18 Psychiatric Intake Screening

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■ INTRODUCTION

The correctional population in the United States is expanding at an epidemic rate. The Bureau of Justice Statistics[1] reported that between June 2002 and June 2003, an estimated 1100 inmates per week entered America's jails and prisons. By mid-year 2003, 2,078,570 people in this country were in jail or prison. In other words, as of June 2003, 1 in every 140 U.S. residents was behind bars. Not surprisingly, at the end of 2002, state prisons operated between 1% and 17% above capacity and federal prisons were operating at 33% above capacity.[1]

Similarly, the number of jail detainees grew 5.9% from July 2002 to June 2003. As of June 30, 2003, local jails held 762,672 detainees.[1] As Steadman et al.[2] have pointed out, jails are primarily people processing organizations, and many people stay in jail for only a few hours, days, or weeks before achieving some sort of pretrial release.

Given such extraordinary numbers, mental illness in even a small percentage of the incarcerated population translates to a staggering number of persons with mental illness behind bars.[3] The American Psychiatric Association[4] estimated that 20% of jail and prison inmates have a serious mental illness and are in need of psychiatric care. However, the most recent available data indicate that only 13% of state inmates received any type of mental health therapy, and only 10% were on psychotropic medications.[3]

American correctional facilities are extraordinarily diverse, and the nature of mental health service varies accordingly. Local facilities can range from one-person lockups to large urban jails, whereas prisons can vary from small field camps to large walled complexes housing in excess of 5,000 inmates.[5] The jail population is primarily comprised of pretrial detainees, who, for various reasons, are unable to secure bond while awaiting trial or sentenced misdemeanants serving a short-term punishment. Jail confinement often takes place shortly after apprehension, thereby increasing the likelihood of acute symptoms of a mental disorder, substance disorder, or acute intoxication.[6] Moreover, there is an increased risk for suicide and violent behavior among jail detainees. However, the stresses inherent to jail (e.g., relatively recent detainment, potential first exposure to corrections) may result in psychiatric crises in detainees with no history of receiving mental health services, and some of these newly admitted detainees do not immediately appear to be in obvious need of mental health services. Simply stated, the nature of the jail setting demands that psychiatric needs of inmates be identified, assessed, and addressed in as expeditious a manner as possible.

Prisons, in contrast, serve to punish serious offenders, and, by necessity, have a more long-term approach to the nature and scope of service provision.[6] Prison inmates have often been in the criminal justice system for an extended period of time.[4] As a result, they are less likely than jail detainees to manifest acute psychotic or substance-related symptoms and may have begun the process of psychological adaptation to being in custody.[4] Although it is critical that all prison inmates are screened for psychiatric symptoms, prisoners are more likely to arrive with some, albeit oftentimes limited, medical history information. Ideally, prison inmates will arrive at their designated facility with treatment already initiated by competent jail mental health staff. Clearly, this is an optimistic understanding of a jail-to-prison transfer. In reality, even in the best jail mental health systems, systemic and/or time constraints will result in some inmates "falling through the cracks." Or, in many cases, individuals who began treatment in jail may "fall out" of treatment while en route to the Department of Corrections. Moreover, prison inmates may suffer from exacerbation of psychological symptoms as a result of stress associated with transferring to a new facility, adjusting to the implications of protracted incarceration, and negotiating the demands of a new institutional climate.

■ LEGAL REQUIREMENTS AND PROFESSIONAL STANDARDS

Dramatic changes have occurred over the past three decades, shifting from near-absent correctional health care access to a system of judicial mandates and professional standards designed to ensure the constitutional rights of prison inmates and jail detainees.[7] The right to treatment for pretrial jail detainees stems from due process rights guaranteed by the Fourteenth Amendment.[8] Prison inmates' access to medical and psychiatric care is guaranteed by the Eighth Amendment. Moreover, the courts have repeatedly mandated treatment for mentally ill offenders.[8–10] Necessary health care for inmates has been specifically defined to include psychiatric services *(Bowring v. Godwin)*[9] and to extend beyond the simple provision of medication *(Langley v. Coughlin)*.[11] More specifically, case law has set forth minimum standards for jail mental health, specifying the necessity of structured screening and evaluation programs.[12–18]

Although the Supreme Court has determined that standards articulated by professional organizations are not necessarily equivalent to constitutional obligation,[19] the court does look to professional organizations to define adequate care.[7] Several national organizations have created standards and/or guidelines for correctional health care.[6] The most widely referenced guidelines and standards are those published by the American Psychiatric Association[4] (APA) and the National Commission on Correctional Health Care[19] (NCCHC). With this in mind, the APA and NCCHC standards will serve as the framework for the remainder of this discussion.

SCREENING IN JAIL AND PRISON

Comprehensive mental health care requires a logical system of interdependent service elements. From intake to discharge planning, the components of effective mental health care are dependent upon accurate flow of information and the ability to appropriately route patients to the next logical level of service.

Effective intake screening represents the first opportunity to identify mental health need and to send a patient forward through the process of critical mental health assessment and treatment. Flawed or inadequate intake screening can result in critical needs being missed, leading to potentially grave consequences for both the individual and the system as a whole. Screening that is too sensitive can result in the needless expenditure of mental health resources within the jail or prison, whereas screening that is not sensitive enough can result in various tragic consequences for the untreated inmate or detainee, up to and including preventable death. In other words, screening can easily be characterized as the single most important service element in correctional mental health[20] because it is simply not possible to provide necessary treatment for serious mental illness without identifying the specific inmates affected.[4]

Screening has two overarching goals. First, to prevent suicide, it is necessary to identify inmates at high risk for self-harm in the first crucial hours of detention, which have historically held the most peril in regard to jail suicide.[21] The second goal is to identify those inmates most likely to require psychiatric or psychological services during their incarceration, so that they need not experience a crisis to receive help.

Simply put, screening is equivalent to a front-line triage mechanism and serves as the primary filter used to divert inmates toward or away from mental health care. In the interest of accurate identification of need, some of the most important features of intake mental health screening remain salient across jail and prison contexts. Although there are several acceptable ways to provide mental health screening in jail and prison, several elements must be present if the screening is to be useful. Box 18-1 illustrates the essential elements of any initial screen.

TRAINED STAFF

The APA[4] and the NCCHC[19] both allow for initial intake screening to be performed by correctional or nursing personnel, provided that they are adequately trained.* In many facilities across the United States, budgetary and staffing constraints preclude the exclusive use of mental health professionals for screening purposes. Correctional staff, nurses, and case managers can successfully administer intake screening tools provided that they are properly trained on the instrument and where to refer inmates in need of service.

BOX 18-1 Essential Elements of an Initial Screen

1. Trained Staff
2. Documentation
3. Low Threshold
4. Standardization

DOCUMENTATION

Screening data must be documented in a consistent manner and made available to those responsible for the inmate's care and housing. Records must be maintained to facilitate communication between care providers.

LOW THRESHOLD

Screening, by definition, must have a low threshold because it is intended to simply identify the presence or absence of need for further inquiry,[22] especially when it is not completed by a mental health professional. False-positive errors involve relatively little cost, because they only result in an otherwise unnecessary but typically brief interview by a mental health professional. On the other hand, false-negative errors can result in unnecessary emotional or psychiatric consequences, or even death in the case of an otherwise preventable suicide. Any indication of current psychiatric symptomatology or past psychiatric history should result in referral to the next level of evaluation. Because screening data is most often obtained almost entirely by self-report, it is imperative that the process allow for referral based on behavioral observation, despite the potential absence of self-reported psychiatric need. Any observation of bizarre behavior or mannerism should result in the inmate being referred to the next assessment level.[4]

STANDARDIZATION

Routine, standardized collection of screening data at intake, obtained by trained staff, facilitates accuracy and increases reliability. In other words, whether or not a person is screened "positive" should not depend upon who happens to be on duty for that shift.[4] Across all levels of intake screening, the use of a standardized format for data collection improves the reliability and consistency of information.

Regardless of context, screening should be conducted so as to maximize the gathering of valid information. Accurate screening data collection is in the best interest of the inmate, staff, and the system at large. To the extent that the privacy and dignity of an inmate can be maintained, screeners are more likely to be able to obtain a candid account of the inmate's history and current status. Inmates should be informed of the nature and purpose of the screening process and should be advised of their results and implications. For many inmates and detainees alike, the process of entering a facility can be frightening and confusing. Individuals entering a system may be suspicious of the system and may hold preconceived notions about what it means to be labeled mentally ill in jail or prison. Screening personnel should make every effort to develop adequate rapport with the inmate being evaluated and to demystify the process. In many cases, the simple provision of accurate information can go a long way toward eliciting cooperation and heading off potential crises down the road.

The overarching goal of all mental health screening is to ensure accurate and expedient identification of mental illness

*The NCCHC jail standards allow properly trained non-healthcare staff to conduct screenings. The NCCHC also allows trained non-healthcare staff to conduct receiving screens in prisons with a population of less than 500. However, the NCCHC prison standards require screenings by qualified health staff in facilities with an average daily population in excess of 500.

By incorporating screening into the initial reception process, the potential for intervention is maximized. Screening on the front-end provides essential data necessary for appropriate judgments relative to an inmate/detainee's level of need, urgency of need, and housing location (e.g., general population, segregation, observation, hospitalization). Informed decision making early on is invaluable toward diffusing potential crises, thereby saving precious time, energy, and resources, as well as minimizing unnecessary human suffering.

The APA[4] delineated three broad categories of mental health service in jails and prisons: Level A, identification, which includes screening, referral, assessment, and evaluation; Level B, mental health treatment; and Level C, discharge planning. For the purpose of this discussion, we will focus on the components of Level A, beginning with discussion on receiving mental health screening.

Receiving Mental Health Screening

The APA[4] defined the receiving mental health screening in jails as "mental health information and observations gathered for every newly admitted detainee during the intake process by using standard forms and following standard procedure" (p. 32). The definition for prison is similar, with the caveat that in prison settings, the receiving mental health screen takes place for every newly admitted inmate during the normal reception and classification process.[4] Box 18-2 illustrates the essential components of a receiving mental health screen.

Regardless of the context (e.g., jail or prison), receiving mental health screening must take place immediately upon arrival at the facility. As explained by the NCCHC,[19] receiving screening is intended, in part, to identify potential emergency situations among new arrivals. The process helps to identify potential danger to self or others in an inmate or detainee and to rapidly redirect such inmates toward necessary medical care.

For various reasons, mentally ill inmates may be unwilling or unable to provide complete or accurate health history information. As a result, it is critical that receiving staff are well trained in interviewing and observation. Although nonmental-health staff (including appropriately health-trained correctional staff members) may be allowed to conduct screening, the NCCHC[19] requires, in all circumstances, that mental health staff be involved in the training of screening personnel. The degree of training required will depend on the role of nonmental-health staff in the screening process. Current training on screening for mental illness, substance abuse, intellectual impairment, and suicidality is required. The NCCHC[19] specified minimum training requirements for nonmental-health personnel, including: how to take a medical history; how to make required observations; how to determine the appropriate disposition (based on responses/observations); and how to document their findings appropriately.

Receiving screening should consist of structured inquiry into detainee/inmate's mental health history, covering areas including, but not limited to: suicide history, suicidal ideation, prior mental health treatment (inpatient and outpatient), current and past psychiatric medication (as prescribed and as actually taken),[4] and especially whether or not the inmate needed or received mental health services during his or her last incarceration. Screening personnel must be mindful that behavioral observations are equally, if not more, important than self-report data obtained during a receiving screen. Screening personnel must be vigilant in their observation of the inmate/detainee's behavior, toward identifying possible signs of acute psychosis (e.g., hallucinations, delusions, impaired reality testing); thought or communication disturbance (e.g., bizarre speech, disorganized thinking, memory disturbance); mood disturbance; and/or substance abuse. Substance abuse evaluation is of particular importance in a jail setting, where detainees are more likely to remain under the influence of alcohol or drugs upon entry into the facility. An examination of signs/symptoms of acute intoxication and withdrawal is imperative upon reception into jail.

In every setting, screening must include a thorough exploration of suicide potential. This requires a detailed review of prior suicidality. However, given the stressors inherent to the correctional setting, it is critical that current suicide potential be examined regardless of an individual's prior history. In other words, even an inmate/detainee with no known history of suicidal ideation or intent may very well exhibit signs of acute suicidality upon entry into jail or prison. Although behavioral observations are an integral part of intake screening, in general, awareness of subtle and/or nonverbal indicators is of particular importance in the evaluation of suicide potential. Screening staff must be conversant in the signs/symptoms of suicidality and must be prepared to take immediate action in the face of suicide risk.[21]

Whenever possible, it would be ideal to obtain informed consent to send for prior records (if applicable) during, or shortly after, the receiving screen. Obtaining prior records can be a difficult and time-consuming process, and the earlier in the process a request is made the better as far as using such data to assist in both the screening process and, when appropriate, the treatment planning process.

Intake Mental Health Screening*

The APA[4] and NCCHC[19] agree that all inmates must undergo mental health screening within 14 days of their arrival at a facility. The APA[4] defines intake mental health screening for both

BOX 18–2 Receiving Mental Health Screening

1. Occurs immediately upon arrival
2. Consists of observation and structured inquiry into mental health history and symptoms
3. Usually conducted by custodial or healthcare personnel as long as they are trained in mental health screening/referral
4. Intended to determine potential danger to self or others; identify acute/serious mental illness; assess need for emergency or nonemergency mental health referral
5. Completion of a standardized form, documenting responses and observations, to be included in the mental health record
6. Resultant action determined by specific procedures and should include acceptable time frame(s) as determined by policy

*The nomenclature adopted by APA is frankly a bit confusing when applied to jails. Note that "intake mental health screening" can occur as long as 14 days after admission to the jail, which is typically long after the inmate is regarded as participating in the intake process. In prisons, of course, where the intake and reception processes can take weeks to conclude, this name makes more sense.

jail and prison as "a more comprehensive examination performed on each newly admitted detainee (inmate) within 14 days of arrival at an institution" (pp. 34, 41). Although standards allow up to 14 days for intake screening to occur, obviously those inmates/detainees who demonstrate higher-level need at reception must be moved through the system at a rate commensurate with their psychiatric need. Box 18-3 illustrates essential elements of an intake mental health screening as delineated by the APA.[4]

In contrast to receiving screening, which can, in some cases, be completed by correctional staff, intake or initial mental health screen must be conducted by a health care professional. The NCCHC[19] explains, however, that this screening can be conducted by qualified mental health professionals or trained health staff. Trained health staff includes health care professionals who may not have formal mental health training but have received instruction and supervision related to the identification of, and interaction with, persons in need of mental health care. In our opinion, if the receiving screening process is used properly, it will likely be cost-effective to have intake mental health screening conducted by mental health professionals, as opposed to generic health care personnel.

Intake mental health screening is comprised of many of the same elements as a receiving screen, the primary difference being that the intake screen falls under the purview of health care personnel. Areas of inquiry should include a review of data obtained during receiving screen, mental health history, and another assessment of suicide potential.[4]

More specifically, as per the NCCHC,[19] a structured intake screening interview includes an inquiry into the history of inpatient and outpatient psychiatric history; suicidality; violent behavior; victimization; special education; cerebral trauma/seizures; and sex offenses. Areas of exploration regarding current status should include: psychotropic medication; suicidal ideation; substance use; orientation; and emotional response to incarceration. The NCCHC also specifies the inclusion of a screen for intellectual functioning.

For those inmates or detainees who do not demonstrate, via self-report or observation, a need for more comprehensive evaluation, intake mental health screen will complete the intake process. Such inmates must, however, be provided with detailed information regarding access to mental health care. Extremes of noise, temperature, and pressures of overcrowding exacerbate the inherently stressful environment of corrections.[20] Separation from loved ones, loss of autonomy, and the implications of a protracted sentence can have a profound negative impact on the well-being of even the most mentally healthy inmate. Inmates can develop mental illness and psychiatric or emotional crises at any time during their period of detention or incarceration. Mental health staff must take steps to ensure that inmates and detainees understand the avenues of access to care and are aware of the availability of mental health treatment if the need should arise.

Mental Health Assessment and Evaluation

Brief Assessment. Inmates/detainees identified at intake screening as potentially in need of mental health service must be scheduled for more detailed assessment and/or evaluation. The NCCHC[19] requires that evaluations beyond screening are conducted by qualified mental health professionals. Qualified mental health professionals are defined as "psychiatrists, psychologists, psychiatric social workers, psychiatric nurses, and others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for the mental health needs of patients" (p. 77).

The APA[4] defines brief mental health assessment as "a mental health examination that is appropriate to the particular, suspected level of services needed and is focused on the suspected mental illness" (p. 35). Box 18-4 illustrates the essential features of a brief mental health assessment as suggested by the APA.

A brief mental health evaluation should be completed for all inmates/detainees who are identified as potentially in need of mental health service. APA[4] includes the requirement that a written recommendation be prepared regarding future evaluation and treatment.

As stated earlier with regard to the intake mental health screen, although the APA allows 72 hours within which to conduct a brief mental health evaluation, the time frame is contingent upon level of identified need, and urgent cases will require more rapid response. In fact, when clinically indicated, it is appropriate to forego the brief evaluation and proceed directly with a comprehensive mental health evaluation (see next section).

Comprehensive Mental Health Evaluation. Comprehensive mental health evaluation represents the final phase of the intake assessment process. Comprehensive jail and prison mental health evaluation, as defined by the APA,[4] "consists of a face to face interview of the patient and review of all reasonably available health care records and collateral information. It concludes with a diagnostic formulation and, at least, an initial treatment plan" (pp. 36, 44).

A detailed review of the components of a comprehensive mental health evaluation is beyond the scope of this chapter.

BOX 18–3 Intake Mental Health Screening

1. Conducted by a health care professional
2. Standardized questions, including observations, are documented and made part of the permanent health record
3. Resultant action is determined by specific procedures and should include time frames developed by policy and procedure
4. If referral is not necessary at the time of intake screening, detailed information about access to mental health care is provided to the inmate/detainee

BOX 18–4 Brief Mental Health Assessment

1. Conducted within 72 hours of a positive screening and referral (or sooner if clinically indicated)
2. Findings are documented on a standard form and maintain as part of the confidential mental health record
3. Conducted by an appropriately trained mental health professional
4. May or may not result in the development of a treatment plan

As the title implies, comprehensive evaluation involves a detailed treatment of an individual's personal, medical, psychiatric, family, social, educational, vocational, and legal history, as well as an exhaustive review of current and past symptom presentation. Comprehensive mental health evaluation should also include access to psychological and neuropsychological assessment services as well as clinical laboratory and neuroimaging services as indicated.[4] Data gleaned from comprehensive evaluation will serve as the foundation for an inmate/detainee's treatment plan and a framework for the provision of appropriate mental health service.

According to the APA Guidelines,[4] comprehensive evaluation data should be recorded on a standard form and maintained as a part of the *confidential* mental health record. Comprehensive evaluation should be conducted by a psychiatrist, psychologist, or other appropriately licensed or credentialed mental health professional. No specific parameters regarding time frame are demanded by the APA; rather, it is expected that comprehensive evaluation will be conducted in a timely manner as appropriate to the urgency of need.[4]

Referral

Each phase of the mental health process is dependent upon appropriate and timely referral from one level to the next. The APA[4] distinguishes between standard and post-classification referral. Referral is defined as "the process by which inmates who appear to be in need of mental health treatment receive targeted assessment or evaluation so that they can be assigned to appropriate services" (pp. 32, 34, 40, 42). Post-classification referral is defined as "the process by which such individuals are brought to the attention of mental health staff for brief mental health assessment or comprehensive mental health evaluation (pp. 35, 42).

Although our discussion has, so far, focused on primary referral (inmates/detainees flagged during a standard facility reception process and referred to the next level of evaluation), both standard and post-classification referral are critical to effective institutional mental health care. It is important to address the broad implications of effective post-classification referral. Post-classification referral includes all other mechanisms by which inmates or detainees come to the attention of mental health staff.

Psychological symptoms, of course, are not limited to newly incarcerated offenders.[24] On the contrary, chronic anxiety and stress are common byproducts of incarceration, and virtually all inmates will encounter numerous life stressors at some point while in custody. Although intake assessments work well for those inmates/detainees who are forthright in their self-report and willing to seek help, at issue are those who are unwilling or unable to articulate their concerns. Correctional line staff are the most critical and comprehensive data and referral sources available to inmates and clinicians alike, because they have, by far, the most contact with inmates on a daily basis.[25] In fact, a well-trained, conscientious correctional officer is more likely to be responsible for defusing a potential problem than *any* member of the mental health staff.[25] With this in mind, the importance of cultivating a collaborative working relationship between security and mental health staff cannot be overstated. Mental health professionals must take proactive steps to facilitate ongoing and open communication with correctional personnel. The observations of a diligent work supervisor may very well be the critical factor toward intervening in a potential psychiatric crisis for an inmate or detainee. For example, a simple call from the detail supervisor expressing concern about a change in an inmate's affect or attitude can, and should, result in follow-up by mental health staff. All too often, however, mental health staff fail to demonstrate respect and appreciation for the wisdom of seasoned correctional personnel.

Screening Instruments

As previously discussed, inmates in need of mental health services may avoid detection for various reasons. Untreated psychological or psychiatric distress in corrections has profound implications for the individual inmate, his or her peers, correctional staff, and the facility as a whole. In jail, the use of psychological assessment *instruments* for screening purposes is often impractical, if not impossible, because many psychometric instruments require administration and/or interpretation exclusively by highly trained mental health professionals. A useful screening instrument must be concise and easily administered and must include decision tools that are clear and readily understood by staff with even minimal mental health training. Criteria should be included that will facilitate identification of symptomatology that is often more subtle (e.g., anxiety and depression) than the overt signs of psychosis. In fact, to be effective, jail screening procedures must identify both those detainees who manifest acute symptoms as well as those who are at elevated risk of developing such problems during the course of their detention.[26]

To examine this issue, Maloney et al.[16a] used a concept called "risk of mental disorder" and evaluated Los Angeles County Jail inmates on criteria indicative of not only immediate need, but also risk for emergent psychological problems. Results indicated that 28% of men and 31% of women booked into the Los Angeles County jail system met at least one criterion for being at-risk of mental disorder. Data by Maloney et al. were collected, at least in part, by senior psychologists, and their procedure was labor intensive (35 to 60 minutes per inmate), precluding its use as a screen in general corrections. Their findings clearly underscore the need for a comprehensive screening instrument with a threshold low enough to adequately flag the inmates in need. Equally important, the screen must be pragmatic because it must be easily administered and efficient to minimize the burden on already overworked classification staff. Finally, these data suggest that no screen is likely to catch every high risk inmate and underscore the need for a well functioning referral system.

The Referral Decision Scale (RDS)[20] has been presented as a useful screening instrument for use by correctional staff. The RDS was intended to identify gross symptomatology associated with schizophrenia, bipolar disorder, or major depression. The RDS was derived from the Diagnostic Interview Schedule (DIS)[27] and is comprised of three five-item subscales, each having a cutoff that should result in a referral for mental health assessment. Despite supportive preliminary data,[20] however, several studies have called the RDS's validity into question.[28–30]

One potentially viable solution to the absence of viable screening instruments is the Brief Jail Mental Health Screen (BJMHS) (Fig. 18-1). Steadman et al.[2] examined the validity of the BJMHS, which is comprised of the eight yes/no items from the RDS plus an additional item added for their validation

[16a] See Maloney et al. (2003) for a complete list of criteria employed in this study.

BRIEF JAIL MENTAL HEALTH SCREEN

Section 1 (Optional)

Date: ___ ___ / ___ ___ / ___ ___ ___ ___	**Time:** ___ AM / PM	**Detainee #:** ___	**Gender:** □M □F
Date of Birth: ___ ___ / ___ ___ / ___ ___ ___ ___	**Admission Status:**	□ Pretrial □ Sentenced	□ Parole Violation □ Probation Violation
Race/Ethnicity (check ALL that apply):	□ American Indian or Alaskan Native □ Asian □ Black or African American	□ Native Hawaiian or Pacific Islander □ Spanish, Hispanic, or Latino □ White or Caucasian	□ Other (specify): ___

Section 2

Right now...	**No**	**Yes**	**General Comments**
1. Do you currently believe that someone can control your mind by putting thoughts into your head or taking thoughts out of your head?			
2. Do you currently feel that other people know your thoughts and can read your mind?			
3. Have you currently lost or gained as much as two pounds a week for several weeks without even trying?			
4. Have you or your family or friends noticed that you are currently much more active than you usually are?			
5. Do you currently feel like you have to talk or move more slowly than you usually do?			
6. Have there currently been a few weeks when you felt like you were useless or sinful?			
	No	**Yes**	
7. Have you ever been in a hospital for emotional or mental health problems?			
8. Are you currently taking any medication prescribed for you by a physician for any emotional or mental health problems?			

Section 3 (Optional)

Officer's Comments/Impressions (check ALL that apply):

□ Language barrier □ Under the influence of drugs/alcohol □ Non-cooperative

□ Difficulty understanding questions □ Other, specify: ___

Instructions for referral: If yes to item 7 OR yes to item 8 OR yes to two or more of items 1 through 6 this inmate should be referred for further evaluation of mental health symptoms.

■ **FIGURE 18–1.** Form for brief jail mental health screen. Brief Jail Mental Health Screen: Policy Research Associates, Inc., Delmar, NY 12054 © 2004, reprinted with permission.

study. Steadman et al. examined the ability of the BJMHS to predict serious mental illness on the Structured Clinical Interview for DSM-IV-TR Axis I Disorders.[31] They found the BJMHS to be a powerful screening instrument for men, with 74% accuracy overall. Unfortunately, the data for women was less impressive, and Steadman et al. indicated that they could not endorse its use in the female correctional population.

■ CONCLUSIONS

Due primarily to the threat or reality of litigation, there have been dramatic improvements in the care and treatment of mentally ill offenders in many jurisdictions. However, despite the treatment services that may now be available, it remains true that we can only treat the people and conditions of which we are aware. Screening and referral systems that are reliable and valid are perhaps the most essential element of a jail mental health and suicide prevention system. Because of the demographic and socioeconomic makeup of most jails and prisons, it is often difficult or impossible to get adequate prior psychiatric records in a timely and reliable fashion. Further, incarceration can be either a cause and/or the result of tremendous situational stress, which renders people less able to advocate for their own health needs. Finally, despite advances, rare is the jail with enough mental health services to meet all of the needs. For these reasons, correctional settings need the ability to quickly and efficiently identify those inmates in need of suicide prevention or mental health services, so that they can be triaged and responded to according to the severity of their need. Recent advances have improved our ability to meet this essential function in jail mental health.

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