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The structure of correctional mental health services

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INTRODUCTION

The rate of incarceration in the United States hit alarming levels between 1978 and 2009, peaking at approximately 2,300,700 incarcerated adults in jails and prisons by the end of 2008 (Glaze 2010). Small but consistent declines in the population have been the trend since (decreases of 0.7% in 2009, 1.3% in 2011, and 0.5% in 2012; Glaze and Herberman 2013) as the number of releases from state prisons has begun to exceed the number of admissions (Carson and Golinelli 2013). Despite these decreases, the Bureau of Justice Statistics (BJS) estimates the total incarcerated population at the end of 2012 to be 2,228,400, putting approximately one in every 108 adults in the United States in prison or jail (Glaze and Herberman 2013). When compared to the global community, the United States continues to be at the top of incarcerated population rates: approximately 716 prisoners per 100,000 people versus the global average of 144 prisoners per 100,000 people (Walmsley 2013).

Commensurate with the high rates of incarceration in the United States is the high number of imprisoned individuals who suffer from a mental illness. Research indicates that a disproportionate number of inmates and detainees experience mental illness; however, prevalence estimates vary. At the conservative end of the spectrum, roughly 6%–11% of inmates in jail and prison are deemed currently in need of psychiatric care for serious mental illness, while 10%–15% require treatment for general mental illness (American Psychiatric Association [APA], Task Force on Outpatient Forensic Services 2009). Based on the 2012 estimated incarcerated population from the BJS, there were between 222,840 and 334,260 offenders with mental illness requiring treatment in U.S. prisons and jails at the year end of 2012. Teplin and Swartz (1989) noted that even after adjusting for demographic differences, the prevalence rates of schizophrenia and major affective disorder are two to three times higher in jails than in the general population. Steadman and his colleagues (1987) found that the prevalence of severe or significant psychiatric disability among sentenced felons is at least 15%. When coupled with mental retardation or brain damage, at least 25% of the inmate population in the New York State Department of Correctional Services was found to have at least a significant psychiatric or functional disability. Other studies, using vague and overly inclusive criteria, have identified more than 60% of inmates as experiencing a "mental problem" (James and Glaze 2006).

Incongruities exist when looking at the disposition and sentencing of persons incarcerated with a mental illness. Axelson and Wahl (1992) found that psychotic detainees charged with misdemeanors were discriminated against in accessing various types of pretrial release, resulting in lengths of stay six-and-a-half times longer than nonpsychotic controls. Similarly, Valdiserri et al. (1986) determined that psychotic inmates were four times more likely than nonpsychotic inmates to have been incarcerated for less serious charges such as disorderly conduct and threats. In a larger follow-up study to Axelson and Wahl's (1992), Harris and Dagadakis (2004) did not find differences in length of incarceration time between severely mentally ill and nonmentally ill control groups. They did, however, similarly find that the severely mentally ill group, who had less severe and less frequent previous offenses, was often incarcerated for the same length of time as the nonmentally ill group with more frequent and severe offenses.

In correctional institutions, those inmates with serious mental illnesses or in psychiatric crisis present a host of problems to correctional administrators. One problem, of course, is the possibility of serious injury to staff and other inmates posed by those few inmates with serious mental illness whose behavior is uncontrolled and violent. Untreated, inmates with psychoses may be terrified by hallucinations and stay up all night screaming, thereby keeping other

inmates awake, who in turn become angry and violent in response. Thus, housing assignments must take into account the mutual fears of inmates with and without mental illness.

Another problem posed by the occurrence of psychiatric crisis and severe mental illness in correctional facilities is related to liability. Suicides and restraint-related deaths may have dire legal consequences. Despite the stereotype of "guards" as tough and unfeeling, a completed suicide is often devastating to custody staff, who feel responsible for keeping inmates safe. Indeed, public opinion, so seldom sympathetic to inmates, nevertheless solidly expects correctional officials, at the very least, to keep their inmates alive. Even in the absence of adverse judgments or settlements, legal fees can be costly.

The diversity of American correctional facilities is extraordinary. Local correctional facilities range from one-person police lockups to large urban jails, which may house more than 15,000 inmates. Similarly, state prisons vary from very small field camps to prisons of more than 5000 inmates. Notwithstanding the differences between facilities, jails and prisons are alike in many ways. Both are viewed as correctional settings, with uniformed staff, secure perimeters (depending on custody level), and usually stark accommodations. Jails and prisons can also be very stressful environments, due to forced association, segregation by gender, and extremes of noise and temperature. However, the challenge of keeping their respective facilities safe is the most important similarity that jails and prisons share.

Despite such similarities, there are also important differences between jails and prisons. While prisons are self-contained environments that tend to house inmates for long periods of time, jails often hold detainees for only a matter of hours; thus, jails need to be treated as part of the larger communities in which they exist (Steadman et al. 1989). The goals of the two settings also differ. For pretrial detainees, jails exist predominantly to hold and process people until their case is resolved by the courts. Often, jail detention depends solely on external factors such as the ability of the defendant's family to raise money to post bond. For sentenced misdemeanants, jails serve as short-term (usually less than 1 year) punishment, with or without an effort at rehabilitation. Prisons, on the other hand, serve to punish the most serious offenders, and ostensibly to prepare them through various prison programs for their eventual return to society.

Over the past several decades, there have been important changes in community mental health philosophies, the most important being the Recovery Model and an emphasis on Trauma-Informed Services (Pinals and Andrade 2015; see also Substance Abuse and Mental Health Services Association [SAMHSA] 2014). The Recovery Model is a way of looking at mental illness with more hope and respect than had previously been the case. It encourages clinicians to pay attention to each person's strengths and assets instead of merely documenting pathology. It provides a more hopeful way of looking at each person's future, and encourages clinicians to help people acquire the skills that will allow them to live safely with their mental illnesses. This model is slowly being adopted by a few correctional facilities (SAMHSA 2014).

Trauma-informed care is a relatively simple but enormously important change in the way that clinicians look at the people they treat. Clinical training teaches each practitioner to ask each patient, "What is wrong with you?" Instead, a trauma-informed approach to mental health treatment asks an equally important question, "What has happened to you?" The prevalence of traumatic experiences among jail and prison inmates is well documented (Miller and Najavits 2012), and respect for these traumatic experiences can dramatically assist clinicians informing a therapeutic alliance with their clients.

Needless to say, the difficult and stressful correctional environment creates serious challenges to the formation of the therapeutic milieu or relationship (Pinals and Andrade 2015). Nevertheless, correctional mental health workers who understand these principles can provide a higher quality of service to their clients and to the institutions in which they work.

THE LEGAL REQUIREMENTS FOR CORRECTIONAL MENTAL HEALTH SERVICES

O'Leary (1989), Cohen and Dvoskin (1992), Cohen (1988, 1998), and Jones (2015) have written extensively about the legal bases for requiring mental health services in jails and prisons, in addition to the required components and standards that various courts have established for such services.

Pretrial detainees have a due process right not to be punished, while convicted inmates are prohibited from suffering cruel and unusual punishment. For pretrial detainees, the right to treatment stems from due process rights guaranteed by the Fourteenth Amendment. "Detainees are entitled to at least the same level of care as the convicted" (Cohen 1988, 1998). A convicted inmate's right to medical and psychiatric treatment in prison, guaranteed by the Eighth Amendment, stems from the state's role as incarcerator. In *Estelle v. Gamble* (1976), the Supreme Court interpreted this responsibility as the duty to avoid "deliberate indifference" to the serious medical needs of inmates. Other federal and state courts specifically included psychiatric needs within the standard (e.g., *Bowring v. Godwin* 1977), and have required that treatment be greater than the provision of psychotropic medication (*Langley v. Coughlin* 1989). It was not until 1994, however, with *Farmer v. Brennan* (1994), that a clearer definition of this term was presented. The *Farmer* decision equated deliberate indifference with recklessness, and applied the criminal standard of "actual knowledge" of risk. It is not essential to prove that an official clearly believed that harm was imminent; only that an official possessed substantial knowledge of risk (Cohen 1998). Examples of the application of this standard can be found in cases such as *Coleman v. Wilson* (1995) and *Madrid v. Gomez* (1995), both of which speak to the necessity of providing adequate treatment to inmates with mental illness.

To incarcerate someone with deliberate indifference to his or her significant psychiatric needs is thus viewed as cruel and unusual punishment and may be remedied, often through class action lawsuits, by injunctive relief, or by compensatory and/or punitive monetary damages. The conservative turn in the federal judiciary, however, has made it far more difficult for plaintiffs to succeed in such actions (e.g., *Wilson v. Seiter* 1991; *Hudson v. McMillan* 1992).

Congress has also been conservative relevant to prison reform as reflected in passage of the *Prison Litigation Reform Act* (PLRA; 1996). The PLRA established new procedural requirements for suits by prisoners and significantly limited the ability of the courts to order relief. Consent decrees now require a finding of unconstitutional conditions (i.e., admission of such conditions by the defendants), fees are limited for special masters and attorneys, and other restraints to remedies are present. The U.S. Supreme Court in *Miller et al. v. French et al.* (No. 99–224, decided June 19, 2000) upheld the constitutionality of this act that had been challenged on due process and separation of powers principles.

In addition to constitutional litigation, correctional administrators who ignore the mental health needs of at-risk inmates who go on to commit suicide may also be vulnerable to tort liability, such as wrongful death actions (O'Leary 1989). Injuries to staff and other inmates resulting from inadequate mental health services can also lead to tort liability, as well as great expense due to occupational injury leave and disability retirements. In addition, inadequate medical or psychiatric services can result in malpractice claims against both medical and mental health providers in the jail.

Evolving legal requirements

Lower courts, generally via class action litigation, have also dealt with specific programmatic aspects of correctional mental health systems that include the placement of inmates with a serious mental illness in long-term segregation housing units, discharge planning, and the quality improvement process.

Because it is common for inmates with a mental illness to be overrepresented in segregation housing units, especially in systems that have problematic or inadequate mental health services, courts have attempted to partially remedy this problem by requiring mental health screening during the time immediately surrounding transfer of inmates to such housing units and/or establishing a process for providing mental health input into the disciplinary process (*Coleman v. Wilson* 1995). The purposes of the screening process include triaging of an inmate's mental health needs and exclusion of inmates from segregation housing when clinically indicated (e.g., due to psychosis or significant suicide risk). Courts have also required ongoing "rounds" in segregation housing to provide ongoing assessment of segregated inmates (*Coleman v. Wilson* 1995).

Courts have also required that inmates with a serious mental illness housed in segregation units must have access to appropriate levels of mental health treatment based on their clinical needs (*Madrid v. Gomez* 1995; *Ind. Prot. & Advocacy Servs. Comm'n v. Comm'r, Ind. Dep't of Corr.* 2012). Such treatment should include both structured out-of-cell therapeutic programming and unstructured out-of-cell recreational time. For example, for inmates requiring a special needs level of mental health care (e.g., residential level of care), at least 10 hours per week of structured therapeutic activities and another 10 hours per week of unstructured recreational time have been recommended by Metzner and Dvoskin (2006).

Mental health input into the disciplinary process for inmates with a serious mental illness has also been a component of remedial plans designed to reduce the length of stays for inmates with a serious mental illness in locked down settings (*Disability Advocates, Inc. v. New York State Office of Mental Health* 2007). Mental health assessments are designed to answer the question of whether the inmate's rule infraction was related to symptoms of a mental illness and, if so, whether the disposition should be mitigated (e.g., reduced disciplinary housing time) by the hearing officer.

Discharge planning has been increasingly recognized by both mental health and correctional staffs to be an essential element of an adequate correctional mental health system related to both the obvious clinical purposes and due to the benefits from a perceived reduced recidivism rate. Although decided on the basis of state statute and case law, *Brad H. v. City of New York* (2000) is instructive regarding the risks from a legal perspective of not providing adequate discharge services. A settlement agreement was reached in which the city is to provide discharge planning services that include, depending on clinical indications, medications, assistance with housing and entitlements as well as linkage services.

Grubbs v. Bradley (1993), *Coleman v. Wilson* (1995). and *Madrid v. Gomez* (1995) emphasized the importance of a quality assurance/improvement (QI) process in remedying an inadequate correctional mental health system. A QI system has been increasingly recognized within the correctional health–care field as an essential component in order to continually improve the effectiveness and quality of health-care services provided.

DIVERSION PROGRAMS

There are a number of reasons why people with mental illness find their way into correctional settings despite efforts to divert them to alternative dispositions (Lamb and Weinberger 1998). For some, the offense will be severe and unrelated to their mental illness, thus ruling out the possibility of dismissing charges or negotiated insanity pleas. For others, coincidental onset of a serious mental illness, often exacerbated by the stress of their incarceration and the correctional environment may result in decompensation in some individuals who were mentally intact prior to their incarceration (Gibbs 1987; Muzekari et al. 1999). Finally, with the continuously high rate of illegal drug use and its well-documented relationship to criminal behavior

(see, e.g., Petrich 1976; Mirsky 1988; O'Neil and Wish 1990; Office of National Drug Control Policy 2013), urban jails face high numbers of newly admitted inmates who suffer from drug-induced psychosis on arrest.

Diversion programs are essentially intended to shift offenders with mental illness and/or substance abuse problems away from the criminal justice system (The Center for Health and Justice at TASC 2013). This does not imply, however, that mentally ill offenders should not, or would not, ever be detained. Although diversion may prevent incarceration in some cases, it may also mitigate the time spent behind bars, as well as impose contingencies for aftercare upon release. For those offenders requiring detention, mental health services must be provided by the correctional facility. Generally speaking, however, nonviolent mentally ill offenders are not likely to have their ongoing mental health needs best met by serving jail time. Instead, the safety of the community is better served by providing a comprehensive, inclusive diversion program designed to meet the needs of the offender, as well as the mental health and criminal justice systems (Coleman 1998; GAINS Center for Behavioral Health and Justice Transformation [GAINS] 2010).

Mental health courts (MHCs) are a relatively recent development to further assist in diverting offenders with mental illness and/or substance abuse problems. Initially funded by an act of congress, America's Law Enforcement and Mental Health Project (2000), MHCs typically handle nonviolent offenders, diagnosed with a mental illness or a co-occurring diagnosis of mental illness and substance abuse, who agree to the terms of enrollment in the program. They are intended to coordinate all violations, mandated treatment, and connecting the offender with social services in the community, including employment, housing, education, health care, and relapse prevention (American's Law Enforcement and Mental Health Project 2000). Research has largely shown that MHCs are working to reduce recidivism (Moore and Hiday 2006; McNiel and Binder 2007; Hiday and Ray 2010; Hiday et al. 2013) and to connect mentally ill patients with needed treatment in their communities (Steadman et al. 2011). The largest and most comprehensive study to date has been the on-going, multi-site MacArthur Foundation study (Steadman et al. 2011). Results from this study have confirmed a reduction in recidivism rates for those who participated in the MHCs system and also found a shift from crisis treatments to intensive treatments as compared to the control group (Callahan and Wales 2013). These findings indicate that MHCs appear to be working to both reduce recidivism as well as to effectively link offenders with community-based treatments.

Despite widespread agreement about the need for effective jail diversion programs, existing programs share few similarities. Since their implementation in 1992, diversion programs have grown substantially in number, with more than 560 programs existing across 47 states (GAINS 2010). With many varieties of resources and leadership, as well as differing needs of each community, it is not surprising to find significant variations in program models used (Clark 2004). Subsequent disparate definitions of inclusion criteria, strategies, and objectives have resulted in limited meaningful data available to evaluate existing programs and/or to provide guidelines for the continued development of future programs (Steadman et al. 1994a,b, 1995; Draine and Solomon 1999). Steadman and Naples' (2005) multisite evaluation, the largest to date, determined that there is growing evidence in support of jail diversion programs as beneficial to individuals, systems, and the communities they serve. In conjunction with ongoing research regarding the effectiveness of jail diversion programs (see also Steadman et al. 1994a,b), Steadman et al. (1995, 1999) delineated six key elements common to the most successful programs. First, effective programs included interagency involvement (e.g., mental health, substance abuse, and criminal justice systems) beginning at the program's inception. Second, regularly scheduled interdisciplinary communication between representatives was built in to the structure. Third, service integration was orchestrated by a designated "boundary spanner" who served as a liaison between agencies. A fourth key element was the presence of strong leadership. The fifth key element was the early identification of detainees with mental illnesses who meet the criteria for a diversion program. Finally, effective diversion programs consistently employed nontraditional case management strategies.

Whether diversion occurs pre- or post-booking, "the best programs see detainees as citizens of the community who require a broad array of services, including mental health and substance abuse treatment, housing and social services" (APA 2000, 29). Program success has essentially depended on building new system linkages and holding the community responsible for the provision of services (Steadman et al. 1999). Policies providing for the selective diversion of specific mentally ill offenders, and/or their careful reintegration into the community following incarceration, are more desirable than existing alternatives (Cohen 1998). In sum, the development of comprehensive diversion programs may break the "unproductive cycle of decompensation, disturbance, and arrest" (APA 2000, 30) so familiar to many of our nation's citizens with serious mental illnesses.

SERVICE COMPONENTS OF CORRECTIONAL MENTAL HEALTH CARE

Due to the many differences between jails and prisons, the priorities for mental health services are somewhat different in each setting. For example, Steadman (1990) found that for jails, the priority services are screening, crisis intervention, and discharge-oriented case management. Prison environments, on the other hand, due to their typically longer lengths of stay, lend themselves to the possibility of longer-term psychotherapy and psychiatric rehabilitation rarely seen in jails. Despite these differences, the services themselves fall into generic categories that hold up rather well across the two settings. Nevertheless, it is important to be mindful of the inevitable differences, subtle or obvious,

between the implementation of services, as they are adapted to each specific correctional environment.

Perhaps the most comprehensive description of essential correctional mental health programs can be found in the APA's Work Group Report on Psychiatric Services in Correctional Facilities (APA 2015).

Cohen (1998) lists six minimal essential elements underlying the service components, taken from a prison class action suit in Texas (*Ruiz v. Estelle* 1980), as providing a useful framework for planning mental health services (see also APA 1989, 2000, 2015; Hills et al. 2004):

Q2

1. Systematic screening and evaluation
2. Treatment that is more than mere seclusion or close supervision
3. Participation by trained mental health professionals
4. Accurate, complete, and confidential records
5. Safeguards against psychotropic medication prescribed in dangerous amounts, without adequate supervision, or otherwise inappropriately administered
6. A suicide prevention program

In addition, a quality improvement process has become an essential component of most remedial plans or Settlement Agreements during the past decade (Metzner 2012).

Screening

Screening is regarded as perhaps the most important service element in correctional mental health (Pogrebin 1985; Teplin and Swartz 1989; Maloney et al. 2015). Screening is not only a specifically required legal obligation (Cohen 1998) but is clinically and programmatically essential. It is impossible to appropriately treat inmates with serious mental illnesses or psychiatric crises without identifying the specific individuals affected. The APA's Work Group Report on Psychiatric Services in Correctional Facilities (2015) lists four levels of mental health screening and evaluation procedures to be conducted as soon as possible after intake:

> *Receiving mental health screening* consists of observation and structured inquiry into each [inmate's] mental health history and symptoms. Structured inquiry includes questions regarding suicide history, ideation, and potential; prior psychiatric hospitalizations and treatment; and current and past medications, both those prescribed and what is actually being taken….
>
> *Intake mental health screening* is defined as a more comprehensive examination performed on each newly admitted [inmate] within 14 days of arrival at an institution. It usually includes a review of the medical screening, behavioral observation, an inquiry into any mental health history, and an assessment of suicide potential….
>
> A *brief mental health assessment* is defined as a mental health examination that is appropriate to the particular, suspected level of services needed and is focused on the suspected mental illness…. A brief mental health assessment should be completed for each individual whose screening reveals mental health problems in the procedures above….
>
> *A comprehensive mental health evaluation* consists of face-to-face interview of the patient and review of all reasonably available healthcare records and collateral information. It concludes with a diagnostic formulation and, at least, an initial treatment plan…

Q3

The National Commission on Correctional Health Care (NCCHC 2014a,b) recommends similar procedures, with a brief mental health assessment and/or a comprehensive mental health evaluation being required only if positive results occur. Maloney et al. (2015) estimate a typical positive referral rate of 25%–33% for further assessment beyond the initial intake assessment. Although there are a number of acceptable ways to provide this screening, several specific elements must be present:

- *Trained staff.* Standardized screening tools can be successfully administered by line staff, nurses, or case managers, provided that they are adequately trained in the administration of each screening instrument and know where to refer inmates in need of services.
- *Documentation.* The results of the screening must be clearly and legibly documented and available to those responsible for medical care, housing assignment, and follow-up services. Records must be maintained in a manner that assures the privacy and confidentiality of each inmate, while facilitating communication between different mental health and medical providers.
- *Low threshold.* The screening must have a low threshold for referral for more extensive evaluation. That is, any indication of either a history or current evidence of mental illness or psychiatric problems must result in referral for a follow-up evaluation. Likewise, any unusual or eccentric mannerisms or behaviors observed must be specifically documented and referred for further evaluation.
- *Standardization.* By routinely utilizing a standardized screening process during booking and by training staff in the screening procedure, one avoids an idiosyncratic process where a mentally ill inmate's chances of being identified depend on who happens to be on duty when the inmate arrives.

Martin et al. (2013) and Gebbie et al. (2008) provide comprehensive reviews of multiple screening tools available for correctional facilities. Ford et al. (2007) suggest that screening instruments should be brief; contain clear definitions, thresholds, and criteria; have low false-negative rates; and have reasonable false-positive rates. Based on these elements, Maloney et al. (2015) recommend four specific

scales as effective screening devices: variants of the New York instrument, a suicide prevention screening guidelines form developed by agencies in New York (Sherman and Morschauser 1989); the Brief Jail Mental Health Screen (Steadman et al. 2005) used in conjunction with the New York instrument or other suicide screening instruments; the Correctional Mental Health Screen (Ford et al. 2007); and "15 Questions," a screening instrument used in the Los Angeles County Sheriff's Jail system.

Follow-up evaluations

No matter who conducts screening for mental health service needs, it will be necessary to provide more extensive and detailed evaluations for those inmates identified as potentially in need of mental health services. These examinations must be timely and responsive to specific issues raised during the screening, and must result in treatment recommendations that are practical within the correctional setting.

Because psychiatrists are difficult to recruit and are a great deal more expensive than other mental health providers, it makes sense to have these "second-level" follow-up evaluations routinely conducted by psychologists, social workers, or psychiatric nurses with advanced degrees. However, as these evaluations will be primarily diagnostic in nature, they will optimally be conducted by at least master's-level staff (preferably licensed) with training in psychopathology (Dvoskin 1989).

It is important to limit these evaluations to issues that have immediate and feasible treatment implications. Given the generally limited treatment resources in correctional settings, full-scale psychological test batteries should be limited to inmates whose symptoms raise diagnostic questions that can only or best be answered by psychological testing (Dvoskin 1989). For inmates who appear to require psychiatric services such as psychotropic medication, a referral to a psychiatrist or licensed independent provider (e.g., Advanced Practice Nurse Practitioner) will then be in order. Of course, in cases where a detainee enters the jail with psychotropic medication, or a long history of such treatment, it may be cost-effective to bypass this step and have the person referred directly to a psychiatrist.

It is important to have some capacity for the emergency administration of medication during weekends and nights. On-call psychiatrists may provide telephone consultation with on-site nonpsychiatric physicians, registered nurses, or physician's assistants. Twenty-four-hour on-site psychiatric availability is a luxury likely to be found only in a few very large and well-funded settings. In smaller jurisdictions, mobile crisis teams from the local community mental health provider or nearby general hospital emergency rooms may be able to provide services at the jail.

Psychotropic medications

Psychiatrists who work in correctional settings must be aware of all of the usual issues surrounding emergency psychiatry (e.g., Anderson et al. 1976; Salzman et al. 1986; Dubin 1988; Allen 2002). There are several other considerations that are especially or even uniquely important in dealing with inmates who are being treated for a psychiatric condition. People who are put in jails or prisons have often failed or refused to take their psychotropic medications as prescribed. It should therefore not be surprising that inmates may be unwilling to take their medication exactly as ordered by physicians (Smith 1989). Inmates who feel oppressed by the criminal justice system sometimes view psychotropic medication ordered by an institutional physician as an instrument of that oppression. Other inmates, believing the correctional environment to be unsafe, prefer to remain as alert as possible, and decline to take medications that are designed to provide tranquilization. Alternately, it is possible that inmates who are not suffering from a mental disorder may seek psychotropic medication in hopes of alleviating some of the situational stresses associated with their incarceration, or in hopes of selling them for profit.

Limitations in psychiatric resources are a significant issue in the provision of psychotropic medications to inmates. Busy physicians may spend an inadequate amount of time explaining the need for medication, its value to the inmates, or what to do about side effects. It takes time to build trust and create a truly therapeutic relationship between psychiatric providers and their patients, and shortages of clinical staff often make it difficult to do so. Moreover, systemic constraints on the flow of information may create protracted time periods between an inmate's initial complaint of side effects and his or her appointment with a physician. If dosages are

Q4

Case management

Q5

Active case management is invaluable, yet frequently underutilized, in correctional mental health care. Case managers benefit inmates during their period of incarceration, as well as serve an essential role in the discharge planning process. For inmates who are confused and anxious, regular and surprisingly brief visits can provide reassurance that the inmate has not been psychologically abandoned. Often, the simple provision of accurate information about the criminal justice process can relieve a tremendous amount of anxiety and need not always be supplied by mental health professionals.

Within the correctional setting, stressors may build up in the absence of supportive services. It therefore is important periodically to "check in" with identified psychologically vulnerable and mentally ill inmates even during periods of apparently good adjustment. The establishment of a tracking mechanism identifying those inmates who are not receiving active mental health services, yet have a history of mental illness, can be of great benefit toward the maintenance of the inmate's psychological fitness. Case managers are ideal providers of such a service. Even annual visits with a case manager will allow the inmate a sense of connectedness and security, while simultaneously providing the

mental health department with an opportunity to monitor the inmate's status. These very brief contacts are a worthwhile investment, especially if they prevent more serious exacerbations of an inmate's condition, thereby forestalling more extensive and costly services. Therefore, the inclusion of case management services offers the facility a prophylactic tool, reducing financial burden as well as mediating the potential for crises that disrupt normal facility functioning.

Case management is even more effective in linking inmates to appropriate mental health services on their release (Griffin 1990). Prior to discharge, case managers can play an integral role in the building or nurturing of social supports, such as helping the inmate to contact family or friends. Such collateral contact can be particularly helpful toward improving an inmate's quality of life while incarcerated as well as upon return to the community (Jacoby and Kozie-Peak 1997). Perhaps most importantly, however, case managers serve as a bridge, linking inmates with providers in the community. Continuity of care is critical to appropriate mental health service and falls well within the venue of case management service. Even the most impressive correctional mental health–care program can be rendered futile if the inmate patient is not linked with appropriate services after discharge (Steadman et al. 1995). Lamb and Weinberger (1998) assert that appropriate implementation of mental health services (and use of case managers) "would mean tailoring mental health services to meet the needs of mentally ill offenders and not treating them as if they were compliant, cooperative, and in need of minimum controls." Unfortunately, the criminal justice system is largely unprepared to provide case management services to mentally ill offenders upon release (Lamb and Weinberger 1998), and if not carefully monitored and adjusted, the patient may experience a variety of unsettling, uncomfortable, and even dangerous side effects. As a result, correctional nurses need to take special care when administering medications in the jail to ensure that the inmates are not "cheeking" medications to appear compliant or to save for later sale. Minor tranquilizers are especially prone to abuse and black market sale within the jail, and therefore are often not included in correctional formularies.

Crisis intervention

In the correctional setting, psychiatric crises may arise at any time, and involve virtually any offender. Crisis services must be readily accessible at all points during the intake and incarceration process. Even where the very best screening and evaluation services are present, it will still be impossible to identify on admission all of the inmates who will require psychiatric services during their incarceration or detention. No screen is perfect, and even "cutting-edge" instruments will have some false-negative errors. Further, certain kinds of psychoses may allow the inmate to appear, at least temporarily, quite unimpaired even under stress. It is important to note, however, that there are a number of reasons why inmates will either be, or appear to be, psychologically intact upon intake, and later experience a psychiatric crisis within the jail setting.

Jails and prisons can be extraordinarily stressful environments. Overcrowding, extremes of cold or heat, noise, filth, and the fear of assault may all contribute to the psychological deterioration of even the most "mentally healthy" inmate. Jails may be even more distressing than prisons, because most jail inmates have recently arrived and have a great deal of uncertainty as to the outcome of their legal status. For first-time offenders especially, their expectations are likely to be colored by television or movie dramatizations stressing violence in jails. Perhaps most upsetting to first-time offenders is the simple truth that jail inmates are not always very nice to one another. Together, these various stressors can lead to psychiatric decompensation at any time during the course of incarceration.

Another risk factor is any pre-existing psychological condition that makes a person vulnerable to psychiatric crisis or mental illness. Family histories of an affective disorder appear to increase the risk of severe depression, which could be triggered by the stresses associated with incarceration. Certain personality disorders, especially borderline personality disorder, create a variety of risks for psychiatric crises, including suicide gestures, emotional hyper-reactivity, and acute psychoses, especially in response to being locked up (Metzner et al. 1998).

Administration of psychotropic medications in emergency situations can be dangerous, especially with newly admitted inmates whose urine and serum blood toxicology results are pending. As the incidence of illegal drug abuse has increased, the likelihood of a psychiatric crisis being due to illicit drug use has also increased. The safe prescription of medications in emergencies involving newly admitted inmates should thus include a physical examination. Since the time of day will often preclude such safeguards, many physicians will elect such nonpharmacological treatment interventions as constant observation to resolve the immediate crisis and keep the inmate safe until services can be obtained. Other facilities will elect to utilize local general hospital emergency rooms.

Every jail and police lockup that receives direct admissions from the street must have access to medically supervised alcohol and drug detoxification services. However, this detoxification is primarily medical in nature and is not a mental health service. Once detoxification has been safely accomplished, mental health staff should provide assessment of any needed mental health services. For inmates with both mental illness and substance use disorders, upon release, there should be a referral to a community program that provides for integrated treatment of co-occurring mental illness and substance use disorders.

Consultation services, when provided by mental health staff to correctional staff, can vary extensively, from sophisticated suggestions for handling difficult inmates to simply suggesting a cell change. The mental health staff must be viewed as supportive of the correctional staff's mission to make the facility safe for everyone.

Special management precautions in response to psychiatric emergencies include moving the inmate to a different bed location, thereby separating violent inmates from others, possibly allowing for easier and more frequent observation or closer proximity to nursing or other services. Often inmates will be put on "special watches" such as constant observation or one-to-one, especially where suicidal intent is suspected.

The special management precautions are required for two reasons. Each facility has an overriding obligation to protect inmates or detainees from foreseeable and preventable harm. There is also a duty to provide medical or psychiatric treatment, although the two considerations will often overlap. In either case, the most important job in any correctional psychiatric crisis is to ensure the safety of all of the people who live and work there. Thus, crisis response is as much the responsibility of correctional staff as it is the mental health staff, even where 24-hour mental health staff are available.

Verbal counseling in crises is not only the least intrusive intervention available, but often it is the most effective—especially when the crisis is in response to a specific event or the novelty of the incarceration itself. For any inmate, with or without long-standing mental illnesses, these crises are often a response to fear. Inmates fear many things, some real and some imagined. Often, simply providing information, spiking rumors, or offering support can significantly improve an inmate's response to his or her situation.

As with nearly all jail-based mental health services, it is imperative that adequate documentation and communication of crisis responses be maintained. When off-hour providers are contractors or are from other agencies, it is imperative that essential aspects of the crisis and actions taken in response to it be communicated to the mental health, medical, and correctional staff. Likewise, facility correctional and medical staff should, as standard policy, have a mechanism in place by which they can alert mental health staff of concerns about a given inmate. For instance, a third-shift officer might observe idiosyncratic behavior and should have a routine method of documenting his or her observations and informing the mental health department.

Finally, the competent resolution of any crisis must include some reasonable effort to prevent its recurrence. While the provision of information itself can be effective, other steps may include supporting a psychologically fragile inmate through a crisis, or preventive steps such as ongoing supportive therapy or skill building (e.g., how to safely "do time").

Thus, correctional facilities, as a matter of law and sensible policy, must have some sort of ready access to crisis services. These services include psychotropic medication, special watch procedures, psychological or counseling services, detoxification (because drugs may be available inside the facility), information (such as when the inmate will get to see a lawyer or receive visits), and consultation with correctional staff about how to handle problematic inmates.

Suicide prevention

Although suicide is clearly one of many sources of potential crisis in the correctional setting, its impact demands special consideration. Suicides in jails and prisons are often preventable, and jail suicide rates are especially likely to exceed general population rates in the community. The likelihood of higher rates is especially great if a suicide prevention program is not established. Standards for suicide prevention programs or protocols did not, however, begin to formalize and adequately address suicide prevention until the mid to late 1980s (Hayes 1995). The NCCHC (2014a,b) currently provides standards required for suicide prevention programs to follow, in order to maintain accreditation, with the following key components:

- *Training* should be provided for all staff to recognize verbal and behavioral cues that indicate potential suicide.
- *Identification* of ongoing risk should be made through routine and continuous risk assessments, especially at intake.
- *Referral* procedures should be specified, for suicidal inmates, to mental health–care providers or facilities.
- *Evaluation* should be conducted by a qualified mental health professional to determine risk level and the need for treatment of underlying mental illnesses.
- *Treatment* should address the underlying reasons for the inmate's suicidality.
- *Housing* should be safe and as suicide resistant as possible, with special attention to potential anchoring devices such as door hinges/knobs, air vents, and window frames; suicidal inmates should also not be placed in isolation unless constant supervision can be maintained
- *Monitoring* should be conducted at three levels based on status of risk: constant observation, with 1:1 monitoring; intermediate observation at intervals no longer than 5 minutes; and close observation in staggered intervals no longer than 15 minutes
- *Communication* should be ongoing between arresting/transporting officers, correctional staff, facility staff (including medical and mental health staff), and the at-risk individual for any signs or behaviors that may indicate a risk for suicide.
- *Intervention* procedures should address how to handle a suicide in progress, including how to cut down a hanging victim and other first-aid measures.
- *Notification* procedures should be in place for notifying prison administrators, outside authorities, and family members of potential, attempted, or completed suicides.
- *Reporting* procedures should be followed for documentation of the identification and monitoring of potential or attempted suicides.
- *Review* procedures for medical and administrative review in the event a suicide does occur.

- *Debriefing* provides individuals with an opportunity to discuss their thoughts and feelings about an incident.

Especially in local correctional facilities, where suicide rates are typically higher, suicide prevention has received a great deal of attention over the past few decades (Atlas 1989; Cox and Landsberg 1989; Cox et al. 1989; Haycock 1989; Hayes 1989; O'Leary 1989; Rakis and Monroe 1989; Sherman and Morschauser 1989). The combination of increased awareness of the problem and changes in institutional policy and practice have reduced the rates of suicide in jails and prisons by more than half since 1983 (Hanson 2010; Hayes 2012). According to the BJS, jail suicide rates dropped to their lowest in 2007 at 36 per 100,000 detainees but have increased slightly since to 43 per 100,000 in 2011 (Noonan and Ginder 2013). The suicide rate in prisons has remained fairly consistent between 2001 and 2011 at a rate of 14 per 100,000 prisoners, which is only slightly higher than the suicide rate for the general population (Noonan and Ginder 2013).

A comprehensive statewide program in New York enabled sheriff and police departments to dramatically reduce jail suicides (Cox et al. 1989) and has since been replicated in jails across the country. Applying a public health model to suicide prevention, this state-funded program is a simple and locally implemented scheme of staff training and procedure development for identifying and managing inmates at high risk of suicide, and is described in greater detail in Chapter 56.

Q6

As suicide rates have decreased, other trends and challenges have emerged that will require increased awareness and a potential change in protocols. One such trend is the increase in length of time of confinement before suicide occurs. Previously, research indicated that more than 50% of victims had died in the first 24 hours of confinement (Hayes 1983, 1989). The current trend reflects a much larger range: anywhere from 2 days to 4 months of confinement (Hayes 2012). This change is encouraging, in that it demonstrates the effectiveness of initial screening and prevention efforts; however, it also means that correctional staff need to remain vigilant and aware of potential suicidal indicators for a much longer period of time. Nevertheless, the first 72 hours of incarceration remain the focus of attention, especially since these typically include hours during the evenings or weekends when no clinical professionals are present. Suicide prevention also demands consistent staff emphasis on assessments by qualified mental health professionals and taking necessary precautions in handling patients with increased risks of self-harm (Hayes 2012).

As will be discussed in a subsequent section, active training and involvement of correctional staff is an essential component of correctional mental health. This tenet is especially true of suicide prevention. All staff, administrative and/or security that have contact with inmates should undergo specific training in suicide risk assessment and intervention. Although the most common recourse for correctional staff will be to alert mental health personnel about an at-risk inmate, it is vital that they are at least cognizant of both risk factors and intervention strategies in the event that they become involved in a suicidal crisis situation. Laypersons without mental health training may harbor false beliefs regarding suicide potential. For example, many people wrongly believe that a person who is truly suicidal would never talk about it. Dispelling myths about suicide, and adopting an all-inclusive training policy for correctional personnel, can have a substantial impact on the psychological well-being of staff and inmates alike.

In addition to screening, essential aspects of a suicide prevention program include (1) clear policies and procedures governing the actions of all staff, including health care, mental health care, and custody staff; (2) an interdisciplinary suicide prevention committee; (3) investigation and quality improvement analysis of all serious attempts and completed suicides; and (4) assurance that all suicide watches are accomplished in a diligent and timely manner.

External hospitalization

Although access to hospitalization for emergency psychiatric treatment is essential, it is often unavailable, especially to smaller jails. The ability to obtain brief psychiatric inpatient care when necessary is of tremendous importance not only to the inmate requiring the transfer but also to the other inmates and staff. The goal of emergency hospitalization is to reduce severe psychiatric symptoms and stabilize the patient. Follow-up treatment should continue either in the correctional facility or, if pretrial release can be obtained, in the community.

Jails often use inpatient hospitals by transferring the detainee to an outside psychiatric hospital or ward. However, some jurisdictions such as San Diego, California (Meloy 1985), Los Angeles County, and Westchester County, New York, provide inpatient treatment within the local jail itself. Prison systems may house psychiatric inmates (who are unable to function adequately in the general population) at an off-site correctional facility whose purpose is to provide inpatient psychiatric care. Such facilities are staffed with correctional officers specially trained in mental health issues or psychiatric technicians with some correctional or security training. Regardless of context or locale, both jail and prison systems must have access to inpatient psychiatric services ranging from brief crisis intervention to longer-term psychiatric hospitalization.

Telemedicine

Telemedicine is essentially the transmission of electronic information, such as voice data and teleimages across geographically distant communication facilities, thereby allowing for long-distance patient health care and/or diagnosis (Charles 2000). Telemedicine has been used to enhance treatment options for geographically remote patients for almost six decades (Stevens et al. 1999). More recently, however, the rising cost of health care, including mental health

care, and the increasing difficulty in recruiting and retaining psychiatrists have generated heightened interest in telemedicine and its promise of increased accessibility coupled with decreased cost. Technological advances (Mair and Whitten 2000) and decreasing implementation expenses (Strode et al. 1999) have enhanced the appeal of telecommunication as a viable alternate treatment modality.

Complications surrounding geographic isolation and limited access to mental health professionals familiar with the correctional setting may, at times, compromise care for inmates (Magaletta et al. 1998). In the correctional setting, access to any extra-institutional health-care service (psychiatric or otherwise) often requires extraordinary transportation and security expenses. Through telemedicine, correctional facilities, frequently located in remote areas, can minimize costly inmate transport, while concurrently allowing even the most dangerous inmates access to services in a secure environment (Charles 2000). Additionally, when telemedicine allows an inmate more timely access to psychiatric care, the likelihood of agitation and volatility may be reduced, thereby creating a more secure institutional environment for all correctional staff and inmates (Magaletta et al. 1998).

Stevens et al. (1999) reported that nonincarcerated patients and their treating psychiatrists were able to develop rapport via televideo just as well as when they were in the same room. Similarly, Morgan et al. (2008) found no differences in treatment satisfaction or inmates' perceptions of the therapeutic relationship when comparing a group receiving only tele-mental health to a control group receiving psychiatric services face to face. Further, preliminary data from the Federal Bureau of Prisons (BOP) telehealth pilot program indicated that virtually all inmate-patient participants, as well as treating psychologists and psychiatrists, have expressed satisfaction with telehealth services (Magaletta et al. 1998). The BOP telemedicine and telepsychiatry programs have been successful to such an extent that the Bureau is in the process of implementing telehealth technology system-wide (I. Grossman, personal communication, August 29, 2000). As of 2004, telemedicine and telehealth programs were operating in about half of all state correctional institutions and approximately 39% of federal institutions in the United States (Larsen et al. 2004). The Texas Department of Criminal Justice, Institutional Division, in conjunction with the University of Texas Medical Branch (UTMB) and Texas Tech University Correctional Managed Care organizations, has likewise enjoyed a successful telemedicine program. The UTMB region telepsychiatry division alone serves over 200 inmates per month and has received overwhelmingly positive responses from inmates and psychiatrists alike (R. Stanfield, personal communication, August 23, 2000; P. Nathan, personal communication, September 7, 2000[JM2] [JM4]).

Discharge planning

Discharge planning, also known as transition or reentry planning (American Association of Community Psychiatrists 2001), has become an important topic in the past decade as a result of several class-action lawsuits in correctional systems. A settlement was reached in 2003, as part of the *Brad H. v. The City of New* York (2000) class-action lawsuit, which specifically outlined appropriate steps for discharge planning for mentally ill inmates. Several states have expanded upon those requirements to include issues such as general health concerns (see *Foster v. Fulton County, Georgia* 2002) as well as drug and alcohol rehabilitation (see *United States of America v. Nassau County* 2001). Both the NCCHC and the APA also discuss the importance of adequate discharge planning and provide standards of care. Q7

The logistics of implementing adequate procedures can be different for jails versus prisons due to differences in the lengths of stay as well as the unpredictability of discharge dates. For example, high turnover rates and shorter stays in jails require mental health professionals to begin discharge planning as soon as offenders are admitted (Dvoskin and Brown 2015). Although a great deal of variance exists between facility practices and policies, the primary purpose of any discharge planning procedure is to provide necessary and adequate resources in order for prisoners or detainees to safely return to the community. Discharge planning should begin as soon as a prisoner or detainee is identified as mentally ill and continue throughout his or her stay. La Vigne et al. (2008) identified eight essential elements for discharge procedures:

- *Transportation* should be provided upon release to their destination as well as arrangements to ensure access to other locations mandated in their release plan, including transportation to obtain necessary medications.
- *Clothing, food, and amenities* should be provided or discussed, including clean and seasonally appropriate clothing and information for accessing food resources in the community.
- *Financial resources* should be provided to cover bare necessities including subsidized food, transportation, and shelter for the first several days after release.
- *Documentation* should be confirmed or provided in the form of a state-issued identification card.
- *Housing* should be identified that is safe and affordable for the first several days after release, and it should be confirmed that bed space is available prior to release.
- *Employment and education* assessments and referrals should be completed to assist the person in finding and maintaining employment.
- *Health care* facility/provider information in the community should be provided after an assessment of the person's mental and physical health-care status and needs in order to ensure continuity of care, and the person should be provided with enough medications to last until he or she can be seen by a health-care professional in the community; individuals with substance abuse or mental health issues should also have appointments scheduled with counselors in the community prior to release.

- *Support systems*, including family members and/or community- or faith-based organizations, should be provided with the offender's release date and plan in order to provide support after release, and a handbook listing community resources should also be provided.

Despite the best efforts of staff, many challenges still exist in transitioning offenders successfully and safely back into the community. A lack of funding and community resources is a common problem that can significantly affect the ability for released inmates to have their needs met (La Vigne et al. 2008). Another challenge is getting the cooperation and compliance of the offender, which can become more difficult when the offender's ability to manage his or her affairs has deteriorated after adjusting to life in confinement (Nelson and Trone 2000). Especially important is connecting inmates with entitlement programs such as Medicaid that can provide health care for indigent offenders after they are released, at least until they can gain access to employment and health insurance.

PSYCHOLOGICAL THERAPIES

Individual therapy

Environmental pressures inherent to the correctional setting can engender mental distress (Lindquist and Lindquist 1997). Even the most mentally healthy inmates may periodically find themselves in need of psychological services while incarcerated. Often, brief therapeutic contact is sufficient to alleviate situational stresses and transient difficulties encountered in the correctional setting. As previously discussed, case managers or social workers can be an invaluable resource for inmates in need of emotional support, information, or assistance with negotiating the daily demands of incarceration. In fact, the type of "therapy" most valuable to jail inmates is often provided by staff who lack formal training but who have a natural ability simply to treat others with dignity and humanity. Often, jail and prison inmates report that they were most helped through a crisis by a particular correctional officer or nurse, a chaplain, or even a fellow inmate. However, for inmates not formally assigned to a mental health caseload, case managers can serve as the first line of intervention, referring the inmate onward if more extensive service is warranted. Moreover, for short-stay inmates, tenure in jail may be an important opportunity for case managers to ensure appropriate referral to the social service or mental health service delivery system in the community.

For more extreme psychiatric crises, intervention might consist of longer sessions with higher-level mental health professionals. These sessions should focus on identifying personal strengths, which will help the inmate cope with the experience. Often, providing an understanding that others have gone through similar crises and survived can be reassuring. During periods of extreme psychological stress, a real part of the value of a therapist or counselor is to be a nonthreatening source of company. It is comforting simply to be listened to, especially in the middle of what may be perceived as an abusive experience. Inmates who experienced physical or sexual abuse or torture as children may experience incarceration as a reenactment of this trauma (Dvoskin 1990), and may be especially responsive to such support.

For those inmates suffering from severe mental illnesses, the immediate focus of therapy is to protect the inmate from deteriorating in response to the correctional environment. People with schizophrenia especially seem to have trouble adapting to environmental change and may require a great deal of support. One benefit of psychotherapy is to provide the seriously mentally ill inmate with a touchstone to aid in reality testing, to avoid withdrawal into psychosis in response to both real and imagined fears of staff or other inmates.

Group therapy

Group psychotherapy is the most cost-effective method of mental health treatment in corrections (Metzner et al. 1998). It is an ideal modality for providing much-needed services to large numbers of inmates despite the common paucity of resources. Moreover, group therapy sessions may be conducted independently, or be co-facilitated by mental health staff with varying levels of professional training. Creative and thoughtful matching of mental health staff expertise with the subject matter of the therapy group can be of great benefit. For instance, practical and applied topics, such as anger and stress management, are ideal material for correctional group work. Utilizing a staff psychologist (Masters or Doctoral level) in combination with a social worker or case manager affords participants with complementary balance in perspective and feedback. Alternately, a psychiatric nurse may be the ideal candidate to run a medication education or life skills group.

In the correctional setting, group therapy presents a unique set of challenges for participants and practitioners. Particularly when non–doctoral level practitioners facilitate groups, it may be quite useful to engage in active consultation and supervision processes (Morgan et al. 1999). For the participants, confidentiality is often a primary concern. Inmates must be counseled during pre-participation screening as to the importance of maintaining confidentiality of disclosures in the group setting. Other potential problem areas include security constraints, volatility and possible safety issues, and scheduling difficulties inherent to an institutional setting (Metzner et al. 1998).

Substance abuse

As many as 75% of all prisoners can be characterized as having a history of alcohol abuse or illicit drug use (U.S. Department of Justice 1998; James and Glaze 2006). The high rate of comorbidity between substance abuse or dependence and mental illness (Carey 1989) may be nowhere **Q8**

more apparent than among the offender population (Abram and Teplin 1991; Edens et al. 1997; Swartz and Lurigio 1999; James and Glaze 2006). Abram (1990) demonstrated the high prevalence of inmates with co-occurring disorders, including substance abuse and depression, most often with antisocial personality disorder being the primary syndrome.

For inmates with co-occurring mental health and substance abuse disorders, accurate diagnosis and subsequent treatment planning are complex, primarily as a result of the complicated symptom picture presented (APA 2015). Symptoms of one syndrome often mask those of another, and abuse of alcohol and other drugs can exacerbate psychiatric symptoms and even bring about psychotic episodes that may persist after intoxication subsides. The unfortunate result is that the presence of co-occurring disorder is often missed during the screening process (Edens et al. 1997).

Indeed, these co-occurring disorders are a growing concern among virtually all segments of the mental health system. The needs of the multiply disordered population continue to rise and clearly must be addressed (Abram and Teplin 1991). The greater the relevance of substance abuse in an inmate's criminal background, the more important it is to identify and treat the problem, and to continue services upon release (Rice and Harris 1997). However, despite a growing number of treatment options, correctional facilities do not appear to have kept up with the demand for services (Metzner et al. 1998; Swartz and Lurigio 1999; Mears et al., 2002; Chandler et al. 2009). Toward the goal of improving treatment programming, the APA (2015) offers the following strategies to address the issue of co-occurring disorders in the correctional setting:

1. Integration of substance abuse and mental health treatment
2. Treatment of each disorder as primary, while appreciating potential interactions
3. Comprehensive assessment and consultation, focused on individualized planning for treatment of psychosocial issues and skill development
4. Cautious use of psychotropic medication
5. Context-specific interventions
6. Extension of treatment services into the community

STAFF TRAINING AND CONSULTATION

"One of the biggest barriers to care for offenders is the mutual distrust that exists between mental health providers and the community correctional system" (Roskes and Feldman 1999, 1615). Ongoing communication between mental health and correctional staff is an essential feature of effective treatment and intervention programs. Mentally ill offenders present a unique set of concerns in the correctional setting, and management difficulties may arise when correctional officers receive minimal or insufficient training about mental health issues (Versey et al. 1997).

Screening is essential to identify inmates and detainees in need of clinical attention upon arrival, and their subsequent mental health depends in large part on the ability of correctional officers to identify inmates in psychiatric distress and make appropriate referrals. It is therefore important to provide officers with basic training in identifying some of the signs of emotional disturbances, in addition to training the officers how to convey their observations to clinicians. With the well-documented rise in the number of mentally ill inmates nationwide, correctional staff are increasingly likely to be confronted with issues surrounding mental illness in the course of their daily work.

All new employee orientation processes should include a mental health component, presented by a member of the mental health staff. This training is certainly not meant to make diagnosticians of correctional officers, although correctional officers can supplement the efforts of clinicians by learning to assist inmates in coping with the everyday stresses of incarceration (Lombardo 1985). As has been discussed elsewhere in this chapter, staff training can be beneficial for all parties, particularly in facilitating the early recognition of psychiatric decompensation, suicide risk, and crisis intervention. Perhaps the most influential feature of facility-wide staff training, however, is an understanding of how to access available mental health resources when they are needed.

The importance of maintaining an open discourse and rapport between mental health and correctional staff cannot be overstated. The development of a trusting working relationship with officers allows mental health professionals the opportunity to offer opinions and/or suggestions that may diffuse potential psychiatric crises, thereby saving precious time, energy, and resources. Consultation between security and mental health staff will often revolve around the correctional management of inmates or detainees (Brodsky and Epstein 1982). A simple decision to separate two inmates can often prevent a dangerous assault or a psychiatric crisis, and administrators who learn to trust their clinical staff come to value advice in such decisions. Other common topics of consultation include, but are not limited to, assignment to appropriate housing or work detail, and appropriateness for various facility programs or educational opportunities.

Mental health staff have much to offer security personnel in terms of consultation and information sharing, and the benefits of communication are far from unilateral. Ensuring correctional personnel that their opinions and observations are meaningful and important, and welcomed by mental health staff, allows for virtually constant observation of inmate patients. Mental health staff are in direct contact with inmates for only a very brief period of time. Even those inmates participating in frequent therapy sessions still spend the vast majority of their days under the watch of correctional staff. Officers who observe and/or work with inmates on a daily basis often become very familiar with a given inmate's regular presentation. Therefore, officers are likely candidates to note subtle or progressive deterioration in an inmate's functioning. Allowing officers an opportunity to comfortably inform mental health staff

of their concerns about an inmate is an effective method of heading off potential crisis.

Correctional officers can also be extremely helpful in teaching mental health staff about the stresses of day-to-day correctional life in cellblocks and housing units, and how to contribute to a safe institution. When training between correctional and mental health staff members is truly reciprocal, it helps to alleviate some of the natural tensions that occur. On the other hand, if mental health staff present themselves as having all of the answers, it can bolster the long-held myth that security and treatment are competitors. In fact, the opposite is true. Security and treatment are interdependent; without a safe environment, it is very hard to provide meaningful treatment, and without meaningful treatment, the correctional environment becomes more dangerous and unpredictable.

Finally, in addition to treating inmates, mental health professionals can help to reduce job-related stress among correctional line staff (Dembo et al. 1986–1987). Employing an open-door policy for correctional staff, providing literature on stress management, and/or offering consultation and referral services, allows officers an avenue of recourse when work stress becomes overwhelming. But providing mental health services to fellow employees is not recommended, due to the high likelihood of conflicting relationships. Essentially, all persons who live and work in a correctional facility are faced with similar daily stresses in terms of danger, noise, temperature, and the like. Extreme stress in officers may inherently compromise officer-inmate relations, in turn leading to exacerbation of inmates' psychological issues. Once again, open and active discourse, and simple human support may be among the most vital components of a successful program.

SPECIAL HOUSING AND MANAGEMENT OPTIONS

The most common reason for referral of an inmate to mental health services is disruptive or violent behavior, either toward self or others. Frequently, mental health staff will be asked to make a judgment about the level of supervision required to keep the inmate and others safe. Alternatives include transfer to a psychiatric facility, one-to-one or constant observation status, movement to a safer or more isolated cell, or movement to a cell nearer to the observation post maintained by staff.

Other creative approaches include the use of multibed dormitories for suicidal inmates. Company can help alleviate depression, and inmates who are ambivalent about their own suicidality may watch each other far more diligently than staff. Also, it is easier to watch a group of people in one room than in individual rooms.

It is important to be realistic. It is unfair and clinically inappropriate to order a 5-minute watch when the clinician knows there are inadequate staff to perform it. These orders are perceived by staff as an attempt by clinicians to shift responsibility to less well-paid correctional staff. By working together, it is usually possible to work out an arrangement that is both reasonable and clinically appropriate. For example, an order for constant observation could require three staff to observe three inmates in adjoining cells. An order worded "observe every minute," on the other hand, would allow one officer to walk back and forth, and observe all three inmates quite frequently.

For the very small percentage of inmates with severe mental illnesses whose behavior is extremely dangerous, states are increasingly creating secure treatment environments to provide a modified residential level of care. These specialized mental health programs should offer each inmate at least 10–15 hours of out-of-cell structured therapeutic activities per week and another 10 hours of out-of-cell recreational time per week (Metzner and Dvoskin 2006). There are varieties of methods to provide such treatment in a safe manner, which include the use of therapeutic modules, which are stand-alone enclosures somewhat similar to old fashioned telephone booths.

SPECIAL NEEDS INMATES

Minorities

For some ethnic minorities and non-English-speaking inmates, jails can be frightening and oppressive places. For example, Foster (1988) reports that traditional psychiatric approaches may not work well with Native Americans in the federal prison system. Similarly, among inmates with serious mental illnesses, Black and Hispanic inmates are typically less often served by the mental health system (Steadman et al. 1991). This phenomenon may reflect an unwillingness to seek help from predominantly white providers, reflect difficulties in speaking English as a second language or a cultural practice to avoid seeking mental health assistance, but may also reflect subtle and even unintentional racism among those same providers. Toch et al. (1987) found a number of ethnic differences in prison infractions, and concluded that subcultural and psychological predispositions may converge to produce prison adjustment problems.

Women

Female detainees may have a variety of special problems in adapting to correctional settings (Sobel 1980). These include the possibility of pre-existing pregnancies, which require prenatal medical care, as well as recent mothers whose forced separation from their infant children can contribute to severe postpartum depression or even psychosis (see, e.g., McGaha 1986). Further, many more women than men are custodial parents at the time of their incarceration, often causing severe anxiety over the welfare of their children.

For some women, being locked up in a very small space by intimidating male authority figures can be frighteningly reminiscent of childhood experiences. For female inmates, especially those who have survived traumas, being strip-searched and showering under observation can

seem abusive. Incarcerated females in New York frequently reported long histories of sexual violence at the hands of fathers, husbands, boyfriends, and strangers (Browne 1987). This abuse is often directly linked to the instant offense, as in the case of women who kill abusive spouses to protect themselves or their children.

Older inmates

The number of older inmates has increased rapidly since 1990, with an estimated increase of 550% (Williams et al. 2012). In the correctional context, due to histories of poor health care and multiple traumatic injuries, it has been suggested that age 50 years (rather than 65 as is the general population) can be considered a useful criterion for identifying geriatric inmates (APA 2015). Generally speaking, the offender population is likely to have conducted their lives in a manner less conducive to good physical health, thereby lowering the threshold for common ailments associated with aging. The elderly inmate is subject to the normal stresses of growing old, along with numerous exacerbating factors such as physical vulnerability to other inmates, estrangement or isolation, and a greater likelihood that they will die behind bars (APA 2015). As this subset of incarcerated offender continues to grow, so too will the incidence of age-related psychiatric and medical disorders. Correctional mental health professionals should be aware of, and plan for, the special needs of the incarcerated elderly.

Physical disabilities

Regardless of age, inmates—much like the general population—present with myriad medical and physical disabilities. Mental health service providers must be mindful of the special challenges posed to inmates who are physically disabled, deaf, or blind. This population may be especially vulnerable in a correctional setting. In addition to predatory peers, the occupational and recreational opportunities may be limited, exacerbating the normal stresses of incarceration. Although it has become clear that jails and prisons are covered by the Americans with Disabilities Act (ADA), the exact requirements of the ADA in prisons are still emerging. Many jails and prisons are composed of very old buildings with poor accessibility; however, staff must ensure that inmates have access to needed mental health and medical services, their physical disabilities notwithstanding (*Pennsylvania Dept. of Corrections v. Yeskey* 1989).

CORRECTIONAL HEALTH-CARE STANDARDS

Numerous sets of standards and guidelines for correctional health-care programs have been promulgated by national organizations such as the International Association for Correctional and Forensic Psychology (formerly the American Association of Correctional Psychology; 2010), American Bar Association (1989), American Correctional Association (2003), American Nurses Association (2013), APA (2015), American Public Health Association (Dubler 2003), National Commission on Correctional Health Care (1996, 1997, 1999, 2008), National Institute of Corrections (Anno 2001), and the United Nations (1975). There is a clear trend that the various state Departments of Correction (DOC) are attempting to conform to some national set of standards (Hayes 1989; Metzner et al. 1990; Metzner 1993; Hayes 2012).

The most current and widely referenced standards and/or guidelines for correctional mental health services have been published by the APA (2015) and the NCCHC (2014a,b). The NCCHC evolved from a program within the American Medical Association that published its first health-care standards for prisons and jails in 1979. The NCCHC standards focus predominantly on general health-care issues, although they have increased their focus on mental health issues in recent years (NCCHC 2008, 2014a,b). The guidelines developed by the APA task force, which assume compliance with the NCCHC standards, provide more specificity relevant to mental health services.

The American Correctional Association (ACA), through an annual Standards Supplement (ACA 2000), has significantly improved recommendations relevant to health services in correctional facilities. Although the ACA standards are less than comprehensive, they are to be applauded for current efforts to upgrade them. The ACA is in the process of developing performance-based standards that will, hopefully, expand the current (ACA 1989, 2000) recommendations pertinent to health-care standards.

It is beyond the scope of this chapter to compare the various national standards and guidelines. Such a comparison has been carried out by Metzner (1993) and Cohen (1998). This section will highlight common areas that are found in these national guidelines with brief commentary relevant to particularly difficult issues.

Guidelines provide a structure for correctional mental health systems by requiring the development of written policies and procedures that are to be reviewed/revised at least annually. They should include, but are not limited to, descriptions of the following characteristics of the mental health system (Metzner 1997):

- Mission and goals
- Administrative structure
- Staffing (i.e., personnel and training)
- Reliable and valid methods for identifying and tracking inmates with severe mental illness (best done via a computerized management information system)
- Availability of treatment programs
- Involuntary treatment including the use of seclusion, restraints, forced medications, and involuntary hospitalization
- Other medico-legal issues such as informed consent, right to refuse medications, and record release authorizations
- Limits of confidentiality during assessment evaluations and/or treatment sessions with relevant exceptions noted

- Mental health record requirements
- Quality improvement plan
- Training of mental health staff regarding security issues
- Training of correctional staff concerning mental health issues
- Research protocols

The APA guidelines 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 center that *should* be available in the community.

APA and NCCHC both support a correctional health-care system that integrates the medical, mental health, and dental systems under a central health-care authority (at the DOC central office level for prison systems). However, it is clear that a variety of different administrative models are effective, depending on a variety of factors, including the size and type of correctional population to be served. The importance of establishing medical autonomy relative to clinical decisions (i.e., not compromised by security reasons) and having regular administrative meetings between the health-care authority and the warden, sheriff, or official legally responsible for the correctional facility is emphasized by these standards.

The NCCHC recommends that staffing levels include a sufficient number of health services staff of varying types to assure timely inmate access to evaluation and treatment consistent with contemporary standards of care. The APA recognizes the importance of a multidisciplinary mental health staff. The need for adequate staffing by psychiatrists is also emphasized due to the unique importance of psychotropic medication as a treatment modality. The APA suggests that in jails, for every 75–100 inmates with serious mental illnesses who are receiving psychotropic medications, there be one full-time psychiatrist or equivalent. In prisons, with fewer admissions, the caseload of each full-time psychiatrist equivalent can rise to a maximum of 150 patients on psychotropic medications.

The APA recommends three levels of mental health screening for purposes of identifying newly admitted persons to the correctional facility:

- *Receiving screening*, which is frequently performed by trained custody staff upon booking, is a process designed to ensure that every newly arrived person who may require mental health evaluation is appropriately referred and placed in the proper living environment.
- *Intake mental health screening* is performed by appropriately trained health-care staff as part of the comprehensive medical evaluation provided to every inmate entering a correctional system.
- *Mental health evaluation* is performed by mental health staff in response to a referral from the screening process, other staff, or by self-referral.

The APA guidelines define mental health treatment as the use of a variety of mental health therapies, including biological, psychological, and social. Mental health treatment is described as occurring in a number of different settings, including

- Acute care (e.g., crisis intervention, infirmary care)
- Longer-term care
- Transitional care (e.g., residential treatment within the correctional facility)
- Outpatient treatment
- Inpatient hospital treatment

Program priorities described by the APA include recognizing and providing access to treatment for each inmate with serious mental illness and consulting with other health-care staff and correctional staff. Both the NCCHC and the APA discuss the importance of adequate discharge planning, which has also recently been the focus of class action litigation in correctional systems.

The NCCHC standards require regular review of inmates placed in segregation units for purposes of determining any medical contraindication for such placements and assuring reasonable access to needed health care. The APA guidelines expand these recommendations to include regular rounds by qualified mental health clinicians in all segregation housing units.

Compliance with the guidelines recommended by the APA task force report and the NCCHC standards will help ensure that the correctional mental health system is able to obtain necessary resources in order to provide adequate mental health services to the inmate population.

Segregation

Over the years, there has been a dramatic increase in the use of long-term segregation (Browne et al. 2011). It is suggested to be the result of a philosophical change in the management of problem inmates, with the underlying purpose of removing troublesome inmates in order to improve the level of safety of the general population (Riveland 1999; Collins 2004). Although this may be the best and only choice for certain inmates, such as when the safety of staff is at risk or for the most dangerous members of prison gangs, segregation should be used much less frequently and with greater caution. Metzner and Dvoskin (2006) recommend several elements to consider as emerging standards of care for the responsible use of segregation for the benefit of the inmates, the staff who oversee them, and as required by law: first, medical and mental health care is legally required and must be continued; second, a suicide prevention plan should be in place and inmates should be consistently monitored by mental health staff during rounds to detect dangerous psychological deterioration as early as possible; and third, incentive programs should be included where segregated inmates have the opportunity to improve and/or gain more control over their living conditions based on pro-social behavior that is definable, measurable, and achievable. Perhaps most importantly, segregation must truly be used only as a last resort

when there is no other reasonable way to mitigate a serious threat to life safety, escape, or the safe and orderly operation of the facility

Long-term segregation for inmates with serious mental illness should be especially avoided, except for extraordinary circumstances, due to the potential physiological harm created by the extreme environment of segregation (APA 2012). Segregation can be very stressful from a mental health perspective as it typically involves as many as 23 hours in a cell per day, little contact with staff, highly unusual and infrequent social interactions, extremes of noise and silence, and an environment of maximum control. Additionally, the use of segregation can further incapacitate inmates, who may already struggle with atrophied life skills due to their mental illness, from being able to healthily and successfully return to the community. For unusual circumstances that require segregation or an extremely high level of security of a mentally ill inmate for the safety of staff or others, Metzner and Dvoskin (2006) recommend adjusting conditions to include "at least 10–15 hours per week of out-of-cell structured therapeutic activities in addition to at least another 10 hours per week of unstructured exercise or recreation time," (p. 764). Q9

The use of segregation in jails and prisons is controversial, and research on the long-term effects of segregation on mental health is sparse, conflicting, and typically not adequately designed to provide control groups for more meaningful analyses (see Suedfeld et al. 1982; Grassian, 1983; Zinger et al. 2001; Haney 2003). Recently, O'Keefe et al. (2013) found that most inmates, with or without mental illness, placed in long-term segregation housing did not experience significant psychological decline during their stay in segregation. However, inmates in segregation generally experienced more psychiatric symptoms than inmates not housed in segregation, which was largely related to their pre-segregation baseline. Of note, mentally ill inmates generally did not clinically improve while in segregation, which was very concerning because many were experiencing active symptoms. Despite a paucity of empirical evidence, caution, careful planning, and an exhaustion of other resources should be used when deciding to place an inmate into prolonged segregation.

QUALITY IMPROVEMENT

For many reasons, a robust quality improvement system is an essential component of an adequate correctional mental system. Each facility or administrative authority should prepare a regularly updated quality improvement (QI) plan that systematically sets out to review and improve the quality of mental health services (APA 2015). Important elements of a QI system include quality assurance, peer review, and suicide prevention. The QI process should involve health-care staff at all levels as well as key correctional staff. Without active involvement from custody staff, QI efforts to improve relevant processes will be minimally effective at best. QI assessments frequently demonstrate that what is thought to be occurring in a correctional mental health system is very different from what is actually occurring.

SUMMARY

Jails and prisons are saturated with human service need, and the resources will probably never be adequate. Thus, administrators must take into account which services are most costly and sparse and use these resources judiciously.

Although prisons require a broad array of "community" mental health services, in jails and lockups, resources must be focused on short-term crisis services designed to identify, protect, and treat those inmates who are most vulnerable to suicide, injury, or severe psychological distress. The boundaries between the mental health and criminal justice systems are rarely clear (Dvoskin and Patterson 1998). Nevertheless, each setting and discipline must focus on the necessary interface of services that relate to its population and mission. To this end, active interdisciplinary discourse and cooperation are essential to maintaining the integrity and goals of the mental health and criminal justice systems. This chapter outlines the basic legal requirements for correctional mental health, provides an overview of effective treatment delivery, and proposes a structure for meeting those requirements in a cost-effective manner. Above all, resources must be used efficiently, so that each inmate has timely access to the essential services that the law and human decency require. Q10

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