



Framing Evidence For Correctional Mental Health Services

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Authors' Note: *The views expressed herein are those of the authors only and do not reflect the official policy or opinions of the U.S. Department of Justice, the Federal Bureau of Prisons or the Texas Department of Criminal Justice.*

The influence of managed care in health service delivery has penetrated the prison walls such that all health care services, including mental health services, are subjected to increased scrutiny. As a result, correctional administrators have increased their emphasis on evidenced-based practice. Although the past decade has borne witness to increased interest and notable resources for mental health services, correctional administrators, managers and clinicians continue to encounter the question, "What should qualify as evidence for developing best practices?" Addressing this question is necessary for correctional services to meet current health care service-delivery standards. Furthermore, developing best mental health practices in corrections offers much promise for policy and service-delivery models and informs clinicians of the most effective assessment and intervention strategies.

What Qualifies as Evidence?

"Evidence-based practice is the integration of the best research evidence with clinical expertise and patient values."¹ This framework provides three key definitional components of evidence for correctional mental health services: empirically derived, professionally derived and client-derived bases of knowledge. The framework is applied to understand the sources of evidence for correctional mental health services and, on this basis, the future areas of growth that are required.

Mental health services have long been a fixture in correctional practice. In terms of contemporary correctional mental health services, evidence has taken the form of professionally derived, aggregated clinical expertise that has been distilled into the formation and maintenance of standards for structuring mental health services.² It is important to note that although the standards themselves are not typically empirically derived, the experiences of the practitioners developing them may include clinical research findings.

The development of professionally derived, clinically driven evidence has proved critical because it clearly demonstrates an integrated understanding of the context and mission of the corrections profession and the practices and unique knowledge of the mental health profession. Although the absence of this evolution within systems can be cited easily, the vast majority of individual correctional mental health services avoid or minimize critical outcomes on a daily basis. For example, abstinence from drug and alcohol use, decrease in misconduct and health calls, success in skill acquisition, prevention of suicide and sexual assault, and management of mentally ill inmates without significant decompensation provide evidence of appropriate application of clinically derived practice.

Although this process facilitates knowledge accumulation, it has limited the development of correctional mental health service delivery models because it does not formally incorporate the other two definitional prongs — empirically derived and client-derived. As noted, systematic application of standards based on professionally derived clinical expertise does allow for implementation of proper research protocols. Unfortunately, clearing the way for research and actually producing it are two distinct enterprises.

To understand the current, limited state of correctional mental health services research, one must recognize two

key points. First, although evidence-based practices exist for professionally implemented offender programs, such research has remained organized around factors predicting criminal recidivism, re-offending and, sometimes, institutional adjustment.³ These services are not necessarily synonymous with mental health services.⁴ Mental health services are conceptually and operationally distinct from, though related to, programs and interventions that reduce recidivism. Although the field of investigation is in its infancy, the few studies exploring mental illness and recidivism report little or no relationship between them. The relationship between mental illness and recidivism is extremely complicated, and researchers exploring this complexity are beginning to question the assumptions about the connection between mental illness and criminal risk and to propose models for how this relationship might unfold. Most of these theories center on adherence to treatment and treatment engagement while in custody and after release.⁵

Second, as it currently exists, much of the mental health treatment literature does not inform or enhance readers' understanding of the multiple levels of service needs or the populations and treatment targets that regularly require mental health services in corrections. Furthermore, research that has been conducted is generally of poor quality. As one example, Robert D. Morgan and colleagues reviewed 12,000 articles related to the treatment of mentally ill offenders in correctional settings, and only 26 of these articles met inclusion criteria necessary for an empirical review.⁶ Not surprisingly, few published studies inform policy or clinical practice at a level that can be used.

Given the historically limited framework and lack of empirical data suggesting best practices, the development of best practice standards for delivery of psychological services in correctional settings should be supported. Although mental health services in corrections continue to evolve and incorporate new practices (e.g., use of telemedicine for treating mentally ill inmates), parallel research on mental health services in corrections is severely lacking. Of significant concern is that failure to conduct such research could result in the advancement of inadequate systems or failure to ground service delivery in the most solid and appropriate bases. What remains unknown is the central point of correctional mental health services — behind the wall, what services are needed by whom and how should they be planned for?

Advancing Correctional Mental Health Services Research

Overall, research specific to the correctional context that asks the aforementioned questions is scant. In this regard, the following are suggestions for advancing correctional mental health research.

Further consensus and development of models for correctional mental health services are required. Such conceptual models⁷ provide a starting point and a host theory, or structure for understanding that “services” in such a public safety system are constructed through a series of embedded needs and legal mandates. These models are needed to help noncorrectional researchers understand that many mental health services provided in corrections

originate in legal mandates embedded in policy and standards, and these are complementary to or absent from inmate need represented solely through a diagnosis. For example, mental health intake screenings are provided for all inmates regardless of if they have a clinical diagnosis. A similar example can be found in mental health reviews for inmates placed in segregated housing units and policies that exist for suicide risk assessment and reduction of self-harm. Other services are driven through particular requests made at sentencing such as placement in drug and alcohol treatment programs or sex-offender-specific programs. Finally, inmate-centered need, through proximal indicators such a diagnosis or staff referral, are also common and serve as a juncture and threshold for service delivery. Conceptual models that allow these complex realities of the service system to emerge are needed. They serve as the basis for the development of performance-based quality indicators. These indicators, or data points, cannot be addressed, piloted or embedded into databases for analysis until the models for correctional mental health service delivery are refined and made clear.⁸

Research mandates for correctional mental health providers are necessary. The majority of scientists producing correctional research are outside of corrections.⁹ Furthermore, mental health professionals inside the correctional system have limited time to engage in research activities.¹⁰ To enhance service delivery, a research mandate is needed to specify effective research designs that address the question of which practices are effective at multiple levels of the correctional system, including inmate management in prison, control, safety and symptom reduction. Ultimately, potential areas of impact could include decreased treatment costs for chronic conditions and increased staff safety.

Movement in this direction might lead the field to consider how diagnosis relates to the services required throughout an individual's incarceration. It might also lead to an exploration of how the contained prison environment in and of itself may influence the course of a mental illness or the way in which services are delivered. The question becomes, “When access barriers such as insurance and transportation costs are removed, what happens to mental illness and how does this change impact the services delivered?”¹¹ The high co-morbidities with substance abuse also require further consideration, as does the temporal unfolding of mental illness. The correctional mental health service system may work with an individual for anywhere from one to 20 or more years. In sum, to determine whether these trends are positive in nature, research is required on the “interactionist” issues of which inmates need which services and which components of the correctional system are influencing which inmates.¹²

Correctional administrators, managers and clinicians must continue to advocate for a clearer understanding of the relationship between criminogenic and mental health needs. The study of these variables independently is a precursor to address the field's need to understand them together. A strong interrelationship between the two areas is hypothesized; however, proceeding with this supposition without identifying the different foci of each risks grounding the system in flawed information or unknown variables.

Investigate the systemic values of change. Although consideration of patient values is an identified source of evidence-based practices, present models deride consideration of these values. It may be worthwhile to investigate the correctional systems' values of change and how this focus may impact outcomes when compared with certain inmate values such as continued criminality, opposition to the system and anomie.

Staff training must involve information about mental health service-delivery models. Consideration for training correctional mental health providers, as well as cross-training correctional administrators, must incorporate an understanding of the current state of mental health service-delivery models as well as the need for research in this area. As noted throughout this article, evaluating current practices and potentially changing them requires an understanding of the evolution of the system to this point and the foundational principles under which services are currently delivered. In training corrections professionals, the concept that there are multiple sources of evidence must be discussed with a focus on implementing practices that allow research on service delivery to be integrated with the provision of services.

Conclusion

It is important to recognize and give voice to the reality that correctional mental health services have come a long way. An increasingly qualified and rising number of mental health professionals are finding solid training and meaningful work with inmates. Upon this solid platform, the field is entering a period in which the right questions to inform correctional mental health services can be asked¹³ and evidence-based responses considered. In order to positively influence the care and custody of all offenders, the corrections field must now seek out and support the additive influences of professionally derived clinical expertise and best research evidence.

ENDNOTES

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