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Challenges in Residential Treatment for Prisoners with Mental Illness:

A Follow-Up Report

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Abstract

The October 2002 issue of *Archives of Psychiatric Nursing* reported on the design of a prison-based mental health program implemented during the mid 1990s. The aim of this program was to reduce debilitating symptoms and promote coping skills, thereby enhancing both the functional status and clinical management of mentally ill prisoners. This article presents a qualitative study of the same program conducted in 2001–2003, and describes critical issues facing mental health providers, correctional officers, and prisoners involved in this program today. Of key interest is how subsequent developments have eroded the original focus of the program.

Introduction

In the October 2002 issue of *Archives of Psychiatric Nursing*, O'Connor, Lovell and Brown describe a mental health intervention program aimed at enhancing the functional status and clinical management of mentally ill offenders living in Washington State prisons. The McNeil Island Correctional Center Mental Health Program (CCMHP) represented a collaborative effort between members of the Washington State Department of Corrections and a group of University of Washington faculty. The purpose of this collaboration was to develop a humanistic, clinically effective approach to managing mentally ill prisoners. Further, it addressed a mandate from the State legislature to improve the care and treatment of mentally ill offenders in the Washington's prison system.

While the CCMHP continues to be among the most progressive and innovative approaches to prison-based mental health intervention in the United States, a number of challenges threaten to erode not only the aims but also the existence of this intervention. Each of these problems relate directly or indirectly to what has been eloquently described as a “custody-care” dilemma (Holmes, 2005; Mason, 2002; Martin, 2003): the perceived or real tensions between often competing and always compelling demands, including an overwhelming emphasis on security and control as paramount concerns for prison administrators and staff.. This conflict also reflects administrative decisions and resulting changes to the infrastructure, organization, and delivery of the program itself.

In this article, I present a follow-up report on the CCMHP more than ten years after its inception, focusing on how the “custody-care” dilemma has complicated the continued operation of the program. This report stems from a two-year qualitative case study of mental illness and

correctional practices in this prison. First, I describe the original program model as presented in *Archives* five years ago, and highlight how challenges to this model arose in the context of everyday prison practices and policies. Then I briefly outline the framework of this study including major aims and methods of data collection and analysis. Next, I report on the results of this analysis, including three sources of significant challenge to the continuation of the program as originally designed: the co-location of the CCMHP and the IMU in the same unit; the decision to change the CCMHP staffing model and milieu; and professional antagonisms among correctional and mental health staff. Taken alone, any one of these challenges would be difficult to surmount. Together, they threaten to deconstruct the original program so carefully and collaboratively built to meet the needs of prisoners and the prison system alike.

From Clinical Model to Prison Practice: A Brief History of the Program

Before the creation of the CCMHP, the prison system had several mechanisms in place to deal with mental illness, but these options did not always operate consistently or effectively. Prisoners entering the system through the reception center undergo screening for serious mental illness (SMI). If flagged for possible SMI, a psychologist or psychiatrist would then interview these prisoners to assess for SMI. The system also transferred prisoners needing acute intervention such as seclusion and restraint, emergency compelled medication, and close suicide observation transferred to one of two inpatient mental health units. Finally, two other units provide longer-term mental health management, including a residential program—a Special Offenders Center that houses those chronically and persistently mentally ill prisoners who cannot be integrated into general population.

Despite these programs and procedures, the Washington State legislature mandated that the Department of Corrections devise better strategies for dealing with mentally ill prisoners. For example, screening for SMI was not always conducted consistently, so many prisoners with mental health needs may have gone unidentified (Lovell, Cloyes, Allen & Rhodes, 2000; Cloyes, Lovell, Allen & Rhodes, 2006). Further, extant programming focused on either acute management or long-term residency. What was missing from the selection of mental health services provided by the DOC was “an intermediate option to systematically develop [mentally ill prisoners'] skills in collaborating with staff to manage their symptoms and adjustment to life in prison . . . a residential psychosocial skills program” (O'Connor, Lovell & Brown, 2002, p. 233).

The Washington State Department of Corrections and the University of Washington formed a collaborative taskforce in the early 1990s to design, implement, and evaluate a program focused on a vital but missing part of prison-based mental health programming: to provide intervention and management tailored to the unique and more intensive needs of mentally ill prisoners. In their original report on the development of the CCMHP, O'Connor, Lovell & Brown (2002) list a series of “differences between mentally ill and nonmentally ill prisoners” drawn from previous prison research. Significant differences include higher rates of infractions, especially violent infractions such as staff assaults; inadequate coping skills; limited capabilities to process and negotiate the “tense”, “ruthlessly competitive” and complex life in general population; a greater likelihood of receiving and serving longer sentences; failure to accrue good time due to psychotic and/or irrational behavior. The authors point out that while typical prison practice is to treat all prisoners in a standardized way, effective intervention must address the unique set of characteristics and experiences of mentally ill prisoners in terms of both individual treatment and system management. Mental health interventions that fail to account for these special needs and considerations pose risks not only to mentally ill prisoners, but also to other prisoners and staff as well.

Therefore, the foundational goal of the program was to implement a humanistic approach to intervention that acknowledges these differences could be more effective. The design of the CCMHP provides “programs oriented toward stabilizing symptoms and developing coping and other social and living skills” (p. 233) in order to address and mitigate these differences. The ultimate aim of the program was to help mentally ill prisoners successfully transition back into general population settings by teaching them such skills through psychoeducation and cognitive behavioral treatment, and by helping them to learn to recognize symptoms and manage them with psychotropic medication and adaptive coping strategies.

Adjustments and Challenges to Prison Policies and Practices

The CCMHP consists of two associated units—a smaller, high security, locked unit that operates as the admissions and acute care/inpatient unit and a second larger, less restrictive, non-locked milieu unit located in another building. The CCMHP admits prisoners from other prisons in the system into the acute unit as the first phase of the program in order to evaluate and diagnose their illness and stabilize their symptomatic behavior through medication management and treatment planning. Once stable, and after earning privileges that indicate an ability to tolerate a lower level of custody, the treatment team assesses a prisoner's readiness to transition to the less restrictive milieu unit. There prisoners must continue to follow their treatment plan, to take medications and participate in programming, work, and therapy in order to bolster their coping and social skills. Prisoners who successfully engage in the program transfer to general population with the option to return to either the acute or milieu units as needed for a brief respite or re-stabilization.

This program plan calls for a number of adjustments to typical prison unit operations, and certainly to segregation and control unit practice. First, the physical space in both units must indicate that they are part of a therapeutic milieu, a very different orientation than the rest of the prison, or even the rest of the cellblock in the case of the acute unit. For example, in the acute care unit segregation cells converted into interview rooms and staff offices, so that treatment team meetings can occur on the pod without having to shackle prisoners for movement out of the pod. When staff is present in these offices, prisoners are able to approach and speak with staff to ask questions, request meetings, report symptoms or air grievances. During day and evening shifts, correctional staff with specialized mental health training (correctional mental health counselors, described below) would stand at the podium at the front of the acute unit in order to supervise and interact with prisoners. They recorded their observations in the “behavioral log”, a document intended to both record and communicate symptomatic and other behaviors with other officers and mental health staff.

In addition to adjustments in the use of physical space, the CCMHP also introduced changes in staffing models and practices, including in the degree and quality of communication between staff and prisoners, and in the goals of programming. Originally, in addition to a psychiatrist, clinical psychologists and psychiatric nurses, the CCMHP staffing model called for a new kind of prison worker, the “correctional mental health counselor” (CMHC). Counselors were hired based on their interest in working with mentally ill prisoners and “an ability to recognize potential contributions of mental illness to aberrant behavior. . .and to formulate responses that acknowledge both the requirements of security and the vulnerability associated with mental illness” (O'Connor, Lovell & Brown, 2002, p.234). Some of these workers came from other areas of the prison, while some came from the community. Counselors did not attend regular officer training, but participated in trainings aimed at integrating custodial and mental health issues. Further, counselors wore street clothing instead of regular correctional uniforms to enhance the construction of a therapeutic milieu, which they managed through a direct supervisory model. Daily interaction between staff and prisoners was a significant part of maintaining the milieu, as describe above. Unlike other prison programs where officers rotate

among different units, the CCMHP assigned counselors exclusively to the CCMHP to ensure consistency of approach and continuity of care. Together, these changes to typical prison practice and prisoner management increased communication between staff and prisoners and therefore emphasized modeling behavior and verbal interaction as a proactive coping and management strategy.

This arrangement reflects an approach to prisoner management that is different from typical custody on other prison units. However, this certainly does not mean that a therapeutic orientation ever overrides correctional mandates, as custodial concerns always remain paramount in prison. Despite this, the space itself, how it is organized and used, must affect a noticeable shift in the ability of the institution to accommodate the goals of a therapeutic program.

Changes and Challenges: A Follow-Up Report

This study is part of a set of three integrated studies of how mental illness is represented in and across three related sets of textual data. These texts include a court ruling on the constitutionality of housing and treating mentally ill prisoners (*Madrid v Gomez*, 1995); cognitive behavioral programming materials used in the prison; prison and unit policies and procedures; and research interviews with prisoners, officers, and mental health staff. The primary aim of these studies has been to describe and critically analyze the effects of various representations of mental illness on prison policy and practice (Cloyes, 2004).

The issues discussed in this article stem from an institutional ethnographic study (Walby, 2005) of how prisoners, staff and administrators articulate, represent, and organize resources in relation to particular discourses of mental illness operating in this setting. Of key interest were how particular representations of mental illness shape unit policies and practices at a site where the intersections between “custody and care” must be negotiated by staff and prisoners every day. The present report discusses the analysis of the interview data, specifically how mental health staff, correctional officers, and mentally ill prisoners who live and work at the intersection the CCMHP and the prison’s intensive management unit (IMU) represented mental illness (Cloyes, 2004, 2006).

Methods

The University and Department of Corrections Institutional Review Boards reviewed and approved all research activities. Further, I obtained a Federal Certificate of Confidentiality.

The methodological framework of this study combines critical and interpretive theoretical perspectives with an ethnographic focus on everyday practices (Devault, 2006). Ethnographic and historical data collection methods included study of institutional documents related to the history and development of this unit, participant and non-participant observation, and a series of interviews with prisoners with an Axis I diagnosis, unit officers, and unit mental health staff. In formal, open-ended, and semi-structured research interviews, I spoke with participants individually, focusing on participants’ explanations of mental illness, and how it affected everyday life and work in this setting. Interviews took place on the mental health and IMU units, in treatment and conference rooms. I obtained participant permission to digitally audio record all interviews, which were professionally transcribed verbatim. I formally interviewed a total of thirteen participants: five officers working in both the IMU and CCMHP; three mental health providers working in IMU and the CCMHP; and five prisoners with a diagnosis and history of serious mental illness who were either currently living or had lived in both the IMU and CCMHP units. I applied a method of textual analysis developed for this study (for a detailed description of how this method of analysis was developed and applied see Cloyes 2004,

2006). This method of analysis allowed the author to move between close textual analysis of each document and broader social, historical, and political discourses relevant to the situation.

Results: Dislocations and Conflicts in Philosophy and Practice

This study identified three major challenges that have developed since the early implementation of the CCMHP: 1) The administrative decision to co-locate the acute mental health unit of the CCMHP and the intensive management unit (IMU) in the same building; 2) The “blue shift”, a change to staffing models and policies that revert to using correctional officers and rotating staffing patterns in the program units; 3) Professional antagonisms among correctional and mental health staff centered on competing definitions of mental illness. Each of these issues presents a significant challenge to the feasibility of the mental health program as originally designed. Together they effectively threaten to gut the program, leaving a nominal framework unsupported by its driving principles.

Confusion of Purpose: The Unintended Effect of Co-Locating the CCMHP and the IMU

Intensive management units (IMUs) represents the highest level of security in the Washington State prison system and are similar in nature and function to what other states refer to as supermaximum security units or control units. These are solitary and isolation cells where prisoners are in continuous isolation and on constant lockdown, leaving their cells three or four times weekly for one hour, always escorted in handcuffs, leg irons and belly chains by at least two unit officers. At this prison, shortly after the implementation of the mental health program, the administration made a decision to locate an IMU in the same building and directly adjacent to the inpatient acute mental health unit. This event, and consequent decisions that led the CCMHP and the supermaximum security unit to share space, resources and staff, has had profound and far-reaching effects for the CCMHP and its original aims as described by O'Connor, Lovell and Brown (2002).

After the IMU moved in next to the acute mental health unit, perceptions of the purpose of the mental health unit began to shift. Specifically, prisoners and staff began to see the acute mental health unit as, at least in part, a kind of step down program for the IMU. Prisoners living in IMU, mentally ill or not, also face challenges of re-integration with the general prison population due to the solitary and isolative conditions of IMU housing (Cloyes, Lovell, Allan & Rhodes, 2006; Lovell, Cloyes, Allen & Rhodes, 2000). IMU prisoners frequently report difficulties readjusting to lower levels of custody and feeling overwhelmed by the pressures and routine stimuli of less restrictive and more densely populated housing conditions (Human Rights Watch 1997, 2003). Prison staff reasoned that the close proximity of the acute mental health unit, already designed with a transitional function in mind, offered a much-needed opportunity for those prisoners nearing release from the IMU. Such a transition program would permit “appropriate” candidates the necessary time, space and support to readjust to prison life outside the extreme physical and social restrictions of the IMU. Mental health staff reasoned that this transition program might therefore cut down on unwanted behavior once the prisoner returns to a lower level of custody, and prevent or delay their return to IMU.

This reasoning seems sound enough, and the practice itself points toward a definite need for transition programming for IMU prisoners. However, the designers of the CCMHP did not intend the program to meet this need. Despite this, a number of staff asserted that the program serves a transitional purpose for IMU prisoners along with its role in managing and treating mentally ill prisoners. Moreover, while this IMU “transitional program” is certainly considered appropriate for IMU prisoners who are classified as mentally ill, staff narratives indicate that it is also used for *any* appropriate IMU prisoner who fits a series of criteria: the prisoner is eligible for either a promotion to a lower custody status or an “override” because of his special circumstances; the prisoner has some significant psychosocial issues or “problems in living”

that could be amenable to the kind of programming and counseling offered through the CCMHP; custody and mental health staff agree that the prisoner would likely not be able to handle a direct movement from the isolation and decreased stimulation of the control unit to a less restrictive, more stimulating and more densely populated setting; custody staff do not believe that the prisoner presents an undue risk for violent or subversive behavior once out of IMU.

The use of the acute mental health unit as a transition program for IMU prisoners, and the attendant shift in unit practices, presents a number of difficulties reported by frontline staff. First, the intent and governing philosophy of each unit is extremely different (at least in theory). The express purpose of the IMU is to house and discipline those prisoners identified as “the worst of the worst” in terms of violence and willful unmanageable behavior. The purpose of the acute mental health unit was to treat chronic and debilitating mental illness, seen as a combination of psychiatric diagnosis and symptomatic behaviors. Staff reported that having IMU prisoners moving into the acute mental health unit created a kind of cognitive dissonance for both staff and prisoners, including the need to “read” and interpret similar behaviors (for example, aggressiveness or agitation) in very different ways within the same unit. Further, it is foundational correctional practice to treat all prisoners the same, especially those living in the same space. The program achieved the more therapeutic focus of the mental health program in large part by having dedicated, separate units for this purpose. That meant that correctional staff could modify their practices by unit, rather than by prisoner-within-unit. Now staff perceive that two fundamentally different types of prisoners were being housed in the same unit (the “mad” and the “bad”), a situation that forces officers to make judgments instead of apply rules, and to make assessments of motivation and behavior that they feel are outside their proper scope.

Second, staff identified a number of practical problems in managing this mix of prisoners in a therapeutic milieu meant to be less restrictive than conditions in the IMU. Some noted that this led to the mingling of “dangerous” IMU prisoners with mentally ill prisoners at high risk for victimization, making for an unstable and unsafe situation. Mental health staff and officers also suggested that this situation might set prisoners up for negative behavioral modeling and “learned symptoms” that make management more difficult. For example, they described instances where mentally ill prisoners “picked up” what are deemed manipulative techniques from IMU prisoners, and where IMU prisoners in turn learned to mimic those behavior patterns that staff interprets as indicative of mental illness (i.e. reporting bizarre delusions and hallucinations, self-injurious or grossly disorganized behaviors).

Erosion of the Staffing Model: The “Blue Shift” and the Disappearance of the Counselor

The “blue shift” represents a profound change in the staffing model of the CCMHP, and is currently a significant source of conflict among correctional and mental health staff working in program units. This shift occurred in May 2002 when changes policy abolished the practice of staffing program units with designated correctional mental health counselors. According to staff and officers the decision to shift to “blue” (or a staffing model comprised of all correctional officers wearing prison uniforms or “blues”) was made when the original staffing model became untenable. Administrators and staff explained this change in terms of the limited number of correctional mental health counselors, so that complete staffing of the model frequently led to mandatory overtime, higher expense, short staffing, and burnout. Those staff formerly hired as correctional mental health counselors had a choice to take regular officer training and put on the uniform to become a “real” officer, or to leave employment. Because of this shift, the original program staffing model with trained correctional mental health officers wearing street clothes and working exclusively in the acute and milieu units became defunct. Instead, correctional officers with no mental health training rotated between the administrative

segregation unit, the IMU and the acute mental health unit. Further, officers also rotated among the associated milieu unit and other medium security prison units.

Mental health staff described this change as a serious setback to the goals of consistent and informed treatment of the mentally ill prisoners in the CCMHP. The original staffing model was a central feature of what distinguished the aims of the program from typical correctional and segregation practice. The uniforms were not the only feature to migrate from segregation and IMU into the mental health program. As the officers rotated into the program, they brought with them patterns of thinking and behavior that were suited to their roles as IMU officers, but were at times antithetical to the philosophy of mental health treatment. Despite the modification of CCMHP policies and practices to accommodate a more “therapeutic” focus, this established a tendency for officers to apply the policies and practices of segregation and IMU to their work in the acute mental health unit. Correctional staff working across the units began to complain about the “lax” procedures in the mental health program. A number of officers I interviewed essentially contested the therapeutic orientation and purpose of the program describing it as mistaken and wrongheaded, an exercise in “babysitting” or “soft treatment” for dangerous criminals. In their accounts, this approach to prison practices jeopardized the safety and security of the entire unit, staff and other prisoners because of its violation of foundational correctional philosophy.

As a result of these cultural values, officers began to “tighten up” the CCMHP by importing procedures from the IMU. For example, program policy outlined how prisoners could be escorted to treatment team meetings on the acute mental health unit without chains, or how only one officer needed to be present for prisoners to be allowed into the common area of the unit. However, officers argued that these policies were unsafe, and began to apply IMU policies instead. They often insisted on using chains during escorts when program policy indicated this was unnecessary. Further, some officers would not allow prisoners out of their cells into the common areas, or even staff to conduct treatment team meetings, if two officers were not present in the unit. According to mental health staff, these changes seriously interfered with the therapeutic goals of the unit and with the ability of mental health staff to work with prisoners, including timely access to prisoners and the maintenance of a treatment team schedule.

Another unforeseen effect of this “blue shift” stems from the practice of using the acute mental health unit as a step-down unit for the IMU. It highlights the profound connections between the representations of mental illness that generally inform institutional or cultural understandings and specific instances of daily practice, and can be demonstrated with the following example. It is increasingly common that an officer may first encounter a prisoner while working in the IMU, and have weeks (if not months) of interacting with that prisoner through a cuff port in a steel-reinforced door the size of an envelope, or by providing fully chained two-person escorts for that prisoner. Even though this prisoner may have been involved in mental health treatment, while in IMU this is a marginal concern for an officer, whose first duty is to safety and security. Then after serving his IMU time and being promoted off intensive management status, the prisoner is moved to the acute mental health unit next door, and in short, time is promoted to a status in which he can move freely about the day room in the acute mental health unit. Now the same officer, after a few days off, is rotated from the IMU into the acute mental health unit, and once again encounters this prisoner. However, this time, instead of being locked securely in a segregation cell, the prisoner is standing three feet away from the officer without chains or handcuffs holding a metal meal tray. For his part, the prisoner is also now dealing with someone he formerly only interacted with in a very limited, routine and possibly antagonistic way.

For both parties in this example drawn from recent history, this situation demands a significant shift in how to view and interact with each other, and highlights the extreme complexity of this juncture between mental health treatment and correctional practice. Does the officer shift from interpreting the prisoner's behavior as immanently threatening and dangerous, and understand it instead in terms of psychiatric disability? Does the prisoner begin to see his relation to the officer as one of alliance and support instead of antipathy and antagonism? These questions are not academic. Rather, they reflect the difficulties inherent in this changing situation as they are experienced by the prisoners, officers, and mental health everyday.

Professional Antagonisms among Mental Health and Correctional Staff

Analysis of the interviews of mental health staff and unit officers, including statements made about professional training, responsibilities and interests demonstrate pervasive conflicts between mental health and correctional staff, or more precisely between their professional practices. While custodial and mental health staff works together, there are notable instances where conflicting ideologies and identities generate significant tensions. Both groups appear to predicate their professional and institutional status on their own particular interpretation of what should count as evidence of “real” mental illness. Where many officers talked about DSM-IV diagnoses and articulated widely recognized scientific theories of psychiatric disabilities (i.e. chemical imbalance and brain-based disorder), their interviews were nonetheless infused with a significant skepticism regarding mental illness as anything other than motivated, problematic behavior. On the other hand, mental health staff cites how officers are largely uneducated in terms of the clinical acumen needed correctly to identify real mental illness in terms of etiologies, symptoms, and diagnoses. Simply put, mental health staff and officers described their professional identities largely in opposition to what they perceived as the position or function of the other profession. Throughout the interviews, both custodial and mental health staff repeatedly asserted their own professional authority in the detection and identification of “real” mental illness. As a result, a great deal of emphasis placed on whose version or concept of mental illness is most correct in the control unit context, and which should prevail in policy and practice.

For example, officers told how they have more “common sense” than mental health staff. This sense is often described as stemming from street smarts and life in the “real world” (as opposed to the sheltered academic life of mental health clinicians). Further, they described “common sense” not as understanding that is publicly available, but as the sense that an officer would make of a situation given his or her correctional training, experience as front-line staff and daily proximity to prisoners. These officers explained in detail how they are able to assess prisoners' behavior more accurately and respond in ways that are more appropriate to the demands of prison practice. Therefore, officers attach a significant amount of status to this notion of “common sense”, and describe this as a pervasive difference between their professional identity and that of the mental health staff.

This use of “common sense” related to another antagonism present in the interactions between officers and mental health staff, centering on level of education as a marker of social class and professional status. Officers repeatedly referred to the college education of the mental health staff in negative terms, as a factor that actually increases their risk in a prison setting. According to the officers, it is as if common sense is replaced by education, and that the higher the degree the greater the liability in the prison setting. Officers see mental health staff as putting themselves “above security”, and it then becomes the officers job (another in a long list) to protect providers from their own naiveté and wrong-headedness.

For their part, mental health staff describes antagonistic relations with officers as stemming from two sources: the lack of mental health training and education of officers, and illogical and reactionary prison policies that make their positions as prison-based providers and

therapists untenable. Like the officers, mental health staff point to their higher education level as a source of tension, but see it as an advantage that confers specialized understanding as compared with most officers' lack of comprehension of mental illness as a clinical phenomena. Further, officers' lack of clinical awareness was not necessarily seen as a result of individual lack of knowledge, but as evidence of a larger, systemic "correctional" tendency to react to irrational or challenging behaviors with "one size fits all" mandates that seek to suppress rather than solve problems. This tendency is described as incommensurate with a treatment perspective, characterized as a pragmatic recognition of individuality and context that focuses on "thinking and problem solving".

Finally, mental health staff recognizes that to many custodial staff, they are by definition outsiders in the prison environment. This perceived marginality to the central concerns of correctional operations is understood as a function of professional identity, not of physical location or time. Even those providers who have worked in the prison system for years describe this awareness, an impression underscored by the effects of "the blue shift". This creates a situation in which they feel they must constantly prove themselves to the officers who control their access to the prisoners they treat. This was often described as the need to be seen as the "right" kind of provider: a savvy "institutionalized" provider, one who demonstrates acceptance of the correctional perspective that mentally ill prisoners are first and foremost antisocial criminals who manipulate for secondary gain. Being seen as the right kind of provider affords the degree of respect (and thus access) necessary to provide treatment with minimal interference and the cooperation of officers. Ironically, however, it also means that the provider may have to compromise a therapeutic orientation in the process. A difficult balance must be struck between appearing "hard" enough to pass the scrutiny of the officers, yet maintaining enough professional integrity to be an effective therapist. One mental health provider described this as a kind of game that can be won or lost depending on the skill of the player. Certainly this is a game in which the stakes are high: analysis of these conflicted, at times antagonistic relations among officers and mental health indicates that persistent challenges remain in initiating and maintaining effective communication across these professional perspectives, despite (or perhaps because of) the close and sustained proximity of both within the same unit.

Conclusion

Correctional and mental health staff continues to struggle to pursue the original aims of the CCMHP in the face of persistent conflicts and challenges. Perhaps the most significant challenge they face is negotiating the competing and sometimes incommensurable demands has been eloquently and repeatedly described in the forensic practice literature as a "custody-care" dilemma, and it represents a practical and philosophical dissonance that underlies the issues discussed here. Despite this fundamental conflict, the CCMHP has made important strides in improving the treatment and management of mentally ill offenders.

The purpose of this report has been twofold: first, to offer a follow-up account of the status of the ground-breaking CCMHP described in this journal by O'Connor, Lovell and Brown (2002); and second, to describe a set of challenges that threaten to erode the focus and efficacy of this intervention. Given that these challenges can be understood in terms of an overarching and enduring custody/care conflict of interests, it may be that the issues outlined here translate to other innovative attempts at intervention in high security settings. At any rate, this report and the original it follows describes what was once an innovative approach to treatment, as well as the clinical perspectives that informed this approach. While the program itself may now persist on shakier ground than when first established, its original philosophical foundation remains solid: to provide treatment and specialized management for mentally ill prisoners in order to promote both individual functionality and the humanity of the system itself. It may be

that the rifts between design and practice that emerged in the intervening years offer useful lessons.

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