychological Evaluations

CPS performs comprehensive and timely psychological evaluations for the Bucks County judiciary, the District Justices, the Department of Corrections, and certain related County agencies. Most evaluations are performed in the CPS Offices at the Prison or Rehabilitation Center. However, the Doylestown Office of Court Psychological Services, Inc. is available for evaluating individuals who are not located within the Department of Corrections at the time of evaluation. In performing these psychological evaluations, the CPS staff place emphasis upon the appropriate use of individual interviews, psychological testing, family interviews, etc.

(3) On-Going Individual and Group Psychotherapy

CPS provides both short-term and long-term individual and group psychotherapy for residents of the Bucks County Prison and the Rehabilitation Center. Therapy sessions are routinely held in the CPS Offices at the Prison and the Rehabilitation Center for these individuals. In addition, the Doylestown Office of Court Psychological Services, Inc. is used for individual and group psychotherapy sessions for parolees and probationers. Similarly, this latter office is used for seeing Department of Corrections employees who seek individual therapy.

Because of budget limitations, only a few therapy sessions for parolees and probationers are chargeable to the primary funding source, the County government. At the expiration of these initial sessions, individuals are either taken into private practice by CPS staff or are referred to their respective Base Service Units for further therapeutic work. Department of Corrections employees are seen in individual therapy under CPS funding for as long as necessary, provided that they retain their employment with the Department of Corrections.

(4) Department of Corrections Staff Training and Consultation

CPS provides monthly staff training seminars for Department of Corrections personnel. These seminars focus primarily on the recognition and handling of mental health/mental retardation problems within the correctional setting. In this respect,

CPS has developed a brief checklist questionnaire for use by Department of Corrections personnel in detecting emotional disturbance and mental retardation among residents. In addition, the CPS staff participate in Department of Corrections screening boards and promotion boards, lending their expertise to administrative decision-making about residents and staff. Finally, CPS staff are continually available to personnel from the Department of Corrections and related agencies for informal consultations.

In performing the above functions, CPS works under the direction of the Bucks County Board of Judges and the Department of Corrections. In addition, CPS is monitored with respect to both its funding and its programming by the Bucks County Department of Mental Health/Mental Retardation. At the same time, CPS and its parent organization, Court Psychological Services, Inc., are financially and organizationally independent of the local mental health establishment.

Description of the Local Criminal Justice System which Includes How and by Whom Forensic Mental Health Services are Presently Being Delivered

The criminal justice system in Bucks County is composed of the standard component units present in most county systems:

1. Courts (Judges)
2. Courts (Adult Probation and Parole)
3. Corrections - Maximum Security Prison
4. Corrections - Minimum Security Community Center
5. Public Defender
6. Community Services (private and public agencies)
7. Police

The Forensic Program designed by the Department of Corrections and the Courts with the assistance of MH/MR has been a unique feature of the criminal justice system in Bucks County, and all segments of the system are aware of the services provided and their availability. The services have been provided by a community based mental health organization and this type of contractual arrangement continues at the present time. The key feature is the existence of the unit within the walls of the Bucks County Prison and the 24 hour a day availability of service. Due to the availability of service, agencies often request evaluation at the prison for persons entering the criminal justice system.

The Emergency Services Section of County MH/MR is a key element in the process, though they are of course not a criminal justice agency. They provide the support and technical monitoring expertise as well as an advocacy function for continuing the type of services that are provided.

In virtually all instances, inmates who experience crisis problems or who need evaluation and diagnosis are seen within the prison, and the security problems of transporting to base service units or local hospitals do not exist. Furthermore, the in-house concept ensures a continuity of care and case management as well as building a corps of training forensic clinicians. Referrals are handled through prison counselors and staff members of any of the above agencies. Once a referral is made (non crisis) a psychiatrist or psychologist (Ph.D.) will see the client within 24 - 48 hours. Problem areas between agencies or between the criminal justice system and state agencies (hospitals, etc.) are well handled by the Emergency Services Unit, which provides excellent 24 hour a day coverage at the Prison.

The Adequacy of the Services Currently Being Provided and the Need for Additional Services

Since CPS is a new service beginning in January, 1979, it has been impossible to formally assess the adequacy of its programming. However, CPS is believed to be a continuation of basic programming provided by the Court Diagnostic and Treatment Service. In this respect, Court Diagnostic and Treatment Service had been informally evaluated on several occasions, and its programming was routinely found to meet the basic mental health/mental retardation needs of the Bucks County judicial and correctional systems.

CPS provides approximately 79 hours per week of in-house, on-site emergency and routine comprehensive professional psychiatric/psychological service. These services cover a wide range of county needs. However, because of budget limitations, CPS is unable to provide service in several important areas. With respect to these areas, perhaps the most urgent need is in the area of programming for female residents of the Department of Corrections. At the present time, CPS does not employ female therapists nor does it employ individuals with special expertise in providing for the needs of a female population. The female residents of Bucks County Prison are housed in a confined area in an antiquated facility which complicates their emotional needs. Consequently, they require individual and group psychotherapy on an intensive and continuing basis.

Another area for additional services is that of aftercare programming for parolees and probationers following their release from the Department of Corrections facilities. As was mentioned above, CPS does have available an office for continuing therapy with individuals immediately following their release from the Correctional System. However, because of budget limitations, that therapy can only be on a very brief basis. Unless the individual parolee or probationer is able to afford private sessions, he or she is eventually referred to his or her Base

Service Unit. What is needed is a budgeted-after-care program which provides continuity of psychiatric/psychological services on a long-term basis following release.

In this respect, still a third area for additional services is the related concept of halfway housing. These residents of the Department of Corrections who are released following intensive long-term psychotherapy require a high degree of emotional support and encouragement for maintaining the personality changes which have occurred during incarceration. A halfway house could provide these ex-residents with a therapeutic milieu which would facilitate their continued change. However, at the present time, no budgeting is available for such a setting and consequently no such services are possible.

Still a fourth area for additional services is represented by the need for career counseling and vocational testing. One of the more specific skill-building programs which has been demonstrated to be helpful in correctional setting has been that of vocational counseling. At the present time, CPS does employ a psychoiogist with demonstrated expertise in career counseling, and vocational testing is done on only a very limited basis. What is required is the comprehensive assessment of vocational interest and aptitudes, as well as skill-building aimed at helping residents obtain satisfying and satisfactory employment following their release.

The Criminal Justice Facilities Drawing Upon Forensic Mental Health Services

The various facilities that utilize the mental health services include:

1. Courts of Bucks County - Common Pleas
2. Bucks County Public Defenders
3. Bucks County District Justices
4. Pennsylvania Board of Probation and Parole
5. Bucks County Department of Corrections
6. Bucks County Adult Probation and Parole
7. Pennsylvania Bureau of Vocational Rehabilitation
8. Pennsylvania State Hospitals - Commitments in Forensic Wards

III. CLIENT POPULATION DESCRIPTION

The inmates incarcerated at the Bucks County Department of Corrections total an average daily population of about 200 to 225 inmates/residents. The majority of the population have drug/alcohol related offenses (60-70%) and fall within the ages of 19 to 29 years of age. The majority of the inmates/residents are from low income (lower socio-economic) backgrounds

with tested educational levels between the 6th and 8th grades. As a generalization, most of the inmates/residents come from disjointed families, in that the parents are separated or divorced. The average length of stay is about ninety (90) days. The maximum length of stay is up to fifty-nine (59) months.

Statistical Summary For The Court Diagnostic And Treatment Service For Calendar Year 1978

Service Category	Jan. to June 1978	July to Dec. 1978
Total Hours of Service	2143.8 Hours	2104.3 Hours
Administrative Hours	279.5 Hours	303.8 Hours
Evaluative Hours*	303.0 Hours	294.0 Hours
Other Service Hours**	1561.8 Hours	1506.3 Hours
Average Number of People Seen Each Month	132 People	110 People
New Referrals	326 People	252 People
Number of Referral Sources (Individual or Agencies)	557	449
Average Number of Therapists Working in Service Per Month***	10	7.5
Number of Commitments Made By Service to Hospitals	21	24
Number of Potential Commitments To Hospitals****	116	134
Total Cost	$41,774	$42,767

* Includes time spent in both court-ordered and non-court-ordered evaluations.

** Includes time spent in psychotherapy, consultation, staff training, etc.

*** The number of therapists employed by Court Diagnostic and Treatment Service in 1978 ranged from a high of 11 in January to a low of 6 in December.

**** Number of potential commitments refers to the number of

residents who probably would have been committed to psychiatric in-patient facilities had the service not been in existence. These were people who suffered from extreme emotional disturbance but who were maintained in a relatively stable state in the Prison through psychotherapy and/or chemotherapy.

IV. STATEMENT OF GOALS AND OBJECTIVES

The overall goal of CPS is the delivery of comprehensive professional psychiatric/psychological service on both an emergency and a routine basis. Specifically, the priorities of the service are as follows: First, CPS seeks to make available on an around-the-clock basis emergency psychiatric service including emergency voluntary and involuntary commitments, emergency evaluations, and emergency psychotropic medications. Secondly, CPS seeks to deliver comprehensive and timely psychological evaluations for the Bucks County judiciary, Department of Corrections, and related agencies. Thirdly, CPS endeavors to provide effective individual and group psychotherapy on both a long and short-term basis to incarcerated individuals and needy staff. Fourthly, CPS endeavors to provide sound, practical psychiatric/psychological consultation and training to personnel from the Department of Corrections and related agencies. Finally, CPS endeavors to expand its services to meet the full spectrum of the MH/MR needs of the residents and staff of the Department of Corrections. In this respect, CPS attempts to provide ongoing evaluation of its own programming and welcomes feedback from concerned individuals and agencies commenting on the adequacy and breadth of its services.

V. PROGRAM IMPLEMENTATION

The above stated goals for CPS are implemented by the three professional staff affiliated with the service. Within the Prison, CPS operates a suite of offices in the basement of the human services corridor. At the Rehabilitation Center, CPS operates a mental health interviewing office located within the Center building. The Program Director is a licensed doctoral level psychologist working 4/5th time in the offices both at the Prison and Rehabilitation. The Program Director performs all Court ordered evaluations as well as routine evaluations requested by the Department of Corrections and related agencies.

Both he and the staff psychologist, an unlicensed doctoral level working both at the Prison and the Rehabilitation Center, provide most of the routine individual and group psychotherapy both here in the Prison and the Rehabilitation Center. The part time staff psychiatrist (15 hours a week) provides around-the-clock emergency psychiatric coverage. In addition, operating from the CPS offices at the Prison, he sees residents

of the Prison in routine psychotherapy and dispenses psychotropic medication as needed.

All three professional staff cooperate in providing monthly Department of Corrections staff training seminars in the Prison's classroom and in providing formal and informal psychiatric/psychological consultations concerning staff, both at the Prison and the Rehabilitation Center. In this latter respect, a CPS staff member attends the screening board for the Rehabilitation Center and is present at staff meetings and, in addition, CPS staff routinely attend Prison Board promotion meetings.

Finally, the CPS secretary operates the Prison Office on a full time basis, performing scheduling and typing functions of the service.

VI. EVALUATION

Evaluation will proceed through various formal and informal mechanisms. County MH/MR has primary authority for program monitoring. They are well prepared for this role because of their day to day involvement with the Forensic Program at the Bucks County Prison and throughout the County. This gives them an institutional perspective as well as a larger heterogenous view of the total County system. The Supervisor of Emergency Services reports regularly to the Director of MH/MR and any problem areas are immediately noted to the Director of the Department of Corrections. An on-going and free communication exists. The Department of Corrections is receptive to these comments.

The Board of Judges is also officially involved with the overall supervision and direction of the program. The Presiding Judge has appointed two other members of the bench to monitor the program and they receive regular reporting from the Warden on the quality of services. The Judges provide regular feedback to the service provider through the Department of Corrections on the nature and quality of the program. Individual judges also contact the program with comments or suggestions.

Other evaluation tools include field visits by recognized authorities such as LEAA Medical Technical Assistance and the Federal Bureau of Prisons. In 1978 a special LEAA Medical Technical Assistance Study was conducted at the request of the Department of Corrections, and the program received an excellent rating. Program monitoring is also included through the Pennsylvania Bureau of Corrections who visit the Prison regularly as mandated by State administrative guidelines.

APPENDIX F

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END