



E F F E C T I V E P R I S O N

Mental Health Services

*Guidelines To Expand and
Improve Treatment*

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EFFECTIVE PRISON MENTAL HEALTH SERVICES

Guidelines To Expand and Improve Treatment

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FOREWORD

Since the early 1990s, an increasing number of adults with mental illness have become involved with the criminal justice system. State and federal prisons, in particular, have undergone a dramatic transformation, housing a growing number of inmates with serious mental disorders. Complicating this situation is the high proportion of mentally ill inmates who have co-occurring substance use disorders.

Effective Prison Mental Health Services: Guidelines To Expand and Improve Treatment presents historical, legal, and ethical issues relevant to dealing with mental illness in the field of corrections. These issues include determining which inmates to treat and how to treat them; managing inmate behavior and symptoms; adapting treatment regimens to special populations, including older inmates, women offenders, and sex offenders; and using substance abuse services and specialized mental health units effectively.

The manual examines in detail correctional health care programs and suggests guidelines that contain

mechanisms for program implementation. These include national standards, policies, procedures, planning methods, budget development, staffing patterns, and monitoring and evaluation tools necessary for a successful correctional health care program. Each chapter of this manual grew out of a variety of approaches to helping mentally ill inmates, incorporating the observations and recommendations of an advisory group composed of mental health professionals and information gathered from written survey instruments, literature searches, and site visits to correctional institutions.

With the appropriate treatment services in the criminal justice system, and connection to community-based services upon release, these special inmate populations could live successful, integrated lives within their communities.

Morris L. Thigpen
Director
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PREFACE AND ACKNOWLEDGMENTS

As the country's oldest and largest nonprofit organization that addresses all aspects of mental health and mental illness, the National Mental Health Association (NMHA) and its 340 affiliates work to improve the mental health of all Americans, especially the 54 million people with mental disorders, through advocacy, education, research, and service.

Effective Prison Mental Health Services: Guidelines To Expand and Improve Treatment provides correctional administrators and health directors information on meeting the complicated needs of inmates with mental health and co-occurring substance use disorders. With appropriate treatment services in the criminal justice system and connections to community-based services on release, offenders often can live successful lives integrated in their communities without further run-ins with the law.

This document is designed for correctional administrators who have the authority to improve and expand mental health treatment options for people serving time in jails or prisons. The authors offer practical strategies and model service options available in some states to help reduce the difficulties correctional staff encounter when working with people with mental illnesses. A range of topics are covered, including the scope of the problem, treat-

ment options targeting co-occurring disorders, the treatment of women offenders, and model program approaches that can be implemented in other criminal justice facilities.

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A project of this nature would be impossible to conduct without extensive cooperation and assistance from all who participated in the cooperative agreement. In particular, we would like to offer special thanks to Dr. Susan Hunter. It was under Susan's leadership and guidance during her tenure as Chief of the NIC Prisons Division that this project for improving mental health treatment services for offenders in the criminal justice system and providing avenues to community-based services on release came to fruition.

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INTRODUCTION

Since the early 1990s, more and more adults with serious mental illness have become involved in the criminal justice system. Prisons, in particular, have undergone a dramatic transformation, housing a growing population of inmates with serious mental disorders. The U.S. Department of Justice estimates that 16 percent of all inmates in state prisons have a mental illness (Ditton, 1999).

This enormous influx of persons with mental illness into the prison system is most likely due to the following factors:

- The closing or downsizing of state psychiatric hospitals.
- The lack of an adequate range of community support programs for people with serious mental disorders and the chronic underfunding of public services.
- Restrictive insurance and managed care policies that curtail access to more intensive services.
- The poverty and transient lifestyles of many people with serious mental illness, which bring them into contact with police.
- The likelihood that adults with serious mental illness have a co-occurring substance abuse disorder (Sundram, 1999).

Correctional facilities historically have been unprepared to provide mental health services. They typically have not had the physical facilities, staff, staff training, or clinical resources to meet the needs of inmates with serious mental illness. Yet the courts

have made it abundantly clear that correctional facilities are legally and constitutionally required to provide adequate mental health services for the inmates in their custody.

It is important for prison officials to understand the severity and scope of mental illness in their populations and how to treat mental disorders effectively. These issues have important implications for humane and effective facility operation, maintaining safety for inmates and staff, and avoiding litigation.

PURPOSE OF THE MANUAL

Individuals with mental illness pose special challenges to every level of prison staff, from correctional officers to medical staff to administrators. Staff often do not have the knowledge, training, and experience they need to handle inmates with special needs effectively. The sometimes conflicting goals of security and treatment create problems for staff as well as inmates.

The purpose of this manual is to make available to correctional professionals some of what is known about effective mental health services and interventions for offenders in prisons who have a mental illness. The manual describes effective practices in a number of key areas, including screening and assessment, case management, psychopharmacology, and suicide prevention services, and discusses methods for effectively organizing and managing in-prison mental health services. The manual also presents an overview of relevant standards and legal issues that

pertain to mental health services in prisons and discusses the benefits of in-prison mental health programs.

The manual can help correctional administrators become aware of current research about effective services and practices and thereby improve the mental health care available in prisons. It promotes the types of practices that reduce incidents of harm and attempted harm, help inmates function in prison, decrease inmates' symptoms and prevent relapse, and increase the well-being of both inmates and staff. Practical guidelines and tools permit prison officials and staff to assess the appropriateness and effectiveness of their own and other in-prison mental health programs.

SCOPE OF THE PROBLEM

Definition of Serious Mental Illness

Mental disorders vary significantly in their severity, symptoms, causes, responsiveness to treatment, course, duration, and degree to which they impair a person's functioning. There is little consensus about the definitions of the terms *mentally ill offender* and *offender with serious mental illness*. Some researchers and practitioners refer to diagnosable major psychiatric disorders—i.e., schizophrenias, unipolar and bipolar depressions, and organic syndromes with psychotic features—as *serious mental illness* (Jemelka, Trupin, and Childes, 1989). Others are less concerned with diagnosis and believe that “the degree of discomfort and impairment and their duration are important in deciding whether a mental disorder is serious” (Cohen and Dvoskin, 1992).

The consent decree to *Dunn v. Voinovich* (1995), a federal class action suit that alleged inadequate mental health treatment for Ohio's prisoners, stated that prisoners who meet criteria for a serious mental illness must have a “substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality or cope with the ordinary demands of life within the prison environment.”

The illness must also be “manifested by substantial pain or disability” (Pinta, 1999).

Types of Mental Disorders

Mental disorders discussed in this manual include the following:

- Schizophrenia.
- Bipolar disorder (also known as manic depression).
- Major depression.
- Anxiety disorders.
- Personality disorders.

Schizophrenia is a group of mental disorders characterized by major disturbances in thought, perception, emotion, and behavior. Thinking is illogical and usually includes delusional beliefs. Distorted perceptions may take the form of hallucinations; emotions are flat or inappropriate. Schizophrenia impairs a person's ability to think, make judgments, reason, respond emotionally, remember, communicate, interpret reality, and behave appropriately. As many as 5 percent of prison inmates may have schizophrenia (National GAINS Center, 1997; Pinta, 1999), a rate up to four times greater than the rate found in the general population (approximately 1.3 percent) (U.S. Department of Health and Human Services, 1999).

Bipolar disorder, or manic depression, is a mood disorder that includes a number of variations and subtypes. Generally, individuals with bipolar disorder experience serious mood swings, episodes of mania that alternate with episodes of deep depression. Sometimes one mood or the other dominates. Mania is characterized by an elevated, expansive, or irritable mood, well beyond what would be considered normal or typical. Individuals may appear to have an inflated sense of self-worth or grandiosity. The person's thoughts or speech may be very rapid and difficult to follow. During manic episodes, people generally display high levels of energy and little need for sleep. Their judgment is usually poor and they

may behave recklessly in many areas. Mania often co-occurs with substance abuse, which can make diagnosis difficult. Bipolar disorder is thought to affect up to 6 percent of the prison population (Pinta, 1999).

Major depression is a mood disorder that generally occurs as an episode or series of episodes of very severe depression. People suffering from major depression may not only exhibit a depressed mood but may appear to lose interest in life's activities and be lethargic or fatigued. They may have difficulty concentrating, focusing, remembering things, or making simple decisions. They may see their situation as hopeless and themselves as worthless. Major depression may also be accompanied by such psychotic symptoms as delusions. Persons suffering from major depression are at increased risk for suicide and may be preoccupied with thoughts of death. Some studies show that depression may affect up to 9 percent of the prison population (National GAINS Center, 1997; Pinta, 1999).

Anxiety disorders are a group of mental disorders characterized by intense states of apprehension or anxiety or by maladaptive behavior designed to relieve anxiety. Anxiety disorders include generalized anxiety and panic disorders, phobic and obsessive-compulsive disorders, social anxiety disorder, and posttraumatic stress disorder. Generalized anxiety disorder affects about 6 percent of the prison population, but posttraumatic stress disorder is more common, particularly among women offenders (National GAINS Center, 1997; Pinta, 1999).

Personality disorders are characterized by personality traits and patterns of behavior that begin in adolescence or early adulthood, are inflexible, maladaptive, and persistent, and cause significant functional impairment or distress to individuals. They include paranoid personality disorder, schizoid and schizotypal disorder, antisocial personality disorder, borderline personality disorder, histrionic personality disorder, narcissistic personality disorder, avoidant personality disorder, dependent personality disorder, and obsessive-compulsive personality disorder.

People with antisocial personality disorder frequently end up in the criminal justice system due to their failure to conform to social norms and laws. These individuals disregard the wishes, rights, and feelings of others and are frequently deceitful and manipulative in order to gain personal profit or pleasure. Adults with antisocial personality disorder appear impulsive, irritable, and aggressive. They frequently display a reckless disregard for the safety of themselves or others and show little remorse for the consequences of their acts. In correctional settings, many exhibit an arrogant and inflated self-appraisal and a superficial charm. Estimates are that 30 to 50 percent of prison inmates have antisocial personality disorder (Pinta, 1999).

Prevalence Rates

In 1999, the Bureau of Justice Statistics reported that more than 16 percent of state prison inmates had a mental condition or had been hospitalized overnight in a mental hospital (Ditton, 1999). Although this estimate is based on self-reporting by inmates, it indicates the need for mental health services in state prisons.

Other studies have found that—

- 8 to 19 percent of prisoners have significant psychiatric or functional disabilities and an additional 15 to 20 percent of inmates will require some form of psychiatric intervention during their incarceration (Metzner, 1993).
- 8 to 12 percent of inmates at any given time suffer from a serious mental disorder, such as schizophrenia, bipolar disorder, and major depression (DiCataldo, Greer, and Profit, 1995).
- The rate of serious mental illnesses among prisoners is three to five times the rate found in the community (National GAINS Center, 1997).

These figures indicate that an extraordinarily high number of state prison inmates have a mental disorder of some sort that requires treatment.

A 1999 review by Emil Pinta summarizes eight prevalence studies that used rigorous sampling and structured interview processes to determine prevalence rates of disorders among prison inmates. Pinta found on average that 18 percent of inmates have serious disorders such as schizophrenia, bipolar disorder, or major depression at some point in their lives and 15 percent have current (within the past year) disorders. In addition, approximately 19 percent of male and 30 percent of female adult prisoners have “broader definition” disorders that impair their daily activities to a substantial degree (Pinta, 1999).

The National GAINS Center reports that 26 percent of the prison population exhibits active alcohol abuse and dependence and 20 percent exhibits drug abuse or dependence. About 13 percent of the prison population has both a serious mental illness and a co-occurring substance abuse disorder. Among those diagnosed with schizophrenia, major affective disorder, or antisocial personality disorder, the prevalence of co-occurring substance abuse is 90 percent (National GAINS Center, 1997).

Functional Impairment

Many major mental disorders are accompanied by impaired functioning. That is, mental illness not only affects a person’s thoughts, emotions, or behavior but also affects his or her ability to adapt and carry out such important functions as relating to others. Mental disorders in prison are associated with high degrees of disability scores on the Global Assessment of Functioning (GAF) scale (a measure of how much a person’s mental problems interfere with daily living). One study estimated 39 percent of inmates with mood disorders and 35 percent with anxiety disorders had severe impairment; another 56 percent with mood disorders and 15 percent with anxiety disorders were moderately impaired (Neighbors, 1987) (see “Examples of Substantial Disability or Impairment in the Prison Environment”).

Examples of Substantial Disability or Impairment in the Prison Environment

- Hospitalization.
- Placement in a residential treatment unit or observation and crisis cell.
- An impaired ability to complete job assignments or participate in programs.
- Significant impairment in the ability to relate to others.
- Threatened or attempted suicide.
- An ongoing need for mental health treatment and psychotropic medication.

Because of head injuries, substance abuse, and other afflictions to the brain, a significant number of inmates have subtle dementia that impedes their ability to make rational decisions and formulate plans (Taylor, 2001).

Scope of Mental Health Treatment in Prisons

State prisons provided substantial mental health services in 2000. According to the U.S. Department of Justice (Beck and Maruschak, 2001), state public and private adult correctional facilities reported that—

- 95 percent provided mental health services to their inmates.
- 78 percent screened inmates at intake.
- 79 percent conducted psychiatric assessments.
- 84 percent provided therapy or counseling by mental health professionals.
- 83 percent distributed psychotropic medications to inmates.

Ten percent of state inmates received psychotropic medications in 2000, and 13 percent attended mental health therapy or counseling (Beck and Maruschak, 2001).

No studies have evaluated the quality or outcomes of prison mental health services or compared treatment offered in specialized versus general correctional facilities. In 2000, however, two-thirds of all inmates receiving therapy or medications were in facilities that did not specialize in providing mental health services (Beck and Maruschak, 2001), thus illustrating how important it is that every confinement facility be prepared to identify, assess, and treat inmates with mental illness.

CHALLENGES

The high numbers of people with serious mental health problems entering prison present significant challenges. Adults with mental illness often enter prison with histories of chronic health problems, unemployment, homelessness, transient behavior, financial instability, and high-risk behaviors. Typically, they do not have health coverage, and they lack the supportive, positive, and enduring relationships that contribute to emotional health and stability (McVey, 2001). While incarcerated, inmates with mental illness often need housing and services different from those offered to other inmates. They may need extra medical attention, treatment, medication, security, suicide precautions, special programming, rehabilitative services, case management, or transition services. Due to their illness, they may need to be housed in units with higher staffing ratios. Many prison officials find themselves balancing the needs of inmates against the costs of the special services.

Many inmates with mental illness have difficulty adapting to the structure, routine, and social milieu of prisons. Some become overly passive, withdrawn, and dependent (Jemelka, Trupin, and Childes, 1989). Others act out their illness in antisocial ways. Infractions are a primary indicator of prison adjustment and may ultimately affect classification and release decisions. Judgments about what behaviors

are tolerable or are allowed as manifestations of illness, therefore, are important ones (Jemelka, Trupin, and Childes, 1989). Prisons should avoid penalizing inmates for infractions that are a direct result of their mental disorder.

Challenges in Caring for Inmates With Mental Illness

- Determining whom and how to treat.
- Managing inmate behavior and symptoms.
- Recognizing the negative effects of the prison environment on mental health.
- Understanding inmates' difficulties in adjusting to institutional life.
- Determining the need for special services.

Determining Whom and How To Treat

Prison mental health programs typically emphasize treatment for inmates with serious or acute mental illness, those who are suicidal, and those with the most dangerous or disruptive symptoms. Corrections agencies surveyed by the National Institute of Corrections in 1999 reported devoting more mental health resources (i.e., special housing, programming, and management) to inmates who meet predetermined criteria of major mental illness than to those who have lesser needs (LIS, Inc., 2001). A majority of these agencies use formal assessments to determine which inmates have a serious mental illness. Thus inmates with major mental illnesses receive housing and programming not available to inmates who have less serious mental disorders.

But determining how to screen adults coming into the prison system and how to identify emergent mental health problems among inmates is challenging. For a variety of reasons, many adults with serious mental illness go to great lengths to hide their illness from staff or other inmates. Some inmates may not know they have a mental illness or be able to convey information about their symptoms well to

others. Many adults have co-occurring substance abuse disorders, head injuries, or developmental disorders that complicate their diagnosis and treatment. Prison staff must be trained to recognize the signs of serious mental disorders and substance abuse, monitor the entire prison population for signs of emerging problems, and distinguish acute and serious conditions from less serious ones. Knowing what types of treatment and programming are most effective and how to deliver services in a timely, humane, and efficient manner is also an ongoing challenge for prison authorities.

Managing Inmate Behavior and Symptoms

Illnesses such as schizophrenia, schizoaffective disorder, and major depression may affect inmates' ability to care for themselves and to comply with certain orders or procedures. People with major depression or bipolar disorder may exhibit aggression or irritability. Paranoia may result in an inmate's failure to relate well to others. People with schizophrenia may hear voices and have other problems that interfere with their ability to follow directions and behave as expected. In addition, mental illness can evoke fears, hostile reactions, and negative responses from other inmates and staff.

Several studies describe inmates with mental disorders as having a disruptive effect in a prison environment. One study found an elevated rate of incident reports for subjects who rated positive on the schizophrenia scale during their first 90 days of incarceration (DiCataldo, Greer, and Profit, 1995). The Bureau of Justice Statistics found that people with mental illness were twice as likely as other prisoners to be involved in a fight (Ditton, 1999).

Prison administrators must often invest in increased levels of staffing to house offenders with mental disorders safely and humanely.

Recognizing the Negative Effects of the Prison Environment on Mental Health

Overcrowding, the lack of privacy, temperature and noise levels, victimization, and other environmental conditions in prisons can easily exacerbate the symptoms of mental illness for some people. In fact, the prison environment itself can contribute to increased suicide and the inability of inmates with serious mental illness to adjust. Environmental factors can also elicit significant adjustment reactions from inmates who may not have had a previous diagnosis but who become ill while incarcerated.

Prisons are usually located far from an inmate's home. Visitation can be sporadic, and maintaining community ties can be difficult for the inmate, the inmate's family, and service agencies. Additional stressors related to institutional life include—

- Poor living conditions.
- A lack of meaningful work.
- Violence and sexual exploitation.
- The weakening of the inmate's usual affectional ties.
- Forced inactivity (Schetky, 1998).

Finally, the stability of the prison community allows inmate groups, gangs, and hierarchies to develop. Some groups can be problematic or dangerous while others are potentially supportive (Ortiz, 2000). When turnover is low, inmate weaknesses and vulnerabilities surface quickly and are soon exploited. Prisoners with mental illness are sometimes housed in special sections to better protect them, but they may still be mixed with others who exploit or victimize them.

The vulnerability of inmates with mental illness to abuse by other inmates and their tendency to accumulate disciplinary sanctions for disruptive behavior

may more often result in placing offenders with mental illness in protective segregation or isolation. Segregated placements address some environmental problems and create others. Administrative segregation, for example, can have substantial psychological consequences for an inmate with depression or schizophrenia (Reid, 2000). Isolation can increase symptoms for many people. Placing inmates in higher security settings may also limit their access to privileges, programs, work release assignments, and early parole (DiCataldo, Greer, and Profit, 1995).

Understanding Inmates' Difficulties in Adjusting to Institutional Life

The nature of serious mental illness can create problems for an inmate's ability to cope and adjust to the prison environment. Offenders with mental disorders generally have a more complicated adaptation to prison as measured by rule violations and incidents of misconduct. Serious mental illnesses are stress sensitive; changes in housing, staffing, and routine may bring about an adverse reaction. Prison policies and practices such as the following can cause special problems or inhibit the adaptation to prison life for inmates with serious mental illness:

- Prohibiting inmates on psychoactive medications from working in prison industries.
- Misunderstanding an inmate's aberrant behavior, which can turn a minor incident into a serious situation (Morgan, Edwards, and Faulkner, 1993).

Morgan, Edwards, and Faulkner (1993) compared the adaptation to prison by individuals with schizophrenia with that of a control group. For all outcome variables—number of infractions, number of lockups, days in lockup, ability to obtain a job in prison, and ability to obtain release from prison—the scores of the group with schizophrenia were inferior to the control group.

Additionally, that study found that—

- More inmates with schizophrenia remained in prison and completed their entire sentence.

- Fewer inmates with schizophrenia obtained parole or were placed on probation.
- Inmates with schizophrenia incurred more violent infractions and were moved more often for medical or disciplinary reasons.

Inmates with schizophrenia do not adapt well and are less able to successfully negotiate the complexity of the prison environment (Morgan, Edwards, and Faulkner, 1993).

Inmates with mental illness are less likely to earn good time due to their behavior and are more likely to stay longer in prison than other inmates with similar offenses. In fact, 86 percent of severely mentally ill prisoners serve their full sentence (AIS Health.com Managed Care Advisor, 2001).

Determining the Need for Special Services

Many adults with mental illness enter the prison system with histories of problems such as victimization, co-occurring substance abuse, chronic health conditions, or violence. Many inmates with mental illness, especially women, have histories of trauma and abuse prior to entering prisons; others are victimized while incarcerated. Some adults have histories of sexual offending. These subpopulations need specialized treatment services that may be costly to start.

The high rates of exposure to psychological trauma experienced by women offenders and the association found between trauma and psychiatric disorders suggest that prisons serving women need programs to address exposure to trauma and its aftermath (Jordan et al., 1996).

The prevalence of co-occurring substance abuse and mental health disorders is especially high in the prison population (about 13 percent). Research shows that integrated treatment—that is, comprehensive and coordinated treatment for both disorders delivered in the same setting by cross-trained staff—can be effective, but its startup costs can be significant (National GAINS Center, 1997).

Inmates with chronic mental illness pose special challenges. Many prisons acknowledge the need for chronic care programs or special needs housing units within the correctional setting for inmates with chronic mental illness who do not require inpatient treatment but do require a therapeutic environment due to their inability to function adequately within the general population. Designing and staffing these units is a challenge for prison authorities, but the benefits can be significant. If designed appropriately, these units can reduce serious rule infractions, suicide attempts, correctional discipline, seclusion, hospitalization, and the need for crisis intervention.

Geriatric inmates are one of the fastest growing segments of the prison population and one of the most expensive to house and maintain, largely due to their physical and mental impairments. Specially trained staff may be needed to identify and treat geriatric health and mental health problems and prevent suicide attempts (Maue, 2001).

Inmates with histories of violence and sexual offending and inmates with developmental disabilities also deserve special consideration. These special subpopulations within the growing prison population may require specialized mental health programming or treatment services. Balancing the needs of these inmates with the cost of providing effective rehabilitative services is an ongoing challenge for prison authorities.

BENEFITS OF EFFECTIVE MENTAL HEALTH SERVICES

Given the difficulties of serving offenders with mental health needs in the prison setting and the limited human and financial resources available to devote to this population, corrections practitioners and policy-makers at times may question the wisdom of implementing significant prison-based mental health services (see “Three Reasons for Providing Mental Health Treatment in Correctional Settings”).

Treatment within a prison enables inmates to use rehabilitative opportunities within the prison. There

Three Reasons for Providing Mental Health Treatment in Correctional Settings

1. To reduce the disabling effects of serious mental illness and maximize each inmate's ability to voluntarily participate in correctional programs.
2. To decrease needless human suffering caused by mental illness.
3. To help keep prison staff, inmates, volunteers, and visitors safe.

Source: Cohen and Dvoskin (1992)

is little doubt that treatment also reduces management and disciplinary problems as well as liability. Almost all prisoners (95 percent) return to the community. Therefore, providing holistic mental health services to offenders in the prison contributes to the community's health and safety (Wilkinson, 2000).

Because many in-prison programs have never been effectively evaluated, much more is to be learned about which types of interventions are associated with improved clinical outcomes, prevention of relapse and recidivism, enhanced safety within the institution, greater public protection, and overall cost benefit. Many innovative, promising, and comprehensive approaches have not been formally evaluated.

Evidence exists for the effectiveness of interventions in such key areas as treatment modalities, medications, and screening and assessment tools. For example, effective screening and assessment of mental health problems has reduced management problems, improved care, and reduced liability of correctional institutions (Maue, 2001). Likewise, research indicates that cognitive skills training, intensive drug treatment, residential treatment, prison education and work programs, and sex offender treatment interventions work (Gorzycyk, 2001). On the whole, cognitive-behavioral approaches that focus on offenses and behaviors are more successful than sanctions aimed at eliminating future misconduct

(Immarigeon, 2001). A cognitive-behavioral approach to relapse prevention is used by a majority of after-care drug treatment programs.

A number of studies have shown the effectiveness of using the newer psychotropic medications versus older medications to treat offenders with serious mental illness in correctional settings. (Some of these studies are discussed in chapter 7, "Psychopharmacological Intervention for Psychiatric Disorders.") Two treatment methods have shown remarkable success: prison-based substance abuse services and specialized mental health units.

Effectiveness of Substance Abuse Services

A significant amount of data shows the efficacy and cost-effectiveness of prison-based substance abuse services. A 1998 study by the Federal Bureau of Prisons found that 3 percent of prisoners who received drug treatment were rearrested in the 6 months after release, compared with 12 percent of inmates who did not receive treatment (Curley, 1999). Although several types of substance abuse services have been shown to be effective, therapeutic communities are generally acknowledged to be the most effective for treating incarcerated offenders with significant addiction problems (Curley, 1999).

Since the early 1990s, Texas has initiated a number of programs in its prisons and state jails, including an intensive 9- to 12-month in-prison therapeutic community program. Their program includes 3 months of aftercare in a community residential facility, followed by 9 to 12 months of outpatient treatment while on parole. At 12 months, 16 percent of inmates who had completed the program had been rearrested, compared with 30 percent who completed only one component and 30 percent who were not treated (Maxwell, 1999).

In a followup study of offenders admitted to treatment in the Substance Abuse Felony Punishment (SAFP) program in 1993, the Texas Criminal Justice

Policy Council found that 10 percent of those who completed treatment returned to prison within 1 year of release, compared with 26 percent who did not complete treatment and 19 percent who received no treatment. The SAFP program is less expensive than incarceration due to differences in time the inmates serve in prison and the savings associated with reduced recidivism. Based on the cost of treatment and savings in recidivism, the study found that for every dollar spent on treatment, the state saved \$1.85. This formula does not include the savings in regular daily prison costs (Maxwell, 1999).

Effectiveness of Specialized Units

The effectiveness of specialized mental health units for the care of inmates with serious mental illness who are unable to cope with participating in daily activities with the general population but who are not in need of hospital-level care has been demonstrated in numerous prison systems (Wilkinson, 2000).

One study analyzing the use of intermediate care programs for inmates with psychiatric disorders assessed whether inmates admitted to these programs reduced their disruptive and harmful behaviors and whether prison authorities used fewer correctional restrictions and mental health services to address those behaviors. Intermediate care programs provide an intermediate level of clinical and rehabilitative services for inmates who need more than the outpatient services offered by prison mental health units but do not require the intensive inpatient services offered by the state's central forensic psychiatric center. In these therapeutic communities, mentally ill inmates are sheltered from being taunted, exploited, or assaulted by predatory inmates in the general prison population. Inmates receive such services as milieu therapy, individual and group therapy, task and skills training, educational instruction, vocational instruction, and crisis intervention. This specialized unit was indeed effective: Significant reductions were found in very serious rule infractions, suicide attempts, correctional

discipline, and use of crisis care, seclusion, and hospitalization (Condelli, Dvoskin, and Holanchock, 1994).

Specialized mental health units generally reduce the number of institutional crises and management problems and improve the quality of life for impaired inmates. These units have moderate costs, which are more than offset by the decrease in the use of inpatient psychiatric care and improvements in institutional safety and security (Haddad, 1999).

SUMMARY

Today's prisons face enormous challenges in finding safe, effective, and affordable methods to identify and treat the growing numbers of inmates who have serious mental illness. Yet many are finding practices and interventions that succeed both in reducing the suffering and deterioration of inmates with various disorders and in making prisons safer and easier to manage.

This manual provides an overview of effective practices in a number of key areas, including screening and assessment, case management, psychopharmacology, and suicide prevention. It also describes treatment and programming approaches found effective with special subpopulations within prison settings, such as women and offenders with co-occurring mental health and substance abuse disorders. It outlines relevant standards and legal issues that pertain to mental health services in prisons and discusses some of the benefits of in-prison mental health programs.

One goal of this manual is to alert correctional administrators to the growing body of research about effective services and practices and prompt them to assess the appropriateness and effectiveness of their own programs and services. These actions can lead to improved outcomes and reduced recidivism among inmates in their care, reduced liability, and safer places to work.

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SCREENING AND ASSESSMENT FOR MENTAL HEALTH AND SUBSTANCE ABUSE DISORDERS

The ever-increasing numbers of offenders with significant mental illness and substance abuse disorders who enter prisons have made it essential for prison administrators to put into place policies and procedures that will identify and treat these individuals. Implementing effective screening and assessment practices helps maintain an optimal level of safety and security for staff, inmates, and the public. Furthermore, adopting national screening and assessment guidelines minimizes the risk of legal action against the facility. The process of identifying and evaluating this subpopulation of inmates consistent with national standards and guidelines is outlined below. This process outline also includes information on scheduling, staffing, and followup.

Offenders entering into the state prison system should be screened for mental health and substance abuse disorders for both clinical and legal reasons. Screening and assessment for mental illness—

- Identify those at risk for injuring themselves and others.
- Determine whether the inmate is capable of functioning in the prison.
- Determine whether the inmate should be transferred to a mental health facility.
- Determine whether the inmate can benefit from treatment at the prison (Ogloff, Roesch, and Hart, 1993).

Standards for screening and assessment developed by several national organizations suggest that, as

with other acute medical conditions, mental health and substance abuse issues need to be identified immediately on entry into a correctional facility. Significant stressors encountered in adjusting to the prison environment can be particularly problematic for those who have a preexisting psychiatric condition. The sooner individuals can be identified, the sooner treatment providers working in the correctional setting can intervene to help them adapt to the environment. This helps the facility maximize security, maintain its operational routine, and make the prison safer for staff and inmates (Dvoskin and Steadman, 1989). Adequate screening and followup procedures help the offender with mental health or substance abuse problems function better and have the potential to reduce inmate suicide (NIC, 1995), violence, and other predatory behaviors (Cohen and Dvoskin, 1992).

The right of a prison inmate to receive screening and treatment for mental health disorders has developed out of several legal precedents. The U.S. Supreme Court established that it is unconstitutional under the eighth amendment to show deliberate indifference to the serious medical needs of prisoners (*Estelle v. Gamble*, 1976). In *Bowring v. Godwin* (1977), a federal appeals court determined that the right to medical treatment is not distinguishable from the right to mental health treatment. The court ruled that prisoners are entitled to psychological or psychiatric treatment if a physician or other health care provider concludes that the inmate has a serious mental disease or injury and that, without treatment, he or she would suffer some harm. Further,

the court determined that a correctional facility must have a system for screening and evaluating inmates to identify those who need mental health treatment (*Ruiz v. Estelle*, 1980).

The U.S. Supreme Court ruled that inmates do not have a constitutional right to rehabilitation from drug addiction (*Marshall v. United States*, 1974), however, and a lower court, following this precedent, held that it is *not* a violation of the eighth amendment if treatment for alcoholism is not provided (*Pace v. Fauver*, 1979). However, in *Palmigiano v. Garraty* (1977), the court found that inadequate substance abuse screening procedures contributed to inmate suicide and drug trafficking in Rhode Island prisons. In addition, the absence of screening procedures to detect substance abuse symptoms has provided the grounds for unfavorable litigation against correctional facilities (Peters, 1992). Given these court decisions, prison administrators who ensure that offenders are receiving appropriate levels of assessment and treatment for mental health and substance problems will not only be creating safer facilities for staff and inmates, they will also be protecting themselves and their state institutions from potential costly litigation.

Screening, a process of information gathering that includes an interview, a review of existing records, and the administration of specialized instruments or tests, seeks to identify those inmates who may require a particular intervention or treatment. It should cast a large net that allows more false positives than false negatives (Ogloff, Roesch, and Hart, 1993; CSAT, 1994; Peters and Bartoi, 1997). Because many offenders with existing mental health and substance abuse problems have already been identified and treated while incarcerated in local jails, a review of jail treatment records is extremely valuable. Screenings should be completed on entry at reception centers or other permanent institutions, as well as after transfer between institutions. A more elaborate and comprehensive evaluation or assessment should take place for those identified by the screening process as likely to have one or more psychiatric disorders.

Assessment is the process of examination or evaluation following the screening that ascertains the specific nature and severity of the mental health and substance abuse problems and their history and course. It determines what type of intervention or treatment is best for individuals identified as having a mental health or substance abuse disorder by the screening. The assessment provides the necessary information for the planning and implementation of appropriate treatment to best deal with the identified disorders. It should include a detailed interview and record review and may involve the administration of other instruments or tests. Assessment interviews should—

- Include a complete mental status exam (which focuses on the current presentation during the assessment process itself).
- Describe the individual's appearance, orientation, behavior, thought quality, and thought content.
- Note the presence of severe psychiatric symptoms and self-reports of recent changes in appetite, sleep, or sexual drive.

PROBLEMS IN SCREENING AND ASSESSMENT

Most prison authorities acknowledge the wisdom and legal necessity of screening and assessing inmates for mental health disorders. Determining how to screen and the methods to use remains challenging. Mental health professionals who want to work in prisons are in short supply and are generally used to provide treatment, consultation, and training rather than screening. The result is that prison staff, sometimes with limited training, must distinguish on a daily basis inmates who are experiencing symptoms of a serious mental illness from those who are malingering or experiencing adjustment disorders.

A complicating factor is that many people with serious mental illness do not acknowledge they have it or do not want other inmates or staff to know they have it. An inmate's outward expression of bizarre

thoughts or behavior or any loss of control may result in being put on suicide watch, being given medication, or being sent to administrative lockdown. In addition, prison inmates often exploit and take advantage of other inmates' weaknesses. As a result, inmates may fail to report their symptoms, and considerable time may pass before an inmate's mental illness is discovered and diagnosed.

Along with initial screening, ongoing methods are needed to identify emergent mental health problems among the inmate population. Some inmates do not have a preexisting mental condition when they enter prison but develop significant psychiatric problems as a result of incarceration. The sooner these problems can be identified and treated, the sooner these inmates can adjust and cope with their environment. Consequently, it is important that all staff (e.g., correctional officers, teachers, classification) be trained to identify symptoms of mental illness and that formal and informal mechanisms be in place for staff to refer those identified with possible mental health disorders to the appropriate health staff (Ogloff, Roesch, and Hart, 1993).

Inmates with mental illness who stand out and cause problems quickly get attention. Those who are quietly psychotic or depressed are harder to recognize. Prison staff may not see them as a problem. Counselors and nursing staff generally should be aware of the entire inmate population in addition to monitoring those known to have mental illness, substance abuse, mental retardation, or problems adapting (Reid, 2000a).

Suicide is an additional risk in correctional settings, and mentally ill inmates are at particularly high risk. Suicide is the third leading cause of death in prison (Hayes, 1999), and almost all suicide attempts committed in prisons are by people diagnosed with major psychiatric disorders (Bonner, 2000). Prison officials must have ways to recognize inmates with suicidal thoughts and behaviors at any time and intervene quickly.

Malingering, or feigning illness to avoid work, is a fact of life in the correctional setting. Malingering may

include exaggeration as well as complete fabrication of symptoms (Reid, 2000b). Some argue that prisoners will feign mental illness to be admitted to a comfortable therapeutic unit or to remain in it longer than necessary. They might even engage in self-injury or suicidal gestures to obtain a secondary gain, such as transfer to another location, a change in conditions of confinement, or special privileges.

Prison staff must exercise great caution in interpreting what is malingering or manipulative behavior. Misdiagnosing these activities may end in unintended death. There is a high incidence of borderline intelligence and mental retardation in the prison population. An inmate's inability to think abstractly and lack of verbal skills may inhibit his or her ability to put common symptoms and feelings into words that adequately convey a sense of what is happening. Such inmates may be thought to be malingering when they cannot explain what they are feeling. In addition, some offenders may have been instructed by other inmates to report outrageous symptoms to health personnel—such as hearing voices—to get treatment for legitimate problems such as depression (Taylor, 2001).

Finally, cultural differences also play a role in the diagnostic process. It is not uncommon in some cultures for people to see visions, for example. It is the professionals' duty to sift through all the factors to determine whether there is a legitimate problem (Taylor, 2001).

NATIONAL STANDARDS AND GUIDELINES FOR MENTAL HEALTH EVALUATIONS

Numerous national organizations have promulgated standards for correctional health care, including for mental health screenings. Useful guidelines have been developed by the American Psychiatric Association (APA) and the National Commission on Correctional Health Care (NCCHC) (Metzner, 1993).

An APA task force report on psychiatric services in jails and prisons (2000) recommends that a mental health screening be conducted at the time of admission to the prison. This initial screening ensures that any inmate who is mentally ill or developmentally disabled and requires mental health intervention is referred for appropriate mental health evaluation (assessment) and housed in an appropriate level of care. APA recommends that this initial screening involves—

- Observation and structured inquiry with a set of questions.
- Standard questions for all inmates.
- Questions that are administered at the time of admission.
- A qualified mental health professional or trained correctional officer to conduct the screening.

Following this initial screening, APA recommends a more detailed, thorough, and structured intake mental health screening be—

- A part of the standard medical screening given to all inmates.
- Conducted within 7 days of admission to the prison.
- Administered by a qualified health care professional.

APA's guidelines also recommend that any inmate identified by these screenings as having a mental illness or disability be referred to an appropriately trained mental health professional for a more comprehensive mental health examination (i.e., assessment). This assessment should take place within 24 hours of receiving the referral from the screener. A comprehensive assessment could, however, be initiated prior to the intake mental health screening by a referral from other custodial staff or even from the inmate.

NCCHC (1999) also has developed standards for two levels of mental health screenings in prisons. The first is recommended to take place immediately (within 2 hours) on arrival and to be completed by qualified health care personnel. NCCHC interpretation of qualified health care personnel includes professionals or technical workers certified by their state to support or supplement the functions of physicians as long as they do not practice outside their license, certification, or registration.

The second level of screening is a postadmission mental health evaluation (closer to an assessment, as defined above). It is recommended that this evaluation occur within 14 days of admission to the prison and be completed only by qualified mental health personnel. Qualified mental health personnel include psychiatrists, physicians, psychologists, nurses, physician assistants, psychiatric social workers, and others who are permitted by law to care for the mental health needs of patients. This mental health evaluation should include a structured interview that inquires into the inmate's history and current status regarding symptoms and other factors (see "Elements of the Mental Health Evaluation").

Elements of the Mental Health Evaluation

- Psychiatric history, including hospitalizations and outpatient treatment.
- Current use of psychotropic medications, if any.
- Current suicidal ideation.
- History of suicidal behavior.
- Current and prior drug and alcohol usage.
- History of sex offenses.
- History of violent behavior.
- History of being victimized by criminal violence.
- History of special education placement.
- History of seizures or cerebral trauma.
- Emotional response to being incarcerated.
- Intelligence testing for mental retardation (required by NCCHC guidelines (1999)).

NATIONAL STANDARDS AND GUIDELINES FOR SUBSTANCE ABUSE EVALUATIONS

The National Institute of Corrections (NIC) and the Center for Substance Abuse Treatment (CSAT) recommend guidelines on screening for alcohol and drug abuse in prison settings.

NIC's Report of the National Task Force on Correctional Substance Abuse Strategies (NIC, 1991) recommended that—

- The facility develop and implement a standardized and comprehensive method to assess for alcohol or drug abuse in its inmates.
- The assessment be done as early as possible after entry.
- The assessment be done throughout incarceration for all offenders.
- The assessment be documented in a cumulative file.

CSAT (1994) suggests the following basic guidelines for conducting substance abuse screenings with offenders in the criminal justice system:

- Screening interviews should be conducted in private.
- Screenings should be documented in written form in a case file.
- Screenings should be seen as integral to, rather than an adjunct to, other admission processes when entering the facility.
- Screenings should be held at multiple points because an inmate's motivation and readiness to admit to problems vary.
- Staff should be appropriately trained to conduct screenings.

CSAT suggests that assessments be comprehensive and holistic and recommend the most appropriate treatment (CSAT, 1994). The assessment should—

- Use qualified human services professionals with competence in alcohol or drug programs (e.g., licensed social workers, addictions counselors).
- Be conducted with a credentialed or certified counselor in an alcohol or drug field.
- Review archival data including criminal justice and treatment records.
- Assess the impact of alcohol and drug abuse on marriage, family, employment, self-concept, and other areas.
- Identify risk factors for continued alcohol and drug abuse.
- Review medical/health findings.
- Review psychological test findings.
- Include educational and vocational background.
- Include suicide or other crisis risk assessment.
- Assess the inmate's motivation and readiness for treatment.
- Evaluate the inmate's attitudes and behaviors during the assessment.

The assessment should also include a detailed history of the inmate's patterns of alcohol and other drug use, including—

- The onset of alcohol and drug use.
- Behaviors associated with alcohol and drug use (e.g., using for sex, to go to work).
- The method of administration of the substance.
- The presence or absence of tolerance effects.
- The presence or absence of physical withdrawal symptoms.

- Uncontrolled use, such as binges or overdoses.
- The use of alcohol and other drugs to self-medicate painful or unpleasant emotions.
- Attempts to hide alcohol and drug use.
- Physical signs of alcohol and drug use (e.g., needle tracks, emaciation).
- Positive drug test results.
- Previous attempts to stop alcohol and drug use.
- Family dysfunction relative to alcohol and drug use.

SPECIAL CONSIDERATIONS RELEVANT TO SCREENING AND ASSESSMENT

Screening for Suicide

A primary function of screening is to identify inmates who are at risk for suicide. This screening typically occurs when a person enters a reception center or the permanent institution. Inmates who have co-occurring mental health and substance abuse problems are at higher risk for suicide when compared with inmates without such histories (NIC, 1995). A suicide screening should include a review of records, an interview, and possible testing. Peters and Bartoi (1997) recommend that the screening inquire about—

- A history of prior suicidal gestures or attempts and their seriousness.
- Current mental health symptoms.
- Current suicidal ideation.
- The relationship between suicidal behavior and mental health symptoms.

If an inmate presents suicidal ideation, the screener also should inquire about—

- A current suicide plan (i.e., when, what method will be used, its degree of lethality).
- The current level of hopelessness.

When an inmate has an active suicide plan that has a high probability of causing significant harm or when a significant level of hopelessness exists, steps should be taken immediately to protect (but not isolate) the person in a secure environment and start clinical interventions.

Screening for Motivation and Readiness for Treatment

As with most organizations that provide treatment for mental health and substance abuse disorders, prisons generally have a limited amount of resources and must maximize the efficacy of the treatment they provide. To this end, it can be useful to screen all inmates for their level of motivation to change and their readiness to accept treatment. Researchers have found that an individual's level of motivation to change can be an important predictor of treatment compliance, treatment dropout, and treatment outcome (Lehman, 1996; Ries and Ellingson, 1990). Screenings for motivation also can help providers determine what type of treatment intervention to provide. Treatment efficacy can be maximized when treatment interventions can be matched to different levels of readiness to change (Prochaska, DiClemente, and Norcross, 1992; Osher and Kofoed, 1989).

Although several instruments have been developed to screen for motivation and readiness, a few simple interview questions, like those that follow, can provide important data:

- How serious do you think your mental health problems are?
- How important is it for you to receive treatment for your mental health problems?
- How serious do you think your alcohol and drug use problems are?

- How important is it for you to receive treatment for your alcohol and drug problems?
- Do you want to change your alcohol or drug use?
- Have you tried to reduce your alcohol or drug use? (Peters and Bartoi, 1997).

Questions such as these can give screeners an early indication of the offender’s motivation for treatment and help providers plan interventions as early as possible on entry to the facility.

Co-occurring Disorders

Screenings and assessments in criminal justice settings ought to address issues related to mental health, substance abuse, and the interaction between the two (Peters and Bartoi, 1997) (see “Information To Gather To Assess for Co-occurring Disorders”). The screening approach used to identify mental health and substance abuse conditions should be integrated; that is, if either a mental health or substance abuse disorder is detected, the other should be immediately screened for as well. The prevalence of co-occurring substance abuse and mental health disorders is especially high in the prison population. An estimated 13 percent of the prison population

has both a serious mental illness and a co-occurring substance abuse disorder (National GAINS Center, 1997), and 23 to 56 percent of people in the general population who have a diagnosable mental disorder also have a substance abuse disorder (Regier et al., 1990). Of the estimated 16 percent of state prison inmates in 1996 identified as mentally ill, 59 percent reported using alcohol or drugs at the time of their offense and 34 percent had a history of alcohol dependence (Bureau of Justice Statistics, 1999).

Ethnic, Cultural, and Gender Considerations

Ethnicity, culture, and gender play important roles in an individual’s life and in the development of mental health and substance abuse disorders, and screening and assessment in correctional settings must take this into account. According to the U.S. Surgeon General’s report *Mental Health: Culture, Race, and Ethnicity* (U.S. Department of Health and Human Services, 2001), racial and ethnic minorities tend to have less access to mental health care, be misdiagnosed, receive less care, and receive poorer quality care than whites. African Americans represent nearly half of all prisoners in state and federal facilities, but

Information To Gather To Assess for Co-occurring Disorders

<i>Mental Health</i>	<i>Substance Use</i>	<i>Interaction Effects of Mental Illness and Substance Abuse When Both Are Present</i>
<ul style="list-style-type: none"> • Acute mental health symptoms. • Suicidal thoughts and behavior. • Other observable mental health symptoms. • The age of onset of mental health symptoms. • Prior treatment. • Prior use of medications. • Cognitive impairment. • Recent trauma (e.g., sexual abuse, physical abuse). • Family history of mental illness. 	<ul style="list-style-type: none"> • Signs of acute intoxication. • Signs of acute withdrawal. • Signs of tolerance effects. • Negative consequences as a result of substance use. • Age and pattern of first substance use. • Current patterns of use. • Drugs of choice. • Motivations for using. • Treatment history. • Family history of substance abuse. 	<ul style="list-style-type: none"> • The effects of one disorder on the other. • Patterns of symptom expression. • Chronology of the two disorders. • Motivations for treatment of each condition.
<p>Source: Peters and Bartoi (1997).</p>		

incarcerated African Americans with mental illnesses are less likely than whites to receive mental health care. In addition, certain minority groups may present mental health symptoms in ways that differ from what clinicians expect, affecting the accuracy of the information gathered at screening, which can lead to difficulties in diagnostic and treatment planning. For example, African Americans are more likely than whites to express psychiatric symptoms as somatic complaints or symptoms (i.e., symptoms of a physical illness) because physical problems may be a more acceptable way of expressing suffering within their community.

To address some of these issues, assessors and treatment providers in correctional settings should be trained to be culturally competent. Cultural competency requires both knowledge and skills about the differences within and between various cultural groups, especially their views on health, illness, treatment, and care. Culturally sensitive screenings and assessments may show improved accuracy and can result in more positive outcomes for the interventions they help to design. Cultural competence avoids prejudgments or biases about others' cultural beliefs and customs and demonstrates respect for their attitudes, beliefs, and behaviors (CSAT, 1999).

To improve cultural competency in correctional settings, CSAT (1995) recommends that correctional staff be trained in cultural diversity and issues specific to the cultural groups they serve. This training should include—

- Education about stereotypes and biases.
- How language and terminology perpetuate stereotypes.
- Diversity within groups.
- How cultural beliefs relate to alcohol and drug use and criminality.
- The effects of alcohol and drugs on women and stereotypes about women who are alcohol or drug abusers.

- The effects of intolerance on gay men and lesbians seeking treatment.
- The effects of biases about economically deprived offenders.

During an assessment, staff should gather information about how the individual views his or her own race, culture, subculture, and sexual orientation (CSAT, 1994). The accuracy of the assessment depends in part on the assessor's ability to be open and not make assumptions about an individual's self-concept simply by virtue of his or her belonging to a particular group. Inmates should be asked directly what they feel and think about being a member of their culture or group.

To improve competency in assessing minorities and other ethnic or cultural groups, the assessor—

- May need to perform the evaluation in the language of the inmate.
- Must be sensitive to a client who may need to communicate in street language.
- Should use language that is easily understood by the inmate to engage him or her in the process.
- Should be aware of the importance of the inmate's cultural identity and that his or her acculturation into the dominant culture may vary.
- Should not rely on presuppositions about what an individual's culture of origin means to him or her.

Screening and Assessment of Women Offenders

The screening and assessment of female inmates is particularly significant given the growing numbers of women in state prisons and the higher incidence of mental illness and substance abuse disorders when compared with male inmates (Bureau of Justice Statistics, 1999). For example, an estimated 19 percent of female jail detainees are diagnosed with schizophrenia, bipolar disorder, or major depression compared with 9 percent of male detainees (Teplin,

1994; Teplin, Abram, and McClelland, 1996). A history of prior physical or sexual abuse is reported by 30 percent of mentally ill male inmates and 78 percent of female inmates (Bureau of Justice Statistics, 1999). An often-cited study that randomly sampled nearly 1,300 detainees awaiting trial at the Cook County Jail (Teplin, Abram, and McClelland, 1996) found the following:

- More than 80 percent of women detainees suffered from one or more lifetime psychiatric disorders.
- More than 70 percent of women offenders were alcohol or drug dependent.
- 34 percent of women offenders suffered from posttraumatic stress disorder (PTSD).
- Almost 17 percent of women detainees had experienced an episode of major depression in their lives.
- As many as 14 percent of women detainees had a depressive episode in the 6 months before arrest.

In the most comprehensive survey of women offenders ever conducted in U.S. prisons, approximately 40 percent reported a history of physical or sexual abuse (Bureau of Justice Statistics, 1994). Female inmates were three times more likely than male inmates to report past abuse and six times more likely to report past sexual abuse. In one California Department of Corrections study (Bloom, Chesney-Lind, and Owen, 1994), 80 percent of women offenders reported experiencing physical, sexual, or emotional abuse.

Screening and assessment of women offenders, therefore, need to be particularly sensitive to the presence of mood symptoms (predominantly depression) and anxiety symptoms (predominantly PTSD). The high prevalence rates of abuse and the symptoms of PTSD that sometimes result make adjustment difficult for these women. In addition, leaving abused women offenders unidentified and untreated can lead to serious management problems for correctional staff. Women offenders with PTSD

may have problems directly associated with their history of abuse such as difficulty interacting with male authority figures who remind them of their abusers, being physically restrained, and being unclothed (Veysey, 1998). In addition, symptoms associated with PTSD, such as hypervigilance (constant scanning of the environment for danger), an exaggerated startle response (physical overreaction to loud noises or sudden movements), phobias, auditory and visual flashbacks, and anger/rage reactions, can have a significant impact on the way these women relate to others and on the safety and the security of the facility. Specialized instruments facilitate early and accurate identification of these symptoms (see appendix).

Women offenders also may feel inadequate as mothers, wives, and working women, which requires additional considerations for the screening process (CSAT, 1994). CSAT recommends that staff assess the following aspects of women offenders' lives:

- Parenting skills.
- Prenatal care and birth control practices.
- Responsibilities for child care and the care of other dependents.
- Roles within the family and how they relate to the women's cultural identity.
- A history of violence or rape.
- Employment and income history and how it relates to hazardous and criminal behaviors (e.g., prostitution, selling drugs).
- Opportunities for education and intellectual growth.

METHODS AND TOOLS FOR SCREENING AND ASSESSMENT

Drug Testing

Drug testing, urinalysis, and toxicology screening are integral components of comprehensive screening

and assessment for substance abuse (Peters and Bartoi, 1997). Although other methods of detection can evaluate the presence of drugs and alcohol (e.g., hair analysis, sweat patches), they generally are not used in correctional settings. Regular drug testing can—

- Alert staff to the presence of inmate substance abuse.
- Help detect relapse during treatment.
- Increase inmates’ motivation to remain abstinent.
- Reduce substance abuse in the facility.

Because most drugs and alcohol are detectable through urinalysis for relatively short periods of time, testing should be carried out frequently throughout the period of incarceration. (For example, alcohol is eliminated from the body within several hours and cocaine within 72 hours.)

Drug testing should follow established procedures or guidelines that promote reliability and validity of results and should include—

- Direct visual observation of the collection of the urine sample where possible. Exceptions should be made for “shy bladder.”
- A determination of water loading that might taint a sample.
- The documentation of chain of custody for the samples collected.
- The verification of drug testing results if they are contested.
- Treating refusals to submit and tainted samples as positive test results.
- Testing for major drugs of choice and alcohol (usually a breath analysis).
- Testing for the most commonly used drugs in the institution’s geographic area.
- Testing for the most common drugs in correctional settings, including marijuana, cocaine, opiates (e.g., heroin), PCP, and amphetamines.

Screening and Assessment Instruments

Screening for Co-occurring Disorders

For mental health disorders (choose one)

- Brief Symptom Inventory (BSI).
- Referral Decision Scale (RDS).

For substance abuse disorders (choose one)

- TCU Drug Dependence Screen (DDS).
- Simple Screening Instrument (SSI).
- Alcohol Dependence Scale (ADS) and Addiction Severity Index (ASI) (drug use section)

This combined screening takes approximately 10 to 15 minutes to administer and score. If additional time is available, also use the Beck Depression Inventory (BDI) to obtain a more detailed screening of depression.

Screening for Motivation and Readiness for Treatment (choose one)

- Circumstances, Motivation, Readiness, and Suitability Scale (CMRS).
- Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES).
- University of Rhode Island Change Assessment (URICA) Scale.

Assessing Co-occurring Disorders

For mental health disorders (choose one)

- Minnesota Multiphasic Personality Inventory–2 (MMPI–2).
- Millon Clinical Multiaxial Inventory–III (MCMI–III).
- Personality Assessment Inventory (PAI).

For substance abuse disorders

- Addiction Severity Index (ASI).

This combined assessment takes approximately 3 hours to administer and score.

Instruments for Interviewing and Test Measures

Peters and Bartoi (1997) examined many instruments and tests available to screen and assess co-occurring mental health and substance abuse disorders among inmates. Each instrument's overall reliability and validity, as well as its validity for use in criminal justice (versus community) settings, were evaluated, along with costs, scoring procedures, and training required for staff to administer the tool (see their recommendations in "Screening Instruments", see p. 22). Instruments to screen for motivation and readiness for treatment are also recommended by Peters and Bartoi (1997).

When screenings indicate the presence of symptoms of mental health/substance abuse disorders, an assessment should follow to elucidate the specific diagnosis, the history of each mental health and/or substance abuse disorder, and a more thorough understanding of their interaction. The assessment also assists in developing an individualized treatment plan to effectively treat the conditions.

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MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT

MENTAL HEALTH TREATMENT

A number of court rulings affirm that prison inmates are entitled to mental health care equal to that available in the community. Yet, few if any prisons are able to offer a comprehensive array of mental health services for all inmates who may require or request them. Limitations of mental health staff and resources force most prison officials to prioritize inmates with the most severe impairments and dangerous and disruptive symptoms. Inmates with adjustment disorders and less severe mental health problems may wait lengthy periods for treatment or get no treatment at all.

Ruiz v. Estelle (1980) established the minimum components needed to deliver adequate mental health treatment in prison, including the use of trained mental health professionals in sufficient numbers to identify and treat inmates who are mentally ill (Metzner, 1993). But determining who gets treatment, what types of treatment are appropriate and in what amounts, who should deliver treatment, and how treatment gets delivered are major decisions for correctional administrators and their health administrators. These decisions have important ramifications for the health and safety of inmates and staff, costs to the facility, and legal liability.

National Standards and Guidelines

Although the courts do not mandate the use of any particular mental health service delivery model, they do expect correctional facilities to maintain policies and procedures that will reduce needless suffering

and allow access to needed services (Cohen and Dvoskin, 1992). Several national organizations have created guidelines for the establishment of adequate mental health systems in prisons and provide recommendations for treatment.

American Psychiatric Association. The American Psychiatric Association (APA) (2000) guidelines recommend that a variety of biological and psychological therapies be available to treat mental health disorders that significantly interfere with an inmate's ability to function in prison. Treatment should be multidisciplinary, eclectic, and consistent with generally accepted mental health practices and institutional requirements. APA's guidelines require the following components to be available:

- A crisis intervention program with infirmary beds available for short-term treatment (less than 10 days).
- An acute care program (inpatient treatment for inmates with significant psychiatric symptoms that interfere with their ability to care for themselves).
- A chronic care program (a special housing unit for inmates with a chronic mental illness who do not need acute inpatient care but cannot function adequately within the general population).
- Outpatient treatment services.
- Consultation services (including consultation with other prison officials and departments and the training of officers and program staff).
- Discharge/transfer planning (including both transfer to other institutions and release to the community).

National Commission on Correctional Health

Care. APA's guidelines were designed to be used in conjunction with the standards developed by the National Commission on Correctional Health Care (NCCHC) (Anno, 2000). In addition to issues of care and treatment, NCCHC standards address administrative and personnel issues, support services, special needs and services, health records, and medical-legal issues. Care and treatment issues stipulated by NCCHC include the following:

- Inmates must be screened for mental health problems by a qualified health professional within 2 hours of admission.
- Inmates must be informed within 24 hours of arrival of the types of mental health services available and how to access them.
- Inmates must have a health appraisal within 7 days of arrival that includes taking a history of any prior mental health problems, hospitalizations, psychotropic medications, suicide attempts, and alcohol and other drug abuse.
- Inmates must receive a mental health evaluation within 14 days of arrival that includes a complete mental health history and current mental status and screening for mental retardation and other developmental disabilities.
- Treatment plans must be created for inmates who are identified as having serious mental health needs and who are developmentally disabled.
- Inmates should be seen by a qualified professional within 48 hours of a request for nonemergency mental health services (72 hours on a weekend).
- Prison procedures must address psychiatric emergencies and suicide attempts.
- Mental health treatment should occur in private (except for high security risks) and with respect for the offender's dignity and feelings.

Metzner (1993) has integrated several sets of national guidelines and recommends to organizations developing a comprehensive mental health system

Issues To Be Addressed in a Prison's Comprehensive Mental Health System

- A mission and goals.
- Administrative structure.
- Staffing (e.g., personnel, credentialing, job descriptions).
- Reliable and valid methods for identifying inmates with severe mental illness.
- Treatment programs available to inmates.
- Involuntary treatment, including the use of seclusion, restraints, forced medications, and involuntary hospitalizations.
- Medical/legal issues, including informed consent and the right to refuse treatment.
- Confidentiality.
- Mental health record requirements.
- A quality assurance and improvement plan.
- The training of mental health staff regarding correctional and security issues.
- The formal training of correctional staff regarding mental health issues.
- Research protocols involving human subjects.

that their policies and procedures address 13 issues (see "Issues To Be Addressed in a Prison's Comprehensive Mental Health System").

Informed Consent and the Right To Refuse Mental Health Treatment

Although APA, NCCHC, and other guidelines exist to ensure that offenders receive adequate mental health treatment, the right of inmates to refuse mental health treatment also must be addressed by policies and procedures in prison settings. This right to refuse treatment is inherent in the notion of *informed consent*, which NCCHC (1999) defines as follows:

...the agreement by a patient to a treatment, examination, or procedure after the patient receives the material facts about the nature, consequences, and risks of the

proposed treatment, examination, or procedure, and the alternatives to it. (p. 113)

Informed consent, a familiar concept in community health care, should become a standard part of mental health care in prisons, in accordance with each state's laws.

The right to refuse treatment in prisons usually involves forced medications but can also involve counseling or other less intrusive mental health interventions. Although the federal courts have been reluctant to recognize the broad right of offenders with mental disorders to refuse treatment, they allow for states to expand on this right, which a number of state courts have done (Hafemeister, 1998). It is therefore critical that prison administrators create policies concerning the right of inmates to refuse treatment that conform to court rulings of the jurisdiction in which the facility is located (APA, 2000; NCCHC, 1999).

If an inmate invokes his or her right to refuse a mental health intervention or treatment, NCCHC recommends the following:

- The refusal should be in written form.
- The refusal should specify the condition for which the treatment was offered.
- The refusal should specify the procedure that was to be provided.
- The refusal should be made directly to health care staff.
- The refusal of a specific treatment should not be considered a “blanket” refusal for all treatments.
- A refusal at one point in time should not be considered a refusal for subsequent care.
- Health care staff should counsel an inmate against refusing treatment when they consider the treatment to be in the inmate's best interest.

There are exceptions to the need for informed consent. When, for example, mentally ill inmates pose an imminent danger to themselves or others, they can

be treated despite their refusal. These exceptions should be clearly delineated in written procedures.

Scope of Mental Health Treatment in Prisons

The National Institute of Corrections (NIC) conducted a survey of 49 state departments of corrections (DOCs), the Federal Bureau of Prisons, and correctional agencies in Canada, Guam, and Puerto Rico to study the range of services provided to meet the mental health needs of inmates (NIC, 2001). The survey found that—

- Many state DOCs distinguish between inmates with serious mental illness and inmates with other mental health needs.
- Some DOCs provide mental health care to all inmates with mental health needs, regardless of the severity of their condition.
- Although all DOCs typically emphasize treatment for those with significant mental illness, many provide treatment (usually counseling) for inmates who have other mental health needs and who request such services.
- Depending on the formal diagnosis or other mental health classification, an institution may vary the type, level, and intensity of treatment (e.g., individual versus group, medication versus therapy, inpatient versus outpatient housing).
- Inmates who do not have an acute mental illness will typically receive less than 1 hour per week of mental health counseling.
- Most DOCs use formal criteria to determine when inmates need to be housed in a special unit or apart from the main population due to mental health concerns.
- When inmates are acutely symptomatic, they are typically housed in infirmary units or other settings that allow for close supervision by health care staff.

- Some DOCs house mentally ill inmates who require inpatient treatment in special units within their prisons; some designate entire facilities to house and treat them; others house them in outside hospitals run by other state agencies.

Most state correctional facilities use residential treatment units designed to house inmates with chronic mental illness separate from the general inmate population and to provide a range of structured therapeutic interventions. These units are often referred to as “transitional care units” or “intermediate care units” because inmates function at a level between those in the general population and those in a hospital. This type of unit has been shown both to dramatically improve the quality of life for mentally ill inmates who are more vulnerable to the predatory behaviors of other nonmentally ill inmates and to make the prison more safe (Cohen and Dvoskin, 1992). Inmates are placed temporarily in these residential units, for example, when being moved between inpatient hospitalization and the open population. They are placed in such units permanently when their mental illness prohibits them from ever being safe in the general population. These therapeutic units should be self-contained and equipped both to provide standard services and to offer the treatment and programming necessary for their special needs, such as individual and group therapy, medication, and such recreational and vocational activities as art therapy and music therapy when possible (Metzner et al., 1998).

Mental Health Treatment Modalities

In the community as well as in correctional settings, four basic forms of clinical intervention are used to treat mental health symptoms and the functional impairments that result from mental health disorders: psychotropic medication, individual psychotherapy, group psychotherapy, and family intervention.

Psychotropic Medication. Medications are effective and important treatment interventions within prison settings (see chapter 7, “Psychopharmacological

Intervention for Psychiatric Disorders” for more detail). Generally, Metzner and colleagues (1998) recommend that—

- The use of psychotropic medications be consistent with community standards (i.e., according to the same practice guidelines followed by health care professionals when treating the general population in the community).
- All classes of psychotropic medications be available to inmates (although the availability of certain medications that are often abused should be limited).
- Psychotropic medications be dispensed by licensed health care professionals, not by correctional officers or other inmates.
- Psychotropic medications be dispensed in single doses.
- Psychotropic medications be prescribed only in the context of an adequate clinical examination.

Individual Psychotherapy. Individual psychotherapy often is not as available as other forms of treatment within prisons because of limited resources. However, therapy can benefit the overall mental health and coping ability of individuals with mental illness in prison settings, and supportive individual psychotherapy for those with serious mental illness should be available. In addition, when individual psychotherapy can be provided to a larger population than inmates with severe mental illness, other issues, such as the inmate’s ability to safely adapt to the facility, can be addressed. Common therapy issues in correctional settings relate to feelings of helplessness and apathy as a consequence of incarceration and attempts to adapt to violence, intimidation, and sexual or financial exploitation (Metzner et al., 1998). Grief and loss can be particularly difficult for offenders to deal with when they learn of family members who have died or broken off all contact with them. Research also suggests that—

- Individual psychotherapy can be provided in outpatient, inpatient, or special treatment settings.

- Individual counseling should focus on psychoeducation and developing improved coping strategies.
- Cognitive-behavioral interventions are typically the most beneficial to help inmates who deny and externalize responsibility.
- Inmates with borderline personality disorder, posttraumatic stress disorder, and dissociative disorders may benefit from longer term individual psychotherapy (Metzner et al., 1998).

Group Psychotherapy. Group therapy is the most often used treatment intervention in prison settings in part because it is the most cost effective. Group therapy can also be provided in outpatient, inpatient, or special treatment settings and can help inmates—

- Realize they are not unique in having emotional and mental health problems (Metzner et al., 1998).
- Develop interpersonal and communication skills.
- Develop anger management skills.
- Learn how to cope with alcohol and substance abuse.
- Learn about mental illness and psychotropic medications.

Professionals from various disciplines (e.g., social work, psychology, nursing) may be qualified to provide individual and group psychotherapy. These individuals, however, should possess the necessary education, training, licensure, certification, and experience to qualify them.

Family Intervention. Although family therapy is not regularly offered in state correctional settings, a variety of studies have found that increased contact between inmates and their families can contribute to an inmate's successful reintegration into the community after release (NIC, 2002). Prison programs and family visitation can help to encourage healthier family relationships and develop a critical element in the offender's postrelease support system, which in turn may lead to more successful reintegration and a

reduced risk for reoffending. Family involvement can be especially helpful for offenders with mental illness as transition issues for these inmates are often even more complex and stressful. Treatment staff can arrange for supervised family visits and psychoeducation can be provided to the family. These sessions often yield important historical data that can make prison interventions more successful interventions and better prepare the inmate for release.

Mental Health Staffing

Guidelines and standards from national organizations such as the American Public Health Association (APHA), APA, and NCCHC do not stipulate how many or what type (i.e., from which discipline) of mental health or substance abuse professionals should be employed by each prison. They recommend only that there be qualified mental health professionals at sufficient levels to ensure that inmates can receive the treatment equal to contemporary standards of care (Metzner, 1993). Very little empirical data exist to help administrators select a particular staffing model for providing mental health services to inmates (Rice and Harris, 1993; Dvoskin and Patterson, 1998). The numbers and types of mental health care providers required at any particular facility depend on the number of inmates being treated, the particular needs of those inmates, and the scope of services being offered (e.g., inpatient, outpatient, special programs) (NCCHC, 1999). It is recommended, however, that the professionals providing mental health and substance abuse services meet the state licensure, certification, and registration requirements necessary to practice outside of the prison setting so as not to compromise the quality of care provided to inmates (NCCHC, 1999).

Treatment of Antisocial Personality Disorder

Some clinicians consider antisocial personality disorder to be untreatable (Maier and Fulton, 1998), and many DOCs will not provide treatment for it when it is the only presenting problem. Some research has

shown, however, that certain treatments can be effective in reducing antisocial behaviors (Gacono et al., 2000). The most frequently used interventions recommended for the treatment of antisocial personality disorder in prison are based on cognitive-behavioral strategies and social learning principles.

One widely used cognitive-behavioral approach to treat antisocial personality disorder focuses on getting the inmate to accept responsibility for his or her behavior (Yochelson and Samenow, 1976). This approach relies on psychoeducation and skills-building interventions to help inmates identify their distortions and errors in thinking. Treatment focuses on teaching inmates the relationship between these criminal thinking errors and their criminal (i.e., irresponsible) behavior. If thinking errors are eliminated, the expectation is that prosocial behaviors are more likely. Inmates correct their thinking errors through daily journal writing that details their thinking process and group therapy where they can be directly confronted about their criminal thinking patterns and the resulting behaviors.

Therapeutic communities, based on a social learning model, are used to treat antisocial personality disorder (De Leon, 1985). Inmates in these specialized communities are taught that they are residents or family members and that they must follow the rules of the community, submit to the authority of the group, and suffer sanctions imposed by the group when they violate the community's principles and values. Therapeutic communities are not routinely created in prison settings for the primary treatment of antisocial personality disorder, however. They are generally used for the treatment of alcohol or drug abuse disorders, but they can help to mitigate the antisocial personality traits of offenders because they emphasize prosocial values.

Treatment Planning

Regardless of the specific treatment or setting where services are delivered, an individualized treatment plan is essential to the provision of prison-based mental health services. The plan includes a

series of written statements that address key components of the inmate's mental health issues and treatment (Metzner et al., 1998). A treatment plan should include—

- An objective description of the problems the inmate faces as a result of mental illness.
- An objective description of short- and long-term goals of treatment.
- The types of therapeutic interventions that will be used to achieve those goals and how often they will be delivered.
- The providers who will deliver the treatment.

Treatment plans also can address interventions or activities to be provided by nonmental health staff that can be critical in helping inmates with mental illness function adequately and provide relief from symptoms. These interventions and activities may include attending school or vocational programs, recreational activities, family visits, and work assignments (Metzner et al., 1998).

Crisis Intervention Services

Offenders who require long-term mental health interventions and treatment are generally seen in residential units or at outpatient clinics. There are times, however, when emergency interventions for crisis situations must be provided to inmates who may or may not be receiving mental health services on a regular basis. Crisis intervention is needed when inmates' mental illnesses make them dangerous to themselves or others or leave them unable to adequately care for themselves. Most often, this is the result of an acute suicidal depression or an acute exacerbation of psychosis (Cohen and Dvoskin, 1992).

On these occasions, the success of the crisis intervention in preventing further psychiatric decompensation (the appearance or exacerbation of a mental disorder due to the failure of defense mechanisms) and in protecting the inmate and others depends on the timely response by staff and the ability to

provide the necessary services, including access to—

- Mental health screening and assessment.
- Psychotropic medications.
- Supportive psychotherapy.
- Crisis stabilization beds.

Long-term mental health treatment may or may not follow these crisis intervention services. At times, it is a crisis situation that first brings an inmate into contact with mental health staff. This may be true for several reasons: the inmate's initial screening and assessment did not reveal mental illness, the inmate's mental illness was in remission prior to the crisis, or the illness developed while incarcerated (Cohen and Dvoskin, 1992). When a crisis provides mental health staff with the opportunity to determine that a mental health disorder exists, the inmate should be referred to the appropriate level of ongoing services and treatment (e.g., outpatient, residential, hospital). Long-term followup is generally not required for inmates who return to their previous level of functioning after the crisis is resolved and for whom no significant mental illness is assessed to be present. However, one or two followup appointments with mental health staff may be judicious simply to ensure that the inmate can maintain the level of functioning he or she had prior to the crisis.

State prisons can meet the legal requirement of providing psychiatric hospital treatment for inmates who need extensive inpatient care using one of these three models:

- A prison psychiatric hospital, which is run by the mental health staff who work for the prison.
- An entire prison facility that serves as a psychiatric hospital designated to house and treat mentally ill offenders, which is run by mental health staff who work for the corrections authority.
- Outside hospitals usually run by other state agencies to which inmates are transferred until they can return to prison.

When deciding which model to use to treat inmates who require extensive inpatient care, administrators should consider which has the best funding, resources, continuity of care, and timely access to required services (Hafemeister, 1998). The benefits of using the first option, small psychiatric hospitals within the prison (Maier and Fulton, 1998), include the following:

- Less entrenched in excessive security.
- A greater level of trust.
- Better staff communication.
- Better opportunities for specialized treatment.

Case Management

A good deal of variability exists in the systems prisons use to deliver mental health services (Goldstrom, Manderscheid, and Rudolph, 1992; NIC, 2001). The particular model a state department of corrections uses often depends on such factors as the size and location of the system and the quality of the relationship between the DOC and the state's mental health department. One key component of the system should be case management, a process designed to effectively monitor and provide services to offenders with mental illness (Jemelka, Rahman, and Trupin, 1993).

Case management was first developed in the 1960s and 1970s as a way to help those with mental illness access the social and health services they need to function on a day-to-day basis in the community (Chamberlain and Rapp, 1991). At least five variations on case management have since been described, all based on the involvement of a professional who works closely with clients with mental illness to broker (and sometimes directly provide) a multitude of services the client may require. The traditional functions performed by case managers working with adults with mental illness are listed in "Typical Tasks Performed by Case Managers."

In correctional settings, case managers may be assigned to inmates who have mental health

Typical Tasks Performed by Case Managers

- Assessment of the offender's needs.
- Planning services to meet the needs identified through assessment.
- Advocating for the offender's needs.
- Linking offenders to the services identified by service planning.
- Monitoring the offender's progress in achieving the objectives detailed in the service plan.

disorders, alcohol or drug abuse disorders, or both (co-occurring disorders). In a prison, the community comprises the general, or open, population housing units and the various departments and programs that deliver services to the offenders. The case manager may need to broker between both correctional administrative systems (e.g., security, classification, housing) and treatment-oriented services and programs (e.g., education, vocation, health/medical, mental health, and alcohol and drug abuse services).

At one time, this brokering of services was the sum total of a case manager's job. Increasingly, it has been recognized that interventions with inmates who have mental illness need more intense involvement and that the relationship between the case manager and client should be emphasized (Chamberlain and Rapp, 1991). Case managers in a recent National Institute of Justice (NIJ) document (1999) reported that informal counseling with their clients was a vital component in their relationship. Further, with appropriate education and training, case managers also can provide treatment in the form of counseling and psychotherapy.

Case managers employed by state prisons may come from a variety of backgrounds and disciplines. Some facilities use trained mental health staff as case managers, while others rely on classification staff to fulfill the function. The use of case managers who also are trained mental health professionals provides services that meet or exceed most of the legal, correctional,

and professional standards established for the provision of mental health services. Requiring that case managers be properly trained mental health professionals also is consistent with national guidelines that recommend that the training and competence of the qualified mental health personnel employed in correctional facilities be equal to community standards (APA, 2000; NCCCHC, 1999).

To avoid a conflict of roles, clinicians who provide mental health treatment in forensic settings should not also provide correctional services (Metzner et al., 1998). Jemelka, Rahman, and Trupin (1993) provide guidance on effective case management:

Mentally ill offenders are best managed by an identified mental health case manager who is responsible for activating and monitoring a continuum of treatment and classification services to a caseload of mentally ill offenders. The purpose of this approach is to monitor each offender's individualized mental health treatment plan, and to regularly evaluate the adequacy and appropriateness of the plan, making modifications where necessary. Effective case management will ensure consistency of service delivery, and will monitor mentally ill offenders' progress, including changes in levels of functioning and treatment needs. (p. 15)

Prison-based case managers who work with offenders with mental illness perform the following activities:

- Create and monitor an individualized service plan or treatment plan that provides a detailed account of the inmate's multiple intervention needs.
- Assess the inmate's programming needs and refer the inmate to programs as appropriate.
- Meet regularly with the inmate to monitor and assess his or her psychiatric functioning and evaluate for decompensation.
- Provide counseling and psychotherapy.

- Refer the inmate to other mental health and medical staff as needed.
- Act as a liaison between classification, security, and health services.
- Provide information to security and classification staff to help them in their decisions regarding such issues as an inmate's housing and responsibilities.
- Communicate with various institutional staff who have contact with the inmate to help monitor his or her level of functioning.
- Plan for aftercare upon discharge from the prison and release back to the community.
- Communicate with the probation or parole agency.

Inmates with mental illness often fall through the cracks when they return to the community. Case managers can be instrumental in helping them obtain the services they need to best function outside the institution. APA guidelines (2000) emphasize this type of discharge and aftercare planning for offenders with mental illness to ensure continuity of care when they are released to the community and being transferred to another institution.

Case managers are responsible for the following aspects of discharge and aftercare planning:

- Arranging appointments at mental health agencies in the community for inmates who require mental health treatment upon release.
- Arranging for the continuation of psychotropic medications.
- Making other types of referrals, such as vocational rehabilitation, substance abuse services, self-help groups, and financial assistance.
- Helping inmates apply for public assistance and other benefits in preparation for release.
- Notifying staff at other facilities about the mental health needs of transferring inmates.

Staff Training

Prison-based case managers working with inmates with mental illness should possess, at a minimum, the skills needed by any successful prison staff member, including correctional officers (Rice and Harris, 1993).

Studies suggest that staff who are most likely to succeed with correctional or mentally disordered offender populations are those who use authority to enforce rules but in a nonconfrontational manner, who model prosocial (and anticriminal) attitudes and behaviors, and who are at the same time empathic and interpersonally skilled. (p. 110)

Line correctional staff assigned to work with inmates with mental illness are best prepared for this role if they receive the same training as direct care workers in psychiatric hospitals (Hafemeister, 1998). Correctional officers can be highly effective when they are trained to—

- Understand that simply listening and talking to mentally ill inmates may resolve crises.
- Understand that frequent contact by staff, even brief contacts, can help calm confused and anxious inmates.
- Provide accurate information about the institution and how to access mental health services to inmates.
- Observe and record inmate behavior.
- Receive and relay inmate requests for assistance from mental health staff.
- Consult with mental health staff about mental issues.
- Monitor inmates who take psychotropic medications for compliance and side effects.
- Identify the early signs and symptoms of mental illness and implement suicide prevention (Hafemeister, 1998).

Basic training for all correctional staff should therefore include the following information:

- How to recognize the early signs and symptoms of serious mental illness and suicide.
- The nature and effects of psychotropic medications.
- The mental health services available in the prison.
- How and when to make referrals to mental health services (Cohen and Dvoskin, 1992).

Case managers should demonstrate the ability to—

- Establish rapport with inmates.
- Educate inmates about the institution and its mental health services.
- Link inmates to other services and departments.
- Link inmates to community services on release.
- Prepare treatment plans.

SUBSTANCE ABUSE SERVICES

Reports from state and federal prisons indicate that as many as 80 percent of criminal offenders have an alcohol or drug abuse problem (NIC, 1991).

In 1991, a report of the NIC national task force on correctional substance abuse strategies recommended the following:

- Institutions should provide a range of services, from drug education to intensive residential programs, for substance-abusing offenders.
- Services should include assessment, self-help groups, drug education and information, counseling, comprehensive drug treatment, and intensive therapeutic communities.
- Frequent and random urinalysis should be employed in conjunction with all treatment approaches as a strong deterrent to relapse for drug-dependent offenders.

- Continuity of care is an important concern as offenders move through the system.
- Drug education should be provided to all offenders. The possibility of spreading acquired immune deficiency syndrome (AIDS) through intravenous drug use should be emphasized (NIC, 1991, p.8).

In addition, NIC recommends that prison-based alcohol and drug treatment includes the following components:

- An integrated staffing approach to delivering treatment.
- The cooperation of treatment and security staff to ensure program effectiveness.
- The sensitivity of treatment staff to security concerns.
- The education of security staff about substance abuse issues.
- The participation of community treatment and supervision agencies in mutual training and support activities.
- Incentives and sanctions to increase offenders' motivation for treatment to be included in all correctional substance abuse programs (see "Coerced Treatment for Substance Abuse Disorders").

Coerced Treatment for Substance Abuse Disorders

Although some clinicians and researchers argue against coerced alcohol or drug treatment on philosophical, constitutional, or clinical grounds, others believe that without external motivation or coercion, many chronic addicts would not enter treatment (CSAT, 1995). Limited empirical evidence suggests that coercion does not lessen treatment effectiveness and, further, that legal pressure may increase admission rates into programs and promote treatment retention (Simpson and Friend, 1988; Anglin, Brecht, and Maddahian, 1989; De Leon, 1988).

- The increased availability of self-help groups as an adjunct to treatment and as an integral part of aftercare (e.g., Alcoholics Anonymous, Narcotics Anonymous).
- Targeted treatment programs for special needs populations (e.g., women, pregnant women, HIV-positive inmates, sex offenders, elderly inmates, inmates with mental illness, minorities).
- Education and treatment for relapse prevention.
- Enhanced prerelease treatment programming.

Three interventions and services recommended by NIC—therapeutic communities, relapse prevention, and self-help support groups—are explained in further detail.

Therapeutic Communities

Therapeutic communities provide a comprehensive set of treatment interventions within a residential environment where inmates are usually segregated from the general population for 6 to 24 months. The therapeutic community philosophy, based on a social learning model, teaches that alcohol and drug abuse are disorders of the entire person. The main goal is a total change in the inmate's lifestyle that includes not only abstinence from alcohol and drug use but also the development of prosocial attitudes, values, and behaviors (CSAT, 1995). Therapeutic communities provide a comprehensive set of rehabilitation services for offenders and are generally reserved for the chronic alcohol and drug abuser. Some research suggests that, with appropriate followup on release, inmates treated in prison therapeutic communities have lower rates of reincarceration (Simpson, Wexler, and Inciardi, 1999). In addition, research suggests that treating alcohol- and drug-abusing inmates in prison therapeutic communities has a positive impact on prison management by reducing the number of disciplinary infractions committed by the inmates and thereby reducing prison management costs (Wexler and Lipton, 1991; Prendergast, Farabee, and Cartier, 2001).

Relapse Prevention Skills

Relapse prevention, rooted in social learning principles, explains relapse to alcohol and drug use as the result of a predictable series of cognitive and behavioral events (Hills, 2000). The offender is taught to identify his or her particular triggers and high-risk situations that can set into motion the gradual process of relapse (CSAT, 1993). After the triggers are identified, the inmate is taught how to avoid or overcome them through increased self-awareness, strengthened resistance, and positive coping strategies. Relapse prevention skills learned while incarcerated can be particularly helpful on release from prison, when offenders often are faced with limited community or family supports and significant deficits in educational and vocational skills and opportunities.

Self-Help Groups

Self-help groups such as Alcoholics Anonymous, Narcotics Anonymous, and Dual Recovery Anonymous often play an integral role in prison-based substance abuse programs and, like relapse prevention skills, they are often an important part of an inmate's postrelease planning. Support groups are not a formal treatment intervention and are led by inmates' peers in prison, just as they would be in a community setting. (In correctional settings, staff may be present to monitor or supervise.)

Self-help groups are appealing to correctional program administrators because they can be used as an adjunct to both outpatient and residential/therapeutic community prison-based programs. The NIC task force report (1991) states that:

Groups like Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) for offenders can support the effort to intervene in substance abuse by communicating strength and hope to offenders, who are often pessimistic about their future. These groups provide an alternative to a drug-involved system of relationships and can serve as an "adopted family" in which prosocial values and behaviors are supported. (p. 15)

Because traditional 12-step self-help groups are organized around a spiritual philosophy, it is important that organizations offer alternative self-help groups for inmates who might reject participation in them. The SMART Recovery model, for example, is based on the principles of Rational Emotive Behavior Therapy (REBT) (Ellis and Velten, 1992). SMART Recovery groups are led by peers, and members learn how to maintain and increase their motivation to quit, handle urges without acting on them, develop new ways of coping with problems, and create a healthy, balanced lifestyle.

CO-OCCURRING DISORDERS

Of the 16 percent of state prison inmates with a mental illness, 59 percent reported using alcohol or drugs at the time of their offense, and 34 percent have a history of alcohol dependence (Bureau of Justice Statistics, 1999). Although the terms “dual diagnosis” and “co-occurring disorders” refer to a spectrum of individuals who have more than one disorder, for the purposes of this discussion, inmates with co-occurring disorders are those who have a severe and persistent mental illness and a substance use disorder.

Inmates with severe and persistent mental illnesses who require alcohol or drug treatment in correctional settings are often excluded from the programs that serve the alcohol or drug dependent inmate (Hills, 2000). Programs sometimes exclude those who are taking psychotropic medications, and some inmates’ mental illnesses are exacerbated by substance abuse programs that use highly confrontational treatment methods. The Center for Substance Abuse Treatment (1994) has, therefore, recommended that this special population receive treatment separately from other offenders. Service needs also may be addressed, however, with crossover services or overlay programming when the development of independent and segregated programs is not possible (Hills, 2000).

The Federal Bureau of Prisons, Guam, Puerto Rico, the Correctional Service of Canada, and 37 state

DOCs offer specialized services for inmates who have co-occurring disorders (NIC, 2001). Three models of treatment are commonly used for the delivery of service to inmates with co-occurring disorders: parallel, sequential, or integrated treatment.

Parallel Treatment

In a parallel approach, the inmate receives mental health services from one or a team of clinicians to deal with the mental disorder and receives substance abuse treatment from another professional. The offender might be in a substance abuse program while also being carried on the caseload of a mental health provider. A case manager coordinates the two treatments by scheduling the sessions, attending the groups, and meeting with the treatment teams.

Sequential Treatment

Alternatively, an offender can be treated for mental health and substance abuse disorders sequentially; that is, the inmate receives treatment for one problem before the other is addressed. For example, a person might be told by a mental health professional that psychotherapy or psychotropic medications are not appropriate until a substance abuse counselor has been seen and the addiction is under control. Similarly, the substance abuse professional or treatment program might refer the inmate to the mental health department to have symptoms of anxiety or depression stabilized before treatment of the inmate’s addiction or abuse could begin. In criminal justice settings, the sequential approach is most commonly used (Hills, 2000).

Both the parallel and sequential treatment approaches may be adequate for offenders with less severe co-occurring disorders, but they are not the treatment of choice for inmates with severe and persistent mental illness.

Integrated Treatment

In 1997, the National Advisory Council of the U.S. Substance Abuse and Mental Health Services

Administration (SAMHSA) recommended that treatment for co-occurring disorders be integrated and that—

... the delivery of mental health and substance-related treatment and rehabilitation should be reorganized to provide integrated services that are responsive to the unique, complex interactivity of co-occurring disorders. (p. 23)

This integrated model calls for a single professional or team of professionals trained in both mental health and substance abuse to provide comprehensive treatment that addresses both disorders simultaneously. The inmate with a dual diagnosis has the opportunity to develop a trusting, therapeutic relationship with a single individual or team and can learn how to effectively deal with multiple conditions and their often complex interaction with each other.

An integrated treatment approach has numerous advantages; offenders—

- Are more likely to receive a consistent explanation of their conditions.
- Are less likely to receive contradictory or conflicting treatment strategies.
- Can expect greater continuity of care over time.
- Can expect treatment interventions to be specifically tailored for them based on their progress in the recovery process.

Hills (2000) recommends the following key principles be incorporated in corrections-based treatment programs for offenders with co-occurring disorders:

- Services should follow the integrated model.
- Both disorders should be treated as primary in importance.
- Individual programming should address the severity of symptoms and skill deficits.

- Psychopharmacological interventions should be used when appropriate.
- Phases of intervention should be tailored to the particular setting (e.g., prison-based treatment should take into account the length of the sentence).
- The treatment continuum must extend into the community.
- Support and self-help groups are critical in successful reintegration to the community.

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USE OF SECLUSION, SEGREGATION, AND RESTRAINTS

Finding safe, humane, and nonpunitive methods for handling inmates who are experiencing the symptoms of mental illness is an ongoing challenge for prison administrators. The nature of serious mental illness may create major problems for managing the behavior of these inmates. Some symptoms of serious mental illness may result in inmates' committing disciplinary infractions. Prison administrators must work to maintain order in their facilities but must also work to avoid penalizing inmates with mental illness for behavior that results directly from their illness. Inmates with mental disorders who do not fully comprehend the rules or who are unable to control their behavior often get into trouble and are punished even when they clearly have diminished responsibility, comprehension, or self-control (Faiver, 1998).

The American Psychiatric Association (APA) has expressed concern that inmates who have difficulty understanding or adhering to institutional rules as a result of their mental illness will find their way into segregation units unnecessarily in prisons with inadequate mental health services (APA, 2000). This concern is heightened when it comes to supermax facilities, as inmates could spend years in segregation in those units. Solitary confinement or extended segregation may cause extreme stress for a mentally ill person and can promote decompensation and exacerbate the illness (Faiver, 1998).

MENTAL HEALTH SERVICES IN SEGREGATION

As do other inmates, offenders with mental illness violate institutional rules and commit infractions that

would normally result in discipline, including segregation and confinement. Although administrators must ensure that such behaviors trigger appropriate consequences (lest inmates deduce that having a mental illness excuses disciplinary violations), caution must also be taken because segregation for mentally ill offenders can severely exacerbate their psychiatric symptoms. Segregation may be so anxiety provoking for some that they may go to extreme lengths to avoid it, including threatening or attempting suicide (Hafemeister, 1998). Given that offenders with mental illness will at times be placed in administrative or disciplinary segregation, mental health staff should be readily available onsite to identify inmates who are experiencing significant psychological problems and to provide an adequate level of services.

National Commission on Correctional Health Care (NCCHC) standards specifically stipulate that health care must continue to be made available to inmates in segregation (Anno, 2000). Routine checks (rounds) must be made by health staff at least three times a week for inmates in administrative segregation and daily for inmates in disciplinary segregation. Although the NCCHC standards do not address the frequency with which mental health staff should visit inmates in segregation, the APA has recommended that they make the rounds of segregated inmates at least weekly to check their mental status (Anno, 2000; APA, 2000). Anyone needing further evaluation or treatment should be referred for followup interventions and seen in an appropriate clinical setting.

APA (2000) recommends that, when inmates are in segregation for any reason, mental health staff should make a special effort to assess and address serious mental health needs because of the stressful

nature of segregated housing (see “Meeting Mental Health Needs in Segregated Housing”).

Meeting Mental Health Needs in Segregated Housing

- Inmates should not be confined in segregated housing units solely because they exhibit symptoms of mental illness.
- Segregated inmates must continue to receive any mental health services that mental health staff determine essential.
- Inmates in current, severe psychiatric crisis, including but not limited to acute psychosis and suicidal depression, should be removed from segregation until they are able to psychologically tolerate segregation.
- Inmates who have been identified as having serious mental health needs, especially those with severe and persistent mental illness, must be assessed regularly by mental health staff to identify and respond to any crises as soon as possible.

Unlike the NCCHC and American Correctional Association (ACA) guidelines, APA specifically recommends that mental health staff conduct regularly scheduled rounds in all segregation units and have contact with every inmate. APA also states that mental health staff need to communicate with security staff to help identify offenders who show signs of decompensation.

USE OF SECLUSION AND RESTRAINTS

Both seclusion and mechanical devices that restrain are used at times to protect mentally ill offenders from harming themselves and others. Because of the high potential for misuse of these devices (i.e., to control or punish an inmate rather than as a therapeutic intervention), specific and well-articulated policies and procedures must be in place to govern who can use them and under what conditions. When restraints are used for therapeutic interventions by

health and mental health staff, NCCHC standards stipulate certain requirements (Anno, 2000):

- The facility must have written policies and procedures governing their use.
- Only soft restraints may be employed.
- Only a physician or other health provider permitted by law may order restraints or seclusion.
- Health staff may only use restraints or seclusion as part of a treatment regime and not for disciplinary or custody reasons.
- Any single order for restraints or seclusion cannot exceed 12 hours.
- Inmates in restraints or seclusion must be checked at least every 15 minutes.

APA recommends that staff consider that many inmates, especially women, may have suffered from a history of abuse and trauma and may be retraumatized when secluded and restrained (APA, 2000). They recommend that the treatment team work together with the inmate to use other methods to manage behavior; for example, “much of the behavior that may seem to require restraints may be de-escalated by ‘talking the person down’ and understanding what is really going on” (p. 53).

APA recommends that correctional facilities follow their state mental health laws and professional practice guidelines when they determine their policies on medical and psychiatric seclusion.

The new ACA standards for health care (ACA, 2001) also stipulate that correctional institutions have policies and procedures that address the use of restraints for psychiatric reasons. These policies and procedures must include the conditions under which restraints may be applied, the types of restraints allowed, the staff qualified to decide when they are to be used because less restrictive measures would not be successful, the length of time they can be applied, documentation of efforts for less restrictive alternatives as soon as possible, and an after-incident

review. Although ACA guidelines state that all of these issues must be addressed, the specific details are left up to the organization to determine.

MENTAL HEALTH SERVICES IN SUPERMAX PRISONS

Supermax prisons are either freestanding facilities or distinct units within facilities that are designed to manage inmates who are violent or seriously disruptive. Because these inmates are a threat to the security of the facility and the safety of others, their behavior is controlled by separation, restricted movement, and limited access to staff and other inmates (NIC, 1999). In most of these facilities, programming, such as education, substance abuse treatment, anger management, and vocational training, is generally limited to video broadcasts and written correspondence. However, some facilities allow services to be delivered at the cell front, and some even allow small groups of inmates to gather in classroom settings close to the housing units.

In some states and jurisdictions, inmates with mental illness are excluded from supermax facilities; in others, they are not. Some supermax facilities have designated segregated units to house offenders with mental illness, while others provide mental health services within the main facility.

Many professionals believe the following NIC recommendations (1999):

Insofar as possible, mentally ill inmates should be excluded from extended control facilities. Each inmate being considered for such a facility should have a mental health evaluation. Although some mentally ill offenders are assaultive and require control measures, much of the regime common to extended control facilities may be unnecessary, and even counterproductive, for this population. (p. 12)

The isolation and deprivation in supermax prisons and their potential for inducing mental health problems has led many mental health professionals to oppose their use altogether. It is recommended that, at a minimum, mental health staff regularly visit all inmates in these facilities to determine their mental status and screen for signs of mental illness. Treatment for those who require it must be made available either at the supermax itself or elsewhere and should follow the policies and procedures for comprehensive mental health care that would be provided to any other inmate in any other correctional facility.

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SUICIDE PREVENTION

Perhaps nothing is more tragic and unsettling for prison staff and inmates than the suicide of an inmate. This event can shake an institution and leave doubts, fears, anxiety, recrimination, and anger in the minds of both staff and inmates for a considerable length of time. It is important for prison administrators to adopt the most effective standards and procedures to prevent suicides and manage suicidal inmates. Staff must be equipped to identify inmates who are at risk so they can intervene and prevent this tragedy.

Suicide remains a leading cause of death for prison inmates, ranking third among all deaths that occur in prisons (Bureau of Justice Statistics, 1993). However, since the 1960s significant advancements have been made in the prevention of suicide in U.S. correctional facilities (Lester and Danto, 1993). *Prison Suicide: An Overview and Guide to Prevention* (NIC, 1995) contains the most current data on prison suicide and its prevention, including a report on a 10-year survey of prison suicides conducted by the National Center on Institutions and Alternatives (NCIA) from 1984 through 1993. Important findings of this survey include the following:

- Suicides in prisons occurred at the rate of 21 per 100,000 inmates per year.
- Suicides in the general population occurred at the rate of 12.2 per 100,000 people per year.
- Suicides in jails occurred at the rate of 107 per 100,000 inmates per year.

- Prison suicide rates gradually and steadily declined throughout the country from 1985 through 1993.

Hayes (NIC, 1995) reviewed local, state, and federal studies on prison suicides and found common characteristics among prison inmates who successfully completed suicides (see “Risk Factors for Prison Suicides”).

The number of male inmates who successfully complete suicide greatly outnumbers the number of females who do so. For example, throughout the Federal Bureau of Prisons system, 43 inmates committed suicide from 1988 to 1992 (White and Schimmel, 1995). All 43 were male, despite that the number of females in federal prisons had increased to more than 7 percent of the total prison population during that period. In jails, male offenders committed 95 percent of suicides (Hayes and Rowan, 1988).

NATIONAL STANDARDS IN SUICIDE PREVENTION

Because suicide remains a leading cause of death for prison inmates, suicide prevention is generally addressed as a separate issue in most national correctional standards. Although prisons are not required by law to follow them, these standards help institutions minimize their legal liability (NIC, 1995).

Risk Factors for Prison Suicides

- The presence of significant mental illness.
- A prior history of suicide attempts.
- Having a lengthy sentence (20 years or more).
- Being 31 to 40 years of age (which is older than the age of most jail inmates who successfully complete suicides).
- Having institutional problems (e.g., being in protective custody).
- Being housed in a segregated or isolated housing unit.
- Being male.

American Correctional Association

The American Correctional Association (ACA) has developed the most widely recognized suicide prevention standards (Bonner, 2000). These standards require the following:

- A written policy and procedures to ensure that all special management inmates are directly observed at least every 30 minutes.
- More frequent observation for inmates who are violent or have a mental illness than for inmates who are not violent and do not have mental illness.
- Continual observation for actively suicidal inmates.
- A written suicide prevention and intervention program approved by a qualified medical or mental health professional.
- Training for all correctional staff in the suicide prevention and intervention program.
- Intake screening, identification, and supervision of inmates who may be prone to suicide.

National Commission on Correctional Health Care

Like ACA, National Commission on Correctional Health Care (NCCCHC) standards (1999) require a written suicide prevention plan. NCCCHC also suggests 11 essential components for such a program:

- **Identification.** Initial screening should include observation and interview data related to an inmate's potential suicide risk.
- **Training.** All staff should be trained to recognize verbal and behavioral cues that indicate suicide risk.
- **Assessment.** A qualified mental health professional should designate the inmate's level of suicide risk.
- **Monitoring.** The facility should develop a procedure for monitoring at-risk inmates that includes regular and documented supervision.
- **Housing.** Suicidal inmates should not be isolated unless under constant supervision. When constant supervision cannot be maintained, the inmate should be housed with another inmate or in a dormitory and checked every 10–15 minutes.
- **Referral.** Procedures should be developed for referring inmates who are at risk for suicide or have attempted suicide to mental health staff.
- **Communication.** Effective communication must take place between correctional and health staff about an inmate's status.
- **Intervention.** Staff should develop procedures on how to handle a suicide attempt in progress (e.g., first aid measures and how to cut down a hanging inmate).
- **Notification.** Procedures for notifying family, prison administrators, and other outside authorities regarding potential, attempted, or completed suicides should be developed.

- **Reporting.** Staff should document in detail all potential, attempted, or completed suicides.
- **Review.** The facility should perform administrative and medical reviews of completed suicides.

NCCHC also provides recommendations for the assessment, housing, and observation of suicidal inmates through a level system that allows for a more individualized approach to the problem of suicidal potential and behavior:

- **Level 1.** Inmates who have recently attempted suicide should be observed continuously in a safe and protected room.
- **Level 2.** Inmates at high risk for suicide based on current mental status and history should be placed in a safe and protected room and observed every 5–10 minutes.
- **Level 3.** Inmates at moderate risk (e.g., coming off level 1 or 2) should be observed by staff every 10 minutes when awake and every 30 minutes when asleep.
- **Level 4.** Inmates who have a significant risk history and could become severely depressed or suicidal should be observed every 30 minutes when awake or asleep.

National Center on Institutions and Alternatives

NCIA integrated the ACA and NCCHC standards and generated its list of the most critical features of any comprehensive suicide prevention program (NIC, 1995):

- Staff training.
- Intake screening and assessment.
- Housing.
- Levels of supervision.
- Intervention.
- Administrative review.

NCIA assessed how each state department of corrections (DOC) addressed these critical areas and cited model examples of each.

Staff Training. The need for proper training for all staff to recognize potential inmate suicides and respond appropriately is emphasized in the national standards of both ACA and NCCHC.

The key to any suicide prevention program is properly trained correctional staff, who form the backbone of any prison facility. Very few suicides are prevented by mental health, medical, or other professional staff because suicides usually are attempted in inmate housing units during late evenings and on weekends when inmates are outside the purview of program staff (NIC, 1995).

NCIA's analysis cited the Nevada Department of Corrections as a model organization that meets this particular standard. Nevada's policies stipulate both preservice training for all new employees, which teaches the identification and referral to mental health services of suicidal inmates, and an annual inservice training for current employees provided by mental health staff on advanced issues in suicide prevention. Nevada's procedure also specifies that this advanced training be provided annually for all staff including custody, program, and medical staff and that it cover—

- Signs and symptoms of a potentially suicidal inmate.
- Risk factors in evaluating a potentially suicidal inmate.
- The management of potentially suicidal inmates.
- The levels of suicide prevention.
- The administrative review of mental health issues.

Intake Screening and Assessment. Both ACA and NCCHC recommend that all inmates entering a correctional institution be screened and assessed for the potential for suicide.

The best assurance against suicide is screening all new inmates and continually monitoring individuals

found to be at risk throughout the critical first hours of incarceration (Atlas, 1989).

NCIA highlights the following Connecticut Department of Correction (Connecticut DOC) procedures for screening and assessment:

- Health services staff screen all inmates for obvious and subtle signs of the potential for suicide within 24 hours of admission to the facility.
- Any indication of potential suicide results in an immediate referral to mental health staff, who administer a suicide intake screening form.
- Mental health staff recommend appropriate followup, including housing and other referrals.
- Guidelines on suicidal risk are provided to staff to help them identify potentially suicidal inmates.
- All staff are educated to take seriously all suicide threats or attempts and all reports regarding a potentially suicidal inmate, even when the information comes from other inmates.

Housing. One of the most important and consistent findings in suicide prevention research is the strong correlation between segregation and successful suicide.

Overwhelmingly consistent research shows that isolation should be avoided whenever possible. NIC has stated, “Whether its use is disciplinary or observational, isolation can pose a special threat to inmates who have limited abilities to cope with frustration” (NIC, 1995, p. 7).

National standards are consistent: potentially suicidal inmates are to be housed in the general population or in a mental health or medical unit located close to staff whenever possible. Housing for potentially suicidal inmates should be designed to maximize staff interaction with them, and physical restraints and removal of their clothing should only be a last resort when there is imminent danger of self-destructive behavior. In addition, housing should be tailored to suit the level of an inmate’s suicide risk. NCIA cited the Virginia Department of Corrections

as meeting this standard because its policy for suicide prevention addresses these issues in an unambiguous manner.

Levels of Supervision. National standards support two levels of supervision for suicidal inmates: close observation, for inmates who have expressed suicidal ideation or have had a recent history of self-destructive behavior, and constant observation, for inmates who are threatening to or have engaged in an act of suicide. Inmates under close observation must be directly observed at least every 15 minutes, while those under constant observation must be observed continuously. NCIA cited the Connecticut DOC’s suicide prevention policy for its specific language on how to implement observation procedures (see “Connecticut Suicide Prevention Policy on Observation”).

Intervention. The promptness with which staff respond to a suicide attempt and the actions taken are critical factors in determining whether the victim

Connecticut Suicide Prevention Policy on Observation

Close Observation

- A 15-minute watch is used for inmates who have expressed suicidal thoughts but who are not actively suicidal at the present time.
- Officers must physically observe the inmate in staggered intervals at least every 15 minutes.
- An officer should enter the cell if necessary to determine the inmate’s status. A TV monitoring system cannot be used as a substitute but can supplement observation.

Constant Observation

- Continuous one-to-one observation is used for inmates threatening or engaging in suicidal behaviors.
- Officers must maintain a clear and unobstructed view of the inmate at all times.
- The officer must document the suicide watch on an Observation, Seclusion, and Restraint Checklist Form.
- TV monitors may be used as a supplemental tool but not a substitute.

will survive. National standards on intervention generally agree that—

- All staff who have contact with inmates should be trained in CPR and first aid procedures.
- Any staff member who discovers an inmate engaging in a suicide attempt must alert other staff, who should call for medical personnel and begin first aid and/or CPR.
- Staff must never presume an inmate is dead and must initiate and maintain lifesaving procedures until the arrival of medical staff (NIC, 1995).

The Louisiana Department of Public Safety and Corrections meets this standard; its procedures stipulate in detail the responsibilities and duties of the first and second officer on the scene, as well as the role of the supervisor and medical personnel. The department's procedures also state the type of equipment that must be immediately available to all officers on duty in the event that they must respond to a suicidal inmate.

Administrative Review. National guidelines from ACA and NCCHC recommend that the following steps be taken after a suicide:

- A critical review of the circumstances surrounding the event.
- A critical review of the facility's relevant procedures.
- A synopsis of the relevant training received by the staff who were involved.
- A review of the mental health and medical services provided to the victim.
- Recommendations for changes in policy and procedure, staff training, physical plant, and medical and mental health services as a result of the incident.

The Pennsylvania Department of Corrections' policy on administrative review serves as a model because it stipulates who will order the review, who will carry it out, how and why it will be conducted, what

information should be kept confidential, and what information should be shared with correctional staff for training purposes.

When an inmate takes his or her own life, the impact on corrections staff and other inmates can be dramatic (NIC, 1995):

One of the most tragic, debilitating events that can happen to a prison is an inmate suicide. It will shake your structure. The initial response is always—"What happened? Who was making the rounds? Did the inmate need mental health services?" (p. 40)

In the aftermath of a successful suicide, correctional staff from all departments can be emotionally and psychologically affected. In addition to experiencing grief over the loss of the inmate, staff can become preoccupied with thoughts of what could have been done to prevent the death and also can become anxious and fearful regarding the assigning of blame or responsibility. Inmates may respond with increased anxiety and begin to lose trust in the staff to keep them safe. When inmates begin to blame staff and act out their anxiety and anger, management problems can result. Staff debriefing and referrals to mental health counselors for both inmates and staff should be encouraged to help them cope with the event.

FEDERAL BUREAU OF PRISONS FIVE-STEP PROGRAM FOR SUICIDE PREVENTION

The Federal Bureau of Prisons (FBOP) has used a five-step suicide prevention program since 1982, which includes—

1. The initial screening of all inmates for suicidal potential.
2. Criteria for the treatment and housing of suicidal inmates.

3. Standardized recordkeeping, followup procedures, and collection of data relevant to suicides.
4. Staff training.
5. Periodic reviews and audits.

After the first 10 years of the program, FBOP inmate suicides decreased by 43 percent (White and Schimmel, 1995). Although a direct causal link between the implementation of the program and the reduction in suicides cannot be proved, it is logical to deduce a correlation. The authors believe that the written policy providing clear guidelines and unambiguous procedures was a key factor in this success. In addition, the National Institute of Corrections (1995) supports the FBOP program, stating the following:

While all aspects of FBOP's program might not be applicable in a particular setting, its basic structure provides the essential components of a responsive, professionally managed suicide prevention program that merits consideration by other correctional facilities and systems. (p. 56)

SUICIDAL GESTURES AND MANIPULATIONS

Prison administrators and correctional staff must differentiate those inmates who are genuinely distressed to the point where suicide has become a legitimate option in their minds from inmates who threaten suicide or make suicidal gestures (e.g., superficial cuts to wrists) to effect some change in their situation. Inmates may make such threats to receive attention and preferential treatment from staff, to be transferred to a medical unit or another prison, to avoid a transfer or court appearance, to maintain a facade of serious mental illness, and to gain the sympathy of family.

Regardless of the motivation, it is a serious mistake for prison officials to ignore inmates and their parasuicidal (intentionally self-harmful) behaviors for fear of reinforcing the manipulation. Further, it is even more egregious for inmates to be punished and isolated as a consequence. It is common for inmates who manipulate their situation by these threats or gestures to escalate their behavior in an attempt to achieve their goal and, in so doing, to die either accidentally or by miscalculating how the staff will respond (NIC, 1995).

Some clinicians believe it is meaningless to attempt to distinguish between manipulative and nonmanipulative suicide attempts (Haycock, 1992). In this view, there is no reliable basis by which to make this judgment and death can result in either case. Therefore, all inmates who express suicidal or parasuicidal intention or behavior should be treated according to the institution's suicide prevention protocols.

However, other forensic clinicians attempt to make this distinction and recommend different interventions accordingly (Haycock, 1989). For those inmates assessed to be genuinely suicidal, close supervision, social support, and access to psychosocial resources are recommended (NIC, 1995). For those believed to be manipulating for secondary gain, interventions should combine close supervision and behavioral management techniques to modify the behavior.

In the final analysis, all correctional staff share the responsibility for preventing inmate suicide. Inmate suicides are tragic events (Bonner, 2000) in which—

Fundamentally, the suicidal inmate suffers from a hopeless state of mind whereby emotional relief, future outcome, and reasons for living do not exist for the individual. (p. 375)

The challenge for correctional administrators is to provide staff the training and resources that put them in the best possible situation to help at-risk and hopeless inmates whenever possible and prevent this type of tragedy from occurring.

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TREATING WOMEN OFFENDERS

The characteristics of women offenders differ from those of men. The increase in the number of women in the justice system ought to bring with it more attention to their unique needs. Yet, there has been little movement to redesign services to be gender specific. This chapter highlights the unique needs of women inmates and describes several promising practices to meet them.

The number of women in prison is on the rise; some research indicates that, between the years 1984 and 1999, their numbers increased by 273 percent (Gilliard and Beck, 1996). Women offenders are a diverse group. Many of them are ethnic minorities, have had significant academic or educational difficulties, are survivors of child maltreatment or domestic violence, and have histories of substance abuse. In addition, many suffer from a sexually transmitted disease or other chronic health condition. Many women's involvement in the justice system exacerbates the difficulties they face due to their traumatic histories. The often punitive culture within the justice system may trigger a reliving of past traumatic events, which may cause them to present with symptoms associated with posttraumatic stress disorder.

According to the Bureau of Justice Statistics (Greenfield and Snell, 1999) women in prison tend to be unemployed at the time of arrest; high school graduates, recipients of a GED, or enrolled in college; and never married. More than 46 percent are African-American, 36 percent are white, and 14 percent are Hispanic. More than 75 percent of women have minor children, and 6 percent are pregnant

when they enter prison and in almost all cases are abruptly separated from their children after giving birth. Black and white offenders accounted for nearly equal proportions of women committing robbery, aggravated robbery, and aggravated assault.

Women inmates represent about 10 percent of the total criminal justice population and have higher rates of mental illness than men (Gilliard and Beck, 1996). Women involved in the criminal justice system are more likely than men to enter because of drug-related charges. According to the Bureau of Justice Statistics, almost half of the women in prison reported committing their offense under the influence of drugs or alcohol.

SUBSTANCE-ABUSING WOMEN OFFENDERS

Substance abuse offenses are increasing at greater rates for women than for men within the correctional population. The ethnicity of women who are involved in the criminal justice system and who have histories of substance abuse is significant. For example, 60 percent of substance-abusing women in California state prisons in 1994 were women of color, including 31 percent African American, 25 percent Latina, and 3 percent Native American. Health risks are very high for women offenders, regardless of ethnicity (Taylor, 1996). In addition, women offenders with histories of drug addiction reportedly have low self-esteem and are isolated, anxious, depressed, and cut off from their feelings.

Treatment implications for women offenders who are substance abusers include the following:

- Women who are substance abusers have specific medical, vocational, psychosocial, educational, transportation, and childcare needs.
- Women who are substance abusers have experienced female gender socialization, which limits their skills in identifying and asserting their personal needs. Many women come from families with a high incidence of mental illness, suicide, substance abuse, and violence. Others are victims of incest, rape, and physical abuse.
- Many women who are substance abusers suffer from low self-esteem, depression, anxiety, isolation, and detachment, which suggests that interventions should be designed to build on women's strengths.

WOMEN OFFENDERS WITH HISTORIES OF VICTIMIZATION

On average, half of women in prison report histories of physical or sexual abuse at some point in their lives (Greenfield and Snell, 1999). Seventy-three percent of those who reported having an emotional condition had been sexually or physically abused. Women who have been abused may have difficulty dealing with restraints, seclusion, and searches, which they may perceive as dangerous or threatening and which may result in retraumatization.

Many women offenders are passive, dependent, and subservient to men. They feel powerless, rarely assume responsibility for their lives, and frequently come under the control of men, usually other offenders. Many report physical battery and psychological abuse by husbands and partners. Dependency, low self-esteem, high levels of anxiety, limited interpersonal and resource networks, and difficulty negotiating with others are consistently reported to be more common in drug-dependent women than in men with similar drug problems (Taylor, 1996).

Many women with histories of trauma have been diagnosed with co-occurring mental health and substance abuse disorders. Treatment methodologies must focus on both the residual effects of the trauma and the women's subsequent mental health and substance abuse issues. This integration of approaches will enable a path to health and recovery.

INCARCERATED WOMEN AND THEIR CHILDREN

The majority of women in prisons are mothers. The Bureau of Justice Statistics (Greenfield and Snell, 1999) reported that more than 75 percent of women in prisons had children under the age of 18. African American and Latina women were more likely than white women to have children under age 18. The majority of women under correctional supervision have minor children; two-thirds of women in state prison and one-half of those in federal prison had children in their care prior to their incarceration (Greenfield and Snell, 1999).

More than 1.3 million minor children are offspring of women under correctional sanction, and more than 250,000 of these children have mothers who are serving time in prison or jail (Greenfield and Snell, 1999). Women bear more physical, financial, and emotional responsibility for their children than do men and, as a result, separation from children during incarceration is particularly traumatic. Contact with children and families is sporadic. Institutional visits are few, and children often are afraid to go to prison to visit their mothers. The predominant form of communication between mothers and their children, when it occurs, is by telephone.

Due to the limited number of gender-specific correctional facilities, women are ordinarily much farther away from home and family than the average male prisoner. This increased distance causes substantial transportation problems for children of prisoners and as a result deprives women prisoners of contact with their children.

PROMISING PRACTICES FOR WOMEN OFFENDERS

Due to the prevalence of co-occurring substance abuse and mental health disorders among women victims of violence, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) conducted the Women, Co-Occurring Disorders and Violence Study in partnership with its Center for Mental Health Services, Center for Substance Abuse Treatment, and Center for Substance Abuse Prevention. The study's goal was to identify promising practices for the treatment of women with co-occurring disorders who also have histories of violence. Although the study did not address treatment during incarceration, the attributes of successful treatments that address the specific needs of women with both co-occurring disorders and histories of violence can and should be applied to all systems that provide intervention to women, including the justice system.

The SAMHSA study reported that treatment for women with co-occurring conditions and histories of violence works best when it contains the following four components:

- Focus on each individual woman's strengths.
- Acknowledge a woman's role as a parent.
- Improve interactions between the parent and child.
- Use a comprehensive approach to coordinate specific types of treatment for the mother and her children.

Focusing on Strengths

A woman with co-occurring disorders and a history of victimization has within her certain strengths that should be acknowledged and addressed during treatment: devotion to her children and strong motivation to protect them; compassion and empathy toward children vulnerable to loss, grief, and pain; and enormous courage and perseverance.

Acknowledging Women's Roles as Parents

Treatment provided to mothers with co-occurring disorders and histories of violence should acknowledge their roles as parents and incorporate maternal themes within individual and group therapies. Opportunities should be provided for regular, ongoing contact between mothers and their children.

Strengthening Parenting Skills

Education and parental support can improve a mother's parenting skills. During incarceration, correctional systems should provide ongoing parenting skills education and training to mothers to prepare them for family reunification after their release.

Parenting education, according to the SAMHSA study, should consider the following issues:

- Mothers may have inappropriate expectations for their children's behavior. They can improve their parenting skills by becoming aware of their children's developmental issues.
- Mothers may have lapses in empathy for children because they are absorbed with pressures in their own lives. When they are supported, mothers are able to better pay attention to their children's needs.
- Mothers may "reverse roles," causing them to look at their children for fulfillment of their own needs. Developing satisfying relationships with other adults may ease a mother's need to turn to her children for emotional sustenance.
- Some mothers use corporal punishment because they are not aware of alternatives. Providing them with other strategies increases their ability to manage their children's behavior.

SAMHSA also recommends that attention should be paid to mothers' struggles with issues of shame and guilt, which can exacerbate their mental health problems.

Using a Comprehensive Treatment Approach

The SAMHSA study recommends that the following should be considered to provide women with co-occurring disorders and histories of violence the treatment that addresses their unique needs:

- Issues of trauma, mental illness, and substance abuse should be interwoven to better integrate treatment.
- Treatment should be tailored to the developmental needs of each woman and the age of her children.
- Issues relating to historical involvement with other systems should be addressed; for example, custody, previous mental health and substance abuse treatment, and primary health history.

The overarching justification for integrating issues of parenting, mental illness, trauma, substance abuse, and violence into treatment is to improve outcomes for incarcerated women and their children. It is assumed that when mothers' needs are addressed, their children, consequently, will be affected. If the issues of substance abuse, mental illness, co-occurring disorders, trauma and violence, and maternal-child relationships are addressed during incarceration, there may be increased opportunities for women to be successfully integrated into their communities and reunited with their families.

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PSYCHOPHARMACOLOGICAL INTERVENTION FOR PSYCHIATRIC DISORDERS

Numerous medications were discovered in the second half of the 20th century that can diminish the symptoms experienced due to major mental illness. In the 1950s, drugs were accidentally discovered to be effective; today, drugs are “designed” by altering their chemical structures to produce new-generation medications that are more effective and have fewer side effects.

The use of medication to ameliorate symptoms of mental illness is an essential component of prison- (and community-) based mental health treatment. Their use in prison must be closely monitored because inmates have been reported to be overmedicated in some cases as a management strategy. Some inmates may seek out medication in the belief that it will give them a “high.” Although some psychotropic medications do result in mood changes or elevations, the vast majority offer no such experience. Folklore about their effects persist, however, and can lead to bartering and hoarding of certain medications by inmates. Close monitoring is essential in any case.

Although psychotropic medications are important in the treatment of severe and persistent mental illness, comprehensive mental health treatment involves additional components. These other interventions may vary depending on the inmate’s diagnostic presentation, but they typically include individual or group psychotherapy that focuses on acquiring psychosocial and daily living skills (see chapter 3, “Mental Health and Substance Abuse Treatment”).

CANDIDATES FOR PSYCHOPHARMACOLOGICAL INTERVENTION

In the prison population, persons with severe and persistent mental health disorders are often treated with psychotropic medications. Medications may also be used to treat a range of less severe mental health disorders or to reduce cravings associated with addictions. Medications help inmates stay calm, feel less angry or anxious, sleep better, and manage stress.

MAJOR CATEGORIES OF PSYCHOTROPIC DRUGS

Pharmacotherapies that act similarly are grouped into the following broad categories:

- Antidepressant agents should be used to treat severe forms of major depression and bipolar (depression + mania) disorder. Drugs in this category include tricyclic and selective serotonin reuptake inhibitors (SSRIs).
- Antipsychotic agents are used most commonly to treat forms of schizophrenia. Some of the newer generation medications are called atypical antipsychotics.
- Antianxiety agents are used in instances of significant presentation of anxiety symptoms that affect functionality. Some drugs in this category are not

allowed in correctional settings due to their potential for abuse.

- Mood stabilizers, or antimanic agents, can act to modulate symptoms of mania and aggressive impulses in patients with other disorders. Drugs in this category include valproic acid and divalproex sodium.

If all individuals diagnosed with a severe and persistent mental health disorder were on medication, no more than 15 percent of the total census of a prison would be prescribed medications from the categories described above. If rates of prescription exceed 25 percent of the total institutional population, it is likely that medication is being used for management or in response to inmate requests—not for symptoms that indicate a diagnosable mental illness (Maier and Fulton, 1998).

EFFECTIVENESS OF MEDICATIONS

A number of studies have shown the benefits of using psychotropic medications, particularly the newer ones, in correctional settings.

Clozapine, risperidone, and olanzapine, called atypical antipsychotic agents, are effective in forensic populations (Maier, 1992). An increasing body of evidence has found them to be “more efficacious in treating schizophrenic pathology than typical antipsychotics” (Baillargeon and Contreras, 2001: 51). Quetiapine (brand name Seroquel) is likewise receiving increased attention in correctional settings for the management of psychotic symptoms. Atypical antipsychotic medications typically are well tolerated and safer to use than some of the older medications.

Other studies done with corrections populations around the use of atypical antipsychotic medications have found the following:

- The noncompliance rate for inmates taking typical antipsychotics can be nearly double that for atypical antipsychotics (Roskes, 2000).

- Atypical antipsychotics are more cost effective or cost neutral than typical neuroleptics (Roskes, 2000).
- Atypicals carry a greatly diminished risk for movement disorders, thus lessening the need for side-effect medications, which have abuse potential in correctional settings (Burns, 2000).
- Atypicals have demonstrated their efficacy in decreasing hostility and aggression, which leads to a decreased use of seclusion and physical restraints, less expressed hostility and aggression, decreased inmate-on-inmate assaults and potential injuries, and improved ability to manage inmates (Burns, 2000).
- Clozapine, in particular, has been shown to reduce the risk of suicide in patients with schizophrenia (Burns, 2000).

A number of studies have shown the following benefits of using the newer antidepressants over older medications:

- Fewer and less severe side effects.
- Fewer deaths, especially suicide, associated with overdoses.
- Enhanced inmate compliance with taking medication, which leads to greater treatment success.
- Less potential to be valued by inmates as drugs of abuse (Metzner, 1999).

Some correctional mental health care systems restrict newer antidepressant medications and atypical antipsychotics from prison formularies for cost reasons, but this activity is often self-defeating. Many inmates find the side effects of older antidepressants so unpleasant that they discontinue taking the medications. This often leads to increased suffering and increased use of more expensive services, such as inpatient hospitalization or infirmary services. Because of the increased risk of suicide or lethality from overdose when using older antidepressants exclusively as frontline treatment, prisons risk increased liability when they try to save money by

offering cheaper but less effective medications. Finally, newer antidepressants and antipsychotics have become the accepted standard of care for civilian populations. Medications offered in correctional settings should be consistent with those available in the community.

RISKS OF MEDICATION USE

All medications, no matter how safe, carry the potential for side effects (see “Typical Side Effects of Psychotropic Medications”). This is, in part, why the American Psychiatric Association (APA) recommends that psychiatrists have the ability to prescribe all psychotropic medications. APA also recommends that medications be distributed by qualified medical personnel and that 24-hour nursing coverage be available wherever persons with acute psychiatric problems are held.

Typical Side Effects of Psychotropic Medications

- Akathisia: feeling restless, jittery, fidgety.
- Akinesia: feeling slowed-down, having no “mental energy.”
- Anticholinergic effects: dry mouth, blurry vision, trouble urinating, constipation, memory difficulties, confusion, hallucinations.
- Tardive dyskinesia: writhing movements of the hands, mouth, tongue.
- Sexual/menstrual effects: loss of drive, cessation of menses.
- Tremors: typically in the hands.
- Weight gain.

Source: Diamond, 1998.

Because most people taking these medications report some side effects, their use must be closely monitored. In some instances, additional medications are prescribed to reduce side effects. A cost-benefit analysis that measures the degree to which side effects are bothersome versus the drug’s benefit

must be done with each individual to determine whether to continue the drug or try another. Many persons with psychiatric disorders discontinue or refuse to take medications when they experience unpleasant side effects.

Some psychotropic medications are not well suited for correctional settings because they require more comprehensive medical monitoring. The following drugs can be prescribed only when laboratory facilities are available to regularly assess blood levels and possible side effects:

- Lithium carbonate.
- Clozapine.
- Medroxyprogesterone.
- Anticonvulsants.

In addition, adjustments and refinements to medication protocols can take 6 months or more with close monitoring of symptom changes. In inmate populations living in stressful circumstances, it may take even longer to bring symptoms under control. Prison authorities must address and accommodate issues of movement within the institution, access to medical staff, and the requirements of dosing schedules. Inadequate access to medical supervision while on medication can lead to inmates experiencing unpleasant or even dangerous side effects.

Inmates taking antipsychotic medications can experience difficulties with regulating their body temperature during hot weather. Those taking low-potency medications, such as clozapine or chlorpromazine, are much more likely to suffer from heatstroke; death can occur in otherwise healthy young men. Inmates taking these medications should have access to plenty of fluids and air-conditioned spaces during periods of hot weather (Diamond, 1998).

The use of certain medications in correctional settings should be limited due to their potential for abuse, which can include—

- The misuse of these medications by inmates with substance use disorders.

- Overuse to induce sleep.
- Bartering or selling for their effect on mood or cognition (perception of a “high”).
- Their potential for lethal use by persons who may be suicidal.

Drugs with a potential for abuse include all sedatives–hypnotics, benzodiazepines, and stimulant drugs.

PRESCRIPTION AND DELIVERY OF MEDICATIONS TO INMATES

The use of medications in a correctional facility should be consistent with use in the community; that is—

- Their prescription should occur only in the context of an adequate psychiatric evaluation.
- They should be dispensed by licensed health care professionals, not officers or inmates.
- Their inappropriate use includes excessive dosing or polypharmacy with the goal of inmate behavior control or population management.

As inmates near release, some institutions use self-medication programs, sometimes called keep-on-person strategies, which allow inmates to take personal responsibility for their medication and dosing schedule. Procedures and allowable medications vary by institution and are typically established collaboratively by the administration and psychiatric medical staff.

NCCHC prison standards (1997) outline recommendations for the storage and distribution of pharmaceuticals. These include—

- Maximum security storage for DEA-controlled substances, syringes, and other items that have potential for abuse.
- Maintaining control of medications under appropriate staff members and in a clean, safe, and dry environment.

- A review of storage and dosing methods by a pharmacist at least quarterly if no pharmacist is onsite.
- The use of medications only when clinically indicated and not for disciplinary reasons.

For cost-control purposes, some institutions use a sealed, prepackaged unit dosing schedule in which unused medications can be returned to the pharmacy if a prescription is changed or the inmate is released. In general, oversight of who is prescribing, delivering, storing, and accessing psychotropic medications is essential. Prison psychiatrists must have a manageable caseload to be able to appropriately oversee inmates’ use of and response to medications. Although it is difficult to make recommendations about caseload issues in many areas of mental health treatment, “something of a consensus has been reached” with regard to caseloads for psychiatrists serving persons on psychotropic medications (APA, 2000): In prisons, one full-time psychiatrist should not serve more than 150 patients on psychotropic medications.

ISSUES IN ETHNOPHARMACOLOGY

Recent years have witnessed an increased focus on how ethnic and cultural influences can alter an individual’s response to medication. Differences can arise from genetic, psychosocial, or environmental causes. Variations in response to medications have been attributed to these ethnic and cultural factors:

- Dietary differences.
- Metabolic rates.
- Adherence to medication regimens.
- The simultaneous use of alternative and traditional healing practices with pharmacological therapy.

Most of the ethnic variation in drug metabolism is related to the reduced activity of drug-metabolizing enzymes, which can result in higher amounts of medication in the blood and increased side effects

(U.S. Department of Health and Human Services, 2001). A recent study by Ruiz et al. (1999) concluded that Hispanic patients need lower doses of neuroleptic medications than African Americans and whites to treat their schizophrenia.

Help-seeking behavior and responsiveness to treatment can be influenced by cultural factors. Language issues can also influence compliance with dosing strategies. In addition, persons affiliated with certain ethnic groups may use alternative herbal remedies, which can interact with prescribed medications. More research is needed to identify these issues and offer comprehensive guidelines for those prescribing across a range of ethnic groups.

BIAS IN PRESCRIBING PRACTICES

Some studies have revealed that minority inmates are less likely to receive mental health treatment than are white inmates (Steadman, Holohean, and Dvoskin, 1991). In their study examining prescribing practices related to antipsychotic medications in the Texas prison system, Baillargeon and Contreras (2001) found that “blacks were prescribed atypical antipsychotic agents less frequently than whites or Hispanics” (p. 52). This is of particular concern, as Trestman (2001) notes, because—

- Minorities are disproportionately incarcerated, and a disproportion of those are African American.
- African Americans are more susceptible to the development of tardive dyskinesia or dystonia than are diagnostically similar members of other ethnic groups.

It is unclear, based on the data from Baillargeon and Contreras’ (2001) investigation, whether the apparent racial bias that exists in their sample reflects an “ongoing bias that may exist in the community regarding diagnosis and/or treatment” (Trestman, 2001, p. 55).

The use of prescribing guidelines or decision algorithms may help to reduce biases in practice. To the extent that the use of these algorithms standardizes practice, they are likely to improve decisionmaking (Trestman, 2001).

LIABILITY ISSUES IN THE PRESCRIBING AND DISPENSING OF MEDICATION

A comprehensive review by Vaughn (1997) assesses the potential for civil liability against prison officials under Title 42 of the United States Code, section 1983, for failure to provide appropriate medication. The article reviews the financial costs associated with supplying medications to inmates and the simultaneous pressure that administrators face to reduce costs and it concludes that—

[P]rison administrators who attempt to reduce health care expenditures by supplying inmates with inefficacious medication ultimately may cost their jurisdictions more money in legal fees and civil litigation than in medication if their cost-cutting attempts amount to deliberate indifference to the serious medical needs of inmates. (p. 318)

In his review, Vaughn points out that civil liability can be incurred when—

- Prison officials fail to follow standard medical procedures.
- Prison officials declare that budget issues have prevented them from efficacious and more expensive medications.
- Contraindicated medications are supplied.
- Medications are not delivered in a timely fashion.
- Medications are prescribed or withheld for non-medical reasons.
- Medications are prescribed to control or punish inmates.

Case law demonstrates support of prison administrators in disagreements about the type, dosage, or strength of medications prescribed (Vaughn, 1997).

RIGHT TO REFUSE MEDICATION

Prisoners have a right to refuse treatment, including medication, and do so for many of the same reasons that patients in community settings or hospitals do; they—

- Do not like the medication's side effects.
- Do not believe the medication is effective for their symptoms.
- Do not believe they are ill.
- Try to gain leverage over staff to bargain over unrelated issues.
- Are confused about giving consent for treatment.
- Wish to assert their legal rights.

The relationship the physician has with the offender-patient likely sets the tone for the patient's acceptance of medication recommendations. Physicians should try to get the informed consent of the inmate to the treatment after the inmate has received information about its nature, consequences, and risks. NCCHC (1999) recommends that signed consent be obtained when there is some risk to a patient associated with the treatment.

Many courts have considered the right to refuse treatment. When asked to rule on requiring medication, "judges rule for medication in almost 100% of cases" (Wettstein, 1998, p. 146).

Most clinicians favor the review of all treatment decisions by an independent clinical review board for inmates that accept or refuse treatment. This increases clinical safeguards and decreases malpractice liability exposure (Wettstein, 1998).

INVOLUNTARY MEDICATION OF INMATES

Forced medication of adult inmates is allowed under NCCHC standards in an emergency situation that contains an imminent threat to the inmate or others and when other interventions have been attempted. To act in an emergency situation, policies and procedures must be in place that specify the following:

- The requirement of authorization by a physician.
- The anticipated duration of the regimen.
- Where, when, and how the procedures may be used.
- A description of when less restrictive alternatives may be initiated (NCCHC, 1997).

In nonemergency situations, case law has been less clear about the individual's right to refuse treatment, especially psychopharmacological intervention. In *Vitek v. Jones* (1980), the U.S. Supreme Court ruled that prisoners are entitled to procedural protection if they refuse a treatment recommendation. In this case, the Court concluded that the inmate should have received prior written notification that a transfer was being considered, been given time and help to prepare for a hearing, and been afforded the opportunity to cross-examine those testifying against him. The Court also concluded that the decision should have been made by an independent decisionmaker. In *Washington v. Harper* (1990), the Supreme Court overturned a state opinion that prisoners should have a right to a judicial hearing when involuntary medication is involved. In this decision, the Court did not want to question the skill or ethics of those prescribing the medication but rather weighed in to protect the state's interests regarding protecting the institution's officers, other staff, and other prisoners. Here the Court allowed that the medication could be forcibly administered "if the inmate is dangerous to himself or others and . . . it is in the inmate's medical interest" (Haney and Specter, 2001, p. 60).

THE ROLE OF PHARMACOTHERAPY IN REDUCING SUICIDE RISK

Most disorders or circumstances that increase suicide risk are common in incarcerated populations (e.g., substance dependence along with a history of impulsivity or violence; current life stress that may overwhelm an at-risk person) (Ivanoff and Hayes, 2001). Individuals with mental illness also can demonstrate suicidal thoughts, impulses, and, sometimes, overt behaviors. No studies have verified the efficacy of psychosocial or psychopharmacological treatments to reduce suicidal behavior in jail or prison populations. Although depression and substance abuse can be associated with suicidal behavior, other conditions can be associated with increased risk, including—

- Acute agitation or anxiety.
- The experience of command hallucinations.
- Unmanageable psychotic or manic episodes.
- Paranoid delusions (Silverman et al., 1998).

Some studies have found medication to be successful in reducing impulsivity and, therefore, apparently reducing acts of self-harm. The medications used in these investigations have included carbamazepine, lithium, and propranolol (Conacher, 1997).

THE ROLE OF PHARMACOTHERAPY IN ADDRESSING VIOLENT OR AGGRESSIVE BEHAVIOR

No psychopharmacological intervention has been developed specifically for the treatment of violence or violent impulses. Some researchers believe that the majority of violent offenders would neither “require nor benefit from” medication for their violent impulses (Serin and Preston, 2001, p. 256). However, the following medications have shown some beneficial effects:

- Antidepressants have been used with some success in modulating violence in the context of such mental illnesses as depression, dementia, schizophrenia, and personality disorders.
- Lithium may have similar effects in similar populations but may increase aggression in persons with temporal lobe epilepsy and other organic mental disorders.
- The sedating effects of antipsychotic agents can reduce violence associated with delusions or hallucinations but should not be used for long-term management of aggression. They also can lower seizure threshold.
- Antianxiety agents are often used to manage agitation or violent behavior that is associated with alcohol withdrawal, acute psychosis, mania, or episodic temper outbursts. They are not considered to be useful long term because confusion, memory problems, depression, and dependency on the substance can result.
- Antihypertensive agents (typically beta blockers) may reduce aggressiveness in children and adolescents with explosive disorders as well as adults with a range of organic brain syndromes.
- New-generation antipsychotic agents (e.g., clozapine, risperidone, olanzapine, sertindole, and quetiapine) may reduce aggression and violence in persons with psychosis (Salekin and Rogers, 2001).

CONTINUITY OF MEDICATION

As with all forms of intervention for health disorders, psychopharmacological interventions should be administered as they were when the person was receiving care in the community, if that precedent exists. The NCCCHC position paper on continuity of care (1999) states that inmate health care should be considered part of the health care continuum that extends before, during, and after a person’s period of incarceration—both for the individual’s protection and that of the community as a whole. Inmates who

require continued health care should have a prerelease plan developed and an appropriate health care provider identified prior to their release. Institutions vary widely on practices regarding continuity of medication from the institution to the community, providing 3 to 30 days of medication to inmates at the time of their release. No formal policy exists in the national standards with regard to a recommended or required strategy. Issues regarding the continuity of care are discussed in other chapters.

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TRANSITIONAL SERVICES

On any given day, many individuals transition into and out of U.S. jails and prisons. They may be transferred—

- From a jail to a prison.
- From a jail to a reception center to a prison.
- From one prison to another prison.
- From one unit to another unit within a prison.
- From a prison to a community hospital.
- From a prison to the community.

For inmates with mental illness, these transitions can be very stressful and, without good planning, can lead to exacerbation of their symptoms.

Most of the discussion in this area has focused on the needs of offenders who leave prison and return to the community—and yet, in most places, this transition does not go as well as it could. The reasons for this are multifaceted. The remote location of many prisons, the paucity of affordable housing and other services in local communities, procedural barriers to applying for assistance, and the lack of integration between prisons and parole systems all frustrate efforts to ensure a meaningful and seamless transition for inmates with mental health and substance use problems (McVey, 2001).

Transition from one prison unit to another or from one prison facility to another is likewise stressful for inmates and needs careful planning to be done well and avoid discontinuity.

ASSESSMENT OF TREATMENT NEEDS

Inmates being moved from one institution to another should have a health screening to determine if they pose a health or safety threat to themselves or others. According to National Commission on Correctional Health Care (NCCHC) prison standards, all inmates who are transferred within the system, return from furlough, or have an “established health record for their current incarceration” (NCCHC, 1999, p. 58) should be evaluated by a qualified health care professional within 12 hours of their arrival to ensure continuity of care. Further, signs in the intake area should instruct inmates on how to access care for their immediate health needs. The screening should determine at a minimum whether the offender—

- Is on medications.
- Is being treated for a medical or dental problem.
- Has any medical or dental complaints.

The screening also provides the opportunity to assess the individual’s general appearance and behavior and determine whether he or she has any physical deformities or displays evidence of abuse or trauma (ACA, 2001). The NCCHC standards (1999) also state that allergies, current treatment plans, pending appointments for diagnostic work, and specialty instructions for transport should be included in transfer reports and forms. Additionally, mental health screens should assess for the presence of

current suicidal ideation, a history of suicidal behavior, and a history of mental health or substance abuse treatment. The NCCHC prison standards offer examples of summary transfer forms (NCCHC, 1999). Details about what might be covered in a comprehensive assessment are discussed in chapter 2, “Screening and Assessment for Mental Health and Substance Abuse Disorders.”

REENTERING THE COMMUNITY

More than 90 percent of prisoners will return to the community. Most will not be under continued supervision, depending on the probation, parole, or community control system in place. Although the concept of transition or reentry services is not new, it has received more attention in recent years.

A successful reentry is the result of thorough assessment and planning. Discharge planning begins when the person is identified as having a mental health or substance use disorder and continues throughout the person’s institutional treatment period. An appropriate referral to community-based services can be achieved only if the individual has been accurately and comprehensively assessed (U.S. Department of Justice, Corrections Program Office, 2001).

A community support plan that matches an individual’s strengths, weaknesses, and treatment needs with available resources is needed to reintegrate mentally ill offenders into the community (Jemelka, Trupin, and Childes, 1989). It is very important to involve the following stakeholders in discussions about the reentry process:

- The offender.
- Mental health and/or substance abuse treatment providers.
- Medicaid representative.
- Labor, employment, and vocational services’ representatives.

- Faith-based community organizations’ representatives.
- Recreational organizations’ representatives.

Additionally, no aftercare plan will work unless the offender “buys in” to it. Years of institutionalization can make people feel passive or unable to take control of or give direction to their lives. Prison can offer those who have never successfully managed their mental illness an opportunity to learn how to manage and take responsibility for their illness. This should also be an explicit component of treatment programs for individuals who have a history of significant criminal behavior that is interactive with their symptoms of mental illness or substance use disorder.

CONTINUITY OF CARE

Ensuring continuity of care for offenders with mental illness is a significant challenge for prison officials. As a rule, community providers and prison officials do not communicate or exchange records when a person enters the prison system or during incarceration, and individuals are released directly to the community with little or no transition planning or information exchange. This lack of continuity and communication works considerable hardships on offenders with mental illness. Not only are many offenders overwhelmed by the transition from a highly structured environment to a less structured one with little or no support, but important treatment gains made during incarceration can be undermined or lost. Without good coordination between institutional and community programs, the offender’s disorder, anxiety, or both are likely to weaken the gains made in treatment and trigger a relapse (Field, 1998).

Continuity of care is “required from admission to transfer or discharge” from the facility (ACA, 2001). This includes sharing appropriate information with community-based mental health or substance abuse service providers. One of the challenges facing discharge planners in institutional settings is the lack of

services available to the offender in their home community. Another is the disjointed nature of the service system. All agencies involved should acknowledge their responsibility in ensuring continuity of care. In some locations, an interagency, multidisciplinary team designs a coordinated system of case management for released offenders (McVey, 2001).

Although a number of states and communities have developed continuity of care programs for prison inmates, few communities offer comprehensive services that integrate care for co-occurring mental illness and substance use disorder. See “Maryland’s Shelter Plus Care Housing Program” for an example of a program that does integrate services.

One of the most significant issues facing people with serious mental illness when they are released from

prison is their ability to continue their psychotropic medication. Not having medications on their release or transfer can pose a significant stressor for individuals leaving correctional institutions. Courts have ruled that the state must provide an outgoing prisoner who continues to require psychotropic medication with a supply sufficient to ensure the availability of the medication during the time reasonably necessary to consult a doctor and obtain a new supply (*Wakefield v. Thompson*, 1999).

In a survey of prisons with capacities of more than 1,000 (67 percent reporting), Veysey and Schacht (2001) found that 25 percent of prisons offer prescriptions and 33 percent offer a 14- or 30-day supply of medication. Institutions must review their

Maryland’s Shelter Plus Care Housing Program

In 1992, the Maryland Mental Hygiene Administration (MHA) developed the Maryland Community Criminal Justice Treatment Program (MCCJTP) through a collaborative partnership with local corrections officials, local government leaders, and representatives from the private sector. MCCJTP brings treatment and criminal justice professionals together to screen inmates with mental illness while they are confined in local jails and detention centers, prepare individualized treatment and aftercare plans, and provide followup in the community after their release.

MHA expanded the scope of its services in 1995 to include the Shelter Plus Care Housing Program. This program, which is sponsored by the U.S. Department of Housing and Urban Development (HUD), provides tenant or sponsor-based rental assistance to homeless persons with disabilities. Eligible participants include individuals who are incarcerated in local detention centers or are on probation and parole for misdemeanors and nonviolent felonies, are homeless, and have a

mental illness. The program assists homeless individuals who are preparing to leave MCCJTP facilities or are in the community on the intensive caseloads of probation and parole agencies in 21 Maryland counties. Case managers help program participants apply for entitlements, locate housing, negotiate leases, budget their money, link to services, monitor supportive services involvement, and maintain their homes.

In 2002, 92 percent of those who participated in the Shelter Plus Care Housing Program maintained permanent housing and 87 percent maintained or increased their income. Only 6 percent were reincarcerated for criminal offenses, 1.5 percent were hospitalized for psychiatric treatment, and 1 percent returned to homelessness.

For more information about Maryland’s Shelter Plus Care Housing Program, contact—

Marian Bland, Director
Shelter Plus Care Housing and
Homeless Program

Maryland Mental Hygiene
Administration
8450 Dorsey Run Road
Jessup, MD 20794-1000
E-mail: blandm@dhhm.state.md.us

Staff from MHA’s Division of Special Populations have provided onsite technical assistance to several states. For information about technical assistance, contact—

Joan Gillece, Clinical Director
Division of Special Populations
Maryland Mental Hygiene
Administration
8450 Dorsey Run Road
Jessup, MD 20794-1000
E-mail: Gillecej@dhhm.state.md.us

For more information about the Shelter Plus Care Housing Program nationally, visit <http://www.hud.gov/offices/cpd/homeless/programs/spluscl/index.cfm>.

Source: U.S. Department of Justice, Corrections Program Office, *Proceedings of the National Corrections Conference on Mental Illness*, Boston, MA, July 18–20, 2001.

policies to ensure continuity of care in this important dimension of mental health treatment.

AFTERCARE

The term “aftercare” carries with it a range of interpretations. In this manual, it means creating a continuum of care pertaining to mental health and substance abuse services as an inmate is released to the community. Aftercare also includes referral and engagement in a range of community services needed by the individual to successfully reintegrate into the community, including:

- Case management.
- Supported housing.
- Supported employment.
- Relapse prevention services.

Since the 1970s, the concept of aftercare as a rehabilitative tool for all offenders has shifted to addressing those populations of individuals who need specialized rehabilitation services on release, including:

- Sex offenders.
- Individuals with severe mental illness.
- Individuals with mental retardation.
- Individuals with substance use disorders.
- Violent offenders.

According to Ashford, Sales, and LeCroy (2001), it is assumed that these individuals have “distinct need configurations that influence their relapse potential and likelihood of making a positive adjustment to the community” (p. 375).

Persons with mental illness leaving prison have the same needs for care as patients leaving a state hospital, including case management, day treatment, medication services, and housing (Jemelka, Trupin, and Childes, 1989). The need for posttreatment release supervision and coordination between mental health

and correctional authorities is a central issue in reintegrating offenders with serious mental illness into the community for several reasons:

- On release from prison, offenders with a mental illness find few opportunities in the community for treatment, employment, housing, and social services. Reluctance to serve offenders with mental illness can be found in virtually all areas of community-based care (Jemelka, Trupin, and Childes, 1989).
- Offenders with mental illness usually have difficulties planning for housing, employment, medical, mental health, substance abuse, and social service needs. Their cognitive and social skills may be impaired, and family and appropriate social supports in the community are often lacking.
- Offenders with serious mental illness are unlikely, without support, to be effective self-advocates in negotiating the complex system of care (Jemelka, Trupin, and Childes, 1989).
- Release to the community in a decompensated mental state, combined with the unavailability of housing, jobs, and community mental health and dual diagnosis treatment, puts these individuals at risk for homelessness, psychiatric hospitalization, and reincarceration (American Association of Community Psychiatry, 2001).

It is easy to suggest to inmates that they should refrain from using drugs or maintain stable housing and another thing entirely to help them in those endeavors. Institutions must make efforts to—

- Provide and coordinate with community members for the needed services.
- Negotiate entry for persons perceived as less than desirable.
- Help people connect with housing, case management, treatment programs, and other followup care.
- Avoid middle-of-the-night releases.

- Discontinue unanticipated releases from mental health units to the community.
- Discontinue anonymous referrals to community programs and providers.

Institutions should also consider stepdown programming, including transitions to work-release programs, halfway houses, and increasingly less restrictive environments.

Components of Aftercare

Case management strategies have been developed since the 1960s to help people move successfully from hospitals to community treatment settings. The role of the case manager is to identify, recommend, and, in most cases, facilitate the referral of individuals to services that will help them maintain stability in their functioning. Case managers work to ensure continuity of care through a series of steps, including—

- Assessment of need.
- Development of a case plan.
- Referral and linkage to available services.
- Monitoring of continued services.
- Evaluation as to whether services are achieving the intended goals.

In the correctional system, case managers often function purely as brokers of service because many are not trained mental health professionals. Some observers contend that case managers should not only facilitate the receipt of services but also use their relationship with the person to encourage compliance with rules and treatment and to provide support. Alternatives to “brokerage” models have focused on helping individuals—

- Obtain material resources.
- Develop coping skills to deal with everyday stressors.
- Develop support systems.

- Disentangle themselves from negative relationships.
- Learn to relate appropriately to community members, including police, service providers, support persons, and family members.

Educational or Vocational Transitions and Aftercare

In some settings, transitional services involving offenders with disabilities may refer specifically to the transfer of students in special education and the movement of their educational records within the justice system or between the justice system and the community. Even in this context, transitional services have been referred to as the “most neglected component of correctional educational programs” (Rutherford, Griller-Clark, and Anderson, 2001, p. 237).

As it relates to educational or vocational services, transition should include the following aspects:

- Interagency communication and coordination.
- Joint planning around program placement.
- Records transfer.
- Transitional (prerelease) programs that include independent living, social, and vocational skills (Coffey and Gemignani, 1994).

The transition involved in vocational planning may include a focus on postrelease employment, continued vocational training or education, and independent living.

CONDITIONS OF RELEASE

The goals of transitional services are to ensure continuity of treatment and reduce recidivism. Numerous reports have suggested that the intensity of supervision and services provided following release is an important factor in reintegrating individuals into their communities (Edens, Peters, and Hills, 1997; Dvoskin and Steadman, 1994).

The following conditions of release might be imposed for some special needs offenders or offenders with mental illness:

- The acquisition of stable employment.
- The acquisition of stable housing.
- Prohibitions against associating with known criminals.
- Prohibitions against possessing weapons.
- Involvement in mental health treatment, including medication compliance.
- Abstinence from drugs.
- Involvement in case management (Edens and Otto, 2001).

Former incentives and sanctions to participate in treatment and maintain prosocial behavior may not be as strong in the community as they were in the institution. Without incentives, especially to continue sobriety and a crime-free lifestyle, offenders may revert to old patterns of behavior (Field, 1998).

If an individual continues to be monitored, a return to substance use or noncompliance with treatment or medication regimens likely will be detected. This monitoring, rather than being punitive, can offer the offender the opportunity for reengagement in community-based services rather than reentry into the justice system. This is especially true if a range of options is considered in response to infractions, including increased supervision, hospital commitments, day fines, or brief jail sentences rather than revocation of parole (Edens and Otto, 2001).

LEGAL ISSUES

Significant case law exists regarding the release or monitoring of offenders with mental illness who are returned to the community and who subsequently harm someone. The issue of a duty to warn has come into play in these cases. The courts have

generally considered the mental health professional's amount of prior contact with the offender, the degree to which the offender's acts are deemed foreseeable, the offender's previous history of reckless or violent behavior, and the degree to which the offender's mental health has deteriorated. Despite the considerable burden these interpretations can have on mental health professionals, the courts appear to be looking for greater assurance that "placement . . . back into the community will not result in the recurrence of violent or harmful behavior by the offenders" (Hafemeister, 1998, p. 98). Many states have enacted legislation to immunize persons and institutions from liability when a person released to the community harms someone. Overall, if professionals can demonstrate that they acted within "professional standards," they will not incur liability. How that standard is determined, however, can be a complex and challenging task.

POSITIVE OUTCOMES IN TRANSITIONAL CARE

An obvious goal of transitional care is to ensure that a person's treatment goes on as seamlessly as possible. To foster this, treatment providers within an institution or agency and partners in the community need to establish referral relationships through which clear and consistent information can be conveyed. Persons with complex, multiple disorders cannot be expected to negotiate complicated treatment systems and effectively communicate their treatment history and future service needs. Treatment providers must act as their agents to provide the continuity of care that is essential to stabilize symptoms. Having to repeat their entire treatment history to a new set of providers each time they are transferred is frustrating (and defeating) to clients with mental illness. Although transfers are inevitable, they can be done effectively with appropriate planning and understanding of the stressful nature of the experience combined, typically, with the offender's treatment ambivalence.

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TREATMENT OF SPECIAL POPULATIONS

Several subpopulations within the prison are often referred to as “special populations” because they require a level of care or specialized services not required by other groups. These groups sometimes include adults with serious mental health disorders, as well as offenders with mental retardation, violent offenders, sex offenders, and geriatric offenders.

TREATMENT OF PERSONS WITH MENTAL RETARDATION OR DEVELOPMENTAL DISABILITY

Individuals with mental retardation have “significantly subaverage intellectual functioning” and other indicators of impaired functioning that occurred prior to the age of 18. Although intelligence quotient (IQ) scores are an indicator, most clinicians would agree that assessing the need for special services requires gathering information about an individual’s levels of adaptive behaviors, social maturity and development, and communication skills. Histories of those requiring specialized services often reveal that they had significant behavioral problems throughout childhood and may have received specialized residential treatment and/or schooling. It is also likely that they were raised in an environment that did not allow for much skill building, as other members of their family may also be of limited ability (Day and Berney, 2001).

Estimates suggest that individuals with mental retardation are overrepresented in prison—at rates two to three times greater than those found in the community (2–3 percent in the community versus up to

10 percent in prisons) (Gardner, Graeber, and Machkovitz, 1998). Prevalence estimates regarding rates of offenders meeting criteria for mental retardation are controversial, however, because of both test measurement issues (e.g., using group-administered tests) and sociocultural variables that may affect test scores (e.g., misrepresenting those from impoverished backgrounds as being impaired).

Many more individuals in prison systems are considered to have “borderline” retardation. Some of these individuals (with IQ scores in the 70–85 range) may be best served in the context of mental retardation services and others may do well in mainstream arenas; this decision depends on the evaluation of the pattern of need of the individual at the time (Gardner, Graeber, and Machkovitz, 1998).

Offenses that bring individuals with mental retardation into custody (and into treatment) may include the following:

- Sex offenses related to poor impulse control, sexual naivete, and a lack of normal sexual outlets.
- Arson offenses related to impaired communication and emotional expression and as a response to stress.
- Property offenses related to low frustration tolerance, exposure to delinquent peers, and disturbed family environments (Day and Berney, 2001).

Much of the research about offenders with mental retardation has looked at male offenders. Different issues generally bring women offenders into care: promiscuity, behavior problems, and self-neglect.

Some research has shown that women in this group tend to have histories of self-mutilation and grossly disturbed family histories (Day and Berney, 2001).

An estimated 40 to 70 percent of individuals with mental retardation also meet criteria for a psychiatric disorder (APA, 2000). Because of their often limited language skills, it is difficult to determine the type of disorder they may have (e.g., anxiety, depression). In the context of their limited ability to generate enough information to make an accurate diagnosis, the prescription of psychotropic medication is more often focused on behaviors or observable symptoms.

Prison staff may experience challenges with these clients for a variety of reasons. Inmates with mental retardation may experience one or more of the following:

- Difficulty in comprehending and responding to instructions. This can be counteracted by using clear, simple language and giving the person adequate time to respond.
- Low frustration tolerance. This may lead to excited behaviors or inappropriate verbalizations/ speech. Persons who can calmly redirect the individual may need to intervene.
- Impulsivity. Difficulty controlling impulsive behaviors and positive or negative affect may cause the individual to behave impulsively (APA, 2000).

When violence occurs, it may be the result of limited communication skills, a sense of being threatened, misinterpreted social cues, or flawed concrete logic (believing that acting in a violent fashion was the only reasonable solution to the situation) (Day and Berney, 2001).

A comprehensive assessment must first be done to treat some of the factors that led to the criminality of the person with mental retardation. This assessment should include intelligence and personality testing, investigation of educational attainments, and level of adaptive behavior. Genetic testing should be used to identify specific genotypic abnormalities, and

EEGs can determine the presence of brain damage or epilepsy. To assess the likelihood of reoffense, the offense pattern or cycle should be analyzed for frustration tolerance, impulsivity, emotional reactions, and the person's understanding of the offense.

Prison staff must take extra care to make certain that inmates with mental retardation are not ridiculed or preyed on by other offenders. Inmates with mental retardation should be observed frequently so that these issues may be addressed. Some prison systems have established special programs for inmates with mental retardation (see "Sample State Programs Serving Inmates With Mental Retardation").

Sample State Programs Serving Inmates With Mental Retardation

The Center for Intensive Treatment (CIT), operated by the New York Office of Mental Retardation and Developmental Disabilities, is a highly structured residential program within a secure setting. Most residents have histories of assaultive and aggressive behaviors and many were found not to be criminally responsible for their actions due to their mental retardation. The unit has a 14-foot inward curving fence and a card-reading locking system that provides access to various areas of the facility, depending on the resident's level of independence (Gardner, Graeber, and Machkovitz, 1998). Treatment goals include improving decisionmaking and vocational training through a mentoring program with maintenance staff.

Resulting from a class action lawsuit, a program for offenders with mental retardation was initiated by the state of Texas. This specialized program provides offenders with adequate housing and work conditions, appropriate discipline, and protection from other offenders. Staff working in these specialized units are trained to "ensure sensitivity" to the individual's needs (Gardner, Graeber, and Machkovitz, 1998).

Treatment Programs for Offenders With Mental Retardation

Although some offenders with mental retardation may come to prison, "the majority . . . can be

managed in the community supported by social, probation, and specialist psychiatric services” (Day and Berney, 2001, p. 206). Within prisons, programs for offenders with mental retardation typically focus on building social skills and educational training. Token economy systems reward desirable behaviors, and unwanted behaviors result in loss of tokens and “timeouts” or seclusion (in response to violent behaviors). These programs usually offer structured training programs and operate with higher staffing ratios and multidisciplinary teams that include nursing staff.

Focused Treatment Interventions

Sex Offenses. Rates of sex offenses among offenders who have mental retardation are four to six times greater than among the general offender population (Day, 1993). Many of these offenses stem from offenders’ limited information about sexual relationships and courtship skills. Persons who have mental retardation need basic sex education but also need to be informed about laws and social codes related to sexual behaviors. Treatment regimens that involve learning arousal control skills, cognitive restructuring, group therapy, anger management, and social skills training—in various combinations—have been effective with individuals whose intelligence scores range from 55 to 85 (Day and Berney, 2001). These treatments also can be used with persons with mental retardation who have committed sexual offenses.

Antiandrogen drugs are used in some programs to reduce the sex drive and facilitate engagement in a behavior management program. Although their use is contraindicated in some patients with medical illnesses, they can be effective in reducing deviant impulses and fantasies. Use of this class of drug should be discussed in detail with the individual and his parent or guardian; written consent should be obtained.

Fire Setting. Fire setting is also overrepresented in the population of offenders with mental retardation. Fire setters may benefit from therapies that help them evaluate antecedents to fire setting and teach

skills to reduce stress and improve coping. These individuals should be closely monitored, housed in lower stress living environments, and searched frequently.

Control of Anger or Violence. Anger management techniques such as relaxation training and the use of cognitive self-statements (“calm down”) have been used successfully in offenders with retardation. Psychopharmacological agents can be effective but must be used judiciously because they can have adverse effects, especially in individuals with underlying brain disorders. Neuroleptics, antiepileptics, lithium, and beta-adrenergic blockers can be effective in reducing episodic violence. Due to historical reports of overprescription, however, all use of these medications for violence reduction should be carefully monitored for adverse side effects and initiated at small dosage levels (Day and Berney, 2001).

National Commission on Correctional Health Care (NCCHC) prison standards (1997) require that prison administrators and treating clinicians communicate about individuals with special needs, including those with developmental disabilities, regarding special housing considerations, work or program assignments, and admissions and transfers from institutions (NCCHC, 1999). These standards also caution that security staff need orientation and training regarding the impairments in thinking (e.g., concrete thinking, slowness) that characterize individuals with mental retardation.

TREATMENT OF VIOLENT OFFENDERS

The Centers for Disease Control and Prevention and NCCHC have declared that violence is a “public health problem” and that correctional institutions must play a role in addressing violence among their populations (see “Stemming Violence Among Inmates”).

Strategies for the treatment of violence are increasingly specific, depending on the individual’s pattern of violence. Tolan and Guerra (1994) describe four

Stemming Violence Among Inmates

The National Commission on Correctional Health Care recommends that prisons take the following actions:

- Incorporate violence risk assessment into all intake assessments.
- Refer individuals with violent histories to treatments that are provided by adequately trained staff and that take a biopsychosocial approach.
- Establish guidelines for violence prevention, including awareness of nonphysical methods for controlling disruptive behaviors.
- Work with community providers to ensure continuity of care once the offender is released.

Source: National Commission on Correctional Health Care, 1999.

common patterns (with prevalence estimates among adolescent violent offenders):

- Situational, related to environmental cues and social factors (25 percent).
- Relationship, involving interpersonal conflict and social/psychological factors (25 percent).
- Predatory, goal-oriented violence that may be related to gang activity (5 percent).
- Psychopathological, reflecting repetitive violence across settings; may be due to neuropsychological deficits (1 percent).

Findings based on interventions from the conduct disorder literature suggest that interventions should emphasize skills acquisition and be delivered over the long term to solidify and sustain gains (Kazdin, 1993). Persons who are true psychopaths (a very small proportion of the offender population) may not benefit from treatment.

Therapies for aggression fall into several categories:

- Psychopharmacological, although “no medication has been developed or approved specifically for treating violent behavior” (Serin and Preston, 2001, p. 255).

- Psychological, including behavior modification, social skills training, anger management, problem solving, empathy, and perspective taking.
- Self-regulation techniques, including relaxation, stress inoculation, and arousal reduction.
- Cognitive-processing strategies, including modifying appraisals and expectations, generating alternative solutions, and redirecting “criminal thinking.”

Despite the range of available interventions, little technology currently exists to help match offenders with the “correct” prescription of care. Even if this did exist, issues of staff resources and the ability to offer multiple and varied programs would pose a significant challenge to correctional authorities.

TREATMENT OF SEX OFFENDERS

Almost all incarcerated sex offenders fall into one of two groups: rapists, most commonly men who have assaulted adult women, and child molesters, men who have committed “hands-on” offenses against prepubertal children. Persons with lesser offenses such as exhibitionism, voyeurism, and indecent exposure are typically not seen in institutional programs but are treated in community-based settings.

Most sex offenders are given DSM-IV (*Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*) (APA, 1994) diagnoses of sexual sadism or pedophilia. Most would also receive a diagnosis of antisocial personality disorder, though this is not typically a specific focus of mental health treatment.

Most sex offenders do not have a concurrent diagnosis of serious mental illness (e.g., schizophrenia or bipolar disorder). It is recommended that the small group of sex offenders who do have a major mental illness receive mental health services to stabilize the symptoms of this disorder before being referred for specialized treatment of their sexual behavior (Rice, Harris, and Quinsey, 2001).

Categories of treatment for sex offenders include the following:

- Nonbehavioral psychotherapy.
- Surgical and pharmacological treatments.
- Cognitive and behavioral psychotherapy (Rice, Harris, and Quinsey, 2001).

Nonbehavioral psychotherapy (unstructured group or individual counseling) has not been validated empirically to reduce the likelihood of reoffending. Some research suggests, in fact, the opposite: that those treated with these strategies are more likely to reoffend (Rice, Harris, and Quinsey, 2001).

Surgical castration has been evaluated in Germany and Denmark, but based on the evidence from these investigations, it remains difficult to recommend this procedure.

Psychopharmacologic interventions have been used much more commonly in North America. Drugs that reduce circulating testosterone (cyproterone acetate and medroxyprogesterone acetate (MPA)) evoke fewer ethical concerns because their effects can be completely reversed when the drugs are withdrawn. Individuals prescribed these drugs report a reduction in sexual interest, sex drive, sexual fantasies, and masturbation; no information on reduction of reoffending has been reported, however. Both drugs have side effects that make them undesirable, including loss of body hair, headaches, depression, gastrointestinal problems, weight gain, and fatigue.

Most investigations on the effectiveness of pharmacological interventions reported large numbers of dropouts. Reviews conclude that few sex offenders will agree to take medications such as MPA, and fewer still will stay on them over the long term. Some evidence suggests that those who stay on the medication and receive additional treatment may reoffend at lower rates. Some researchers believe, however, that these individuals are the most highly motivated members of the group, and that this therefore is not fairly testing the effects of the drug (Rice, Harris, and Quinsey, 2001).

Behavioral therapies typically link aversive events to deviant fantasies through covert sensitization or operant conditioning. Other elements of treatment often include—

- Training in social competence.
- Anger management.
- Sex education.
- Victim awareness and empathy.
- Family therapy.
- Other counseling.

Although diverse interventions have been developed and implemented, most have not been completely and correctly evaluated to test their effectiveness. This leads some researchers to conclude that “the efficacy of treatments for child molesters and rapists remains to be demonstrated” (Rice, Harris, and Quinsey, 2001, p. 305).

Despite this pessimistic conclusion, many programs operate and continue to investigate interventions in an effort to reduce reoffending. Special consideration, therefore, must be given to sex offenders in maintaining confidentiality about their mental health treatment. Identification as a sex offender is recognized as putting an individual at increased risk for violence within an institution (APA, 2000).

TREATMENT OF OLDER ADULTS

The National Institute of Corrections (NIC) uses the term “geriatric” for inmates who are 50 years of age or older. This fairly liberal categorization is suggested because of the higher “biological age” of the inmate population due to higher rates of smoking, poor nutrition, lower socioeconomic status, and limited access to prior health care (APA, 2000). The high-risk behaviors inmates commonly engage in have resulted in appraised medical ages 5 to 10 years older than their chronological ages (McVey, 2001).

Longer sentences and increased curtailment of parole have made older offenders the fastest growing population in state prisons (Ortiz, 2000). Older offenders are also the most expensive group to house and maintain, largely due to their physical and mental impairments. Data from several sources suggest that the cost of medical care for elderly prisoners is almost three times the average cost for the general population (Faiver, 1998).

Specific concerns related to the mental health treatment of older adults include diagnostic issues associated with the common co-occurrence of physical health disorders. Issues of polypharmacy have to be closely evaluated in populations being treated simultaneously for multiple physical and mental health disorders.

Other important issues in the treatment of older adult inmate populations include their—

- Physical vulnerabilities when housed with aggressive, younger adults.
- Potential lack of connection to other inmates.
- Greater rates of successful suicides.
- Increased risk for death during their term of incarceration.
- Greater difficulty in adapting to prison (APA, 2000).

All these vulnerabilities can exacerbate underlying psychiatric disorders.

Hopelessness and despair are common as older male and female offenders gradually lose contact with their families and face long prison sentences. Elderly offenders' losses progress slowly over time, contributing to grief. Specially trained staff may be needed in prison settings to identify and treat geriatric health and mental health problems and to prevent suicide attempts. Treatment of both mental health and substance abuse problems must be individualized to meet the needs of these offenders (Maue, 2001).

Because many have aged out of the workforce, this population has special programming needs and significant issues regarding discharge planning, sex-offender counseling, long-term housing, medical costs for chronic conditions, and hospice care.

Community Reintegration for Older Adults

Discharge planning is important for older offenders who have any likelihood of being returned to the community. The planning should focus on—

- Medicare and Medicaid enrollment.
- Reinstatement of veterans' benefits.
- Securing community mental health treatment.
- Obtaining housing.
- Obtaining employment.
- Applying for public assistance.
- Renewing family ties (Faiver, 1998).

Older discharged prisoners usually face substantial difficulties on reentry to the community. As a group, older offenders frequently experience depression, isolation, and loneliness, all of which contribute to difficult community reintegration (McVey, 2001). Prior prison experience is strongly associated with the probability of homelessness for the elderly, and discharge planning is vital to prevent this.

Specialized Facilities and Units for Older Adults

Younger inmates often take advantage of and abuse inmates who are old and weak. Younger, more active prisoners may get annoyed or irritated by older inmates who share the same housing and activity space. As physical limitations and confusion begin to appear in older inmates, some systems have found it helpful to arrange separate living units with special programming. Many studies suggest that older inmates be housed separately and have specialized

gender-responsive programs for their protection and well-being that provide them with a sense of community and belonging (Ortiz, 2000).

NIC's 1997 national survey on special issues in prison medical services found that most state corrections agencies provided specialized medical care to elderly inmates at several facilities but many have consolidated medical care for elderly inmates at one or more main sites. The most common approaches to provide specialized medical care for elderly inmates include chronic care clinics, preventive care, and increased frequency of physical examinations. More than half of the corrections agencies reported the availability of special nutrition and dietary care, special housing, and the use of inmate aides to provide nonmedical assistance (e.g., reading, pushing wheelchairs). Other services included physical therapy, special visitation policies, and special recreation or work opportunities. Some had 24-hour physician access and delivery of medications to reduce ambulation (LIS, Inc., 1997).

Elderly, Disabled, and Terminally Ill Inmates

NCCHC describes the elderly population as those who may need help addressing issues associated with death and dying, depression, and memory impairments (NCCHC, 1999). Elderly and disabled inmates require special accommodations for their deteriorating physical and mental conditions, increased supervision and protection, and more frequent escort to health care services (Faiver, 1998). The frail elderly's difficulties with accomplishing activities of daily living can overwhelm available staff in many mental health or substance abuse treatment programs. Some states have developed secure extended-care facilities or nursing homes for elderly inmates.

Faiver (1998) suggests that a specialized program for elderly and handicapped inmates could include such services as—

- Preventive health activities to decrease medical costs.
- A diet appropriate to elderly individuals.
- Enhanced creative therapy programs.
- Self-help programming, community service, and work opportunities.
- Sex-offender counseling and therapy.
- Life-coping skills for maturing adults.
- Assistance with activities of daily living and personal care needs related to Alzheimer's disease, arthritis, diabetes, cardiovascular and respiratory problems, loss of eyesight and hearing, and other chronic or acute debilitating conditions.
- Worship and religious counseling.
- A hospice program for terminally ill residents.
- Nursing care.
- Discharge and reentry planning.

As inmates become disabled or terminally ill, many will no longer represent a real threat or danger to society, and consideration should be given to seeking approval from the parole board or the Governor for compassionate release. For those who cannot be released, humane environments, hospice, and palliative care options should be prepared for the terminally ill. A social work component is essential for a prison facility specializing in the elderly.

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PROFILES OF THREE STATES

This chapter highlights successful programs for offenders with mental illness in Maryland, Oregon, and Texas and presents a brief history of each program, a description of its key features, and a discussion of its unique characteristics and future plans.

MARYLAND

In the early 1990s, correctional officials' mounting concerns about the growing number of individuals with mental illnesses revolving in and out of the Maryland correctional system and the lack of sufficient trained staff prompted the establishment of a Governor's task force to examine the problem and recommend a coordinated approach by the behavioral health and criminal justice systems. The Maryland Department of Health and Mental Hygiene, Mental Hygiene Administration (DHMH/MHA) allocated \$50,000 in each of four counties as seed money to establish the Jail Mental Health Program. These dollars funded case management services to help identify offenders with mental illness, enhance communication between mental health and corrections staff, and reduce disruption associated with offenders with mental illness.

The success of the pilots led DHMH/MHA to expand the program's array of services and implement it throughout the state. The primary goals of the program, now known as the Maryland Community Criminal Justice Treatment Program, are to meet the comprehensive needs of this population, reduce recidivism to state psychiatric hospitals and the criminal justice system, and reduce homelessness.

Key Program Features

Each participating jurisdiction is required to develop an advisory board that includes representatives of organizations that serve ex-offenders in the community, such as mental health, alcohol and drug abuse, public defender, judicial, parole and probation, law enforcement, social service, and consumer and advocacy agencies. To receive funding, each advisory board must develop a memorandum of agreement that defines the specific services each agency will provide. The program focuses on individuals 18 years of age or older who have a serious mental illness. The individual also may have a co-occurring disorder such as substance abuse or HIV/AIDS, be homeless or deaf, or a combination of these. DHMH/MHA provides a total of \$1.5 million annually for case management and psychiatric services that begin in the correctional system. All individuals who meet the criteria for medical need are offered an array of services through DHMH/MHA managed care fee-for-service system. Local governments, detention centers, and agencies also have provided funds. Approximately 4,500 individuals were served during Maryland's fiscal year 2001.

On incarceration, offenders receive a comprehensive screening and assessment for mental illness and substance abuse, and crisis intervention services are provided as necessary. Medication may be prescribed following a medical evaluation. An individual treatment plan is developed, and the indicated therapies are begun as soon as possible. A program designed to help women offenders with substance-abuse problems and the effects of traumatic life

experiences is available in 8 of the 24 jurisdictions. Plans are under way to expand the number of sites and provide similar services to men.

The services provided during prebooking and incarceration lay the foundation for discharge planning. In 1995, DHMH/MHA received a \$5.5 million housing grant from the U.S. Department of Housing and Urban Development to provide rental assistance to parolees and probationers who are homeless or in danger of being reincarcerated. In total, 407 individuals, including children and families, have been housed through this program. The recidivism rate of those in the program has been less than 4 percent. DHMH/MHA has been innovative in blending federal, state, local, and private funds to underwrite program costs.

Unique Characteristics

The following guiding principles have contributed to the program's success:

- Offenders with mental illness are part of the community and deserve treatment and community services.
- Public safety issues are paramount in the service delivery system.
- Holistic and coordinated treatment is most effective and efficient.
- Local jurisdictions should have autonomy in program implementation, within state guidelines.
- All public service providers should contribute their share of services and resources to helping offenders with mental illness.

Other areas identified as key to the program's success include the following:

- Intensive case management.
- Program flexibility.
- Community partnerships.
- Strong advocacy.
- Blended funding.

- An individualized continuum of care.
- Monthly monitoring of supportive services.

Future Plans

In addition to expanding its services to include more trauma services for men, the Maryland program will provide services to pregnant and postpartum incarcerated women and their infants. These services are designed to enhance the environmental, ecological, and institutional health and growth of mothers and their infants. Clinical interventions will strengthen the bond between mothers and their babies.

OREGON

Until the mid-1990s, the Oregon State Hospital provided most of the mental health services for people with mental illness incarcerated in the criminal justice system in Willamette Valley, Oregon. As the number of incarcerations increased, prison facilities were established beyond Willamette Valley to meet the increased need for prison cells. As a result, the arrangement with the state hospital became progressively less effective. To improve the situation, the Oregon Department of Corrections designed its own program to treat people with mental illnesses incarcerated in the prison system. The number of people receiving mental health services in the prison increased from 1,050 in 1997 to 2,018 people in 2002.

Key Program Features

The Oregon Department of Corrections established a system of mental health services based on outreach case management. The service system enabled case managers who work in the prisons to meet with offenders throughout the institution instead of being restricted to scheduled office appointments. These informal visits take place in the cell block, recreation yard, and hallways and allow for interactions between the mental health provider and the offender without the need for an appointment and outside the confines of a doctor's office.

This design has additional advantages for both providers and offenders. It enables mental health providers to watch offenders interact in their everyday environments. Correctional officers can inform the mental health professionals of any problems they may have noticed. In addition, these interactions allow for early identification of and intervention for offenders with mental illnesses.

Two principles guide mental health services within the institution: services are prioritized to serve offenders with the most severe and persistent mental illnesses and the staff responds rapidly to that population. To determine eligibility, staff identify people with special health needs through a general health screening and the Personality Assessment Instrument (PAI). Nurses assess each person entering the Oregon Department of Corrections within the first hour of intake. This general health needs screening frames the individual's incarceration/transition plan, which follows him or her throughout the entire term of incarceration. Within 48 hours of intake, each person must complete a PAI, which provides more thorough information than the general health screening.

Individuals identified as having a mental illness receive a face-to-face mental health evaluation within 2 weeks of intake. If an emergency occurs, face-to-face assessments can be done very quickly.

Unique Characteristics

The Oregon Department of Corrections offers the following services to meet the needs of people with serious and persistent mental illnesses within their institutions:

- 62 crisis/residential beds.
- 70 day treatment beds.
- 208 dual-diagnosis treatment beds.
- Individual and group treatment (offered to 410 individuals).
- Case management and medication management (offered to 2,018 individuals).

- A stepdown program to prepare individuals to live within the general prison population.
- A co-occurring disorders program.
- A transitional program to help individuals obtain housing, medication, and support services prior to release.

Program staff work collaboratively with the state mental health authority on various projects on a regular basis. Staff also work with mental health advocates at their request to increase access to treatment services for people in the criminal justice system.

Challenges

The Oregon Department of Corrections has worked through the following challenges:

- The number of people with mental illnesses entering the criminal justice system is increasing.
- The severity of the mental illnesses of people who enter the criminal justice system is increasing.
- Space to meet with people in a neutral, private setting in prisons is limited. Space constraints hinder the growth of such programs as self-help groups.
- The cost of medication continues to increase.
- Recruiting mental health staff in rural areas where new prisons are being constructed is difficult.

The program is working to overcome these challenges to ensure that offenders who need mental health treatment can be served expediently and effectively.

Measures of Success

Even before case management outreach services were implemented, 60 percent of people with mental illnesses incarcerated in the criminal justice system received mental health services. With the new structure, fewer people with mental illnesses are segregated from other inmates, which reduces the

personal deterioration that comes from long-term isolation. Oregon's in-prison mental health services are cost effective and have generated more participation in prison education and work programs by offenders with mental illness than offenders without mental illness.

TEXAS

The mission of the Correctional Health Care/Mental Health Services Program of the Texas Department of Criminal Justice is to provide public and institutional safety, promote positive change in offender behavior, and reintegrate offenders into society through the provision of health care. To accomplish this mission, the 550-bed John Montford Unit in Lubbock, Texas, was established to provide a full range of inpatient psychiatric services to offenders with mental illness in the state correctional system. Offenders throughout the state are referred to Montford to receive individualized treatment in a safe environment.

Key Program Features

The Montford psychiatric hospital meets the needs of offenders in the state criminal justice system by offering a range of services at varying intensities.

Offenders referred to Montford are first transferred to the crisis management unit, where they receive a psychiatric evaluation, psychological evaluation, and, if necessary, physical evaluation. Initial goals are to resolve any immediate crises and decide what services best meet each person's needs.

When offenders are admitted to Montford, they are transferred from crisis management to acute care, where they stay 10 to 14 days for additional evaluation and development of an individual treatment plan based on the medical model. As individuals stabilize, they are given increased privileges, individual treatment plans are adjusted, referrals are made to various groups offered by the staff, and offenders are evaluated to determine their educational needs.

If hospitalization is required after acute care, offenders are transferred to a subacute care program. This program follows a biopsychosocial model that emphasizes group therapy. Individuals are closely monitored to determine their response to medications, and treatment plans are refined. The average length of stay in a subacute care unit is 90 to 180 days.

Unique Characteristics

The Montford Unit provides the following psychiatric services:

- 550 psychiatric beds.
- 400 trusty camp beds.
- A 48-bed general medical and surgical unit.
- Geriatric services.
- Nontraditional therapies, such as art therapy, music therapy, occupational therapy, and recreational therapy.
- A trusty camp, gardens for the Lubbock food bank, housing, stables, and roads located on 120 acres.

Challenges and Future Plans

Staff at the John Montford Unit continue to develop programs to meet the many needs of people who use their services, such as a program for people with serious character disorders. They are also considering a program for people with co-occurring psychiatric and substance use disorders.

SUMMARY

Incarceration can be very traumatic for individuals who have a mental illness. The programs highlighted in this chapter illustrate that mental health programs designed to divert individuals from the criminal justice system, provide appropriate services while they are incarcerated, and help them reenter the community can have positive effects on the quality of their lives.



APPENDIX. INSTRUMENTS FOR SCREENING
AND ASSESSMENT OF MENTAL HEALTH AND
SUBSTANCE ABUSE DISORDERS



Appendix



INSTRUMENTS FOR SCREENING AND ASSESSMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE DISORDERS

INSTRUMENTS FOR SCREENING AND ASSESSMENT

Brief Symptom Inventory. This is a short form (53 items) for another instrument, the Symptom Checklist 90–Revised (SCL–90–R). It provides both global indices of psychopathology and specific psychiatric symptom dimensions (Derogatis and Melisaratos, 1983).

Referral Decision Scale. This self-administered, 14-item instrument specifically identifies the mental health problems of individuals entering jails (Teplin and Schwartz, 1989).

TCU Drug Dependence Screen. This instrument provides diagnosable symptoms of substance use and includes 19 items. It is in the public domain and therefore available at no cost (Simpson, 1993).

Simple Screening Instrument. This instrument examines five areas related to drug and alcohol dependence. It is in the public domain and therefore available at no cost (Center for Substance Abuse Treatment, 1994).

Alcohol Dependence Scale. This 25-item instrument screens for symptoms of alcohol dependence and was derived from the larger 147-item Alcohol Use Inventory (AUI) via factor analysis (Skinner and Horn, 1984).

Addiction Severity Index. Developed by the National Institute on Drug Abuse (NIDA), this is the most widely used instrument for measuring substance abuse. Its structured interview examines

seven areas of functioning commonly affected by substance abuse. It is in the public domain and therefore available at no cost (McLellan et al., 1980, 1992).

Minnesota Multiphasic Personality Inventory–2 (MMPI–2). The MMPI–2 is a restandardized version of the MMPI. This 567-item self-report measure provides scores on 10 clinical scales, 10 supplementary scales, and 4 validity scales (Hathaway and McKinley, 1989).

Millon Clinical Multiaxial Inventory–III. This self-report instrument yields scores on clinical syndromes and validity scales (Millon, 1983 and 1992).

Personality Assessment Inventory. This self-report instrument contains 344 items and yields scores on 22 clinical scales (Morey, 1991).

Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES). This instrument has two forms (one for alcohol use and one for drug use), with 19 items each. Subscale scores indicate which stage of change the individual is in. It is in the public domain and therefore available at no cost (Miller and Tonigan, 1996).

University of Rhode Island Change Assessment (URICA) Scale. This instrument does not require clinical training to administer and, like SOCRATES, subscale scores indicate which stage of change the individual is in (McConaughy, Prochaska, and Velicer, 1983; DiClemente and Hughes, 1990).

INSTRUMENTS FOR ASSESSING TRAUMA

The Traumatic Antecedent Questionnaire (TAQ).

This widely used instrument measures lifetime experiences of trauma in 10 areas, e.g., physical, sexual, witnessing trauma (Herman, Perry, and Van der Kolk, 1989).

The Dissociative Experiences Scale (DES). This self-report measure examines several areas of dissociative phenomena (e.g., amnesia, identity alterations, and spontaneous trance states) that are often sequelae of trauma (Bernstein and Putnam, 1986).

Clinician-Administered PTSD Scale (CAPS). This clinician-administered scale provides an accurate diagnosis of posttraumatic stress disorder (Blake et al., 1995).

Trauma Symptom Checklist 40. This 40-item, self-report instrument evaluates symptoms in adults that may have arisen from trauma experienced as a child or adult. The instrument contains six subscales, and items are rated on a 4-point scale and cover frequency over the previous 2 months (Briere, 1996).

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