

The Georgia Department of Corrections: A Review of Georgia's 'Other' Public Mental Health System

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Abstract

Consistent with the increase in the prison and jail population, the number of inmates with mental disorders (prevalence rate) has substantially increased. Even more interesting is that there are more than twice as many persons with serious mental illness in jails and prisons as opposed to state mental health facilities. Essentially, the mental health services provided in jails and prisons have become a separate public mental health service system. Using widely available data, relevant case law, and published literature, this review highlights the mental health services within U.S. prisons, with special emphasis given to one state's prison mental health service system. Because the state of Georgia has made significant strides in providing mental services to inmates, the progress that has been made within the Georgia Department of Corrections serves as a "case study" worthy of highlighting.

Keywords: Corrections, Criminal Justice, Inmates, Law, Mental Health, Prisons, Public Health, Health Equity, Social Justice

1. Introduction

Since the dramatic expansion of psychiatric asylums during the mid-19th century in the United States, the mental health system and the criminal justice system have been seen as two separate entities. The primary mission of the criminal justice system has been punishment of offenders, while the primary mission of the mental health system has focused on the treatment of those who suffer from mental disorders. As McShane explains (1996), criminals were sent to prisons, those with mental disorders went to hospitals, and a few institutions were specifically established for the criminally insane. Despite the separateness of these two systems, boundaries between the two have blurred since the mid to late 1970s (Jemelka, Trupin, & Chiles, 1989).

The purpose of this article is to describe the current state of the correctional system regarding mental health services to incarcerated offenders in the United States, with specific attention focused on Georgia. First, the significant growth of mentally ill inmates in the U.S. correctional system (jails and prisons) is discussed. Second, a broad overview of the provision of mental health services to prisoners is presented including relevant court cases. Because the Georgia Department of Corrections has developed a more comprehensive system, an overview of Georgia's correctional mental health program is delineated. Finally, implications regarding Georgia's "other" public mental health system are discussed.

2. The U.S. Correctional System

The U.S. correctional system has experienced significant growth since the mid 1980s. In 1985 jails and prisons held an estimated 313 persons per 100,000 United States residents. Ten years later, this number had increased to 615 men and women per 100,000 residents, or one in every 163 residents (Bureau of Justice Statistics, 1997). The criminal justice "explosion" continued into the new millennium. In 2008, there were 1000 persons per 100,000 residents incarcerated in the U.S. (Bureau of Justice Statistics, 2008).

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Despite a downward trend starting in 2009, jails and prisons in the U.S. still hold approximately 700 persons per 100,000 residents. Hence, the U.S. rate of 1 in 110 persons remains among the highest in the world (Bureau of Justice Statistics, 2013; Wagner and Rabuy, 2017).

2.1 Mental Illness among Prisoners

What do we really know about the prevalence of mental disorders in jails and prisons? Consistent with the increase in the prison and jail population starting in the 1980s, the number of inmates with mental disorders (prevalence rate) has increased substantially. Several studies have shown that a significant number of inmates suffer from a mental disorder (Beck & Maruschak, 2001; Diamond, Wang, Holzer, Thomas, & Cruser, 2001; Powell, Holt, & Fondacare, 1997; Sarteschi, 2013). Even more interesting is the fact that research has shown that more than twice as many persons with serious mental illness in jails and prisons as opposed to state mental health facilities (Torrey, 1995). Based on the prevalence studies conducted thus far, the true prevalence rates of mental disorders among incarcerated offenders (jails and prisons) are unknown (Sarteschi, 2013). For example, a study conducted by Steadman et al., (1987) revealed that 5% of the then 36,144 inmates in the New York State correctional system were classified as “severely psychiatrically disabled.” Another 10% were classified as “significantly psychiatrically disabled.” The “severely psychiatrically disabled” group was similar to that found in acute patients in state mental health facilities, while the “significantly psychiatrically disabled” group was similar to patients in crisis beds in the community.

Although there is a belief that the prevalence of serious mental illness in correctional systems is between 6% and 15% (Elliott, 1997), some commentators have reported mental health problems among prison inmates as high as 35% (Baskin, Sommers, & Steadman, 1991) to 50% (Sarteschi, 2013). Several factors account for the various rates. One such factor has been how researchers have defined mental disorders (Severson, 1992, 1994). Other factors relate to many methodological issues (Metzner, Cohen, Grossman, & Wettstein, 1998; Roesch, Ogloff, & Eaves, 1995). For example, many researchers have not employed random sampling when examining rates of mental disorders.

3. Provision of Mental Health Services to Prisoners

Ferrara and Ferrara (1991) characterized the evolution of prison mental health services as having three distinct stages, each with unique features and underlying forces. Stage one is known as the inmate model which lasted from 1900 to about 1975. During this stage inmates themselves sometimes provided mental health services to their peers. Prisons did not offer many services to inmates. Professional services that were offered were often given by practitioners who lacked proper credentials. The second stage is known as the court model because of the federal court cases that dictated the nature and scope of mandated mental health services. This model is discussed in more detail below. The third model is known as the rehabilitation model. This model is a mixture of the two previous models, but moves further towards the goal of helping inmates achieve optimal functioning after release.

3.1 The court model of mental health services

The court model is discussed in more detail because it can be seen as the model that has had the greatest impact on mental health services to prisoners in the United States. Although there is no specific legislation which requires governments to address the mental health needs of those who are incarcerated, correctional mental health services have been driven by litigation challenging the conditions under which prisoners must live and the resulting case law addressing medical and mental health services. The legal source of the right to treatment for inmates and detainees has been based primarily on two constitutional amendments: the Eighth Amendment’s proscription of cruel and unusual punishment [for convicted inmates]; and the Fourteenth Amendment’s due process clause [for jail detainees] (Cohen & Dvoskin, 1992).

The constitutional basis of a prisoner’s right to treatment is the Supreme Court’s decision in *Estelle v. Gamble* (1976). Here, a Texas inmate brought litigation after he was injured by a 600-pound cotton bale while working at the prison. The prisoner claimed that he had suffered a work-related injury, while the state claimed that physicians saw the inmate and gave some medical care. However, the inmate did not show that the failure to perform some diagnostic tests usually associated with back injuries triggered a constitutional violation. The applicable standard derived from the decision is whether deliberate indifference to a prisoner’s serious medical needs was shown (Cohen & Dvoskin, 1992; Severson, 1992).

Although the *Estelle* case determined that prisoners had a right to treatment, it was not clear whether the meaning of “serious medical needs” applied to mental health (Cohen & Dvoskin, 1992). One year after the Supreme Court’s ruling in the *Estelle* case, the Fourth Circuit in *Bowring v. Godwin* (1977) found no reason to distinguish physical from mental illnesses for the purposes of constitutional safeguards. Here, an inmate who was denied parole claimed that the denial emanated from a psychological evaluation which suggested he might not be a good candidate for parole. The court ruled that the state was responsible for providing the inmate with treatment. It was concluded that inmates are entitled to mental health treatment if a condition exists which can worsen if not treated and can be improved if treated (Severson, 1992).

In addition to the *Estelle* and *Bowring* cases, a number of other cases have been cited as being major contributors to creating mandated services for prison inmates (Severson, 1992, 1994). *Ruiz v. Estelle* (1980) mandated standards by which inmates would be assessed for treatment needs. *Pugh v. Locke* (1976) addressed the issue of inmate classification. The court in *Pugh* ruled that a detailed classification plan be prepared on each inmate. The court extended the deliberate indifference standard much more in *Wilson v. Seiter* (1991). The court in *Wilson* ruled that deliberate indifference should apply to all prison condition cases--- cases involving overcrowding, exercise, ventilation, and so on.

One case has more directly shaped the current provision of mental health services to prisoners in Georgia. In *Cason v. Seckinger* (2000) the plaintiffs sought injunctive relief from alleged constitutional violations regarding prison conditions at the Middle Georgia Correctional Complex (the Middle Georgia Correctional Complex consisted of four institutions – three for males and one for females). The original lawsuit was filed in 1984 and claimed that prison officials violated the constitutional rights of inmates in twenty-four different areas. Four areas related to mental health service delivery: (1) the illegal use of stripping clothes from and placing restraints on mentally ill inmates; (2) deliberately indifferent medical, dental, and mental health care; (3) adverse psychological effects of detention; and (4) inadequate mental health therapy and counseling. The parties eventually resolved any differences by entry of a series of consent decrees.

The aforementioned court cases have provided the legal mandate for inmates to receive mental health treatment. Without these cases, it is plausible to believe jails and prisons of today would probably continue to ignore much of the needs of mentally ill inmates. Although these cases provide the legal mandate, other issues must be addressed, including planning and providing appropriate and effective services to incarcerated women and minorities, two of the fastest growing incarcerated populations.

4. Mental Health Services within the Georgia Department of Corrections

The Georgia Department of Corrections (GDC) currently has approximately 53,000 inmates (6th largest in the nation) under its supervision (Georgia Department of Corrections, 2016). With moderate growth of 3.14% in its prison population from 2010 to 2013, Georgia has had one of the fastest growing prison populations in the nation. This unprecedented growth presents a challenge to the correctional system as the demand for space could continue to increase. Media reports of overcrowded conditions are likely to contribute to staff shortages and the need for restructuring of facilities. For example, one major concern is the rise in the number of GDC prisoners from 39,326 in fiscal year 1999 to 53,663 in fiscal year 2007 against the decrease in GDC employees from 14,601 to 14,006 during the same period (Georgia Department of Corrections, 2007). This increase in the overall prison population in Georgia has also contributed to an increase in the number of mentally ill inmates living within the GDC. Currently, 1 in 6 inmates in Georgia has been diagnosed with a mental illness (de Moura, 2018).

4.1 Determination of Need for Mental Health Services

Inmates within the GDC can receive MH services through one of two processes. First, inmates can enter the mental health program based on a reception screening at one of the diagnostic units within the GDC. Second, inmates can enter the mental health program through the MH referral and triage process. All MH referrals coming from the MH reception screening process or through the MH referral process must go through a MH unit director for assignment to the appropriate evaluation track.

4.2 MH Reception Screening

After entering one of the GDC diagnostic facilities, all inmates are interviewed and screened for mental illness, suicidal ideation, recent suicide attempts, inability to function in the general population as a result of mental illness, current or recent use of psychotropic medication and/or mental health treatment within the last two years. A qualified mental health professional conducts this initial intake screening. If an offender presents a serious danger to self or others (i.e., is self-injurious, suicidal, or acutely psychotic), the inmate will immediately be referred for an emergency evaluation by a licensed mental health clinician. If the inmate is currently prescribed psychotropic medication(s) for mental health purposes, he/she will be immediately referred for an initial psychiatric evaluation by a psychiatrist. Following the completion of the mental health reception screening recommendations for a MH evaluation are made.

4.3 MH/MR Referral and Triage

The referral and triage procedure differs from the diagnostic unit screening in that the referral and triage procedure pertains to inmates that have completed the diagnostic process (i.e., inmates are currently housed in the general population). All staff members are charged with reporting any unusual or bizarre behavior which may be signs or symptoms of severe mental illness or a mental health crisis, or any words or actions indicating suicidal or self-injurious thoughts or intentions to their supervisors and to the inmate's assigned counselor. Thus, a referral for a routine mental health evaluation can be initiated by any staff member. In addition to referrals by staff members, an inmate may make a self-referral to request a mental health evaluation. The inmate can make the request verbally or in writing to the MH unit director or designee, or through the sick call process at facilities with a MH unit. At all facilities the inmates can request a referral through the formal sick call process. When an inmate makes a self-referral, the staff member receiving the written or verbal request for the evaluation will complete a mental health referral form. At facilities with a mental health unit, the MH unit director will schedule the inmate for an evaluation. Chief counselors at facilities without a mental health unit will contact the mental health unit designated for their facility in a specific MH catchment area and schedule a mental health evaluation.

4.4 Determining level of need

After an inmate is placed on the mental health caseload, it is necessary to determine the level of care that the inmate is to receive. The level of care is based on the level of need. The GDC uses six separate levels to denote need: one to six. Lower levels denote less need while higher levels denote a greater need. An inmate's need for MH services is based on a MH evaluation of his ability to function in the general population. Additionally, an individualized treatment plan is developed to determine the type of services an inmate will receive.

As can be seen via the above description, the GDC mental health program is comprehensive. Overall, one can argue that mentally ill inmates within the GDC receive services that are comparable to services provided in other institutional and community-based settings. However, it is not clear if the services, particularly psychotherapy, address cultural issues for specific populations (e.g., African Americans and Hispanics).

Mental health service needs for inmates continue to increase across the Georgia prison system. Most recently, GDC reported that 8,993 inmates are diagnosed with mental illness which constitutes 17% of its population (Georgia Department of Corrections, 2014). Because mental health caseloads across the state in general continue to grow, this pattern is expected to place increasing fiscal demands on the system over time. For example, the healthcare cost per inmate per day in the system has continued to rise as evidenced by a \$7.06 cost in 1999 compared to a \$11.07 cost in 2007 – a 156% rise in healthcare cost over this period. An 8.7% rise in healthcare cost increase was noted over the previous fiscal year (FY2006 vs. FY 2007). Officials attribute this increase in cost to the population aging, increasingly suffering with chronic (physical) and mental illness, and the high cost of services (Georgia Department of Corrections, 2007). Despite these demands, officials continue to make an effort to address the mental health needs of inmates within the GDC. Table 1 highlights the prisons within GDC that provide mental health services to inmates.

Table 1. List of Prisons with Mh Services

PRISON	CAPACITY	MISSION	MH SERVICES
1	1200	Provides housing for younger adult/juvenile males primarily between the ages of 17 and 22.	Provides diagnostic, MH/MR, academic/vocational, substance abuse programs and other basic program services.
2	1126	Provides centralized acute and specialized medical services.	Provides Level IV mental health services for male and female inmates.
3	1508	Houses close security general population inmates who may not be suitable for a medium security institution due to their sentence, offense or behavior.	The prison contains a 176-bed mental health unit.
4	992	Provides diagnostic processing for inmate boot camps, parole revocation centers and general population inmates.	Offers mental health Level III services in a supportive living unit with a four bed CSU and a nine bed ACU. Provides mental health evaluation services for the region in which it lies, maintains a variable diagnostic mental health caseload and serves 50 MH level II outpatients who live in the general population.
5	1222	Houses medium security general population prisoners that may not be suitable for a county institution due to their offense or physical limitations.	The prison has 180 level II beds designated for mental health.

TABLE 1 (CONTINUED)

PRISON	CAPACITY	MISSION	MH SERVICES
6	775	This facility operates a Correctional Industries Garment Factory. It is also the central tool/vehicle storage and warehouse for the Inmate Construction Divisions.	The prison has a supportive living unit for MH/MR inmates.
7	1580	Provides diagnostic and intake services.	Maintains a level III mental health unit.
8	1785	Provides primary diagnostic services (males) for the Department of Corrections. The prison also houses inmates under death sentence.	
9	1334	Houses the most recalcitrant and aggressive male adult offenders incarcerated in the Georgia prison system.	The prison also has a mental health unit.
10	1356	Houses inmates with behavioral problems that cannot be addressed at other prisons. A prison boot camp and general population unit is attached outside the perimeter fence.	The prison also has a mental health unit.
11	1036	Houses inmates who have had management problems at other prisons or centers, and those who could pose a risk if housed elsewhere.	The prison provides all levels of mental health services to include Level IV crisis stabilization. A supportive living unit for level III mental health probationers is provided at a prison annex.

TABLE 1 (CONTINUED)

PRISON	CAPACITY	MISSION	MH SERVICES
12	1236	Houses medium security general population inmates and supports an extensive farming operation which provides vegetables, meats and milk for other prisons.	The prison also has a small mental health unit.
13	582	Houses medium security general population inmates.	The prison also has a Level II and Level III mental health unit.
14	870	Houses primarily close security inmates.	Offers mental health services and specialized counseling programs.
15	705	Provides diagnostic services and chronic/acute medical services to female inmates (includes a 13-bed infirmary).	Provides the highest level of mental health services for female inmates (excluding the state mental hospital's forensic unit).
16	1048	Houses female inmates of all security levels; maintains a residential therapeutic substance abuse program; supports a correctional industries garment plant.	Houses Level II outpatient mental health inmates. Has a supportive living unit for Level III mental health inmates.
17	856	Houses close security general population female inmates. There is also a female probation detention center.	The prison has a small mental health unit.

5. Discussion

Recent years have seen substantial changes in the delivery of mental health services within the U.S. and Georgia prison systems (federal and state). Similar to other states, Georgia's prison mental health system continues to evolve. The continued deinstitutionalization of state mental hospitals and mandatory minimum sentencing are the two most likely contributors to the increase in the prison population, which has also led to an increase in the number of mentally ill inmates. The result of this increase has created what can be seen as a separate public mental health system, one that traditionally has not been on the radar screen of public health professionals (Daniel and Korr, 2007, 2008).

Unlike the traditional public mental health system, where organization and financing have been primarily driven by legislation, mental health services within the prison environment have been driven by federal and state courts. As a result of judicial decisions, mental health and medical services are now a constitutional right for those who are incarcerated – a right that has not been found among those in the general population. Georgia has had its own share of litigation that has helped shape the delivery of mental health services within the GDC. Despite its past legal issues regarding mental health services to prisoners, the GDC has taken steps toward created a “model” public mental health system.

The GDC mental health program is comprehensive. Mentally ill inmates within the GDC receive services that are comparable to services provided in other institutional settings as well as community-based settings. Additionally, Georgia is one of thirty-seven states that provide specialized mental health care to women who are incarcerated in a state prison (National Institute of Corrections, 2001).

Notwithstanding its “model” mental health service delivery, the GDC (like forty other states) lack specialized mental health care to racial and ethnic minority groups (National Institute of Corrections, 2001). Race and ethnicity are significant variables that can affect the mental health services delivery system (Takeuchi & Kim, 2000). There is an increasing racially/ethnically diverse population in the United States. According to the 2010 census figures, more than a quarter of the U.S. population identifies itself as something other than white alone (U.S. Census Bureau, 2011). This increase in a diverse population has created a mandate to provide mental health services that are culturally appropriate (Daniel & Lowe, 2014; Matthews & Hughes, 2001; Sue & Sue, 1999). Despite the call for an increase in diverse mental health services, little information is available regarding the mental health service needs of incarcerated minorities. The need to gain a better understanding about service delivery to racial and ethnic minority groups has greater implications in the prison environment, especially in Georgia where the minority population is greater than 30 percent. As stated earlier, the increase in the number of inmates has also given rise to a number of mentally ill inmates. Despite a decrease in some state systems, there is still an increase in inmates with mental health issues.

Members of ethnic minorities are overrepresented among prison inmates (Dowdy, 2002; Wagner and Rabuy, 2017), which means that a large number of the inmates suffering from mental illness are most likely to be a member of a racial/ethnic minority group.

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