Providing Psychiatric Services in Correctional Settings

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Introduction

Persons with mental illnesses present special problems to corrections administrators and staff. Left untreated, they are at increased risk of suicide, victimization, causing disturbances among inmate populations, and disciplinary infractions. In the community, these problems persist, as well as increased risks of homelessness, health problems, and, under certain circumstances, violence.

Providing mental health services to offenders who require them is necessary for the safety and well-being of offenders and staff, the smooth operation of corrections, and community safety and quality of life. To ensure continuity of care, police and corrections administrators must come together with mental health and substance abuse providers to identify and close the gaps in service. Law enforcement and community corrections staff, in particular, must work aggressively with community leaders to develop effective linkages to help persons with mental illnesses live successfully in the community, particularly at critical transition points between incarceration and the free community.

Each point in the criminal justice system brings with it unique service challenges. Institutional corrections differ significantly from community corrections. Jails and prisons, while similar in many aspects of psychiatric care, differ on several points. The following sections discuss the opportunities to provide mental health services in jails, prisons, and community corrections.

Jails

The United States has approximately 3,500 jails today. These locally operated facilities provide pretrial detention and short-term confinement after sentencing. They are best characterized as people-processing organizations with heavy flowthrough. Jails are increasingly important in identifying and treating acute and chronic medical and psychiatric conditions at a time when indigent care is dwindling. Unlike community-based treatment providers, jails, by their very nature, cannot refuse any individual presented to them by legitimate authority.

Jails have a substantial constitutional obligation to provide minimum care. Custodial facilities have both the duty to protect and the duty to treat serious medical and psychiatric conditions. In addition to case law such as *Estelle* v. *Gamble*[1] and *Bowring* v. *Godwin*[2] that establishes the standards of medical and mental health care, *Langley* v. *Coughlin*[3] provides a list of the several specific claims that, in conjunction with deliberate indifference, indicate constitutionally inadequate mental health care.[4] Clearly, providing mental health services to persons with mental illnesses who come into contact with the criminal justice system is not an option, but a constitutional necessity. Despite these requirements, a study of mental health services in U.S. jails with rated capacities of 50 or more detainees indicated that, while most jails offered at least one mental health service, few jails provided a comprehensive range of services.[5] Approximately 83 percent of all U.S. jails provided intake screening and 60 percent

provided mental health evaluations, but only 42 percent provided psychiatric medications. In response to emergencies, only 43 percent provided crisis intervention services, 73 percent provided suicide prevention services, and 72 percent provided access to inpatient hospitalization. Finally, only 21 percent of jails provided case management or discharge planning.[6]

Jail mental health services are typically focused on identification, crisis management (including suicide prevention), and short-term treatment. Two basic principles guide the minimum requirements: (1) persons in detention should not leave the facility in worse condition than when they arrived and (2) persons should not be punished for being identified as having a need (i.e., the identification of a mental illness should not affect access to other services or the length of time spent in jail).

Screening, assessment, and evaluation

Screening, assessment, and evaluation are the three stages at which jails identify persons in need of psychiatric care. The initial screen is typically conducted by a corrections officer at booking. The purpose of this screen is to identify persons in need of a more detailed mental health evaluation and those at risk for suicide. Officers are not trained clinicians and are not expected to make decisions regarding treatment. The booking officer's job is to refer all individuals who, because of their responses to specific questions or by their appearance or behavior, appear to be at risk.

A mental health assessment is often a second step toward providing treatment. This can be done by a mental health worker or by medical staff within the context of a medical history. Both the booking screen and the medical examination are done on all individuals who are booked into the jail and assigned housing. The mental health assessment is conducted only on persons identified by the booking screen or by the medical department. At the final stage, persons assessed as needing psychiatric services are referred for a full psychiatric evaluation. Psychiatric evaluations are usually conducted by a psychiatrist and often result in the prescription of medication.

Screening, assessment, and evaluation are critical points in the service delivery system for providing appropriate services because information uncovered at these points affect classification decisions and whether detainees will receive mental health and other treatment services. Screening instruments used by booking officers should include a minimum set of questions related to symptoms of affective and psychotic disorders, history of mental health treatment, current use of prescribed psychotropic medication, and risk of suicide.

Classification and housing

Structurally, jails are designed to control the potential for violence. Their primary mandate is to hold individuals in a secure environment and prevent physical injury to either staff or detainees. Single-cell tiers and pods, highly regimented schedules, lack of privacy, and an expectation of an unquestioning response to authority are characteristics of correctional facilities designed to maximize control and reduce opportunities for breaches in security (e.g., escapes, riots and violent incidents, use of contraband). Individuals with acute mental illnesses may have extreme difficulties conforming their behavior to what is required. This structure may, in fact, create an additional unintended burden on detainees with mental illness and increase disciplinary incidents and related punishment.

Classification refers to the process by which individuals booked into the jail are assigned housing. Appropriate classification takes into account the seriousness of the current offense and risk of violence; special needs, such as medical or mental health problems; gender and age; and adjudication status. Most jails assign different security levels within their facilities and have different kinds of housing, including general population, medical (where persons diagnosed with acute mental illnesses or suicide risk may be placed), and administrative segregation. Some jails also provide specialized housing, such as

mental health units for persons with stable conditions, substance abuse therapeutic communities, trustee housing, and juvenile units.

Because many jails do not provide inpatient care or specialized housing for individuals diagnosed with mental illnesses, many detainees are transferred to civil psychiatric facilities to receive treatment. While this is a humane and medically sound policy, it has serious, unintended consequences. First, a transfer out of the jail for evaluation or inpatient treatment interrupts and may significantly delay the adjudication process, extending the period of confinement. Second, the inpatient facility may not be within the locality. This means that the individual may not be able to see family and other support persons easily, if at all.

Medication and psychiatric followup services

Medication and medication monitoring are major issues for jail psychiatry. Some jails do not allow the prescription of certain antidepressants and tranquilizers because of their cost or potential for abuse. Despite indications or previous treatment, some individuals cannot receive the medication of choice due to standing policies. On the other hand, these policies exist for good reason. Detainees with significant addictive disorders may request psychiatric medications as a substitute for their drug of choice. Each case must be reviewed carefully before medication is prescribed and at regular intervals thereafter to assure that the medications are appropriate to the need.

Overprescription of medication is as problematic as underprescription. Because many facilities are overcrowded, housing is limited and management of detainee populations is more difficult. In stressed environments, there is a temptation to overprescribe medications for the sole purpose of tranquilizing the detainee. From the jail's perspective, this is a reasonable policy because it enhances the jail's security. From a human rights perspective, it is an unjustified use of chemical restraints and violates constitutional rights. In addition, the medication may interfere with the detainee's ability to participate in his or her adjudication process.

Crisis intervention and suicide precautions

Every jail should have established procedures to identify and respond to psychiatric crises, including suicide risk. Emergency responses may include emergency evaluations, close observation in a special housing area, removal of the individual to a medical/surgical or inpatient unit within the jail, or transfer to a psychiatric facility outside the jail. In addition, physical and chemical restraints may be used under the supervision of medical staff. The critical feature of emergency response is providing a safe environment for acutely distressed detainees. This sometimes requires the removal of objects that may be used to injure oneself or to harm others. This should not be interpreted to mean that clothing should be removed or that the individual be isolated. These two common procedures often exacerbate the problem.

The policies and procedures governing the use of seclusion and physical and chemical restraints should be carefully reviewed for their application. Some mental health systems are beginning to consider these issues in response to a growing awareness of how these procedures damage individuals' physical and emotional well-being.

Case management and discharge planning

Most jails do not provide case management or discharge planning services. Arguably, release planning can be the most important service a jail can provide to reduce the probability of return. For all persons with special needs, linkages to community services, particularly if the linkage is more than a telephone appointment, can make a significant difference in engagement in community-based services.

Although most jails acknowledge this important service, the manner in which inmates are processed limits a jail's ability to develop effective linkages. Most importantly, it is critical to understand that the court makes release decisions. Except when inmates serve specific sentences, jails do not typically know when someone will be released, whether it is pretrial or on sentencing. Therefore, beginning discharge planning early

in confinement is important. On release, individuals with mental illnesses typically require specific community-based services, including, at a minimum, housing, financial support and entitlements, health care, and mental health clinic services. Of all the potential problems that jails encounter in discharge planning, the most difficult to negotiate is continuity of mental health treat-ment, particularly providing uninterrupted med-ication. Lack of medication and basic necessities of life (i.e., housing, clothing, food, and health care) virtually guarantee the return of the individual to jail.

Prisons

Prisons are correctional facilities that hold sentenced inmates generally for more than 1 year. These facilities are operated by the Federal and State governments, and increasingly by private companies. Currently, the Federal government operates 112 facilities, including traditional prisons; work farms; boot camps; and Immigration and Naturalization Service, Bureau of Indian Affairs, and military facilities. State governments operate 928 facilities, including traditional prisons, youth detention facilities, work farms, boot camps, and specialty units for prisoners (e.g., forensic hospital units, substance-abuse treatment facilities, medical units). Private companies currently run 156 correctional facilities, including traditional prisons and specialty facilities (e.g., sex offender units, substance abuse facilities). The responsibility for mental health provision varies from State to State; in some States, psychiatric care is provided under the auspices of the State mental health authorities, and in others, under the auspices of the State corrections authority. As in jails, behavioral health services in State and Federal prisons are frequently contracted out.

Of the State-operated adult prison facilities, 83 percent provide mental health screening and assessment, 80 percent provide and monitor medications, and 77 percent provide access to inpatient care. In addition, 36 percent of prisons have specialized housing for individuals with stable mental health conditions and 87 percent of correctional facilities offer some form of counseling or verbal therapy.[7]

Jails and prisons differ somewhat in the scope of mental health services provided. This reflects the difference in average lengths of confinement. As stated earlier, jails process a large volume of detainees and have relatively short lengths of stay. Therefore, jail mental health services are primarily concerned with suicide prevention and stabilization of acute conditions. Prisons, on the other hand, are more aptly described as contained communities where individuals may spend many years. Therefore, prisons provide a greater range of services emphasizing long-term support, including residential units for individuals with stable conditions who cannot be placed in general population, case management, and counseling and verbal therapies.

Screening and assessment

Most States have a reception center where inmates are processed and assigned permanent housing. This central facility often holds new inmates for several months, during which time the inmates' needs and security levels are determined. This is the key point in identifying mental health treatment needs. Because inmates may arrive from local facilities in stable condition with or without accompanying medical and psychiatric records, prisons must have a capacity to assess individuals continuously for psychiatric problems.

Screening and evaluation are conducted in prisons in much the same way as in jail settings. An initial screen is conducted on all incoming inmates and evaluations are ordered for those who appear to require services.

Crisis intervention and suicide precautions

Mental health crises can occur at any time. Given the cyclic nature of many serious mental illnesses, crises should be expected. Therefore, crisis services must be available 24 hours a day in all facilities. Early response is critical to stabilize the individual and prevent further deterioration of the inmate's condition. Possible emergency responses are similar to those in jails, including emergency evaluations, close observation in a special housing area, physical or chemical restraints, and moving the individual to an inpatient unit inside or outside the facility.

Mental health treatment

Given the long periods of confinement of most prison inmates, greater opportunities exist to provide long-term mental health care. In addition to medication and periodic reviews, individual or group therapies and rehabilitation programs may be developed and implemented in prison settings. Some behavioral interventions appear promising.

Specialized housing and inpatient care

Meeting the needs of inmates with mental illnesses over long periods of time requires a full array of housing options, including inpatient care, short-term crisis beds, long-term residential treatment units, and general population housing. Inpatient care is a necessary component of treatment, but does not necessarily have to be provided within the facility. Prisons, however, must have the capacity to access such care.

Other residential alternatives can dramatically reduce the need for inpatient beds. These units do not necessarily require 24-hour medical supervision and are a cost-effective alternative to inpatient care. Acute crisis beds may be available to provide short-term relief short of inpatient hospitalization. Inmates with mental illnesses often have difficulty adjusting to and managing the stresses of prison life and are often vulnerable to abuses by other inmates and staff. Long-term residential treatment units can provide a safe and therapeutic environment in which to live. These units may be permanent or transitional.

Discharge planning

Discharge planning is more complicated in prisons than in jails. First, prisons are often located far from the inmate's home community. Further, formal or informal relationships are rarely developed between State prison staff and local providers. A prison-based case manager can do little to facilitate continuity of care on the inmate's release. In the case of a release to parole, communication between corrections departments may allow for prerelease planning and the possibility of requiring mental health treatment as a condition of release.

Community Corrections

Community corrections is a generic term used to describe the authorities responsible for supervising offenders serving a community sentence and individuals released from detention while awaiting trial. These include traditional probation and parole departments, pretrial services, and alternatives to incarceration programs. According to the Community Corrections Division of the National Institute of Corrections, the primary intent of community corrections supervision in most U.S. jurisdictions has changed from rehabilitation to risk reduction through a community-based sanction.[8] The main goal is the protection of the community. With growing correctional populations and ever increasing costs of incarceration, community corrections alternatives, with their emphasis on "control, treatment, and services outside an institutional placement," are gaining popularity.[9]

Risk reduction functions by motivating offenders to refrain from criminal activities or, for those who cannot or will not refrain, removing the offender from the community. It is becoming clear that an emphasis on surveillance alone increases the probability of early detection of violations, but does not reduce criminal behavior or assist offender rehabilitation. If the goal of probation is risk management, programs that are designed to reduce criminal activity or increase community integration may offer long-term solutions by intervening before recidivism occurs.

Like jails and prisons, probation and parole departments have experienced explosive growth over the past decade. In 1995, 2,620,560 adults were under active probation supervision and 648,921 were under active parole supervision. The growing community corrections population includes increasing numbers of persons with special treatment needs. Although probation caseloads continue to grow, departmental expenditures have not kept pace.[10] With ever-greater reliance on community corrections to manage persons at risk, departments are required to provide quality services with fewer resources.

The management of persons with mental illnesses is particularly problematic for community corrections agencies. Unlike jails and prisons, community corrections incur no constitutional mandate to provide health care, including psychiatric services, to individuals under community supervision. Because community corrections agencies do not have 24-hour physical custody of the offender, they are not required to maintain an individual's health status. Community corrections agencies are not required to provide universal medical or psychiatric care or even access to these services. For persons with mental health treatment conditions, community corrections must only assure access to appropriate treatment and supervision of participation. If mental health treatment is not a condition of release, individuals receiving mental health services do so voluntarily. These persons should be able to access mental health resources in the same manner as any other community member.

The double stigma of being identified as both an offender and a recipient of mental health services (and commonly with comorbid substance abuse or dependence) creates real barriers in accessing services in the community. In this time of fiscal constraints and competition for scarce resources, offender services and services for persons with serious mental illnesses have a low priority. In addition, decreasing community resources, particularly the lack of 24-hour emergency mental health services, have increased the likelihood that persons with mental illnesses will come into contact with the criminal justice system.[11] Without an affirmative decision to make this group a priority, these individuals will continue to cycle through the criminal justice and public mental health systems.

Roles for mental health practitioners in community corrections

Because providing mental health services is not required, the involvement of mental health practitioners in community corrections is not clear or obvious. There are, however, several opportunities for community corrections to engage community-based mental health practitioners to assist them in accomplishing their goals. These fall into the general categories of assessment/evaluation, training, and treatment, and exist at the points of adjudication and probation intake, investigation, or supervision.

Adjudication and the courts

An important change in the interface between community corrections and mental health occurs in the administration of specialty courts. Over the past decade, mental health diversion programs and, more recently, mental health courts have been gaining in popularity. Many jurisdictions are using these programs to engage offenders in community-based mental health services instead of serving jail time. Whether the programs are for pretrial release or fully adjudicated cases, community corrections agencies often supervise these offenders and their participation in required services in the community. Court-based or program-based mental health professionals (including psychiatrists, psychologists, and psychiatric social workers) play an important role in assessing the status and needs of persons appropriate for specialty courts or diversion. These programs cannot function as intended without professionally trained staff to assist in screening and recommending services.

Training and education

Community mental health practitioners can provide an invaluable resource to community corrections departments through preservice and inservice training and education. Field officers who may supervise persons with mental illnesses on generic caseloads and officers who supervise mental health caseloads both need training. The intensity and detail of the training may differ depending on the officer's role in relation to persons with mental illnesses. A basic understanding of mental health issues and appropriate crisis management, as well as substance abuse and emergency medical treatment, should be included in preservice training, supplemented as needed by inservice training. Community corrections officers who supervise specialized caseloads of individuals with mental illnesses should have a greater knowledge base, including the symptoms of mental illnesses; uses and effects of common psychotropic medications; the range

of mental health services, their purposes, and goals; and most important, the availability of emergency and community-based mental health services and how to access them.

Cross-training is an important component in all settings where criminal justice and mental health professionals work together. For effective community supervision of persons with mental illnesses, community corrections staff and mental health providers must understand each other's roles.

Mental health treatment, rehabilitation, and support programs

Community corrections is first and foremost a corrections agency. Community corrections should continue to perform its traditional duties without expanding its responsibilities to include treatment. Mental health treatment providers are experts in their fields and should be fully utilized by community corrections departments. Accomplishing the overall goal of community integration and long-term success of persons with mental illnesses requires community corrections department involvement in partnerships with community mental health, substance abuse, and other human services agencies. Creative collaboration can accomplish the goals of all systems.

Most community corrections departments provide access to mental health treatment on an as-needed basis. Community corrections departments or individual officers broker services as the need arises. In this case, the department will identify all necessary services and negotiate access for specific individuals. Given the small percentage of persons with mental health treatment conditions under community supervision, many departments believe that arranging for services for individuals as needed accomplishes the community corrections department's short-term goals of meeting the court's supervision requirements in the most flexible, cost-effective manner. This ad hoc brokering approach may be the best strategy in small communities, where familiarity with the offender and informal interagency relationships are the norm. In larger communities, however, this approach to access to services is time consuming, labor intensive, and may create service redundancies.

Some community corrections agencies have developed standing contracts with community providers. These working agreements support the activities of both systems and the clients they jointly serve. Community agencies that work with individuals serving community sentences are more likely to be familiar with corrections practices and more receptive to involuntary clients. Such arrangements may also allow community corrections officers to intervene at the mental health service provider site when emergencies involve persons under their supervision.

Some of the most comprehensive and promising programs for individuals with mental illnesses are jointly sponsored and developed by community mental health agencies and community corrections departments. Departments that have developed surveillance and revocation practices in conjunction with appropriate, integrated mental health services that individuals are willing to use have had good results. Joint ventures acknowledge that the community corrections department is not the best agency to determine the clinical and support needs of persons with mental illnesses. Typically, collaborative efforts between community corrections and community mental health agencies use one of two strategies: (1) single-point access to services; or (2) holistic programs with colocation of services.

Single-point access to community-based services. This approach involves the joint development of community corrections–mental health case management programs, particularly Intensive Case Management (ICM) or Assertive Community Treatment (ACT) programs. The core ideas within both of these service approaches are: (1) client centered, (2) continuity of care, (3) comprehensive services, (4) 24-hour, 7-day availability, (5) small caseloads, (6) and service delivered in natural environments. ICM models may use one case manager or a team of case managers. ICM programs typically provide support for many domains of living, including

mental health, substance abuse, housing, money management, and other support services. Intensive case managers may also provide counseling and training in daily living activities. ICM funding and the intensity of the services are flexible. Such programs appear to be effective in reducing the inappropriate use of psychiatric services and the number of days spent in hospitals and jails by some of the most difficult to serve individuals.

ACT models share many of the same core components as ICM models. The distinguishing feature of ACT models is the use of interdisciplinary teams of clinical and support staff. Teams typically include psychiatrists, registered nurses, psychiatric social workers, and other paraprofessional case workers. Each team is able to provide "generic mental health services, psychiatric evaluations, crisis intervention, individual therapy, group therapy, medication administration/monitoring, assistance with activities of daily living, budgeting, and full case management services."[12]

These models have had a great deal of success, reducing both hospital admissions and average number of inpatient days among persons with mental illnesses in the community.[13] Applied to criminal justice populations, several studies have found that ICM programs reduce the risk of violence in the community, including fewer average days in jail, fewer arrests, and reduced incidence of harmful behavior.[14]

Collaborative colocation of services. It is often difficult for persons with mental illnesses to negotiate one, much less multiple, service systems. In response, some innovative programs for persons with mental illnesses use day reporting/day treatment centers that combine community corrections monitoring with comprehensive mental health services. In addition to core clinic and case management services, these programs often provide money management, housing, assistance with gaining other needed supports, education and job training, and close monitoring through daily reporting.

Both single-point access and comprehensive colocation of services appear to be effective strategies in managing persons with mental illnesses who are serving community sentences. These programs reduce the duplication of services (particularly case management services), increase information flow, and have superior client outcomes, while reducing recidivism and attending to the individual's reintegration into his or her community.

Notes

1. *Estelle* v. *Gamble*, 429 U.S. 97 (1976).

2. *Bowring* v. *Godwin*, 551 F.2d 44 (4th Cir 1977).

3. *Langley* v. *Coughlin*, 888 F.2d 252 (2d Cir. 1989).

4. Cohen, F., and J. Dvoskin, "Inmates with Mental Disorders: A Guide to Law and Practice," *Mental and Physical Disability Law Reporter* 16(3–4)(1992): 39–46, 462–470.

5. Steadman, H.J., and B.M. Veysey, *Providing Services for Jail Inmates With Mental Disorders*, Research in Brief, Washington, DC: U.S. Department of Justice, National Institute of Justice, 1997, NCJ 162207.

6. Ibid.

7. Manderscheid, R.W., and M.A. Sonnenschein, eds., *Mental Health, United States, 1992,* Rockville, MD: U.S. Department of Health and Human Services, 1992, DHHS (SMA) 92–142.

8. Barajas, E., Jr., B.J. Nidorf, and R.P. Stroker, "Reinventing Community Corrections," in *Topics in Community Corrections,* Longmont, CO: U.S. Department of Justice, National Institute of Corrections, Summer 1993.

9. Ibid.

10. Byrne, J.M., A.J. Lurigio, and C. Baird, "The Effectiveness of the New Intensive Supervision Programs," *Research in Corrections* 2(2)(1989): 1–49; Jacobs, J.B., *Inside Prisons: Crime File Series Study Guide,* Washington, DC: U.S. Department of Justice, National Institute of Justice, 1986, NCJ 100743.

11. Veysey, B.M., and H.J. Steadman, *Double Jeopardy: Persons With Mental Illnesses in the Criminal Justice System,* report to Congress, Washington, DC: Center for Mental Health Services, 1995.

12. Plum, T.B., and S. Lawther, "How Michigan Established a Highly Effective Statewide Community-Based Program for Persons With Serious and Persistent Mental Illness," *Outlook* (July–August–September 1992): 2–5.

13. Ibid.

14. See Dvoskin, J.A., and H.J. Steadman, "Using Intensive Case Management to Reduce Violence by Mentally Ill Persons in the Community," *Hospital and Community Psychiatry* 45(7)(1994): 679–684 for a review of the New York, Texas, and British Columbia studies.