

## Update on the Oklahoma DOC Mental Health Services MH-Levels Classification System

January 2013

by

Robert J. Powitzky, Ph.D.  
Chief Mental Health Officer

The new challenge facing corrections today is the relatively recent phenomenon of a dramatic increase of the number and percentages of persons with some form of mental illness in correctional care and custody. This phenomenon is an accepted fact nationally by professionals working in jails, courts, community corrections, probation, parole, and prisons. During the last five decades, closure of state mental hospitals, or “Deinstitutionalization,” began with the best and noblest of intentions. This was good policy, but like many policies, vision was lacking, funding was inadequate, and implementation was poorly executed. Society reacted with a new version of the old “warehousing mentality”- or “containment model” - by locking up anyone who made the community uncomfortable in jails and prisons instead of state mental hospitals. *From deinstitutionalization to reinstitutionalization.* Moreover, prior to deinstitutionalization, compliance was often coerced by the constant threat of civil commitment to a psychiatric hospital. That tradition has now been replaced by threat of criminal incarceration in jails or prisons. As a result of these and other systemic changes, untreated and unsupported life on the streets left persons with serious mental illness vulnerable to predatory criminals and other criminogenic factors and exposed them to a lifestyle in the community or in jail or prison wherein they had to acquire criminal lifestyles, attitudes, and social acquaintance in order to survive. This is where and how persons with serious mental illness have been and continue to be criminalized.

Because this is such a new change for corrections, a void has existed for a common sense, useful management tool - a framework - for adequately defining the problems and for developing solutions related to the management and treatment of persons with mental illness in the correctional setting. Correctional administrators need to know how to efficiently manage their scarce resources in a manner that meets constitutional requirements. Legislators need useful information to make critical decisions for allocation of those scarce tax dollars and for development of necessary oversight guidelines. Consumers and advocacy groups need to understand the nature of the problems and what is being done to address those problems. Researchers and academicians need comparable data to formulate and analyze hypotheses.

Before discussing the Oklahoma DOC Mental Health Classification system, it may be helpful for the reader to understand what other states have been doing. Historically, the widely accepted tools for trying to classify groups of mentally ill offenders were not useful, mostly because we were not asking useful questions! We need to know how to ask useful questions in order to get useful information. The following are three of the most common examples of frequently asked, non-useful questions:

### What are typical non-useful questions?

1. “How many offenders have a serious mental illness?” OR “What is the prevalence of serious mental illness in your correctional population?”

These seemingly straightforward questions ignore the fact that there is no widely accepted operational definition of “serious mental illness.” Prevalence studies have included a wide range of definitions from a) those persons with a history of mental health treatment, to b) only those diagnosed with certain mental illnesses, to c) all mental disorders found in Axis I of the Diagnostic and Statistical Manual IV-Revised (DSM-IVR). In addition, Courts have joined forces with experts and scholars to develop rational, scholarly definitions of serious mental illness. In practice, these definitions still leave wide latitude for interpretation. Until a recently published BJS report, the most quoted prevalence studies are based on 1996-1998 offender populations, while actual current management information show those studies do not represent the recent increases in the numbers and percentages of mentally ill offenders/inmates. The most recent report has only added to the confusion when it concluded that more than half of 2004 jail and prison inmates have a “mental health problem,” which many readers have misinterpreted to mean that many offenders have a mental illness. One reviewer said, “If apples were being harvested in 1998, oranges are being harvested in 2004.” Again, unclear or conflicting definitions have resulted in non-useful information. A corollary problem that will be discussed in more detail in the following sections is the non-useful manner in which they typically try to include the concept of “adjustment to incarceration.”

**2. “How many inmates are diagnosed with having Schizophrenia, Bi-Polar Disorder, And Major Depression?”**

What useful information does this question generate? Very little. There can be a wide range of possible management-relevant information within any diagnostic category. For example, one person with Paranoid Schizophrenia may be currently functioning quite well in society, on work release, in the general correctional setting, or even in university settings (witness the movie, A Beautiful Mind), while another with the same diagnosis may require intensive, acute care. In addition, this reliance on psychiatric diagnoses may cause us to ignore many of the offenders who require a large percentage of correctional mental health staff resources and time. These include a) the developmentally/cognitively disabled, b) severe personality disorders with psychotic features, and c) co-occurring disorders that defy simple diagnostic categorization. Thus, this data is not useful to correctional managers.

**3. “How many inmates/offenders require outpatient, intermediate and acute levels of care?”**

This question is not useful for several reasons. First, this question is too interdependent upon the resources currently available. In reality, we actually end up asking, “How many beds are available in each level of care?” A second problem inherent with this question is the variation between correctional systems of descriptions of what constitutes each level of care. This prevents any kind of meaningful inter-system comparison analyses. Third, this non-useful question also incorporates the concept of “institutional adjustment,” while ignoring the need to consider the offender’s needs for reentry (“adjustment”) into the community when released. An extreme example of the misuse of “institutional adjustment” is evidenced in the recent supermax cases where states like California, Wisconsin, and Ohio gradually lost perspective when inmates with mental illnesses were placed in a single isolation cell, which coincidentally eliminated behavioral or “institutional adjustment” problems. More

subtle examples of management strategies to help the mentally ill offender to “adjust” can be found in every correctional setting in the country. These include matching an inmate with a nurturing cellmate who guides and protects the ill inmate, or placing the inmate in protective custody or administrative segregation. Unfortunately, these strategies merely teach the inmate with mental illness how to become institutionalized (i.e., to “adjust”) in a correctional setting, not the life skills necessary to live as independently as possible in the community.

### **What are some useful questions that need to be asked and answered?**

The following are useful questions that can be answered using the management information framework proposed in this paper:

1. How do you define your levels of needs for mental health services?
2. How can their needs be communicated between all relevant correctional disciplines without violating federal HIPAA regulations?
3. How many inmates/offenders are there in each of the different levels of mental health service needs?
4. What are the staffing patterns needed for each level of mental health services?
5. What strategic management initiatives, if any, are needed to meet the mental health service needs of your correctional population?
6. What are the trends evidenced in the data?
7. How do the populations of other facilities within the department compare with each other?
8. How does the mental health population of one state system compare to others?
9. What are the most effective models for correctional mental health services?

### **A Proven Management Tool for Correctional Mental Health Services**

#### History:

In January 2001, the ODOC mental health services staff formed a task force to develop criteria for assessing levels of mental health service needs of the inmate population. Each proposed set of criteria was then submitted at three monthly statewide meetings of ODOC mental health staff for further refinement. Next, a few facilities were asked to do a pilot run using the proposed set of criteria. The criteria that resulted from this process were issued in a narrative paragraph format.

In November 2001, a pilot study was undertaken using the first, narrative-form version of the criteria of the classification levels. The data produced through this process was analyzed, and, with

feedback from the professionals, further refinements were made to produce the criteria, presented in Table A, which were utilized in a March 2002 system-wide classification of ODOC inmates in all facilities. The major changes in the final version presented in Table A include: 1) making the wording more operational; 2) highlighting the critical items that distinguish one level from the lower level(s); 3) reinforcing those criteria that must be assessed independently of available resources; and 4) emphasizing the need for treatment that prepares for discharge rather than “institutional adjustment.”

**Table A**

**Mental Health Service Levels Classification System Criteria**  
**Oklahoma Department of Corrections**  
 (Revised, November 1, 2006)

MH- 0

- Inmates who do not fit the following criteria.

MH- A (Able)-

- \*History: mental health diagnosis/treatment or serious self-injurious behavior and/or suicide attempt/ideation, but not within the past 12 months (Treatment not to include exclusively substance abuse, marital and/or anger management programs/therapy).
- \*Current observation of mild-to-moderate symptoms of mental illness.
- Symptoms may be acute or episodic, not chronic.
- Can be seen on outpatient basis
- Seen on self-referral or staff-referral, not on scheduled monitoring or therapy, or participates in non-prescribed scheduled psycho- educational program or therapy.
- Does not currently require psychotropic medication.
- Mild to moderate adjustment problems.
- Does not need blanket exemption from random housing assignment

MH-B (Baker)

- \*Requires psychotropic medications.
- \*Current major diagnosis of Psychotic Disorder, Bi-Polar, or Major Mood Disorder.
- \*Requires scheduled periodic to frequent clinical monitoring. \*\*
- \*Requires prescribed, scheduled treatment program or therapy (Which may not include psychotropic medication). \*\*
- \*Suicide attempts/ideation within last twelve months and/or current suicide ideation.
- \*Needs exemption from random housing assignment, although may be housed in regular housing as appropriate. \*\*
- \*Self-injurious behavior within the last 12 months.
- Moderate to severe adjustment and/or impulse control problems.
- Can be seen on outpatient basis.

MH- C1 (Charlie 1)

- \*Requires special intermediate housing unit with intensive treatment track(s) to be able to adjust to incarceration. \*\*
- \*Adjustment dependent upon special arrangements administrative overrides/housing. \*\*
- \*History of cycling or consistent non-compliance with prescribed treatment with resultant behavioral and/or mental deterioration.
- \*Requires specialized intensive treatment track(s) and release planning to be able to function upon release to community. \*\*
- Needs exemption from random housing assignment.

MH- C2 (Charlie 2)

- \*Developmentally disabled and/or significant cognitive deficits
- \*Requires special intermediate housing unit with intensive treatment tracks to be able to adjust to incarceration. \*\*
- \*Requires specialized intensive treatment track(s) and release planning to be able to function upon release to community. \*\*
- Needs exemption from random housing assignment.

MH- D (Delta)

- \*Due to mental illness, is a danger to self or others or is grossly impaired in ability for self-care, and this situation is predicted to last more than 72 hours.\*\*
- \*Requires 24 hour medical monitoring. \*\*
- Needs exemption from random housing assignment.

---

\* Indicates criteria that distinguish this level from lesser level.

\*\* Indicates criteria met independent of resources available.

Note: Criteria without asterisks are listed either to differentiate lower from higher levels or as designation of random housing exemption status.

---

During all phases of development and implementation of this system, three major objections or criticisms were expressed. The first was an initial concern that this system was a replacement for the traditional Diagnostic and Statistical Manual, Revised-IV nomenclature and the corollary treatment regimes that professionals are taught in their education and training. In fact this management tool heavily relies on such training and knowledge; moreover, it helps to direct this professional framework in the most effective manner. An example is the MH-C1 criterion item, "History of cycling, sporadic, or consistent non-compliance with prescribed treatment with associated behavioral and/or mental deterioration." This criterion places inmates with a wide range of diagnoses and treatment regimens into one level of mental health service needs, because the time intensity, staffing patterns, and housing issues are similar. However, the specific treatment plan for each inmate meeting that criterion will depend on the diagnosis and treatment regimen provided by the traditional skills and knowledge of the trained clinician.

A second objection is the use of a history of mental health treatment as a criterion for inclusion in MH-A. This criterion was kept for two reasons. First, the most often-quoted prevalence studies used history of mental health treatment as a major criterion in assessing prevalence. Thus, the data collected can be useful in trend analyses, using past prevalence studies with the same criteria. Secondly, since one of the best predictors of future mental health problems is a history of mental health problems, including this inmate on the mental health caseload list as MH-A would seem useful in case of future deterioration.

A third objection actually serves to highlight one characteristic of how this proposed system differs from the traditional mindset of the clinician. Some of the clinicians involved in the testing of the final version of the criteria asked why the more "minor" diagnoses, such as Post Traumatic Stress Disorder, were not placed in MH-A rather than MH-B. We were able to use this as an excellent example of the shift in thinking required for this classification system, because the "service needs" are similar regardless of the type of medication prescribed. We discovered it takes a total of 20-30 staff contacts (or "service units") to process a prescription: from the doctor's order, to the nurse review, to sending the order, and all the steps until the pill is actually delivered. Thus, any diagnosis of a mental illness that requires a prescription is serious enough to warrant a higher level of service.

The validity and reliability of the data collected with these criteria was supported in at least three ways. First, the assignment of mental health levels to inmates at time of intake was analyzed over a six-month period, and these summary data were consistent with the department-wide “snap-shot” reports of the numbers by level during a one-month period. Secondly, a test given at the time of training revealed a significant level of inter-rater reliability. What few mistakes did occur were usually made by classifying the inmate in a lower level of service needs, most frequently assigning a MH-C1 classification to a MH-D inmate. This trend, although not a significant one, reinforced the confidence that the data would err toward more conservative, rather than liberal, estimates of the levels of mental health service needs. Finally, the affirmative reactions of experienced correctional administrators who reviewed the data gave credence that the system was accurate and useful.

As simple as the criteria appear at first glance, experience supports the need for fairly intensive training, which involves teaching the clinician to think in terms of a mental framework different from the commonly accepted disease model of mental health assessment and treatment. In one session, clinicians were given the criteria in writing with little verbal instruction and were asked to rate various scenarios developed by a panel of experts. In the second session, they received item-by-item instructions and discussion, and they again were asked to rate the scenarios. Although both sessions resulted in significant interrater reliability, the second session showed a significant increase in accuracy. Training is needed because this system is different from the usual disease model in at least two major ways. First, it incorporates both pathology of the inmate and type and intensity of service required. This requires the clinician to think in operational terms in addition to their usual diagnostic nomenclature. It also requires the mental health professional to assess the need for services that would prepare the inmate for reintegration into the community rather than just the inmate’s “adjustment” to the particular prison facility. In our training, we found that for many clinicians, especially those with many years of clinical experience, it was difficult to shift their assessment paradigm. We also found newer non-doctorate, clinical staff were statistically less accurate than doctorate-level staff.

A third similar training session conducted in October 2006 produced similar results of acceptable reliability coefficients.

In 2006, a research study entitled “Mental health classifications and violence,” was conducted by Sumer Ledet, a doctoral psychology student and Dr. Dennis Combs, a psychology professor, both from the University of Tulsa. This report concluded:

- More severe mental health levels were *not* more violent during incarceration than less severe levels.
- Individuals classified in severe mental health levels were *not* incarcerated for more violent offenses than people in less severe mental health levels.
- Stability—The system remains stable over time.
- Validity—The system is categorizing individuals as intended, according to IQ, medication, and illness severity.
- Stability and validity of the system may be conducive to meeting treatment needs, housing needs, and management/staffing needs.

Practical uses of the MH-Levels:

The Oklahoma MH-Levels Classification System was first developed to assist the Lexington Assessment and Reception Center (LARC) staff in determining to which correctional facility incoming offenders should be designated. A second, corollary issue that needed to be addressed was whether certain offenders with mental illnesses could be identified to justify an exception to the general random housing assignment policy. The implementation of the MH-levels system in May 2002 resulted in dramatic improvement of designating new offenders with mental illnesses. A third benefit was quickly realized in giving Program staff a tool for determining appropriateness of Program assignment. Fourth, by the summer of 2004, OP-060125, entitled "Department Inmate Disciplinary Procedures," required that MH-Levels be considered in whether to request a mental health determination of responsibility and/or competency. New ways of utilizing MH-Levels arise every day. If you have any suggestions or comments, please talk with you nearest mental health professional or Dr. Powitzky, Chief Mental Health Officer.

Table A should be considered a proposed framework that is a work in progress. It is expected that the generic criteria presented therein will be improved with future refinements in operational definitions and distinctions. One refinement already implemented at LARC has been the creation of distinctions between a B1 and B2, which informs the population management personnel where to make facility assignments based on the mental health staffing patterns of different facilities. Future areas of refinement include more specialized sub-categories (e.g., suicidal history, self-injurious behavior, dual diagnoses, etc.), while always maintaining the paradigm's emphasis on simplicity and utility. One other planned management use includes the development of staffing ratios and resource allocations based on the data. Useful trend analyses can now be accurately made and used in planning. In addition to clinical treatment planning, this system can be utilized in refinement of correctional management policy and procedures such as housing/facility assignments, and program planning/assignments.

### **SUMMARY**

The Oklahoma Department of Corrections MH-Levels Classification System is a proven, uniquely useful management tool. It is hoped that the Oklahoma MH-Levels System will prove to be as useful to other systems of correctional mental health services as it has been to the Oklahoma Department of Corrections.

The concept of rehabilitation of the "normal" offender has been debated during the last three decades. We as a society cannot afford the same debate for offenders with mental illnesses or disabilities. We must provide the medically necessary care to help them successfully reenter into the community. This proposed management tool with a necessary shift in paradigms should provide a framework for sound, efficient understanding of the magnitude of the problems of mental illness in corrections and for innovative solutions.