

National Overview of Mental Health Issues in Corrections

**Prepared for the Correctional Institution Inspection Committee
by the Correctional Institution Inspection Committee Staff**

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Introduction

Mental illness exists throughout societies, but the presence of mental illness among incarcerated individuals represents a larger percentage than what is found among society's general population. The focus of this brief is not on the reasons for this demographic fact, but rather on the care, corrections, and programs provided to individuals of this classification who are living in state penal institutions and emerging as parolees.

Executive Summary

State departments of corrections are emerging as the primary provider of services to mentally ill offenders following closure of many state mental institutions. There is, therefore, an increase in interest in this area of criminal justice. Collective knowledge about the care, corrective and rehabilitative measures, understanding of programs, and knowledge of the psychological and physical needs of inmates deemed to be seriously mentally ill and/or in a high-risk category is important to the delivery of appropriate services and programs. The research relays that some of the higher costs in corrections are those associated with higher-security/high-risk inmates. The mentally ill have traditionally been placed in the high-security/high-risk categories. A clear understanding of this segment of the population is needed to develop and deliver care, correctional measures, and programs that favor the goals of ethical and practical responsibility and fiscal accountability.

Most of this brief is presented in three sections (I, II, III) under **Findings**.

- I: Overview of Issues and Broad Recommendations Impacting the Topic.
- II: Summary Points and Key Statements.
- III: Review and Comparison of Programs in Other States.

Research Process and Sources of Information

The research process in preparation of this brief included the extraction of data from several reports, some of which were prepared following surveys and research, by noted organizations involved in this subject. Other sources include state legislative bodies and state agency level research, and are predominantly represented in Section III.

Section I is a compilation of comments from many sources found online as well as in print. Core issue concepts as well as details worded as operational directives are presented briefly in list format and represent some of the primary thoughts that were conveyed with frequency throughout the sources consulted. The brevity of the list is intentional, offering a quick overview of topics attracting attention and generating opinion. Most of the entries in the list appeared more than once and in multiple sources,

thus there are no individual citations. This list is not intended to be comprehensive; it simply provides a sampling of topics often addressed within the discipline. The comments are not intended to be interpretations of absolute truths, but rather of generally communicated opinions and concerns within the industry.

Section II is a synthesis of a report, Effective Prison Mental Health Services: Guidelines to Expand and Improve Treatment, which was produced by the National Institute of Corrections (NIC) for the U.S. Department of Justice in 2004. The NIC is considered to be an authority within the corrections industry. Applicable citations referenced in the NIC report are included in this brief. Information in this report is likely to have practical application to any consideration of recommendations and standards of institutional operation. Throughout the report references are made to ‘recommendations.’ Where possible, a ‘summary’ of the recommendations is included and may appear as a list. In other cases, ‘recommendations’ are simply imbedded in the narrative of the text.

Section III presents some data to show some of the efforts and activities that have occurred in several states in dealing with mentally ill offenders. The information in Section III is not intended to provide a comprehensive state-to-state treatment, but simply allows for a view of some of the work that has been completed in this area of corrections.

The sources that were consulted in preparation for this brief are found in the following list. Some of these sources were recommended due to their authority in the field and other sources were discovered as the research progressed.

SOURCES

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- *Ill-Equipped: U.S. Prisoners and Offenders with Mental Illnesses.* Human Rights Watch, New York. 2003. Pages 1-215.
- *Linking Mentally-Ill Offenders to Community Care.* Legislative Analyst’s Office, California.
www.lao.ca.gov/analysis_2000/crim_justice/cj_2_cc_mentally_ill_an100.htm
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- *Provisions of Mental Health Care in Prisons: Special Issues in Corrections.* U.S. Department of Justice, National Institute of Corrections, Information Center, Longmont, Colorado. February 2001. Pages 1-9.
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- Rold, William J., *Consideration of Mental Health Factors in Inmate Discipline.* National Institute of Corrections, Information Center. Correctcare, Volume 6 Issue 2, Spring, 1992. Pages 1-6.
- *What Do We Know About Mental Disorder and Violence?* January, 1993. National Institute of Mental Health.

Findings

SECTION I

Overview of Issues and Broad Recommendations Impacting the Topic

The following overview of comments was extracted and blended from the above named sources. Some of the sources used nearly the same or similar words to convey the concepts. The list may serve as an overview of commonly posed and/or generally accepted issues for consideration. By virtue of their frequency or prominence in the literature, they may help one to see which issues appear to be claiming attention for study and potential applicability to the current evolution of corrections as it relates to individuals who are mentally ill and incarcerated.

Complexity of Mental Illness

1. Mental illnesses and disabilities among offenders is a complex issue.
 - a. Mental illnesses and disabilities underlie some, but not all, disruptive behaviors.
 - b. Public perception prevails that there is a direct link between mental illness and violence, which is not always true and in the least is an oversimplification of the true correlation between mental illness and violence.
 - c. Insanity and competence should be distinguished. There is a distinction drawn between *insanity* (mental status at time of alleged act) and *competence* (ability to understand legal proceedings and assist in defense at trial).
 - d. Specific and diverse populations may be found among the mentally ill population: women (statistically, more women than men are considered to be in need of mental illness services), those with a dual diagnosis (mental illness and substance abuse, mental illness and sex offense), maximum security or ‘supermax’ inmates, juveniles, elderly, and ethnic, racial, or cultural minorities.

Care of the Mentally Ill as a State Responsibility

2. The care of the mentally ill offender has increasingly become the responsibility of state departments of corrections due to the closure of state mental health hospitals.
 - a. While there has been a history of containment regarding the mentally ill, the concept of treatment over containment suggests that there is value in managing and treating mentally ill offenders through mental health resources rather than criminalizing them. Even though the mentally ill offender is likely to receive prison sentencing, it is becoming acknowledged that incarceration of the mentally ill may not be the best solution.
 - b. There is an emerging philosophical premise that suggests that people should not be punished for behavior that they are not mentally responsible for, by virtue of their mental illness or insanity. Consequently, punitive treatment of people with mental illnesses within institutions has become a topic for attention and a subject for reformation in recent years.
 - c. There exists, however, an absence of protection in some prison or jail environments and penalties may be administered to the mentally ill. The application of 'grace' for acts committed under mental illness in the prison or jail may not always prevail.
 - d. There is an argument for the state to provide a variety of dispositions and sanctions that accommodate mental health differences. Customization of each inmate's treatment, including penalties for noncompliance, and giving consideration to the effects of certain forms of sanctions on specific individuals and forms of mental illnesses, may prove to produce favorable results in cultivating improvements in the care of the mentally ill. Specific approaches may add more fairness to disciplinary processes applied to the mentally ill. Newer approaches may ameliorate unnecessary suffering, broaden understanding of mental illness as an illness rather than a character flaw, and avoid litigation and associated costs.
 - e. The issue of violence in state institutions associated with the mentally ill generates debate. Some philosophies suggest a shift from the use of larger and more secure institutions to the use of proactive and preventative strategies to reduce violent incidents among the mentally ill within institutions. Modification of inmate behavior through the use of specific programming and treatments, while the inmate is still in general population and prior to separation in segregation, is representative of some theoretical changes to reduce violence.

Percentage of Inmates Who Need Psychiatric Intervention

3. The percentage of prison inmates in need of psychiatric intervention may vary, but estimates in the literature suggest an average range from approximately 16% to 25% of inmates in state prisons are candidates for psychiatric services. In addition to mental illnesses among inmates, mental retardation, developmental disabilities, and seizure illnesses exist.

Identification Criteria

4. Identification of levels of mental illnesses and disabilities among inmate populations requires the use of certain criteria. The following criteria may be among those used in establishing measurements and ratios of prevalence within institutions.
 - a. Number of inmates classified at specific psychological grades or mental health ratings.
 - b. Number of inmates requiring placement in special units or mental health facilities.
 - c. Number of psychotropic medications that are prescribed.
 - d. Number of inmates with major mental illnesses.
 - e. Number of incident reports involving inmates affected by mental illness or disorders.

Risk Assessment

5. Research should continue in risk assessment and how to prevent violence. Risk is the potential for serious misconduct within the prison. Studies should research the effects that environment has on behavior, impact of prison architecture on behavior, and management methods and the behaviors that result. Included in studies should be issues related to super-maximum security facilities, identification of inmates in need of special management, length of time an inmate should remain in segregation, interventions that may be effective in controlling high-risk behavior, guidelines for returning inmates to general population, and how inmates behave following transition steps. Screening tools should include the following measurements.
 - a. General criminology or criminal behavior.
 - b. Sex offenders' risk of recidivism.
 - c. Psychopathic violence level.
 - d. Gang affiliation or gang influence.

Classifications of Mental Illnesses

6. Classifications of mental illnesses are assigned to individuals in order to determine levels and intensity of mental health services and a treatment plan to provide those services to the inmate. Levels should be included for intermediate and chronic mental services. Mental health services should be provided in both gradations and intervals, and also provided in a continuous and long-term manner.

Outdated Data Systems

7. Some states are in need of upgrading data systems to quickly and accurately aggregate the number and types of prisoners, including those classified as mentally ill, who are in their custody.

Inconsistent Terminology

8. There is a need to see the larger picture in philosophies, operations, and results associated with the handling of mentally ill inmates. The current lack of consensus and common terminology should be replaced with consistent and cross-jurisdictional definitions for such concepts as general population, special management, administrative segregation, disciplinary segregation, protective custody, severe mental health care, and severe medical care.

Need for Best Practices

9. Relevant to operations, there is a need to identify, replicate, and revise “best practices” to assure that practice directly addresses need. Also, new or model programs may be considered. Identification of existing best practices found across jurisdictions could include a consideration of target populations, screening processes, specific common and unique programs and services, breadth (variety) and depth (intensity and duration) of programs and services, and staffing levels.

Management and Treatment

10. Screening and assessment are most commonly used to distinguish an inmate’s need for services and a treatment plan respectively and are essential to the delivery of appropriate services. Screening should take place at reception.
11. Categorically, topics related to operational procedures in the management and treatment of inmates with mental illnesses could account for most of the voiced concerns dealing with mentally ill offenders. Methods and treatments become imbedded in current and evolving operational practices applicable to the care of mentally ill offenders. Regulations and operating procedures have evolved over recent decades, beginning in the late 1980s when some separate consideration was given to mental health factors, especially relevant to determining discipline to inmates. Innovative and promising programs need to continue to be developed

and considered, especially those that are relevant to the management and treatment of the mentally ill offender. Some of the prominent operation-related or method-related points that emerged from the sources are presented below.

- a. Comprehensive care for the mentally ill often includes the use of psychopharmacological approaches (medications), counseling, separate housing, a variety of programs (including innovative and peer-based programs), periodic mental status reviews relevant to appropriate classifications, and treatment plans that may link to services beyond incarceration.
- b. Psychopharmacological treatments may offer newer, improved, and additional modes of treatment, but may also carry some risks, benefits, offsetting costs, and should be managed only by qualified physicians and staff.
- c. Counseling for non-acute mentally ill inmates may vary among institutions. The amount of time for delivery of counseling averages approximately one hour per week from state to state.
- d. Separate housing issues may cause much debate due to diverse philosophies and management approaches. It is generally accepted that ideal housing should accommodate mental needs and be flexible in order to change in response to inmate needs. Some state agencies try to mainstream and other agencies prefer to separate the mentally ill from general population. The use of segregation housing for the mentally ill has come under scrutiny and subject to debate in recent years. Policies of prohibiting isolation or the solitary confinement of inmates with severe mental disorders or a current psychotic disability have received attention. Given that individuals with mental disabilities often have low frustration tolerance in certain situations, segregation or seclusion can be counter-therapeutic for mentally ill and disabled inmates by exacerbating mental conditions and causing more deterioration of mental functioning. Mental health professionals often conduct a mental health review prior to segregation placement and at intervals while in segregation. An inquiry into the consequences of proposed dispositions and sanctions on inmates is a valid and important step in the review. Institutions commonly use specific criteria to determine housing.
 - i. Common criteria are used to determine if and when separation is made. Among the criteria are (1) treatment for inpatient care, (2) in crisis or acute state of mental illness, (3) cannot function adequately or cope with general population, (4) severely impaired or is becoming more psychotic or decompensating, (5) is considered dangerous, suicidal, or at risk of self-injury.

- ii. Other criteria include when the inmate needs structure, his or her General Ability to Function (GAF) score drops under 50, needs help staying on medications, becomes a management problem, is unable to care for himself or herself, is vulnerable, needs more observation, becomes a threat, or is sanctioned.
 - iii. Separation housing may consist of short-term units, long-term units, designated DOC institutions, special facilities operated by other state entities (such as a state hospital), or outside state agencies (such as a Department of Mental Health).
 - iv. Restrictions of segregation housing may or may not include cell restrictions of 22-23 hours per day, limited visitor contact, required restraints at all times when moving, restricted inmate contact or no inmate contact, little or no participation in a transition program prior to re-entry to the general population. Some segregation policies establish maximum limits on the length of stay in a segregation unit.
 - e. Programs must be appropriate to the needs of the inmate and program efficacy (effectiveness) should be determined. Objective, rather than subjective, analysis would give credibility to determinations of whether to continue, alter, or discontinue specific programs, treatments, or management practices.
12. Treatment plans should be in place for each mentally ill inmate and the plans should consider the nuances of the mental illnesses and disorders; for example, environmental factors can play a role in prompting a violent incident (see comments relevant to segregation and isolation housing in 9d). The probability of risk of violence in persons with mental illnesses may increase if the person perceives a threat against them. Treatment plans should be inclusive of all details that impact and affect the inmate. Treatment plans should involve input from both mental health administrators and correctional agencies.
13. Reviews of mentally ill inmates are an essential component in the delivery of appropriate services, beginning with an initial inquiry by a trained hearing officer, continuing throughout the sentence period, and completed at transition points and at discharge from a psychiatric hospital or prior to returning to solitary confinement. Sources identified that qualified mental health professionals should conduct reviews, however there is a need for all hearing officers and security staff, including those in jails, to become trained and better equipped to deal with the special needs of psychiatric patients.
14. Cooperation between correctional agencies and mental health administrators should be maintained. Collaboration between both professional entities is necessary for effective services to be delivered.

Staff Training

15. Staff training is at the core of effectiveness in operating procedures. Without training, corrections staff in prisons and jails may not recognize or understand that an inmate's mental disability may be at the root of many inappropriate inmate actions. Jails are generally not as well equipped in training staff to deal with the special needs of psychiatric patients as the state prisons. Staff training programs vary in the number of hours, frequency of training sessions, levels and types of mental illnesses studied during training, and may take the form of pre-service or in-service training. Personnel responsible for managing and treating offenders with mental illnesses need a solid understanding and training in problems, strategies, principles, practices relevant to treatment delivered during incarceration, and to the process of planning an inmate's re-entry into the community.

Re-Entry Planning

16. Re-entry planning should start early. Planning for community re-entry should include identification of obstacles to implementation.

Litigation

17. With a rise in litigation, issues should be addressed fully and with accountability. Issues that may be addressed in courts have previously included, for example, the criteria used for designating an inmate for special management, the conditions of confinement, and the process or lack of a process for releasing an inmate back to the general population.

Fiscal Research

18. Research in fiscal issues relevant to meeting the needs of special management and high-risk inmates with mental illnesses should be ongoing and begin with the premise that a reduction in special management population and replacement of traditional models of special management operations may reduce some costs. Complete risk assessments of fiscal increases and decreases should include both actuarial assessments and professional assessments.

SECTION II

Summary Points and Key Statements (from the National Institute of Corrections for the U. S. Department of Justice)

The information in this section represents the findings of the U. S. Department of Justice, National Institute of Corrections, and published in the May 2004 report, Effective Prison Mental Health Services: Guidelines to Expand and Improve Treatment.

The report offers information in eight categories, which reiterate the major topical themes found in other literature relevant to the handling of mental health issues and the mentally ill within correctional institutions. The eight categories identified in the report include (1) screening and assessment, (2) treatment plans, (3) segregation, seclusion, and restraints, (4) suicide prevention, (5) treating women offenders, (6) psychopharmacological intervention and psychiatric disorders, (7) transitional services, and (8) treatment of special populations.

Beginning with an acknowledgement, as that stated in the Effective Prison... report, that individuals with mental illness pose special challenges to every level of prison staff, from correctional officers to medical staff to administrators, and that staff often do not have the knowledge, training, and experience they need to adequately handle inmates with special needs, some consideration and study of each of the eight identified topics seems justified.

An expansion in practical knowledge that has the potential to transform the delivery of services to mentally ill offenders and simultaneously improve the efficiency and effectiveness of institutional operations is a worthy endeavor. The following paragraphs in this section represent a synthesis of the treatment given to the eight themes as discussed in the report. Wherever possible, information from the report that is suggestive of a philosophical or operational guideline or a *recommendation* has been included. Some of the narrative may, therefore, read as if to be instructional directives.

Screening and Assessment

Policies and procedures for assessing, screening, and treating inmates for mental disorders and substance abuse are increasingly necessary in prisons due to increasing prevalence. Valid reasons to screen are twofold: the improvement of clinical services to the inmate and the need to comply legally with the rights of the inmate to receive appropriate services and thus, prevent unnecessary litigation. To start, a close analysis of the definitions of 'screening' and 'assessment' offers clarification, which should contribute toward maintaining quality in the application of these two processes.

Screening is a process of information-gathering that includes an interview, review of existing records, and administration of specialized instruments or tests to identify inmates who may require particular intervention or treatment. *Assessment* is a process of examination or evaluation following the screening. Assessment determines what type of intervention or treatment to deliver. It provides information for planning and implementation of appropriate treatment, and it includes detailed interview and record reviews. The assessment may also include the administration of other tests or instruments. Assessment interviews include (a) current mental status exam, (b) description of appearance, orientation, behavior, thought quality, and thought content, and (c) noted presence of severe psychiatric symptoms and self-reports of recent changes in appetite, sleep, or sexual drive.

One of the challenges to maintaining highest quality in the screening and assessment processes includes the accuracy of the screening, which is determinant upon the quality of staff training and resultant staff skills. Staff members are not always trained to recognize all symptoms. For example, making distinctions between serious mental illness and malingering or adjustment disorders requires specific training. Another set of screening challenges exists when inmates do not know that they have a mental illness or do not want others, including fellow inmates, to know that they have a mental illness, or when preexisting conditions are compounded by newly developed conditions that develop as a result of incarceration after entry into the institution. An inmate's inability to think abstractly or lack of verbal skills may inhibit their ability to put common symptoms into words. Quietly psychotic or depressed inmates are harder to recognize and suicide prone inmates may not be readily identified, which puts them at high risk. Even cultural differences may make a difference in the screening and assessment processes; for example, some cultures accept the hearing of voices.

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

The APA recommends an initial screening immediately upon entry (at the time of admission) to the system that includes observation and structured inquiry with a set of standard questions for all inmates to be administered by a qualified mental health professional or trained correctional officer. Following the initial screening, APA recommends a more detailed, thorough, and structured intake mental health screening to be included as part of the standard medical screening received by all inmates within seven days of admission by a qualified health care professional. APA recommends a subsequent assessment within 24 hours of receiving a referral from the screener for any inmate who is identified through the screening process as having a mental illness or disability. The assessment should be completed by an appropriately trained mental health professional.

NCCHC has developed standards for two levels of mental health screenings. A first screening within 2 hours of arrival should be completed by qualified *health care* personnel (licensed, certified, or registered professionals or technical workers who assist physicians within the state of their practice). A second level of screening is a postadmission mental health evaluation or assessment within 14 days of admission to the prison and 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. The following elements are included in the NCCHC's recommended mental health evaluations.

1. Psychiatric history, including hospitalizations and outpatient treatment.
2. Current use of psychotropic medications, if any.
3. Current suicidal ideation.

4. History of suicidal behavior.
5. Current and prior drug and alcohol usage.
6. History of sex offenses.
7. History of violent behavior.
8. History of being victimized by criminal violence.
9. History of special education placement.
10. History of seizures or cerebral trauma.
11. Emotional response to being incarcerated.
12. Intelligence testing for mental retardation, which is required by NCCHC guidelines (1999).

Separate guidelines and recommendations for *screening substance abuse* have been developed by the National Institute of Corrections (NIC) and the Center for Substance Abuse Treatment (CSAT). The guidelines and recommendations for screening substance abuse are not included in this report, but are available from the organizations that developed them.

Special Considerations Relevant to Screening and Assessment. Considerations for several mental health issues should be structured into the screening process. A primary function of screening is to identify inmates who are at *risk of suicide*. This screening typically occurs at reception or entry to a permanent institution. When an inmate screens positive for suicide risk, 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 and change* can help providers determine what type of treatment intervention to provide and how to maximize treatment efficacy by matching interventions to different levels of readiness to change. *Co-occurring disorders*, such as mental illness and simultaneous substance abuse, prompt special screening and special consideration. *Ethnic, cultural, and gender issues* should be taken into consideration in screening and assessments due to the differences that ethnicity, culture, and gender (including a growing number of women offenders) play in accepted ways of expressing their suffering emotionally, physically, and psychologically. Professional competency in this area requires full knowledge of the differences relevant to these personal context issues, an unbiased attitude, and an absence of prejudgments toward the differences.

Methods and Tools of Screening and Assessment. Inasmuch as some mentally ill inmates also suffer from substance co-dependency, a drug test, urinalysis, and toxicology screening have become part of the comprehensive screening and assessment process for substance abuse. Testing should be carried out frequently. Reliability and validity of results must be upheld. Procedures and guidelines should be established and include the following components:

1. Direct visual observation.
2. Determination of water loading.
3. Documentation of chain of custody for samples collected.
4. Verification of results if they are contested.

5. Treating refusals and tainted samples as positive.
6. Testing for major drugs of choice and alcohol.
7. Testing for the most commonly used drugs in the geographic area.
8. Testing for the most common drugs in correctional settings: marijuana, cocaine, opiates (e.g. heroin), PCP, and amphetamines.

When screenings indicate the presence of symptoms of mental health/substance abuse disorders, an assessment should follow. The assessment should include the specific diagnosis, the history of each disorder and their interaction, and an individualized treatment plan.

Treatment

Following screening and assessment, treatments should be delivered.

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. The APA recommends that treatment be multidisciplinary, eclectic, and consistent with generally accepted mental health practices and institutional requirements. The APA requires six treatment components: crises intervention with short-term infirmary beds, acute psychiatric care program, chronic inpatient care program, outpatient treatment, consultation services, and discharge/transfer planning. The National Commission on Correctional Health Care (NCCHC) (Anno, 2000) standards are used in conjunction with the APA standards. The NCCHC standards address issues that go beyond care and treatment. The NCCHC standards include some that are related to administrative and personnel issues, support services, special needs and services, health records, and medical-legal issues. The following six topics have specific relevancy to the treatment plans and the delivery of services to mentally ill offenders.

Informed Consent. The issue of *informed consent* is addressed by NCCHC (1999) standards to insure that inmates have a right to refuse treatment, usually applicable to forced medications. States have some latitude in the application of the right of refusal, so state policies should be created concerning the right of refusal, as recommended by both APA and NCCHC.

Residential Treatment Units (RTUs). RTUs are temporary units designed to house inmates with chronic mental illness separately from the general population to provide structured therapeutic interventions. RTUs, known as transitional care units, allow for care between what is available in general population and that of a hospital. RTU units may become permanent housing for inmates who are not safe in general population. Standard services include treatment and programming for special needs, which includes individual and group therapy, medication, and recreational and vocational activities such as art and music therapy.

Treatment Modalities. Treatment modalities include psychotropic medications, individual psychotherapy, group therapy, and family therapy. Individual psychotherapy is not as available as other forms of treatment due to limited resources. Group therapy is the most often used treatment intervention in prison settings in part because it is cost effective, can be provided in a variety of settings, can help inmates develop a variety of skills, and can cause individual awareness that others have emotional and mental health problems as well (Metzner et al., 1998). Family intervention is *not* regularly offered even though some studies indicate that additional family contact can aid reintegration into the community (NIC, 2002).

Staffing. Staffing for mental health services is another key component in addressing the needs of mentally ill inmates. Guidelines and standards do not stipulate quantities and types of personnel, but do recommend that staff be qualified, licensed and/or certified appropriately in the same manner and levels as if practicing outside of prisons. The quantity, type, and specific services rendered is dependent upon the needs and number of recipients within the institution.

Case Management. Case management serves as a process and system to provide/deliver and monitor services. Case managers have historically acted as brokers of a variety of services, and more recently, broadened their role to deliver some counseling and psychotherapy as well. Requiring that case managers possess appropriate education and training is consistent with national guidelines applicable to mental health personnel. Case managers play an important role addressing the details of the transition process of the inmate back into the community after completing their required incarceration or in transferring to another institution, especially with regards offenders with mental illness.

Co-Occurring Disorders. Inmates with co-occurring disorders are considered to be those who have a severe or persistent mental illness and a substance abuse disorder. Inmates with co-occurring disorders are frequently treated in programs designed for their special needs. Three models of treatment, designed for co-occurring disorders and not used in other treatment plans, are commonly used for delivery of services: parallel, sequential, or integrated treatment. In a parallel plan, the inmate is served by one team of clinicians for mental disorders and a second team of clinicians for substance abuse, and a case manager coordinates the parallel treatments. In sequential treatment, the inmate receives treatment for one disorder followed by treatment for a separate disorder. Research by Hills in 2000 indicated sequential to be the most commonly used treatment for co-occurring disorders. Integrated treatment has emerged as the most recommended form of treatment by some research (Hills, 2000). In integrated treatment, services are provided by either an individual or a team trained in *both* mental health and substance abuse so that treatment for both issues occurs simultaneously and is delivered by the same person or team.

Seclusion, Segregation, and Restraints

While ACA guidelines indicate issues that must be addressed, the individual institutions have autonomy to determine the details. Administrators are faced with the challenge of finding safe, humane, and non-punitive methods for handling inmates with mental illness without penalizing the offender or exacerbating the mental illness for behavior resulting from the illness. Solitary confinement and extended segregation may cause additional stress for the mentally ill, and once in segregation, mental health services may be inadequate. Recommendations regarding this aspect of care for the mentally ill have been offered from multiple sources, including the APA, NCCHC, and National Institute of Corrections (NIC). Among the collective list of recommendations relevant to seclusion, segregation, and restraints are the following practical suggestions:

1. Mental health services must continue in segregation. Mental health staff should be readily available to address inmates' problems regularly. Mental health staff should assess weekly and address mental health needs.
2. Routine rounds should be made at least three times a week in administrative segregation and at least daily in disciplinary segregation.
3. Full communication is necessary among mental health staff and security staff.
4. Inmates should not be confined in segregation solely because of symptoms of the mental illness.
5. Inmates in severe or acute psychiatric crises must be removed from segregation until they can handle segregation.
6. Restraint policies and procedures should be specific and well-articulated, due to the high potential for misuse. Restraints should only be soft, ordered by a physician or health provider, limited in use with women, not exceed 12 hours in use, checked every 15 minutes, used after other methods have failed, comply with state health laws and professional practice, and their use should be followed with an after-incident and after-use review.
7. The nature of seclusion is to isolate inmates and reduce contact with others so as to stop violent or seriously disruptive behavior, yet, isolation in a Supermax facility may be unnecessary and counterproductive when applied to the mentally ill. There must be compliance to policies and procedure in Supermax units or institutions just as in any other unit or institution.

Suicide Prevention

The literature suggests that staff must be equipped to identify inmates, including those who are mentally ill, who are at risk so they can intervene and prevent suicide. National standards typically deal with suicide separately from other issues because suicide continues to be one of the leading causes of death in prisons. According to the National Institute of Corrections (1995), applicable standards help institutions

minimize their legal liability. Several national organizations have created standards relevant to suicide prevention in prisons.

American Correctional Association (ACA) has reportedly (Bonner, 2000) developed the most recognized suicide prevention standards. The ACA standards require written policy and procedures that include observation minimally every 30 minutes, more frequent observation of inmates with known mental illness, continual observation of actively suicidal inmates, a written suicide prevention and intervention program approved by a qualified medical or mental professional, training for all staff, and intake screening, identification, and supervision of inmates who may be prone to suicide.

The *National Commission on Correctional Health Care (NCCHC)* requires a written suicide prevention program, and also adds 11 essential components under the following headings: Identification, Training, Assessment, Monitoring, Housing, Referral, Communication, Intervention, Notification, Reporting, and Review. As applicable to each category, institutional staff must carry out their responsibilities making use of observable data that includes verbal and behavioral cues, and takes into consideration the level of suicide risk. Isolated housing is resisted, constant supervision is structured around inmate behavior, referrals to mental health are made, communication channels are open, and intervention procedures are to be followed to handle attempts at suicide and in addressing the incident with family, administrators, and outsiders. Complete records, including details, are required in every potential, attempted, or completed suicide. An institutional review of all details should be completed for all completed suicides. The NCCHC also recommends adherence to an individualized system of suicide prevention that categorizes suicidal inmates by one of four levels dependent upon behaviors and specifies assessments, housing, and observation schedules for each level.

National Center on Institutions and Alternatives (NCIA) was cited by the National Institute of Corrections in 1995 as integrating the ACA and NCCHC standards into the following compact list of critical features: staff training, intake screening and assessment, housing, levels of supervision, intervention, and administrative review. Each of the critical features includes operational details that aid in the translation of policy into practice at the institutional level. The NCIA cited several 'model' states as operating in compliance with one or more of their recommendations, including Nevada, Connecticut, Virginia, Louisiana, and Pennsylvania. Significant in the findings as presented by NCIA, based on research by Atlas in 1989, is that 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.

Also provided in *Effective Prison Mental Health Services: Guidelines to Expand and Improve Treatment* were components of a *Federal Bureau of Prisons Five-Step Program for Suicide Prevention*. It was noted that during the first ten years of the federal program inmate suicides decreased by 43 percent. Although a direct causal link between the program and the reduced statistic cannot be proven, the authors of

Effective Prison... believe that there is a correlation between fewer suicides and the unambiguous procedures in the FBOP program. As presented only briefly in the report, however, the five basic premises would suggest that there may be room for local interpretation and application. The five components of the program include (1) Initial screening of all inmates with suicidal potential, (2) Use of criteria for the treatment and housing of suicidal inmates, (3) Record-keeping in a standardized manner, with follow-up procedures and collection of data relevant to suicides, (4) Training of staff, and (5) Reviews and audits completed periodically.

Under a brief treatment of *Suicide Gestures and Manipulations*, the report identified the following points that would appear to have direct applicability to the reduction of inmate suicides.

1. The National Institute of Corrections suggests that 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 or make suicidal gestures in order to effect some change to their situation.
2. It is a serious mistake for prison officials to ignore inmates and their para-suicidal (intentionally self-harmful) behaviors for fear of reinforcing the manipulation and even more egregious for inmates to be punished and isolated as a consequence.
3. Some clinicians believe it is meaningless to try to distinguish between manipulative and non-manipulative suicide attempts; therefore, all inmates who express suicidal or para-suicidal intention or behavior should be treated according to the institution's suicide prevention protocols.
4. For inmates assessed to be genuinely suicidal, close supervision, social support, and access to psychosocial resources are recommended.
5. 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.

Treating Women Offenders

The *Effective Prison...* report summarized the connection between women offenders and the mentally ill simply by establishing that there are gender differences in the service needs of the growing number of women who are incarcerated, and one of the gender differences relates to the greater presence of traumatic events and history that women bring to the prison life compared to men. The often punitive

culture within a prison may trigger a reliving of past traumatic events, causing women to potentially present with symptoms associated with posttraumatic stress disorder. Also, women have higher rates of mental illness than men. A large percentage of women were under the influence of either drugs or alcohol at the time they committed their offence. Women with drug addictions reportedly have low self-esteem, are isolated, anxious, depressed, and cut off from their feelings.

One study conducted by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and cited in *Effective Prison...* reported that a most-effective treatment with women with co-occurring conditions and histories of violence works best when the program contains four components:

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

An integrated treatment plan for women would likely consider not only mental illness, but also parenting skills, ages of children, trauma, substance abuse, and violence in the development of the plan.

Psychopharmacological Intervention for Psychiatric Disorders

Current corrections practice associated with the mentally ill involves the use of pharmacological interventions. Medications are designed for use with mentally ill offenders typically to diminish symptoms due to a major mental illness. Inasmuch as these medications may help inmates stay calm, feel less angry or anxious, sleep better, and manage stress, these medications contribute to the potential rehabilitation of the inmate and to the safety and security of the institution as well.

Among the recommendations regarding the use of pharmacological interventions, the APA reports that (1) psychiatrists only should have the ability to prescribe all psychotropic medications, preceded by a psychiatric evaluation, (2) medications should only be distributed by medical personnel, and (3) twenty-four hour nursing coverage should be available wherever persons with acute psychiatric problems are held.

The *Effective Prison...* report made the case that the reluctance to use some of the newer psychotropic medications due to cost may actually generate a greater comparative expense when older medications are not effective and/or cause costly side effects and ultimately, the inmate is placed on the newer medication. Also, the report cited that the use of older medications is not in keeping with the drugs that are commonly in use in the civilian community. It was acknowledged that certain drugs should be limited due to their potential for abuse within the institution (e.g. misuse, overuse, bartering or selling, lethal use for suicide). Drugs with a potential for misuse include hypnotics, benzodiazepines, and stimulant drugs.

The following key concepts or points are offered for consideration as practical applications and recommendations relevant to pharmacological practice.

1. Medications should be used only for clinical treatment and never for discipline.
2. Maximum security must be maintained for storage and distribution.
3. Only appropriate and qualified staff should have control of medications and their distribution to inmates.
4. Oversight and close monitoring of the pharmacological presence, use, prescription, delivery, access, and purpose must be in place within the institution/at the institutional level. For example, a pharmacist should complete a periodic (quarterly at a minimum) review of storage and dosing.
5. Maintain cost-sensitive business judgment in the use of pre-packaged, sealed medications, which can be returned for credit if unopened.
6. Maintain a caseload of no more than 150 inmates on psychotropic medications to one full-time psychiatrist.
7. Remove all cultural and gender bias in the use of pharmacological interventions.
8. Become and remain knowledgeable, showing respect and medical skill toward ethnic, cultural, and physical differences among races in the prescription of pharmacological interventions.
9. Respect the inmate's right to receive and the right to refuse some medications; and implement a system of prior written notices and consents relevant to non-emergency situations.
10. Acknowledge that there has been no demonstrated correlation between the prescription of psychosocial or psychopharmacological medications and the reduction of either suicide or violent behavior. Therefore, staff should not disregard the potential for suicide or violent behaviors even when an offender is taking psychotropic medications.
11. Keep in mind continuance factors in the prescription of medications to inmates so that the inmate may be able to follow a pre-release plan and work with an appropriate health care provider relevant to medications prior to and after release. It was noted in *Effective Prisons...* that there are NO formal national standards regarding a recommended strategy for the continuation of medications after an inmate's release.

12. Reduce the risk of civil liability associated with the prescribing and dispensing of medications, as revealed by Vaughn in 1997 and reported in *Effective Prisons...*, based on

- (a) Failure to follow standard medical procedures.
- (b) Declaring budget issues as a reason to prevent the use of more expensive yet effective medications.
- (c) Supplying contraindicated medications.
- (d) Failing to deliver medications in a timely manner.
- (e) Prescribing or withholding medications for non-medical reasons.
- (f) Prescribing medications to control or punish inmates.

Transitional Services

Incarcerated individuals transition in many ways --- from jail to prison, from prison to reception center, to another prison, to a different unit, to a community hospital, to the community, etc. All transitions can be especially stressful events for the mentally ill because discontinuity and other factors may exacerbate their symptoms.

Transitioning to the community in particular can prompt stress due to several factors that are not present with other forms of transition. Common transition stresses, cited by *Effective Prison...* from research by McVey in 2001, are the remote location of many prisons and 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, which seem to lack the coordination necessary to create a seamless and meaningful process.

Effective Prison... suggests that *careful planning* is key to the success of transition. Careful planning ideally begins prior to transition. Recommended components to careful planning may include a pre-transfer health screening to determine if offenders pose health or safety threats to themselves or others and an evaluation within 12 hours of arrival at a new location to ensure continuity of care. Details of screening and evaluation should include the following components:

- 1. Medication status.
- 2. Medical or dental problems or complaints.
- 3. Appearance and behavior.
- 4. Physical deformities or evidence of abuse or trauma.
- 5. Pending appointments for diagnostic work.
- 6. Special instructions for transport.
- 7. Suicidal ideation, history of suicidal behavior.
- 8. Mental health or substance abuse treatment.

Re-entering the Community. Successful reentry is contingent upon thorough assessment and planning. Accurate and comprehensive assessments are the prerequisite for effective referrals to community services. Consideration for all stakeholders is

important to reentry success. In most cases, stakeholders include the offender, mental health and substance abuse treatment providers, Medicaid representative, labor, employment, and vocational services' representatives, faith-based community organizations, and recreational organizations. Key to success is the offender's "buy-in" to aftercare plans and the offender's level of self-efficacy relative to managing and taking responsibility for their illness and overcoming potential passivity or lack of confidence in taking control and giving direction to their lives. Teaching offenders the necessary skills of life management should be a component to the reentry transition. There are numerous transition-related facts and/or issues that suggest a range of recommendations, some of which could be translated into standards of practice. Segmented under four headings from the Effective Prison... report, the following comments suggest desirable standards for continuity of care, aftercare, offender failure, and legal issues.

Continuity of Care. Coordination between the institution and community programs through *good communication and exchange of records* is essential to assure continuity of care and to avoid offenders feeling overwhelmed and losing the gains of therapy while incarcerated. A lack of continuity may render an offender unable to function while transitioning from the tight structure of institutional life to the absence of structure in the community and personal necessity to self-structure life details. Essentially, training to self-structure must be delivered from the institution prior to reentry. Ex-offenders may not have family support and the seriously mentally ill are unlikely to be effective self-advocates, without some support and assistance, in negotiating their complex system of care (Jemelka, Trupin, and Childes, 1989), as reported in Effective Prisons...

Among the bigger continuity of care issues is the continuation of psychotropic medications that the offender requires. Not having medications on release or transfer, not being able to acquire medications in a timely manner, or not knowing how to acquire medications after release can create much stress psychologically and physically on the transferred or reentered offender. Statistically, as found by a survey by Veysey and Schacht (2001), 25% of prisons offer some prescriptions to offenders at release and 33% offer a 14-30 day supply of medications.

Aftercare. Aftercare carries a range of interpretations, but essentially acts as a continuum of care and services that encompass referrals and engagement in community services needed for reintegration into community related case management, housing, employment, relapse prevention, medication programs, and specialized rehabilitation services that are appropriate for sex offense, mental illness and retardation, substance abuse, and violent behaviors. Essential to aftercare is a reciprocal component from the receiving community, however, there is local reluctance in serving offenders with mental illness, whose cognitive and social skills may be impaired causing their requirements of society to be high. Family ties and local supports and knowledge are often lacking in the aftercare environment (Jemelka et al., 1989).

Effectiveness of aftercare programs is often found in the details incorporated into inmate counseling and training. Effective Prisons... suggests that the components of aftercare include training the offender in coping skills applicable to handling everyday

stressors, obtaining material resources, developing support systems, disentangling themselves from negative relationships, and learning to relate appropriately to community members, including police, service providers, support persons, and family members.

The absence of continuity of care and effective aftercare often puts offenders with serious mental illnesses at increased risk for homelessness, psychiatric hospitalization, and reincarceration, according to the American Association of Community Psychiatry in 2001.

Additional recommendations extracted from several studies and offered in Effective Prisons... are (a) avoidance of middle-of-the-night releases, (b) discontinuance of 'unanticipated' releases from mental health units into the community, (c) discontinuance of anonymous referrals to community programs and providers, (d) creation and use of 'step-down' programming for acquisition of successful independent living that would transition offenders through work-release programs, halfway houses, and a succession of increasingly less restrictive environments, and (e) increased emphasis on vocational training or education and employment-related skills.

Offender Failure. Non-compliance to the expectations and conditions of release forces attention to the issue of offender failure and what can be offered as recommendations to aid greater success in this area. Effective Prisons... establishes that incentives and sanctions are necessary components to successful compliance when dealing with mentally ill offenders. Without incentives in the community to remain crime-free, offenders may revert to old patterns of behavior (Field, 1998). Both monitoring and the use of a range of options when infractions occur play significant roles in successful reintegration into society. Monitoring, rather than being punitive, can offer the offender the opportunity for reengagement in community-based services rather than reentry into the justice system. Creative solutions to handling infractions may be found in increasing supervision, hospital commitments, day fines, or brief jail sentences, rather than revocation of parole and reintroduction to the justice system. (Edens and Otto, 2001).

Legal Issues. The issue of legal liability applicable to institutions or persons has relevancy to the transition of offenders into a community when the offender subsequently harms someone after the transition. Effective Prisons... relays that courts appear to be looking for greater assurance that "placement...back into the community will not result in the reoccurrence of violent or harmful behavior by the offenders" (Hafemeister, 1998, p. 98). If professionals can demonstrate that they acted within "professional standards," they will not incur liability. The issue of 'duty to warn' society or the reentry community becomes a topic for discussion and consideration when contemplating the offender's reentry training in life skills that enable him to successfully engage with other members of the community. The mentally ill offender may be unaware of the prevalent community attitude and untrained in how to react to the impact it could have on his attempts to function in the community.

With the overall transition goal being seamless continuity of care, an institution or agency and community partners must develop and maintain referral relationships, acting as members of one team and sharing clear and consistent information. Treatment providers must define themselves and act as agents for the offenders who are their clients. Offenders must be able to rely on their treatment providers to maintain relationships with other service providers so that the offender is not cast into a stressful role of acting as his own case manager without the necessary cognitive or personality skills and established communication channels in place to act effectively in that role.

Special Populations

Insomuch as the treatment of individuals with mental retardation and developmental disability falls under special populations and subject to the special levels of care and specialized services, often delivered by the same professionals who deliver same or similar services to offenders who are mentally ill, both the mentally retarded and developmentally disabled are subjects of focus for mental health departments within agencies and institutions.

Mentally Retarded. The profile of the mentally retarded offender typically includes “significantly sub-average intellectual functioning” and other indicators of impaired functioning that occurred prior to the age of 18. A clinical evaluation for mental retardation would typically include a review of (a) intelligence quotient (IQ) scores, (b) adaptive behaviors, (c) social maturity, (d) development, and (e) communication skills. Also to be considered are the individual’s history of behavior and behavioral problems throughout childhood and the treatment and/or schooling that may have been delivered due to that history. In addition, the environment in which the individual was raised, including the presence of skill building activities and training, and the presence of other members of the same family who also demonstrate same or similar traits and histories, should be reviewed.

Effective Prisons... relays that there is an estimated over-represented population of mental retardation in prisons than in the general population, with approximately 2-3% in the general community compared to upwards of 10% in prisons; and many more individuals in prison systems are considered to have “borderline” retardation with IQ scores in the 70-85 range. Borderline individuals may be served best in the same programs for the mentally retarded or in mainstream programs based on the evaluation of differences in the needs of each individual. (Gardner, Graeber, and Machkovitz, 1998).

Offenses that bring individuals with mental retardation into custody and into treatment may include sex offenses, arson, or property offenses. Traits like poor impulse control, naivete, impaired communication and emotional expression, low frustration tolerance, exposure to delinquent peers, and disturbed family environments may be among the contributing factors (Day and Berney, 2001).

Relevant to standards, operations, and the delivery of care to the mentally retarded in correctional institution mental health departments, consideration may be given to the following recommendations:

1. Use clear, simple language and give the offender adequate time to respond to instructions.
2. Remain calm and redirect individuals who have low frustration tolerance and exhibit excited behaviors or inappropriate verbalizations and behaviors.
3. Be watchful and aware that impulsive behavioral or verbal responses to situations will occur.
4. Complete comprehensive assessments that include intelligence and personality testing, investigation of educational history and adaptive behavior, genetic testing for genotype abnormalities, and EEGs to determine the presence of brain damage or epilepsy. In addition, assessment of offense pattern or cycle(s) should be completed for frustration tolerance, impulsivity, emotional reactions, and understanding of the offense (to assess the likelihood of a reoffense).
5. Provide protection from others by providing extra care to assure that mentally retarded offenders are not ridiculed or placed in situations or environments where they could be preyed upon by other inmates.
6. Make frequent observations of the mentally retarded by qualified staff.
7. Offer programs that focus on acquisition or building of social skills and educational skills, anger management, and education about laws and social codes.
8. Implement token economy systems that reward desirable behaviors and loss of tokens and "timeouts" or seclusion (for violent behaviors) for unwanted behaviors.
9. Incorporate much structure into training programs.
10. Operate with higher staffing ratios and multidisciplinary teams that include nursing staff.
11. Provide staff orientation and training regarding the impairments in thinking that characterize individuals with mental retardation.

The treatment interventions that are recommended for specific types of offenses, such as sex offenses, arson, and anger or violence management are the subject of a more specific study. Among the therapy modalities and treatments in practice are education about the antecedents to the offensive action, personal control tactics relevant to offensive behaviors, individual counseling and group therapies, and pharmacological interventions and treatments.

SECTION III

Review and Comparison of Care, Corrections, and Programs for Seriously Mentally Ill Inmates as Found in Some Other States

A review of some available data and descriptive information regarding the care, corrections, and programs available to the mentally ill in other states may offer food for thought to legislators and others who are giving consideration to how a state might evolve

in making services available to the mentally ill defendant or offender. Several state snapshots are provided in this section. Some state capsules describe programs that do not require confinement of the individual, some offer an analysis that sheds light on the problems that programs have encountered, and others speak of the successes encountered in programs and treatment plans. The responsibilities associated with placement of individuals in programs and the delivery of services will vary among individual states and among state agencies, courts, and community support groups. Nonetheless, the array of information, on a state basis, is presented in the hope that it might trigger innovative thinking and enlightenment relevant to addressing this growing societal condition.

Fundamental to addressing this growing condition and relevant programs is the need to give consideration to the following premises:

1. A broad approach must be kept in mind to assure efficiency in time, funds, and services with minimal risk of duplication of services and costs.
2. The concepts of treatment versus punishment must be determined, including the costs of each and the moral and ethical responsibility to each of those concepts.
3. Establishing the distinction and definition of state responsibilities compared to local responsibilities is essential to a knowledge of which entity could be the most effective provider of specific services to society and to the individual offender or parolee.
4. Consideration must be given to the identification of all known and unknown resources – current, future, and potential.
5. Consideration must be given to required or mandatory treatment(s) that offenders and parolees are compelled to complete versus those treatments that are optional.

STATE: Alaska

Several issues related to mental illness among offenders in Alaska were published in Mental Health Court: Target Problems, and Rationale. The essence of the report is offered as a way of reviewing the activities of one state Department of Corrections in the handling of the mentally ill in the criminal justice system.

Alaska found, in response to a 1997 study, that about one-third of inmates suffered from serious mental illness (approximately twice the estimated national average of 16% as reported by the Bureau of Justice Statistics, 1999). Included in Alaska's seriously mentally ill were persons with developmental disabilities and organic brain injuries. In Alaska, the Department of Corrections was challenged as it became the largest provider of institutional mental health services in the state.

Alaska formed the Criminal Justice Assessment Commission (to examine jail crowding). Applying a recommendation of the Decriminalizing the Mentally Ill Subcommittee to identify inmates who could be diverted from the justice system and into community treatment services, Alaska instituted a Jail Alternative Services Pilot Program and developed special mental health courts.

The two-pronged mental health court included (a) more structured Jail Alternative Services (JAS) Program to handle alternative mental health programming in the community on a selective basis after defendant screening and a candidate qualifying procedure, and (b) less structured Court Coordinated Research Project (CCRP) to identify and treat mentally ill misdemeanor defendants and offenders referred from the JAS program. The CCRP provides an alternative to jail and routine adjudication, trained judges to address and treat mental illness and create linkages and coordination between courts, agencies, and resources. CCRP aims at a broad misdemeanor population, whether confined or not, and aims to link mentally ill defendants with community-based mental health services.

The treatment approach adhered to by the Alaska JAS system includes coordination of resources among corrections, courts, prosecuting and defense agencies, and community health providers to ensure community-based treatment. Court hearings are more informal and flexible with regards input from family members and other support persons; and the courts try to provide positive incentives and support to help establish boundaries of acceptable behavior. Courts emphasize public safety and avoid placing a community at risk from participant behavior. Treatment plans include review hearings and passage of milestones.

For the JAS system, locating appropriate housing is a big challenge, and housing is sometimes less than ideal; but the goal remains to “wrap” the participant in services through the weekdays and assisted living as needed for day-to-day functioning. Of particular challenge is placement of dual-diagnosed participants in treatment. Organic brain impaired participants receive placements that are intended to be permanent in that the clients can stay in the location where treatment is provided even after the jurisdiction of the court has ended.

Compared to Alaska’s structured Jail Alternative Services (JAS) participants, individuals entering the research project courts (CCRP) encounter inconsistencies in treatment plans because it is up to each CCRP participant’s attorney to coordinate a plan. There is no accessible, integrated, or common treatment plan available to attorneys working in the CCRP system. Some attorneys lack experience in developing such a plan, and differences in available participant funds create differences among the plans that attorneys may design. The courts in the research project (CCRP) have less funding than is available to mental health courts, yet the available funding provides for adequate operations, including supervision of participants.

One success or failure measurement of the JAS Program may be found in statistics showing that of 49 individuals entering the program since its inception, 17 individuals have been rearrested on new misdemeanor charges and one was rearrested on a felony charge. The success or failure data on the CCRP participants was not available to reveal a complete measure of success or failure.

STATE: California

The Legislative Analyst's office of California provided a description of issues and challenges relevant to the transition of offenders with mental illnesses into the community upon parole in a paper titled, Linking Mentally-Ill Offenders to Community Care. The following narrative summarizes some of the key comments and summations from that report.

In California, the prisons hold more mentally ill individuals than state mental hospitals, and an increasing number of severely mentally ill individuals are released to communities without an adequate network of supervision, treatment services, and assistance. The Governor's 2000-01 budget bill took aim at keeping the mentally ill out of the criminal justice system by allocating \$139 million for providing more than 21,000 inmates with one of several levels of treatment services. Court rulings have required that the state make improvements in identifying mentally ill offenders and providing services to them. Upon release, many mentally ill offenders find no provisions for clinically effective and cost-effective community mental health services; however, two California programs were reviewed in the literature.

The *Parole Outpatient Clinic (POC)* statewide system provides services to approximately 9,000 of 12,000 parolees with psychiatric histories. The POCs are impacted by several problems. For example, many parolees do not have a serious mental illness, but have been assigned to the system due to statutory requirement or internal California Department of Corrections rules unrelated to any clinically based criteria. Also, funding and staffing for POCs has not kept pace with caseload growth; therefore, serious mentally ill cases may receive inadequate and infrequent services from a clogged system including parolees who are not seriously mentally ill. For example, the special needs of parolees with "dual diagnosis," homelessness issues, and acquisition of Social Security income, Social Security Disability Insurance, and federal veterans' benefits may not be addressed. Clinicians struggle with heavy caseloads that average nearly 160 parolees to each clinical professional.

The *Conditional Release Program (CONREP)* provides intensive supervision and mental health treatment in the community to offenders released from state hospitals either by private providers or by counties under contract with the Department of Mental Health. As reported in the literature, CONREP is relatively expensive, has been clinically effective, and has reduced criminal behavior. However, however, those comments should be weighed against the report that only about 700 patients are simultaneously on the caseloads and the vast majority of offenders are not receiving an intense level of supervision and treatment. Initial treatment assistance is provided, but adequate aftercare and assistance in the continuation of prescribed medications is lacking, thus, there is noted relapse into severe mental health problems and erratic behavior.

Reportedly, California has identified the high cost for recidivism of mentally ill offenders, as have other states, and that mentally ill offenders consume a disproportionate share of resources. Most commonly committed are minor new offenses, however, there

are occasionally violent and felonious offenses committed. The California Department of Mental Health relays that data suggests there is less return to criminal activity when individuals are engaged in treatment programs. Recidivism cost components include those for housing and treatment, as well as expenses to local law enforcement agencies and courts.

Generally, there is a gap in state and county coordination related to delivery of services to parolees from state institutions because often local/county partners voice concern about dealing with state offenders in their local programs and contend these offenders should remain a state responsibility.

Recommendations for improvement to California's programs include continuation of funding at increased levels, focus on short-term assistance in transitioning back into the community through contracts with private providers, increase staffing through additional parole agents (thus allowing for smaller caseloads and more time allotted per parolee), and expanding staffing through enlarging the existing network of Parole Outpatient Clinics (POC) to provide improved services, and for funding provisions for long-term assistance to parolees by county social workers before they leave the care of the transitional assistance program vendors or the POCs.

An analysis of the California Budget Bill for 2000-01 by the Legislative Analyst's Office in California, produced numerous points relevant to the topic of linking mentally ill offenders to community care. Among the points were the following:

1. Integrate substance abuse treatment into plans appropriate for mentally ill parolees.
2. State corrections agency should establish an aftercare system, due to reluctance of counties to provide aftercare. The aftercare system could be based on a program tested in Wisconsin (Wisconsin Community Support Program – a model for money management).
3. Provide a separate containment program for high-risk sex offenders that includes relapse prevention programs.
4. Plan and budget for caseload growth over coming years.

STATE: Iowa

The handling of mentally ill inmates in Iowa was targeted for scrutiny in the late 1990's as a result of *Goff v. Harper*. Findings as recent as October 2003 and published in a book, *Ill-Equipped: U.S. Prisons and Offenders with Mental Illness*, by the Human Rights Watch organization, reveal various criticisms. Criticisms of the Iowa system were offered by a consultant, Dr. Thomas White, working with Human Rights Watch, and were posted to the Human Rights Watch website as recent as March 2005. In the posted article, [Report Cites Serious Abuses of Mentally Ill Prisoners in Iowa](#), several criticisms of the Iowa system were made, among them were the following:

1. Lack of evaluation of mental health needs.
2. Inadequate staff for clinical care.
3. Extended periods of confinement in segregated or disciplinary housing units.
4. Correctional staff who do not take offenders' mental illnesses into account when making custodial or punishment decisions.

The Iowa Department of Corrections responded to the findings. Among their comments was notification of implementation (current or future) of various recommendations, including (among others):

1. Establish a unified mission statement that is widely disseminated.
2. Expansion of review process of self-injury/suicides.
3. Relocation or reconfiguration of suicide prevention rooms.
4. Use social workers to train in pre-release, education, and life-skills topics.
5. Increase out-of-cell time to include work, recreation, and hobby crafts; and expand recreation, hobby craft, and education activity for all offenders.
6. Establish a more therapeutic environment in the Clinical Care Unit (CCU).
7. Increase Mental Health Training for *all* staff.
8. Establish Mental Health Director and Deputy Warden of Clinical Care Unit Operations.
9. Review overall Department of Corrections mental health and operational policies, including suicide prevention.
10. Establish on-call system of mental health staff for off-hours consultation, and move psychologist offices to inmate pods.
11. Establish offender treatment review process.

STATE: Connecticut

As reported in Classification of High-Risk and Special Management Prisoners, which was researched and published by the National Institute of Corrections, Connecticut has been identified as one of several state models that uses a classification system relevant to the management and treatment of mentally ill inmates. The Connecticut Department of Corrections maintains three 'program' levels: (1) Close Custody Gang Management Program, (2) Close Custody Chronic Disciplinary Program, and (3) Administrative Segregation Transition Phase Program. The design of the three programs is based on an examination of outcome data and consideration of the needs of inmates that comprise each group. The process components that characterize each program include (a) reviews that are regular and frequent and are completed by classification staff, and (b) structured movement of the inmates through levels and phases from beginning until release. The Connecticut model has been replicated in Colorado and New Mexico.

State Programs for Managing Disruptive and High-Risk Inmates

Not all of the following state model programs may apply directly to mentally ill inmates or be specifically designed for the mentally ill. There are cases, nevertheless, where mentally ill inmates may be placed into programs and at security levels consistent with those found in the following table. A review of the table may allow for the broader view of the variety of programs that states have developed and made operational.

The following common characteristics were found among the numerous programs, which have been designed for a variety of special populations:

1. Progressive and specific steps and/or levels through which inmates pass in the program.
2. Individualized treatment plans.
3. Multiple programming available to inmates that includes life skills, academic, and vocational curriculum.
4. Assessments of inmate at entry, checkpoints, and exit of programs.
5. Step-down or transition programming prior to return to general population.

A brief summary of programs, some of which may potentially be available to mentally ill inmates, is shown in the following table, taken from a survey conducted and published in 2002 by the National Institute of Corrections, then subsequently included in Classification of High-Risk and Special Management Prisoners: A National Assessment of Current Practices in June 2004 by the National Institute of Corrections.

STATE	PROGRAM	DESCRIPTION
Alaska	Youth Offender Program	Targets high-risk offenders ages 15-20 who are involved in street or gang cultures. Provides classes in cognitive skills, academic subjects, substance abuse, vocational skills, mental health, anger management.
California	Sensitive Needs Yard Program	Provides general population (GP) inmates who have concerns about safety or enemies with an environment free of predatory or gang-affiliated inmates. Allows nonviolent inmates, who would otherwise require segregated placement, full access to programs in a GP setting.
	Violence Control Program	Will provide an alternative to segregated housing for disruptive inmates and include self-help, educational, gang, and drug-awareness programs. Designed to provide progressive steps based on inmates' participation in programs and positive performance.
Colorado	Progressive Reintegration and Orientation Unit	Targets inmates placed in administrative segregation and provides cognitive programs; academics; vocational, recreational, and work assignments; and mental health services.

STATE	PROGRAM	DESCRIPTION
Connecticut	Close Custody Gang Management Program, Close Custody Chronic Disciplinary Program, and Administrative Segregation Transition Phase Program	Programs for gang management, chronic disciplinary problems, and administrative segregation operate at multiple facilities throughout the state, including the Hartford area. Programs target up to 500 male and 25 female inmates.
Florida	Enhanced Close Management Program	Targets closed management (CM) inmates housed in administrative segregation. Inmates are eligible for specific levels of programming based on management level (CMI = most restrictive; CM3 = least restrictive).
Indiana	Residential Treatment Unit	Serves 40 male inmates with mental health issues. Inpatient residential treatment program provides individualized treatment plans, transitioning programming, and rehabilitative therapy. Program is voluntary, with selection based on staff review and recommendations.
Iowa	Reintegration Program	Targets inmates housed in administrative segregation for an extended period of time. Provides classes in anger management, criminality, thinking for success, substance abuse treatment, and recreation. Program is voluntary, with selection based on staff review and recommendations.
New Jersey	Security Threat Group Management Unit	Provides psychological treatment, educational programming, and behavior modification. Serves inmates identified as security threat gang members. (No indication of whether this is a general population or administrative segregation program.)
New Mexico	Cognitive Re-Structuring Program	Serves inmates in a variety of custody levels, including administrative segregation, protective custody, security threat group (STG), high-risk general population (GP), and disciplinary segregation.
Oklahoma	Mental Health Services Needs Classification	Evaluates and classifies mental health of all inmates according to a five-level system ranging from MH-A (GP housing with outpatient treatment) to MH-D (24-hour monitoring in a ward for inmates with acute mental health problems).
Oregon	Close Custody Unit	Serves inmates making transition from the maximum custody intensive management unit (total lockdown) to an open general population (GP) unit.
Pennsylvania	Long-Term Segregation Unit	Houses extremely disruptive, violent, and problematic inmates. Provides extremely high levels of security and sharply reduces level of privileges.
	Special Management Unit	Securely houses inmates who are continually disruptive, violent, or dangerous or who pose a threat to the orderly operation of the facility. Inmates assigned to this unit have been repeatedly subject to disciplinary action or investigation.

STATE	PROGRAM	DESCRIPTION
South Carolina	Stairway Treatment Program	Provides housing and programming for HIV/Aids inmates, who are screened and identified at the reception center. Inmates are housed in a segregated unit but interact with general population (GP) inmates when participating in programs and other support facilities.
	Statewide Protective Custody Housing Unit	Special management unit housing approved protective custody inmates, who are monitored by institutional and central office staff while in the unit. Protective custody placement is validated through a series of interviews and formal investigation and reviewed and approved by an Institutional Classification Committee.
Washington	Assisted Living Facility	Provides assisted living for inmates whose medical condition requires such assistance.
	Special Offender Unit	Houses inmates who have a mental illness or are in acute distress (suicidal). Seeks to stabilize inmates with mental illness and return them to general population (GP) through a diagnostic, treatment, and reintegration program.
	Youthful Offender Program	Houses juvenile offenders sentenced as adults.
	Twin Rivers Sex Offender Treatment Program	Treats sex offenders who have been screened with multiple approved actuarial risk instruments.
West Virginia	Stepdown	Serves inmates who have been housed in the control unit for 6 months or more and making transition back into general population (GP). Inmates progress through the series of gradual stepdowns in the areas of supervision, security precautions, and privileges.

(Source: National Survey of the Management of High-Risk Inmates, National Institute of Corrections, 2002)

Mental illness is a general term for a group of illnesses that may impact on a person's thoughts, perceptions, feelings and behaviours. Mental illness can make it difficult for someone to cope with work, relationships and other demands. Most people can manage their mental illness with medication, counselling or both. The relationship between stress and mental illness is complex, but it is known that stress can worsen an episode of mental illness. Most people can manage their mental illness with medication, counselling or both. This page lists some of the more common mental health issues and mental illnesses. Anxiety disorders. The purpose of this article is to provide an overview of mental health issues and counseling services on college campuses in the USA. The findings from several national surveys are reviewed to estimate the prevalence of anxiety and depression, suicide and suicidal ideation, and violence among college students. Common prevention and treatment programs are then described with particular attention to innovative campus-wide programs. Student outcomes research is examined to determine whether receiving counseling services is associated with academic performance and the likelihood of graduation. Mental health disorders can have a seismic effect on the lives of individuals as well as families, friends, loved ones, and the community at large. The need for guidance can be overwhelming, and while there are many great resources available, there is also a lot of misinformation about every type of disorder. Here's an overview of how addiction works, what to look for, what to do if you suspect addiction, and common treatments. What is it? Addiction can be described as a brain disease. Financial issues. Addicts sometimes spend every cent in their bank accounts, skip on paying bills and rent, and rack up debt in order to buy drugs. Complete financial collapse can be linked to a drug addiction problem. We define mental health and explain the different disorders that may arise, as well as potential treatments. In the United States, the National Alliance on Mental Illness estimate that almost 1 in 5 adults experience mental health problems each year. In 2017, an estimated 11.2 million adults in the U.S., or about 4.5% of adults, had a severe psychological condition, according to the National Institute of Mental Health (NIMH). Risk factors for mental health conditions. Everyone has some risk of developing a mental health disorder, no matter their age, sex, income, or ethnicity. In the U.S. and much of the developed world, mental disorders are one of the leading causes of disability.