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The structure of correctional mental health services

JOEL A. DVOSKIN, ERIN M. SPIERS, JEFFREY L. METZNER AND STEVEN E. PITT

INTRODUCTION

The rate of incarceration in the United States continues to increase at a staggering rate. In June 1999, nearly 1.9 million inmates were incarcerated in the nation's prisons or jails (U.S. Department of Justice 2000a). By year end, approximately one in every 110 men, and one in every 1695 women in the United States were incarcerated (U.S. Department of Justice 2000b).

Commensurate with the rapidly escalating rates of incarceration in the United States is the rising number of imprisoned individuals who suffer from a mental illness. Research indicates that roughly 20 per cent of inmates in jail and prison are in need of psychiatric care for serious mental illness (American Psychiatric Association 2000). According to the Bureau of Justice Statistics, an estimated 283 800 mentally ill offenders were incarcerated in U.S. prisons and jails at midyear 1998 (U.S. Department of Justice 1999). Teplin and Swartz (1989) noted that even after adjusting for demographic differences, the prevalence rates of schizophrenia and major affective disorder are two to three times higher in jails than in the general population. Steadman and his colleagues (1987) found that the prevalence of severe or significant psychiatric disability among sentenced felons is at least 15 per cent. When coupled with mental retardation or brain damage, at least 25 per cent of the inmate population in the New York State Department of Correctional Services was found to have at least a significant psychiatric or functional disability.

Incongruities exist when looking at the disposition and sentencing of persons incarcerated with a mental illness. Axelson (1987) found that psychotic detainees charged with misdemeanors were discriminated against in accessing various types of pretrial release resulting in lengths of stay six-and-a-half times longer than non-psychotic controls. Similarly, Valdiserri, Carroll, and Hartl (1986) determined that psychotic inmates were four times more likely than non-psychotic inmates to have been incarcerated for less serious charges such as disorderly conduct and threats.

In correctional institutions, those inmates with serious mental illness or in psychiatric crisis present a host of problems to correctional administrators. One problem of course is the possibility of serious injury to staff and other inmates posed by some mentally ill inmates whose behavior is uncontrolled and violent. Mentally ill inmates may be terrified by hallucinations and stay up all night screaming, thereby keeping other inmates awake, who in turn become angry and violent in response. Thus, housing assignments must take into account the mutual fears of inmates with and without mental illness.

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

The diversity of American correctional facilities is extraordinary. Local correctional facilities range from one-person police lockups to large urban jails, which may house more than 20 000 inmates. Similarly, state prisons vary from very small field camps to walled prisons of more than 5000 inmates. Notwithstanding the differences between facilities, jails and prisons are alike in many ways. Both are viewed as correctional settings, with uniformed staff, secure perimeters (depending on custody level), and usually stark accommodations. Jails and prisons can also he very stressful environments, due to forced association, segregation by gender, and extremes

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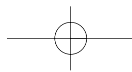


of noise and temperature. However, the challenge of keeping their respective facilities safe is the most important similarity that jails and prisons share.

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

THE LEGAL REQUIREMENTS FOR CORRECTIONAL MENTAL HEALTH SERVICES

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

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

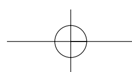
To incarcerate someone with deliberate indifference to their significant psychiatric needs is thus viewed as cruel and unusual punishment and may be remedied, often through class action lawsuits, by injunctive relief, or by compensatory and/or punitive monetary damages. The conservative turn in the federal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

Congress has also been conservative relevant to prison reform as reflected in passage of the Prison Litigation Reform Act (PLRA) of 1996 (18 U.S.C. Section 3626 (b)(2)). The PLRA established new procedural requirements for suits by prisoners and significantly limited the ability of the courts to order relief. Consent decrees now require a finding of unconstitutional conditions (i.e., admission of such conditions by the defendants), fees are limited for special masters and attorneys, and other restraints to remedies are present. The U.S. Supreme Court in *Miller et al. v. French et al.* (No. 99-224, decided June 19, 2000) upheld the constitutionality of this act that had been challenged on due process and separation of powers principles.

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

Finally, while the services described in this chapter need to be available to inmates, they do not necessarily have to be provided by or within the jail or prison itself. Indeed, it is not often especially important who provides the services, or whether the services are brought to the inmates or the inmates are brought to the services. What matters is that the inmates have access to necessary treatment.

Thus, there is a clear constitutional requirement that correctional administrators provide for the psychiatric needs of those they incarcerate. Deliberate indifference is not a high standard (Cohen and Dvoskin 1992), and it should be clear that legal considerations alone will not necessarily lead to ideal or even adequate services. Good public policy will necessitate a balancing of various considerations that include reducing liability, providing humane treatment for prisoners, and maintaining the safety of staff and other inmates, all within a framework of cost effectiveness in an increasingly conservative fiscal environment.



DIVERSION PROGRAMS

There are a number of reasons (e.g., deinstitutionalization, overcrowded state hospitals) why people with mental illness find their way into correctional settings despite efforts to divert them to alternative dispositions (Lamb and Weinberger 1998). For some, the offense will be severe and unrelated to their mental illness,[1] thus ruling out the possibility of dismissing charges or negotiated insanity pleas. For others, the stress of the correctional environment may result in decompensation in some individuals who were mentally intact in the community (Gibbs 1987; Muzekari *et al.* 1999). Finally, with the rise in illegal drug use and its well-documented relationship to criminal behavior (see, e.g., Petrich 1976; Mirsky 1988; O'Neil and Wish 1990), urban jails are facing large increases in the numbers of newly admitted inmates who suffer from drug-induced psychosis upon arrest.

Diversion programs are essentially intended to shift offenders with mental illness and/or substance abuse problems away from the criminal justice system (Draine and Solomon 1999). This does not imply, however, that mentally ill offenders should not, or would not, ever be detained. While diversion may prevent incarceration in some cases, it may also mitigate the time spent behind bars, as well as impose contingencies for after-care upon release. For those offenders requiring detention, mental health services must be provided by the correctional facility. Generally speaking, however, non-violent mentally ill offenders are not likely to have their ongoing mental health needs best met by serving jail time. Instead, the safety of the community is better served by providing a comprehensive, inclusive diversion program designed to meet the needs of the offender, as well as the mental health and criminal justice systems (Coleman 1998).

Despite widespread agreement about the need for effective jail diversion programs, existing programs share few similarities. Disparate definitions of inclusion criteria, strategies, and objectives have resulted in limited meaningful data available to evaluate existing programs and/or to provide guidelines for the development of future programs (Steadman, Steadman-Barbera, and Dennis 1994a; Steadman, Barbera, and Dennis 1994b; Steadman, Morris, and Dennis 1995; Draine and Solomon 1999). In conjunction with ongoing research regarding the effectiveness of jail diversion programs (see also Steadman, Steadman-Barbera, and Dennis 1994a and Steadman, Barbera, and Dennis 1994b), Steadman *et al.* (1999) delineated five key elements common to the most successful programs. First, effective programs included interagency involvement (e.g., mental health, substance abuse, and criminal justice systems) beginning at the program's inception. Second, regularly scheduled interdisciplinary communication between representatives was built in to the structure. Third, service integration was orchestrated by a designated 'boundary spanner' who served as a liaison between agencies. A fourth key element was the presence of strong leadership. Finally, effective diversion programs consistently employed non-traditional case management strategies. According to Steadman *et al.* (1999), there are only about fifty to fifty-five true jail diversion programs nationwide.

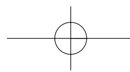
Whether diversion occurs pre or post-booking, 'the best programs see detainees as citizens of the community who require a broad array of services, including mental health and substance abuse treatment, housing and social services' (American Psychiatric Association 2000, p. 29). Program success has essentially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

SERVICE COMPONENTS OF CORRECTIONAL MENTAL HEALTHCARE

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

[1] Virkkunen (1974), for example, reported that only about one-third of violent offenses committed by persons with schizophrenia occurred during psychotic episodes.

[3] Inmates in psychiatric crisis or those with severe mental illnesses are also defendants whose competency to proceed is likely to be questioned. However, it is not necessary that jails or their mental health programs actually provide competency assessments. Such assessments by jail staff could well drain needed clinical resources away from treatment within the institution. For a more complete discussion of this topic, see Chapter 24.



Cohen (1998) lists six minimal essential elements,[4] taken from a prison class action suit in Texas (*Ruiz v. Estelle* 1980), as providing a useful framework for planning mental health services (see also American Psychiatric Association 1989; American Psychiatric Association 2000):

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

Screening

Screening is regarded as perhaps the single most important service element in correctional mental health (Pogrebin 1985; Teplin and Swartz 1989). Screening is not only a specifically required legal obligation (Cohen 1998) but is clinically and programmatically essential. It is impossible to appropriately treat serious mental illnesses or psychiatric crises without identifying the specific individuals affected. While there are a number of acceptable ways to provide this screening, several specific elements must be present:

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

[4] Cohen (1998) also lists fifteen factors combining *legal* requirements with *ideal* components of a correctional mental healthcare program.

Follow-up evaluations

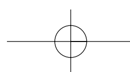
No matter who conducts screening for mental health service needs, it will be necessary to provide more extensive and detailed evaluations for those inmates identified as potentially in need of mental health services. These examinations must be timely and responsive to specific issues raised during the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

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

It is important to limit these evaluations to issues that have immediate and feasible treatment implications. Given the generally limited treatment resources in correctional settings, full-scale psychological test batteries should be limited to inmates whose symptoms raise diagnostic questions that can only be answered by psychological testing (Dvoskin 1989).[5] For inmates who appear to require psychiatric services such as psychotropic medication, a referral to the psychiatrist will then be in order. Of course, in cases where a detainee enters the jail with psychotropic medication, or a long history of such treatment, it may be cost-effective to bypass this step and have the person referred directly to a psychiatrist.

It is important to have some capacity for the emergency administration of medication during weekends and nights. On-call psychiatrists may provide telephone consultation with on-site non-psychiatric physicians, registered nurses, or physician's assistants. Twenty-four-hour on-site psychiatric availability is a luxury likely to be found only in a few very large and well-funded settings.

[5] There are of course other appropriate uses of routine psychological testing. Standardized tests have been used as part of the classification process. Various systems have been developed (see, e.g., Megargee 1976; Edinger, Reuterfors, and Logue 1982) that utilize computer-scored psychological tests such as the Minnesota Multiphasic Personality Inventory (MMPI) to make security and program classification decisions. Standardized testing may also prove useful in furthering research on the mental health need of inmates and detainees. It is not suggested that the use of psychological test batteries as a part of a component psychological assessment has no value. However, in the real world of inadequate resources, it is most unlikely that any jail would have enough psychologists to provide time-consuming clinically administered batteries to more than a small fraction of patients needing follow-up evaluation.



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In smaller jurisdictions, mobile crisis teams from the local community mental health provider or nearby general hospital emergency rooms may be able to provide services at the jail.

Psychotropic medications

Psychiatrists who work in correctional settings must be aware of all of the usual issues surrounding emergency psychiatry (e.g., Anderson, Kuelmle, and Catanzano 1976; Dubin 1988; Salzman *et al*. 1986). There are several other considerations that are especially or even uniquely important in dealing with inmates who are being treated for a psychiatric condition. People who are put in jail are rarely especially compliant. It should therefore not be surprising that inmates may be unwilling to take their medication exactly as ordered by physicians (Smith 1989). Inmates who feel oppressed by the criminal justice system often view psychotropic medication ordered by an institutional physician as an instrument of that oppression. Alternately, it is possible that inmates who are not suffering from a mental disorder may seek psychotropic medication in hopes of alleviating some of the situational stresses associated with their incarceration, or in hopes of selling them for profit.

Limitations in psychiatric resources are a significant issue in the provision of psychotropic medications to inmates. Busy physicians may spend an inadequate amount of time explaining the need for medication, its value to the inmates, or what to do about side effects. Moreover, systemic constraints on the flow of information may create protracted time periods between an inmate's initial complaint of side effects and his or her appointment with a physician. If dosages are not carefully monitored and adjusted, the patient may experience a variety of unsettling, uncomfortable, and even dangerous side effects. As a result, correctional nurses need to take special care when administering medications in the jail to ensure that the inmates are not 'cheeking' medications to appear compliant or to save for later sale. Minor tranquilizers are especially prone to abuse and black market sale within the jail, and therefore are often not included in correctional formularies.

Finally, at least some time should be devoted to explaining to inmate patients the need for psychotropic medication, beyond what may be typically provided for informed consent. More formal prison-based patient education programs, while still comparatively new, have shown an ability to significantly increase inmates' knowledge of the symptoms and treatments of schizophrenia (Melville and Brown 1987).

Case management

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

Within the correctional setting, stressors may build up in the absence of supportive services. It therefore is important periodically to 'check in' with identified psychologically vulnerable and mentally ill inmates even during periods of apparently good adjustment. The establishment of a tracking mechanism identifying those inmates who are not receiving active mental health services, yet have a history of mental illness, can be of great benefit toward the maintenance of the inmate's psychological fitness. Case managers are ideal providers of such a service. Even annual visits with a case manager will allow the inmate a sense of connectedness and security, while simultaneously providing the mental health department with an opportunity to monitor the inmate's status. These very brief contacts are a worthwhile investment, especially if they prevent more serious exacerbations of an inmate's condition, thereby forestalling more extensive and costly services. Therefore, the inclusion of case management services offers the facility a prophylactic tool, reducing financial burden, as well as mediating the potential for crises that disrupt normal facility functioning.

Case management is even more effective in linking inmates to appropriate mental health services upon their release (Griffin 1990). Prior to discharge, case managers can play an integral role in the building or nurturing of social supports, such as helping the inmate to contact family or friends. Such collateral contact can be particularly helpful toward improving an inmate's quality of life while incarcerated as well as upon return to the community (Jacoby and Kozie-Peak 1997). Perhaps most importantly, however, case managers serve as a bridge, linking inmates with providers in the community. Continuity of care is critical to appropriate mental health service and falls well within the venue of case management service. Even the most impressive correctional mental healthcare program can be rendered futile if the inmate patient is not linked with appropriate services after discharge (Steadman, Morris, and Dennis 1995). Lamb and Weinberger (1998) assert that appropriate implementation of mental health services (and use of case managers) 'would mean tailoring mental health services to meet the needs of mentally ill offenders and not treating them as if they were compliant, cooperative, and in need of minimum controls.' Unfortunately, the criminal justice system is largely unprepared to provide case management services to mentally ill offenders upon release (Lamb and Weinberger 1998).

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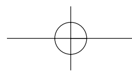


Crisis intervention

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

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

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

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

Every jail and police lockup that receives direct admissions from the street must have access to medically supervised alcohol and drug detoxification services. However, this detoxification is primarily medical in nature and is not a mental health service.[6] Consultation services, when provided by mental health staff to correctional staff, can vary extensively, from sophisticated suggestions for handling difficult inmates to simply suggesting a cell change. The mental health staff must be viewed as supportive of the correctional staff's mission to make the facility safe for everyone.

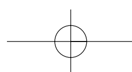
Special management precautions in response to psychiatric emergencies include moving the inmate to a different bed location, thereby separating violent inmates from others, possibly allowing for easier and more frequent observation or closer proximity to nursing or other services. Often inmates will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

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

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

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

[6] Obviously, once detoxification is safely accomplished, assessment should be made of any need for subsequent mental health service, but it is worth reiterating that the act of detoxification is a medical function.



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

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

Suicide prevention

Although suicide is clearly but one of several avenues of potential crisis in the correctional setting, its impact demands special consideration. Suicides in jails and prisons are often preventable and may exceed general population rates if a suicide prevention program is not established. Especially in local correctional facilities, suicide prevention has received a great deal of attention (Atlas 1989; Cox and Landsberg 1989; Cox, Landsberg, and Pavarotti 1989; Haycock 1989; Hayes 1989; O'Leary 1989; Rakis and Monroe 1989; Sherman and Morschauser 1989). In brief, research has shown that the period of greatest vulnerability is during the first 8 hours of incarceration, which may well occur during the evenings or weekends when no clinical professionals are present. Despite a dramatic increase in jail suicides across the nation during the past few years, a comprehensive statewide program in New York seems to have enabled sheriff and police departments actually to reduce suicides (Cox, Landsberg, and Pavarotti 1989). This state-funded program is a simple and locally implemented scheme of staff training and procedure development for identifying and managing inmates at high risk of suicide, and is described in greater detail in Chapter 51.

The results of the New York program have been impressive. In upstate counties, for example, despite increasing admissions, censuses, and overcrowding, jail and lockup suicides dropped from a high of thirty during the year prior to the program's inception in 1985 to successive years of twenty-five, sixteen, eight, and only five in 1989 (New York State Commission of Correction 1989).

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

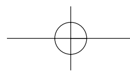
External hospitalization

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

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

Telemedicine

Telemedicine is essentially the transmission of electronic information, such as voice data and tele-images, across geographically distant communication facilities, thereby allowing for long-distance patient healthcare and/or diagnosis (Charles 2000). Telemedicine has been used to enhance treatment options for geographically remote patients for almost four decades (Stevens *et al.* 1999). More recently, however, the rising cost of healthcare, including mental healthcare, has generated heightened interest in telemedicine and its promise of increased accessibility coupled with decreased cost. Technological advances (Mair and Whitten 2000) and decreasing



implementation expenses (Strode, Gustke, and Allen 1999) have enhanced the appeal of telecommunication as a viable alternate treatment modality.

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

Stevens *et al.* (1999) reported that non-incarcerated patients and their treating psychiatrists were able to develop rapport via televideo just as well as when they were in the same room. Similarly, preliminary data from the Federal Bureau of Prisons (BOP) telehealth pilot program indicated that virtually all inmate-patient participants, as well as treating psychologists and psychiatrists, have expressed satisfaction with telehealth services (Magaletta, Fagan, and Ax 1998). The BOP telemedicine and telepsychiatry programs have been successful to such an extent that the Bureau is in the process of implementing telehealth technology system-wide (I. Grossman, personal communication, August 29, 2000). The Texas Department of Criminal Justice, Institutional Division, in conjunction with the University of Texas Medical Branch and Texas Tech University Correctional Managed Care organizations, has likewise enjoyed a successful telemedicine program. The UTMB region telepsychiatry division alone serves over 200 inmates per month and has received overwhelmingly positive responses from inmates and psychiatrists alike (R. Stanfield, personal communication, August 23, 2000; P. Nathan, personal communication, September 7, 2000).

Despite clear benefits associated with these technological programs, the advancement of telepsychiatry and psychology will be accompanied by several ethical and professional issues that must be examined and addressed by sound researchers, licensing boards, and by updating standards of practice.

PSYCHOLOGICAL THERAPIES

Individual therapy

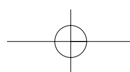
Environmental pressures inherent to the correctional setting can engender mental distress (Lindquist and Lindquist 1997). Even the most mentally healthy inmates may periodically find themselves in need of psychological services while incarcerated. Often, brief therapeutic contact is sufficient to alleviate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

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

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

Group therapy

Group psychotherapy is the most cost-effective method of mental health treatment in corrections (Metzner *et al.* 1998). It is an ideal modality for providing much-needed services to large numbers of inmates despite the common paucity of resources. Moreover, group therapy sessions may be conducted independently, or co-facilitated



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by mental health staff with varying levels of professional training. Creative and thoughtful matching of mental health staff expertise with the subject matter of the therapy group can be of great benefit. For instance, practical and applied topics, such as anger and stress management, are ideal material for correctional group work. Utilizing a staff psychologist (Masters or Doctoral level) in combination with a social worker or case manager affords participants with complimentary balance in perspective and feedback. Alternately, a psychiatric nurse may be the ideal candidate to run a medication education or life skills group.

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

Substance abuse

As many as 75 per cent of all prisoners can be characterized as having a history of alcohol or illicit drug use (U.S. Department of Justice 1998). The high rate of comorbidity between substance abuse and mental illness (Carey 1989), may be nowhere more apparent than among the offender population (Abram and Teplin 1991; Edens, Peters, and Hills 1997; Swartz and Lurigio 1999). Abram (1990) demonstrated the high prevalence of inmates with co-occurring disorders, including substance abuse and depression, most often with antisocial personality disorder being the primary syndrome.

For inmates with co-occurring mental health and substance abuse disorders, accurate diagnosis and subsequent treatment planning is complex, primarily as a result of the complicated symptom picture presented (American Psychiatric Association 2000). Symptoms of one syndrome often mask those of another, and abuse of alcohol and other drugs can exacerbate psychiatric symptoms and even bring about psychotic episodes that may persist after intoxication subsides. The unfortunate result is that the presence of co-occurring disorder is often missed during the screening process (Edens, Peters, and Hills 1997).

Indeed, these co-occurring disorders are a growing concern among virtually all segments of the mental health system. The needs of the multiply disordered population continue to rise and clearly must be addressed (Abram and Teplin 1991). The greater the relevance of substance abuse in an inmate's criminal background, the more important it is to identify and treat the problem, and to continue services upon release (Rice and Harris 1997). However, despite a growing number of treatment options, correctional facilities do not appear to have kept up with the demand for services (Metzner *et al.* 1998; Swartz and Lurigio 1999). Toward the goal of improving treatment programming, the American Psychiatric Association (2000) offers the following strategies to address the issue of co-disorders in the correctional setting:

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

Abram (1990) concluded, 'Intervention programs aimed at substance abusers or (persons with depression) which do not address the elements necessary for treating co-occurring character disorders may have a minimal impact on either the detainee or the crime rates' (see also Mirsky 1988). Timely, comprehensive and integrated treatment of co-occurring disorders is essential toward the goal of ultimately disrupting the offense and criminalization cycle so common in this population.

STAFF TRAINING AND CONSULTATION

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

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

confronted with issues surrounding mental illness in the course of their daily work.[7]

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

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

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

Finally, in addition to treating inmates, mental health professionals can also help to reduce job-related stress among correctional line staff (Dembo, Williams, and Stafford 1986–87). Employing an open-door policy for correctional staff, providing literature on stress management, and/or offering consultation and referral services, allows officers an avenue of recourse when work stress becomes overwhelming. On the other hand, providing mental health services to fellow employees is not recommended, due to the high likelihood of conflicting relationships. Essentially, all persons who live and work in a correctional facility are faced with similar daily stresses in terms of danger, noise, temperature, and the like. Extreme stress in officers may inherently compromise officer–inmate relations, in turn leading to exacerbation of inmates' psychological issues. Once again, open and active discourse, and simple human support may be among the most vital components of a successful program.

[7] Sowers, Thompson, and Mullins (1999) provide an excellent mental health resource for correctional officers.

SPECIAL HOUSING AND MANAGEMENT OPTIONS

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

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

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

SPECIAL-NEEDS INMATES

Minorities

For some ethnic minorities and non-English-speaking inmates, jails can be frightening and oppressive places.

For example, Foster (1988) reports that traditional psychiatric approaches may not work well with Native Americans in the federal prison, system. Similarly, Black and Hispanic people in jail are typically less often served by the mental health system (Steadman, Holobean, and Dvoskin 1991). This phenomenon may reflect an unwillingness to seek help from predominantly white providers, but may also reflect subtle and even unintentional racism among those same providers. Toch, Adams, and Greene (1987) found a number of ethnic differences in prison infractions, and concluded that subcultural and psychological predispositions may converge to produce prison adjustment problems.

Women

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

For some women, being locked up in a very small space by intimidating male authority figures can be frighteningly reminiscent of childhood experiences. For female inmates, especially those who have survived traumas, being strip-searched and showering under observation can seem abusive.[8] Incarcerated females in New York frequently reported long histories of sexual violence at the hands of fathers, husbands, boyfriends, and strangers (Browne 1987). This abuse is often directly linked to the instant offense, as in the case of women who kill abusive spouses to protect themselves or their children.

Older inmates

The number of older inmates has increased rapidly over the past decade (Metzner *et al.* 1998). In the correctional context, due to histories of poor healthcare and multiple traumatic injuries, it has been suggested that age 50 years (rather than 65 as is the general population) can be considered a useful criterion for identifying geriatric inmates (American Psychiatric Association 2000). Generally speaking, the offender population is likely to have conducted their lives in a manner less conducive to good physical health, thereby lowering the threshold for common ailments associated with aging. The elderly inmate is subject to the normal stresses of growing old, along with numerous exacerbating factors such as physical vulnerability to other inmates, estrangement or isolation, and a greater likelihood that they will die behind bars (American Psychiatric Association 2000). As this subset of incarcerated offender continues to grow, so to will the incidence of age-related psychiatric and medical disorders. Correctional mental health professionals should be aware of, and plan for, the special needs of the incarcerated elderly.

Physical disabilities

Regardless of age, inmates – much like the general population – present with myriad medical and physical disabilities. Mental health service providers must be mindful of the special challenges posed to inmates who are physically disabled, deaf, or blind. This population may be especially vulnerable in a correctional setting. In addition to predatory peers, the occupational and recreational opportunities may be limited, exacerbating the normal stresses of incarceration.

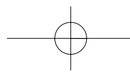
CORRECTIONAL HEALTHCARE STANDARDS

Numerous sets of standards and guidelines for correctional healthcare programs have been promulgated by national organizations such as the American Association of Correctional Psychologists (1999), American Bar Association (1985), American Correctional Association (1990), American Nurses' Association (1985), American Psychiatric Association (2000), American Public Health Association (Dubler 1986), National Commission on Correctional Health Care (1996, 1997, 1999), National Institute of Corrections (Anno 1991), and the United Nations (1975). There is a clear trend that the various state Departments of Correction (DOC) are attempting to conform to some national set of standards (Hayes 1989; Metzner, Fryer, and Usery 1990; Metzner 1993).

The most current and widely referenced standards and/or guidelines for correctional mental health services have been published by the American Psychiatric Association (APA) (2000) and the National Commission on Correctional Health Care (NCCHC) (1996, 1997, 1999). The NCCHC evolved from a program within the American Medical Association that published its first healthcare standards for prisons and jails in 1979. The NCCHC standards focus predominantly on general healthcare issues, although they have increased their focus on mental health issues in recent years (NCCHC 1999). The guidelines developed by the APA task force, which assume compliance with the NCCHC standards, provide more specificity relevant to mental health services.

The American Correctional Association (ACA), through an annual Standards Supplement (American

[8] Male victims of child sexual or physical abuse, as well as other crime victims and combat veterans, may also encounter symptoms of post-traumatic stress disorder while in jail or prison. Therefore, the discussion of trauma and abuse should not be interpreted as gender-specific.



Correctional Association 2000), has significantly improved recommendations relevant to health services in correctional facilities. Although the ACA standards are less than comprehensive, they are to be applauded for current efforts to upgrade them. The ACA is in the process of developing performance based standards that will, hopefully, expand the current (American Correctional Association 1989; American Correctional Association 2000) recommendations pertinent to healthcare standards. The ACA project appears to be similar in scope to another pilot project, involving thirty-two facilities across the United States, established by the Office of Juvenile Justice and Delinquency Prevention (OJJDP) in cooperation the Council of Juvenile Correctional Administrators (CJCA). The OJJDP formulated twenty-two performance-based standards that include the areas of health and mental health, which are being tested in their pilot program (see www. Performance-standards.org/contact.htm).

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

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

- mission and goals;
- administrative structure;
- staffing (i.e., personnel and training);
- reliable and valid methods for identifying and tracking inmates with severe mental illness (best done via a computerized management information system);
- availability of treatment programs;
- involuntary treatment including the use of seclusion, restraints, forced medications, and involuntary hospitalization;
- other medical-legal issues such as informed consent, right to refuse medications, and record release authorizations;
- limits of confidentiality during assessment evaluations and/or treatment sessions with relevant exceptions noted;
- mental health record requirements;
- quality improvement plan;
- training of mental health staff regarding security issues;
- training of correctional stall concerning mental health issues; and
- research protocols.

The APA guidelines recommend that the fundamental policy goal for correctional mental healthcare is to provide the same level of mental health services to each patient in the criminal justice center that *should* be available in the community.

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

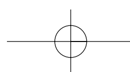
The NCCHC recommends that staffing levels include a sufficient number of health services staff of varying types to assure timely inmate access to evaluation and treatment consistent with contemporary standards of care. The APA recognizes the importance of a multidisciplinary mental health staff. The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

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

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

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

- acute care (e.g., crisis intervention, infirmary care);
- longer-term care;
- transitional care (e.g., residential treatment within the correctional facility);



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- outpatient treatment; and
- inpatient hospital treatment.

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

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

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

SUMMARY AND CONCLUSIONS

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

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

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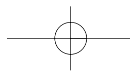

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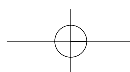

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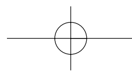

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