CHAPTER 17

Psychiatry in Correctional Settings

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Introduction

Local jails, which are usually administered by city or county officials, are facilities that hold inmates beyond arraignment, generally for 48 hours but less than a year. Prisons are state or federal correctional facilities in which persons convicted of major crimes or felonies serve sentences that are usually in excess of a year. Six states (Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont) and the District of Columbia have combined jail and prison systems (Metzner 1997).[1]

There were 1,965,495 persons incarcerated in the nation's prisons and jails at midyear 2001. Prisoners in the custody of state and federal prisons and the District of Columbia accounted for two-thirds of the incarcerated population (1,334,225 inmates). Prisoners accounting for the other third were held in local jails (631,240). The total correctional population included 94,336 female prisoners, who accounted for 6.7% of all prisoners (Beck et al. 2002). A total of 3,932,751 adult men and women were on probation at year-end 2001, in addition to an adult parole population of 732,351 (Glaze 2002).

[1]Despite the clear legal status differences between pretrial detainees in jails and inmates in prisons, the term inmate will be used throughout this chapter to refer to both.

Recidivism rates are high, as demonstrated by a study of 272,111 state prisoners discharged from prisons in the United States during 1994, which revealed that 67.5% were rearrested for a new offense (almost exclusively a felony or a serious misdemeanor) within 3 years following their release (Langan and Levin 2002).

Psychiatric hospital populations have dwindled during the past five decades, and the locus of psychiatric treatment has increasingly shifted from long-stay state hospitals to acute general hospitals and community-based treatment. As a result, the frequency with which persons with the most serious psychiatric diagnoses interact with the criminal justice system has dramatically increased. It is not our intention to debate the wisdom of community-based treatment; for many consumers it has resulted in a richer and more fulfilling life, whereas for others it has resulted in frequent incarcerations. It is clear, however, that this change in the mental health treatment system has resulted in a "pooling" of some persons with diagnoses of serious mental illness in correctional settings.

Studies and clinical experience have consistently indicated that 8%–19% of prisoners have psychiatric disorders that result in significant functional impairments and that another 15%–20% of prisoners will require some form of psychiatric intervention during their incarceration (Dvoskin et al. 2003; Metzner 1993; Morrissey et al. 1993). Thus, even if the prevalence of mental illness within correctional populations has remained the same, the 71% increase in correctional populations between January 1990 and June 2001 (Beck et al. 2002) has resulted in at least a corresponding increase in the number of mentally ill prisoners.

Psychiatrists should become familiar with these settings and their particular stressors because persons with serious mental illnesses are increasingly being incarcerated in jails and prisons. Psychiatrists, along with other mental health professionals, are needed for their expertise in providing the appropriate mental health treatments to these persons. There are more than 5,000 jails in the United States, and only the larger ones have full-time psychiatrists or mental health staffing. Thus, while correctional psychiatry is an increasingly important and valued specialty, it remains true that the majority of psychiatric care, in local jails especially, will be provided on a part-time or contracted basis, often by general psychiatrists.

Standards of Care in Correctional Mental Health Programs

Numerous sets of standards and guidelines for correctional mental health care programs have been promulgated by national organizations. The most widely recognized are those promulgated by the National Commission on Correctional Health Care (1999) (NCCHC) and by the American Psychiatric Association (2000). The American Psychiatric Association's published guidelines, which use the NCCHC standards as a foundation, recommend that the fundamental policy goal for correctional mental health care is to provide the same level of mental health services to each patient in the criminal justice system that *should* be available in the community.

By definition, of course, this standard is generally higher than that applied to people in the community; it is appropriate to ask why arrest, and perhaps commission of a crime, would entitle individuals to better mental health services than they would receive if they had obeyed the law and stayed out of trouble. The answer lies in both constitutional and common law. Because inmates are prevented from seeking their own food, clothing, shelter, and medical care by the very fact that they are locked up, those who incarcerate have legally been charged with providing these necessities of life to the people they incarcerate. This "necessaries doctrine" and subsequent constitutional law make it illegal for jails and prisons to be "deliberately indifferent" to the serious medical needs of prisoners. State and local governments, perhaps sadly, have no similar constitutional duty to meet the medical needs, however serious, of free citizens (Cohen 1998).

There is, however, a more positive public policy reason to provide a reasonably high "floor" of mental health services to prisoners. Steadman (H. Steadman, personal communication, November 2002) has spoken of the American jail as a "public health outpost," where those in need of services can be started on a course of physical or mental hygiene that will prevent future, expensive exacerbations of serious illness, including consequences such as crime. Correctional officials have a literally captive population that has demonstrated an inability to live safely and freely in the community, one that, under the stress of jail, may be more in need of psychiatric treatment and amenable to such treatment. This is not to suggest that jail or prison is the *preferred* method of entry into the mental health system, but, as is the case with illiteracy, jails and prisons have an opportunity to address some of the failures of other social and health systems in our society. To ignore this opportunity would be bad public policy.

Forensic Evaluations in Correctional Settings

In addition to the essential treatment role that a psychiatrist provides in a correctional mental health system, a general psychiatrist will often

have the opportunity to participate in various types of forensic evaluations within the correctional setting. In jails, forensic mental health evaluations involving pretrial detainees most commonly address issues related to competency to stand trial, diversion programs (related to sex offender treatment, substance abuse treatment, or mental health treatment), presentencing recommendations, and civil commitment. In the prison setting, forensic mental evaluations are most frequently requested to assess parole board issues (e.g., psychiatric suitability for parole, need for mental health treatment upon parole, risk assessments for violence), consultation for classification purposes (i.e., security-level questions), competency and dispositional issues relevant to disciplinary infraction proceedings, and the so-called *Hendricks* (*Kansas v. Hendricks* 1997) assessments related to evaluations of sex offenders for commitment following completion of their prison sentences. As correctional systems become increasingly aware of the legal and ethical obligations to inmates, formal assessments of competency to consent or refuse treatment will become increasingly important and common, and these will require forensic expertise.

The vast majority of correctional or forensic psychiatric evaluations have one thing in common: they require the psychiatrist to make an assessment of risk of interpersonal violence. Although a thorough review of violence risk assessment is beyond the scope of this chapter (but see Dvoskin and Heilbrun 2001), we recommend at the very least that psychiatrists familiarize themselves with the most important types of risk assessment: actuarial, anamnestic, and guided clinical assessment.

Actuarial prediction or assessment (see, e.g., Monahan et al. 2001; Quinsey et al. 1998) is a strictly statistical method of assessing risk that reports a person's risk of violence based on the violent behavior of groups with similar characteristics. Thus far, actuarial instruments have relied predominantly on static, historical variables and have been criticized as overgeneralizing from the populations on which they were normed (e.g., Canada) to populations with quite different base rates of violence. So far, actuarial instruments have not spoken to the severity or imminence of violence risk, but they have demonstrated an impressive ability to assess the likelihood of interpersonal violence.

Anamnestic assessment (Dvoskin 2002) uses the person's own history and patterns of behavior to predict the circumstances under which the person is likely to offend in the future and to guide clinical interventions aimed at reducing the likelihood of re-offending.

Finally, guided clinical assessment (e.g., Hart 1998) includes elements of both actuarial and anamnestic assessment. Guided clinical assessment typically involves a structured set of questions that are investigated, each based on a characteristic that has shown some empirical relationship to violent behavior, either among similar groups of people or in the person's own history.

As in all forensic assessments, the psychiatrist should inform the inmate, prior to beginning the assessment process, about the purpose of the evaluation and limits of confidentiality. Psychiatrists who provide treatment to inmates in various correctional settings should be aware of limitations related to confidentiality. Inmates should be informed about these limitations prior to beginning treatment (except in unusual circumstances—e.g., when the inmate is psychotic and unable to provide informed consent for treatment). These exceptions to confidentiality often vary from one state to another. For example, parole boards by statute often have access to an inmate's health care record, which will include mental health evaluations and treatment notes. The correctional staff is usually provided information by mental health staff that an inmate is on the mental health roster and is generally aware that an inmate is receiving psychotropic medications. Psychiatrists performing forensic evaluations of inmates should attempt to receive informed consent from the inmate, unless not required by law or regulations, to obtain relevant information, both oral and written, from past and current mental health providers.

The nature of the forensic issue to be addressed will certainly help to structure the interview so that relevant information will be obtained and assessed by the psychiatrist. In general, a standard psychiatric examination as described in standard textbooks (Nicholi 1999) should be performed. Depending on the specific referral question, the inmate's history relevant to substance abuse, mental health treatment, support systems, employment, plans if granted release, legal history, and adjustment to the correctional setting are often issues that need to be comprehensively assessed. See Chapter 6 ("The Forensic Examination and Report") for information relevant to writing the forensic report.

Dual-agency issues commonly arise in the correctional mental health setting. This potential problem becomes apparent when disclosing to the inmate one of the exceptions to confidentiality that may occur, such as when the inmate has been assessed to be a threat to staff or other inmates. This issue may also become prominent if the health care record is available to the parole board. There are circumstances in which the treating psychiatrist is asked to perform a forensic evaluation concerning a patient. Under some circumstances, this dual role is not inappropriate or avoidable, but generally speaking, dual-agency roles should be avoided.

Clinical Vignette 1: Evaluation of an Inmate Suicide

Dr. J is a forensic psychiatrist who, in the past, consulted on a part-time basis to local jails. Dr. J received a call from a plaintiff's attorney concerning the death by suicide of Mr. S at the local jail two weeks following his incarceration. Dr. J was asked whether he would serve as an expert witness for the estate of the deceased, which had initiated a lawsuit against the sheriff and mental health director alleging negligence (in contrast to a Section 1983 constitutional rights violation claim). How should Dr. J proceed?

As in all forensic cases, Dr. J first needed to determine his level of relevant expertise, if any, in the issues being litigated. Dr. J had relevant experience in correctional psychiatry and agreed to review this case. He also checked his own records to ensure that he had not personally treated Mr. S, which might create a real or apparent conflict of interest.

Because of the increased risk of suicide among incarcerated jail inmates, especially among those with mental illness, correctional institutions are expected to have suicide prevention programs for identifying and responding to each suicidal inmate. To provide a competent forensic report, Dr. J will need to be familiar with the standard of care relevant to suicide prevention programs in a correctional facility. His opinion concerning this standard of care should not be idiosyncratic to Dr. J; rather, it should reflect and be grounded in statements by recognized experts, prior judicial decisions, published literature, empirical studies, and, perhaps most important, policy statements from relevant professional organizations.

The National Commission on Correctional Health Care (1999) and the American Psychiatric Association (2000) have provided very clear guidelines relevant to this issue. Both organizations require policies and procedures designed to identify newly arriving inmates who may require mental health evaluation and/or treatment. The APA guidelines describe three separate processes (receiving mental health screening, brief mental health assessment, and comprehensive mental health evaluation) that should be in place to identify inmates requiring psychiatric treatment. The NCCHC provides procedures for identifying inmates requiring psychiatric treatment via receiving screening, comprehensive health assessment, and mental health assessment procedures. All of these processes include assessments relevant to an inmate's potential for suicide and procedures to follow when actions are required as a result of positive findings.

The essential components (American Psychiatric Association 2000; National Commission on Correctional Health Care 1999) of an adequate suicide prevention program in jails include the following:

1. Training of all staff who have regular contact with inmates concerning recognition of danger signs and procedures to follow when an inmate may be suicidal
2. Procedures for identification, referral, and evaluation of all newly admitted inmates who may be suicidal, in addition to other inmates who may become suicidal at other times during their confinement
3. Policies and procedures to ensure adequate communication between the arresting/transporting officer and correctional staff, among the jail staff (including correctional, medical, and mental health personnel), and between facility staff and the suicidal inmate
4. Housing options that facilitate adequate monitoring of suicidal inmates by staff
5. Timely provision of mental health interventions to the suicidal inmate
6. Policies and procedures for reporting and notification of suicide attempts or completed suicides
7. Administrative reviews and critical incident debriefing in the event of a completed suicide

Awareness of these standards-of-care issues should result in Dr. J advising the plaintiff's attorney to request via the discovery process the following documents:

1. Policies and procedures relevant to the jail's mental health program, which will include a written description of the suicide prevention program
2. Training records, including the curriculum and the percentage of staff that have received this training, concerning the suicide prevention program
3. The complete health care record of Mr. S
4. A list containing the funded allocated mental health staff positions, which should include vacancies, at the jail during the period of time surrounding Mr. S's suicide
5. The number of suicide attempts and completed suicides during the past 2–5 years, which may help to identify systemic issues at the jail
6. A copy of the administrative review and investigations of Mr. S's suicide, including statements of all staff and inmate witnesses, autopsy and toxicology reports, external investigations, and the like

Dr. J will need to closely examine issues related to the screening procedures administered to Mr. S on admission (e.g., adequacy, timeliness, response to any positive findings), whether the officers with whom he

interacted had received the relevant suicide prevention training, adequacy of the policies and procedures relevant to the suicide prevention program, and whether the jail successfully implemented these policies and procedures. As in other forensic evaluations, the initial review of this basic material will generate other questions and discovery requests to formulate an opinion relevant to liability issues.

After reviewing all of these materials, Dr. J may also want to obtain information from relevant witnesses, assuming that investigations have been completed. These may include other inmates, who either witnessed the event or knew the deceased, family members of the deceased, and various mental health, medical, and correctional staff. This information may be obtained in a variety of ways, such as interrogatories, deposition, and interviews. The specific method is usually determined by discovery procedures.

Ultimately, Dr. J will render an opinion concerning the presence or absence of negligence in regard to the death of Mr. S, if the suit is a simple tort claim of wrongful death or malpractice. In rendering this opinion, Dr. J must be careful to avoid the retrospective bias that may result from his knowledge that Mr. S is dead. Instead, Dr. J must try to judge whether the appropriate standard of care was met.

Clinical Vignette 2: Adult Jail Diversion

> Dr. S consults with a local community mental health center (CMHC). Recently, the sheriff has entered into an intergovernmental agreement with the CMHC to provide a jail diversion program in an effort to reduce the unnecessary incarceration of persons with serious mental illness. The first candidate for this program is Mr. H. What are the relevant issues that Dr. S should address in his evaluation?

Jail diversion programs are organized interagency efforts to identify inmates with serious mental illnesses and establish mental health treatment programs that meet their needs in the least restrictive environment that does not appear to endanger the community. These programs negotiate with prosecutors, defense attorneys, courts, and community mental health providers to develop a comprehensive mental health disposition outside of the jail, either instead of prosecution or as a condition of reduction in charges, or at least to transfer defendants into treatment while awaiting trial. These dispositions usually occur when the charge is for a relatively minor crime (Hoff et al. 1999), although many diversion programs focus on felony defendants.

The first set of questions to be addressed by Dr. S will likely involve the criteria for inclusion into the program. Typically, there will be a requirement that the patient has a diagnosis of serious mental illness. Further, various types of offenses, especially crimes of violence, may disqualify the person for inclusion in the program. Dr. S will need to review recent psychiatric records, which will assist in the determination of Mr. H's diagnosis, and relevant legal documents to determine his current charges and criminal history.

Assuming that Mr. H meets the program's minimum criteria, the next set of questions will address his appropriateness for release and the conditions under which his release is least likely to result in harm to the community. Both of these questions are best answered by a competent risk assessment for violence. Dvoskin and Heilbrun (2001) have summarized the literature on violence risk assessment, including a description of actuarial, clinical, and anamnestic approaches to the task. Briefly, actuarial instruments, despite many limitations, appear to have value in determining the *likelihood* of violence, which is one important aspect of violence risk assessment. However, it is not the only axis, nor is it necessarily the most important. *Severity*, *imminence*, and *duration* of violence risk are all important determinants of Mr. H's appropriateness for diversion and must be considered by Dr. S.

To do so, Dr. S must conduct either a guided clinical evaluation (Hart 1998) or anamnestic (Dvoskin 2002) assessment of violence risk. Anamnestic assessment looks at the person in context and over time, examining and learning from his or her life story. In a sense, it is an ethnographic way of studying people. There should be few differences between this type of assessment and a good clinical evaluation. Both types of assessments should carefully review prior incidents of violence, including the clinical and situational aspects of Mr. H's life at the time of these incidents. This analysis will result in identification of risk-laden situations, clinical risk factors, skill deficits, and strengths or protective factors (which were likely in evidence at times that Mr. H did not commit any acts of violence).

This risk assessment will lead to a set of specific recommendations for services, supports, and monitoring that will address the situational and clinical risk factors identified in Dr. S's assessment. These recommendations must include recognition of the role of various social service and criminal justice agencies, in addition to mental health and psychiatric services in the community. Dr. S and the diversion program staff must take time to familiarize themselves with the practices and resources of local probation, parole, and police agencies and gain an awareness of various federal and state entitlement programs and how to access them.

Finally, no matter how well-crafted the diversion plan is, it must be accepted by prosecutors and judges. To this end, Dr. S or a program rep-

resentative must have access to the courts and enjoy a high level of credibility in the eyes of judges and prosecutors. To accomplish this goal, diversion programs must avoid taking marginal cases early in the program's life. Early successes set the stage for later risk taking, but establishing the program as consistent with public safety is essential, so that the inevitable failure will be seen an exception to an otherwise safe and responsible process.

Clinical Vignette 3: Juvenile Sex Offenders

> Dr. D, who is the clinical director of a sex-offender-specific treatment program for adolescent males, is asked by the juvenile court to evaluate a 14-year-old boy for treatment as part of a diversion program. What are the likely issues that will need to be addressed concerning confidentiality and double agency?

Dr. D will obviously need to have expertise in the evaluation and treatment of adolescent sex offenders to accept the appointment by the juvenile court. It is beyond the scope of this chapter to summarize issues relevant to the sex-offender-specific assessment required, which can be found elsewhere (Colorado Sex Offender Management Board 2002; Matsner and Becker 1999). However, this vignette does provide the opportunity to discuss issues of confidentiality and dual agency in the context of a mandated assessment or treatment ordered by a court.

In many states, such as Colorado, the standard of care relevant to mandated treatment concerning confidentiality is as follows:

> Juveniles who have committed sexual offenses must waive confidentiality for purposes of evaluation, treatment, supervision, and case management to obtain the privileges attached to community supervision. This waiver of confidentiality must be based on complete informed consent of the parent/legal guardian and voluntary assent of the juvenile. The juvenile's parent/guardian must be fully informed of alternative dispositions that may occur in the absence of consent/assent. (Colorado Sex Offender Management Board 2002)

Under such circumstances, the psychiatrist needs to be sure that both the juvenile and the parents or legal guardian fully understands the meaning of this waiver.

These same standards clearly state that "the highest priority of the standards and guidelines is community safety. Whenever the needs of juveniles who have committed sexual offenses conflict with community safety, community safety takes precedence" (Colorado Sex Offender Management Board 2002). In other words, the evaluating or treating psychiatrist is now in the potentially conflicting role of a double agent. However, this situation may be one of the exceptions to the general rule of avoiding dual agency.

This waiver of confidentiality and dual-agency role are often obstacles to establishing a therapeutic alliance with the juvenile offender. However, this difficulty can be decreased by including the juvenile, when possible, in the process that involves sharing of information with others. For example, this information sharing occurs during treatment planning and review meetings, which often include the juvenile's probation officer, social worker, residential treatment staff, and mental health clinicians. The adolescent should attend part of all such meetings (with few exceptions). Discussing issues relevant to the staffing with the adolescent, prior to the actual staffing, can be very helpful in establishing a therapeutic alliance. Including the parents or legal guardian in this process is also helpful. Providing the adolescent with a draft copy of reports sent to the court or probation officer prior to actually sending the reports is consistent with this straightforward approach.

Clinical Vignette 4: Evaluation for Disciplinary Board

> Inmate L was charged with disobeying a direct order from a correctional officer and destroying state property. During the investigation, Mr. L appeared to be agitated and demonstrated disorganized thinking. Dr. S received a referral from the disciplinary board hearing officer for a mental health evaluation of Mr. L prior to going forth with the disciplinary hearing. How should Dr. S proceed?

Dr. S needs to be familiar with the policies and procedures in the correctional institution relevant to such a mental health evaluation. Unfortunately, this area of correctional psychiatry is frequently very unclear, with little guidance being provided in the psychiatric literature (Kirelstein 2002).

In general, these types of evaluations focus on the following three questions:

1. Are there any mental health factors that may cause the inmate to not be able to competently participate in the disciplinary hearing process?
2. If the inmate has a mental disorder, did the disorder contribute to the behavior(s) that led to the alleged disciplinary infraction?
3. If the inmate is found guilty of the offense, are there any mitigating mental health factors that should be considered by the hearing officer in determining the punishment?

It is also not unusual, although it is somewhat controversial, for some correctional systems to ask for consultation relevant to a responsibility (i.e., equivalent to a plea of not guilty by reason of insanity) examination. Many correctional mental health professionals are not trained to do such a forensic assessment, and most systems requesting the specific responsibility evaluations lack adequate standards and definitions for these examinations. It is beyond the scope of this vignette to further discuss issues relevant to responsibility examinations in the correctional setting. However, Dvoskin et al. (1995) have argued against formal evaluations of criminal responsibility in prison, preferring an informal process that will divert fewer clinical resources from treatment and allow the prison mental health professionals to maintain the trust of staff and inmates alike.

Dual-agency issues arise if the mental health assessment is provided by the inmate's treating clinician. In general, the treating clinician should be made aware of the alleged infraction because the inmate's actions leading to the alleged rule violation are often clinically significant. However, to minimize dual-agency issues, the actual consultation provided to the disciplinary board should be provided by a clinician who is not treating the inmate.

Conclusion

Historically, jails and prisons were viewed as the least desirable settings in which to practice psychiatry. However, it has been our experience that correctional settings can be financially, intellectually, and clinically rewarding places to work. In many states, it is sadly true that the most mentally disabled citizens are likely to be found in jails and prisons, and these institutions often have more resources available for the treatment of these individuals than can be found in traditional mental health settings. Finally, medical schools are increasingly contracting out as service providers, creating exciting opportunities for advancing the field by serving the people who need us most.

Key Points

- Forensic evaluations that are relevant to correctional psychiatric issues generally require either of the following:
  1. Knowledge of specific legal standards (e.g., Was the appropriate standard of care followed? Did the inmate have the capacity for a specific competency such as competency to stand trial or competency to refuse treatment?)

  2. Familiarity with relevant treatment resources and their availability because the forensic question being addressed is related to dispositional issues (e.g., Is diversion an option? What psychiatric conditions, if any, should be part of an inmate's parole requirements? Are there treatment settings available that will decrease a particular inmate's participation in dangerous activities if released?)

Practice Guidelines

1. Be familiar with standards and guidelines for mental health services in correctional facilities promulgated by key national organizations such as the National Commission on Correctional Health Care and the American Psychiatric Association. Treatment of inmates should be consistent with these standards.
2. Stay current with accepted risk assessment procedures, which are generally important elements of forensic evaluations in a correctional setting and often relevant to treatment in jails and prisons.
3. Ensure that inmates are fully informed about the many exceptions to confidentiality in a correctional setting, and remain sensitive to treatment issues related to these potential breeches of confidentiality.
4. Avoid dual-agency roles whenever possible. Dual-agency conflicts, similar to issues related to confidentiality, can adversely affect the therapeutic alliance.
5. Be straightforward and respectful in interactions with inmates.

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