Treatment of Mental Illness in Correctional Settings

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Introduction

Treatment for mental illness and other conditions related to mental functioning presents significant challenges to clinicians, administrators, and custody staff within correctional facilities. In this chapter, the term *correctional facility* refers to police lockups, jails, and prisons. The distinctions are important considerations in the provision of mental health care because of the varying lengths of stay and various levels of custodial certainty.

Ethics and Clinical Practice Guidelines

The American Medical Association, American Psychiatric Association, and American Academy of Psychiatry and the Law all promulgate principles or guidelines applicable to the treatment of prisoners that include individualized treatment relevant to patient needs, humane treatment in the least restrictive environment, and confidentiality and informed consent.

The mental health and behavioral health problems encountered in prisons reflect the predictable issues that evolve when individuals with varying pathologies are contained in a crowded, stressful environment, where the mission of the institution emphasizes containment, deterrence, and punishment, with limited concern and/or resources for rehabilitation. A relatively small number of seriously mentally ill individuals have been diverted from corrections through pretrial evaluations resulting in findings of insanity; however, many more individuals convicted and serving sentences do have serious

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R. B. Greifinger (ed.), *Public Health Behind Bars*, https://doi.org/10.1007/978-1-0716-1807-3_18

mental disorders which were not identified or did not exist during the trial process or which did not meet the standard for legal insanity.

The psychiatrist is expected to supervise the development of policies and procedures, conduct training and provide supervision, and provide direct services, where appropriate.

Mentally ill persons in custody require a broad range of psychiatric and other mental health services. What these services should be and how they should be provided in a correctional setting are described in detail in this chapter.

Developing a Mental Health Services Delivery System

How should we address the mental health needs of inmates and detainees housed in jails, lockups, and prisons given the historical, demographic, and public policy factors, such as sentencing structure and the deinstitutionalization of the mentally ill? The approach to addressing these needs begins with defining the six major steps essential for a comprehensive mental health services delivery system:

1. Initial intake screening and referral.
2. Suicide risk assessment.
3. Intake mental health screening.
4. Mental health assessment.
5. Treatment planning.
6. Discharge planning.

Step 1: Initial Intake Screening and Referral

At reception or intake, any detainee or inmate entering a correctional facility should receive an intake screening at the "front door," to identify those with acute medical or mental health needs. In lockups, such initial screening is frequently conducted by an arresting or receiving officer who has determined that someone in custody appears to have mental health, medical, and/or substance abuse issues that may require that they be transferred to the local hospital emergency room. Following clearance at the local hospital emergency room, the detainee/inmate is returned immediately to the lockup. If the inmate has an acute medical or mental illness or if the inmate is suffering from drug or alcohol withdrawal, the individual may require admission to the hospital. Given the very limited services available in most lockup environments, the police or sheriff deputies determine if there is a need to then transport the individual to an outside medical or mental health facility for evaluation.

In small jails (less than 100 detainees), these services are frequently provided by the local hospital. In medium to large jails**,** there are staff and onsite programs for medical detoxification and mental health services for crisis intervention treatment. The reception or intake screening at small jails is frequently conducted by correctional officers who should be trained in the proper administration of reception screens. In larger facilities, screening is most commonly performed by nurses.

The screens are completed during intake processing (within minutes to a few hours of the prisoner's arrival). Frequently, the screening consists of a checklist of questions, inquiring for any history of mental health conditions, medical/mental health treatment, suicide attempts, medication utilization, alcohol and/or drug use, and information as to whether the offense is considered high profile or shocking in nature. Typically, the reception/intake screening also includes documentation about the detainee's behavior, appearance, and apparent state of mind.

When the results of the reception/intake screening indicate the need for referral to a mental health professional, the detainee is to be evaluated within specified time frames. The specific time frames for evaluating referrals are the following:

- "Emergency" referrals are to be seen within minutes to hours and the individual should be directly and constantly observed until seen.
- "Urgent" referrals are to be seen within 24 hours.
- "Routine" referrals are to be seen within 3–7 days.

These criteria should be established through institutional policy, so that the responses by mental health professionals to the referrals are timely. Adequate training for intake staff is essential to ensure that the proper level of referral at the "front door" is generated.

In prisons, there is generally more information available to custody and mental health staffs than in lockups or jails. This is largely because there is usually more opportunity to accumulate information that should be available to custody and healthcare staffs, such as the results of evaluations that may have been conducted during prior incarcerations. This information will often provide an inmate's history of treatment, whether medications were prescribed, self-injurious behaviors, and attempted suicide or self-harm. Community treatment records should be obtained whenever possible for continuity of care while in custody. Information on evaluations conducted prior to trial and conviction or during any previous incarcerations assists prison administrators, custody officers, and mental health practitioners to provide appropriate housing and timely services.

Even though there may have been previous assessments conducted on a detainee/inmate, a reception/intake screening is still performed to determine the acute medical or mental health needs for the incoming population. The purpose of reception/intake screening is to determine whether the arrestee, detainee, or inmate needs immediate medical or mental health services. The screening process does not presume that officers who conduct the screenings have extensive medical or mental health knowledge. The forms are designed to facilitate immediate referral for those in need of medical or mental health services on an acute basis.

The value of adequate training for staff who complete the screening tool and are responsible for notifying the appropriate personnel when positive responses are generated is obvious. Unless there are sufficient policies and procedures in place, along with the training of correctional staff responsible for the reception/intake screening process, the process itself is subject to failure; and failures at the "front door" of any lockup, jail, or prison have been associated with an increased incidence of poor outcomes including medical and psychiatric complications and death, most notably suicide.

Step 2: Suicide Risk Assessment

As a result of numerous tragic suicides, civil rights actions regarding these suicides, and standards for reducing the risk of suicide (Hayes, 1995), there has been an increased emphasis on the importance of assessing the potential risk for suicide in correctional settings. The basic suicide risk assessment requires completion of a standardized form that identifies areas that are important for review and assessment. The risk assessment must be done face-to-face, with review of all pertinent records, including the medical records from prior incarcerations. Suicide risk assessment is indicated, on referral, by: (1) statements made by a detainee or inmate indicating thoughts or intent to harm him- or herself, (2) behaviors that indicate the potential for self-harm, or (3) referral by facility staff for changes in behavior or exhibiting behavior that warrants referral for the suicide risk assessment. The

reports of these behavior changes frequently result from training provided to correctional officers as well as other non-mental health staff who can then better recognize that an inmate's changes in behavior, demeanor, activity level, or relationship with other inmates or staff may be an indication of increased risk for suicide. These behavior changes may include giving away property, having disciplinary problems with staff or other inmates, or no longer taking part in previous activities.

Not infrequently, detainees and inmates send self-referrals to mental health or other staff with a request for an evaluation, "someone to talk to" or sometimes with overt statements of intent to commit suicide or otherwise harm him- or herself. Because there are often large numbers of sick call requests by inmates each day, a functional and responsive screening and triage process is mandatory. This means that training is not only crucial for custody and healthcare staff but also for any other staff who may handle sick call request slips (see Chap. 19 on *Reducing Inmate Suicides* by Lindsay Hayes).

Mental health staff perform the suicide risk assessment, but it may also be done by trained non-mental health medical and nursing staff members. In either case, it is essential that it be performed face-to-face and in privacy, to the extent possible. Further, policies and procedures are in place that require the inmate to be placed in a safe environment, under observation, until the risk assessment can take place in those instances where the referral suggests an emergency or urgent situation.

Segregated housing is identified as a factor in 53% of suicides in the Federal Bureau of Prisons during a 15-year study (White et al., 2002). Based on a 6-year review of completed suicides in the California Department of Corrections, Patterson and Hughes (2006) determined that a number of additional factors should be considered, both in the assessment of suicide risk and the management of inmates who present with potential suicide risks. Additional risk factors include:

- Single-cell housing, particularly segregation.
- Changes in their *dynamic* risk factors, for example, when patients indicate that they believe they have run out of options or feel "backed into a corner," where they see suicide as the most immediate option.
- Concomitant medical illness, particularly chronic and/or life-threatening conditions.
- Changes "from home," for example, dissolution of relationships, divorce.
- Loss of visits.
- New charges that could result in a longer prison term.
- Near of harm from other inmates and/or staff.

The fear of harm from other inmates and/or staff may be related to "prison politics," that is, gang-related activities; inmates who may have been charged or convicted of particular offenses including child molestation or rape that may increase the risk of harm from other inmates; or social issues within the prison population including drug debts, other "favors," or obligations owed to other inmates.

Suicide risk is often described as "none," "low or minimal," "moderate," or "high." Suicide risk assessments should also consider "acute" and/or "chronic" risks. While there are several appropriate criticisms regarding the ability or inability to predict future violence to self or others, the risk must be estimated, and interventions should be targeted toward mitigating or eliminating specific suicide risk factors. Such interventions include, but are not limited to, placement on suicide watch (constant observation); placement on suicide precautions (usually meaning physical observation by a correctional officer or healthcare professional every 5–15 minutes); transfer to a higher level of care (crisis bed care or hospital level of care); follow-up by a clinical case manager, psychiatrist, or other mental health professional within specific time frames; placement on a residential unit; or treatment as an outpatient.

Following release from suicide watch, inmates should have increased clinical and/or custody contacts for up to 2 weeks to reduce the likelihood of subsequent harm. It is helpful to have documentation of these assessments and recommendations for continued follow-up care.

Emergency Response

An obvious, but often faulty, component of suicide prevention is the emergency response process. The emergency response process includes not only assessment but also treatment activities; these characteristically involve both custody and clinical staff. Given that most individuals attempting suicide are discovered by custody staff, the policies and procedures on custody response are crucial. The activation of medical and custody alarms to indicate an emergency is frequently the very first step taken by a custody officer after determining that an inmate may be unresponsive or behaving in a bizarre manner.

Once that occurs, there may be some ambiguity as to the custody officer's responsibility to enter the cell, which depends largely on post orders and may vary depending on the security level of the inmate. Often, segregated inmates may not have their cells entered (by policy) until a supervisor, other officers, or a cell extraction team has been assembled. This means that valuable time may elapse from the moment of discovery until the actual emergency clinical response process is put into place.

There are obvious risks to staff entering cells housing inmates who have already been determined to represent a threat to the staff or the facilities' safety. Therefore, the facilities must have operational policies and procedures and post orders to allow for the safety of its staff, as well as the immediate response to an inmate who may be hanging, bleeding, or unconscious, for example, officers who are the first responders supporting the weight of a hanging inmate to reduce pressure on the neck until they can be cut down.

Greater than 90% of completed suicides within correctional facilities are by hanging or self-strangulation. The use of a cut-down tool is imperative. Cut-down tools must be readily available and supplied to trained custody staff for use prior to resuscitation. Even the use of cardiopulmonary resuscitation is debated in some systems. In a few jurisdictions, custody staff will not perform emergency procedures, because they are not medical personnel and not trained to determine whether CPR is indicated. This is dangerous.

In addition to custody staff, all medical and mental health staff should be trained to respond to an emergency code and implement CPR on anyone who is without pulse or respiration. In a study of suicides in California prisons, the one component that contributed the most to foreseeable or preventable suicides was failure of staff to follow established policies and procedures when responding to an emergency where an inmate was attempting suicide (Patterson & Hughes, 2006).

Step 3: Intake Health Screening and Referral

The mental health and medical screenings are more comprehensive processes conducted after the initial intake screening. A brief mental health assessment should be conducted within 72 hours of the time of a positive screening and referral, with provision for more immediate assessment if there is a determination that the referral should be completed on an urgent basis (Psychiatric Services, 1989). This screening may be completed by medical or mental health personnel within a relatively short period of time (during intake processing) for every newly admitted detainee/inmate. The screening is

structured to include review of the intake screening done on arrival, any past medical records and mental health history, information on the individual's adjustment to the correctional environment since admission, and assessment of suicide risk. The intake health screening form is typically 31 questions, approximately half of which focus on mental health issues.

It is essential that the intake health screening be consistently administered to newly arriving prisoners within a short, specified time period and that the information obtained be documented on a standardized form (handwritten or electronically). The form must include "trigger questions," so that immediate emergency referral for further mental health assessment is accomplished, with safe housing placement until the emergency assessment is completed. The health screening process also identifies those in need of referrals that are not "emergent," for example, "urgent," with a need for the inmate to be seen within 24 hours, or "routine," which allows for typically 3–5 days for inmates to be seen for further mental health assessments.

Based on the results of the initial intake screening or the intake health screening, when emergency mental health services are indicated, staff must be available on an emergency basis, 24 hours per day. In lockups, the arrestee is transported to a local hospital emergency room. In larger jails, there may be mental health staff on the premises of the facility. The detainee must be maintained in a safe environment, on one-to-one direct observation by a correctional officer, until the referral has been completed.

Video Monitoring

Some jails use video monitoring of prisoners on suicide watch or suicide precautions instead of one-to-one observation. In our experience, this is an extremely risky procedure, if video monitoring is the sole mechanism used for observation of a prisoner who is awaiting a more intensive mental health evaluation. Video monitoring should be used only as a supplement to direct human observation, if at all. Although there may be cost efficiencies of video monitoring of multiple inmates, there are several potential pitfalls:

1. The arrangement of the cameras inside a cell, as cells frequently have blind spots.
2. The resolution on the monitors may be poor, obscuring sufficient detail to detect and prevent self-harm.
3. The officer may not be located proximate to the cell, leading to slow response time.
4. The officer may be in a control booth, with additional responsibilities that can lead to distractions.
5. Some facilities utilize inmate sitters to monitor suicidal inmates alone or in conjunction with video monitoring: we strongly advise against using inmate sitters/monitors, if possible, as they are not an adequate substitute for direct observation by trained staff (NCCHC, 2015).
6. Post orders may require officers to wait for additional correctional staff to arrive before the cell can be opened, delaying attempts to intervene with a suicidal patient. Potential harm to the inmate and danger to the staff must be carefully considered and reflected in policies, post orders, and training.

Performance Measurement

Performance on meeting time-standards for referrals should be monitored to assure that the screening and referral process is being followed according to existing policies and procedures. This monitoring

should be conducted by trained correctional and healthcare personnel as part of the healthcare provider's Continuous Quality Improvement process.

Step 4: Mental Health Assessment

The mental health assessment is a formal assessment and includes initial plans for treatment and management. A task force of the American Psychiatric Association (APA) recommended that the assessment be conducted by a trained mental health professional, within a time frame appropriate to the level of urgency, with a face-to-face interview with the patient and review of available healthcare records and collateral information (APA, 2001). Mental health assessment using telemedicine services has become more common, both within larger institutions that have several facilities and smaller facilities that have contracted with an outside health provider. While this is not the standard of care, it is an adequate substitute for isolated locations and for sites without 24-hour onsite mental health staff for limited services such as outpatient treatment.

Suicide risk assessments and crisis or hospital-level care require face-to-face, in-person assessment. Last, a comprehensive mental health evaluation should include additional assessment tools such as psychological testing, laboratory testing, and neuroimaging procedures, where clinically appropriate. The comprehensive mental health evaluation occurs within 14 days of intake (NCCHC, 2018). Where appropriate, the timeframe for psychiatric evaluation is similar to that used for mental health assessment. Many facilities utilize stop-gap measures to ensure continuity of care with psychiatric treatment regimens by having onsite primary care staff review and prescribe facility appropriate medications until the inmate can be seen by a psychiatric prescriber.

Step 5: Treatment and Treatment Planning

For patients with serious mental illness, a primary issue is the balance between security and treatment needs. Quality care can only be provided in a secure environment. While there is no inherent contradiction between appropriate security and quality treatment, these often appear to be competing goals. In practice, security usually takes precedence over treatment, except in emergency or urgent situations where security and treatment processes share equal importance. High-quality treatment programs encourage a patient's participation and assumption of responsibility for his/her behavior.

Barriers

Many traditional correctional practices can negatively impact individuals with serious mental disorders. For example, accumulating "good time" (shorter sentence) can be difficult or impossible for an inmate living on a psychiatric unit in prison, since participation in work assignments, education, or recreation activities may be limited or prohibited. The practice of isolating prisoners who have been disruptive to the environment or threatening the safety of the institution is a longstanding practice. Only in the last two decades have there been serious efforts to ensure that prisoners in isolation are not seriously mentally ill or at risk of decompensation. They should be regularly evaluated by both mental health and medical staff and removed from isolation if their condition requires more intensive mental health services.

In lockups, individuals who are "fresh off the street" may have mental health, other medical or substance abuse histories, and/or current behaviors or symptoms that can be very difficult to distin-

guish by correctional personnel. The historical use of the "drunk tank" or "sobering cells" to allow new arrestees to "dry out" has resulted in bad and even fatal outcomes when those individuals had medical and/or mental health issues that were unrecognized and untreated, not the least of which were consequences of intoxication or withdrawal.

In any correctional environment, behaviors caused by functional impairment, such as hallucinations or delusional thinking, can result in "tickets" or lead to disciplinary violations that may result in punishment including restriction of visitors, or transfer to isolation where the inmate is kept in their cell for 22 hours or more per day (USDOJ, 2016). Tickets may be given for rule infractions, however unfairly, that range from not getting up on time to verbal or other confrontations with security staff, including, in some jurisdictions, "attempting suicide." In all correctional settings, detainees/inmates who exhibit behaviors that result in the accumulation of infractions cannot amass "good time" and consequently are more likely to serve their maximum sentence. The mentally ill in prisons may not be eligible for transfer to halfway houses because they exhibit behaviors that may be a direct result of their mental illness.

Prior to placement in segregated housing, inmates should be evaluated by medical and mental health staff. This provides the opportunity for them to identify any contraindications to placement in segregation, or if the inmate's mental illness played a role in the disciplinary infraction, for example, the inmate did not comply with officer's commands due to commanding auditory hallucinations telling him if he did he would be killed. This process is a joint venture with both the facility and clinical leadership jointly agreeing on alternative housing/interventions when segregated housing or discipline is inappropriate, and potentially harmful, for a mentally ill inmate.

Institutions should consider education and training on ways to build awareness of implicit bias for both clinical staff (Knaak et al., 2017; Stull et al., 2013) and custody officers (Correll et al., 2007) to reduce its impact on the provision of effective mental health and correctional practices and safety.

Rational Alternatives to Isolation

Recently, "behavioral management" services, including cognitive behavioral therapies, are concurrently used to decrease and/or eliminate segregation/isolation for prisoners with mental health conditions. Segregation/isolation has been the traditional "default" option or, in some cases, the primary and established custody and clinical response to "bad," "disruptive," "aggressive" or "threatening," and or non-suicidal self-injury (NSSI). These patients commonly meet diagnostic criteria for a personality disorder diagnosis such as antisocial personality disorder (ASPD) or borderline personality disorder (BPD).

Inmates with BPD, and sometimes ASPD, can also present with NSSI. While the presentation may appear the same, that is, an inmate superficially cuts themselves, the underlying reason each harmed themselves will likely be very different; this impacts the implementation of an effective intervention. For example, inmates with BPD may self-injure to cope with emotional pain because they do not possess effective coping mechanism. Whereas an inmate with ASPD may self-injure after placement in segregated housing to be moved to more desirable housing, for example, a mental health unit. Careful evaluation by a trained mental health professional can help assure that the best therapeutic intervention is provided.

There are six key elements with behavior management to help reduce negative, destructive, and dangerous inmate behavior (Hoke & Demory, 2014):

1. Assessing risk and needs.
2. Assigning inmates to housing.

3. Meeting inmates' basic needs.
4. Defining and conveying expectations for inmate behavior.
5. Supervising inmates.
6. Keeping inmates productively occupied.

The need for adequate assessments and risk identification by clinicians and classification determinations at the "front door" cannot be overemphasized. Appropriate, adequate, and relevant site-specific policies, procedures, and post orders to assist all participants, voluntary or involuntary, and supervision and quality management review and analysis are necessary. Resource allocations, at reasonable salary, and compensation for staff and space configurations for sound confidentiality while maintaining security surveillance and oversight are inherent for any program to be successful.

Levels of Care

Crisis Services

Mental health crisis services usually consist of short-term (10 days or less) stays in designated areas that, in some states, are licensed by the state mental health authority or other licensing body. These cells are typically part of an infirmary-like setting in which there may be medical as well as mental health cells specifically used for crisis management. The distinction between medical and mental health cells is important because cells used for mental health crisis management require special security provisions to make them suicide resistant.

The cells need to have sinks and toilets without sharp edges or protrusions to prevent hanging or self-injury, no clothing hooks, bed frames with no holes in them, no ladders, security air vents to reduce the likelihood of threading sheets or other materials used for ligatures through the air vents, modified window screens, and other physical plant enhancements. These cells may also include cameras for video monitoring of inmates who are on suicide observation and/or observation for psychiatric decompensation.

No cell is completely suicide proof, though the architectural changes reduce risk substantially. More often than not, these crisis bed cells are managed from a custodial point of view in much the same way as administrative segregation or detention cells are managed with meals provided to the inmate through a food-port in modified food trays; limited yard and out-of-cell time and showers, and "limited issue" materials such as paper gowns, suicide-proof blankets, finger foods, and "sporks" (plastic spoons/forks). These crisis bed infirmary-like cells require 24-hour nursing and custody support for inmate movement in and out of cells for whatever reasons. Patients who have not improved sufficiently to be transferred to a lower level of care within 10 days should be considered for transfer to a hospital level of care for more intensive services.

Residential Services

The next less-intensive level of services in jails and prisons that have a comprehensive mental health services delivery system is residential services. Residential services programs are for inmates who have a serious mental illness or severe personality disorder, with self-harming or other behaviors that may require housing with other inmates similarly diagnosed. These inmates require a range of services not available to outpatients. These services are typically provided on a self-contained unit with food service available on that unit, individual and group therapies, and a separate yard for outside activities.

The services on residential units are provided by trained mental health staff, including 24-hour nursing. These units usually have individual and group treatment space in rooms or cubicles that allow

correctional staff to visually observe interactions between clinical staff and inmates but limit the correctional staff's ability to hear what is being discussed. This provides a "sound confidential" treatment process. This compromise within many correctional facilities is intended to allow for some degree of confidentiality in the treatment process while having safety of staff and inmates reinforced by visual observation from correctional officers.

Residential units, depending on the size of the prison and the size of the unit, may be designed for inmates who are "higher functioning," and it is anticipated they will be returning to the general population at some point in the reasonably near future, that is, weeks to months. This contrasts with units where inmates are felt to be "low functioning" and who require housing on a separate and specialized unit for an extended period of time.

The distinction between "higher functioning" and "low functioning" allows for consideration of other factors that contribute to the inmate's overall functioning including co-occurring intellectual or developmental disability, medical illnesses including brain damage and dementia, and chronic substance abuse which may also have contributed to an inmate being at a lower functioning level than would be solely explained by their mental illness.

Successful efforts to safely reduce the use of isolation for prison patients with serious mental illness include, but are not limited to (USDOJ, 2016):

- Special Management Units (SMU) – Special purpose, non-punitive segregation unit for inmates with elevated security concerns due to a history of violent behavior or gang activity. Involves progression through four levels of programming over 18– 24 months with eventual return to general population.
- Steps Towards Awareness, Growth, and Emotional Strength (STAGES) – A residential treatment program for inmates with SMI with a primary diagnosis of personality disorder. The program uses integration of cognitive behavioral therapies, a therapeutic community environment, and skills training. The goal is to increase time between disruptive behaviors, improve living in general population or a community environment, and increase pro-social skills.
- Skills Program – This is a residential treatment program that last one to one-and-a-half years and is designed to improve the adjustment of inmates with intellectual disabilities and social deficiencies to the correctional environment. This program also uses integration of cognitive behavioral therapies, a therapeutic community environment, and skills training to "increase the academic achievement and adaptive behavior of cognitively impaired inmates, thereby improving their institutional adjustment and likelihood of successful community reentry."
- Challenge Program – A residential psychology, cognitive behavioral treatment program for inmates with mental illness and/or substance use who are high-security. The program places an emphasis on violence prevention and avoidance of negative peer contacts and is designed to increase self-control and problem-solving skills and encourage the development of pro-social relationships.
- Token Economy Programs – This is a system of behavior modification that is integrated into several of the psychological treatment programs. Token economy systems utilize positive reinforcement as the core driver of behavioral change. Positive reinforcement is "a powerful behavior change tool" that is used "to encourage and support pro-social behaviors and relationships."

Outpatient Services

Outpatient services for inmates in prison are provided within the facilities or halfway houses. Outpatient services typically consist of scheduled appointments with a clinical case manager or other clinician, as well as scheduled appointments with a psychiatrist, or a mid-level psychiatric provider

for inmates on prescribed psychotropic medications or who need a medication evaluation. Ensuring the inmate is evaluated by the appropriate psychiatric provider is essential and should be based on the severity of mental illness and other presenting problems. It is important to ensure mid-level psychiatric providers have had appropriate training and are provided adequate clinical supervision.[1] Achieving sound confidentiality for outpatients can be more problematic than on residential or crisis management units because of escort requirements or not being able to leave their cell because of segregation or lockdown. This means the patient may need to be seen at cell-side or cell-front. In these cases, other inmates would most likely be able to overhear at least some of the conversation between the clinician and the patient. This reduces the likelihood of legitimate information being provided to the clinician and raises concern for violation of the Health Insurance Portability and Accountability Act (HIPAA). Facilities should provide sound confidentiality.

A special circumstance for outpatient services occurs in segregation units and protective custody. The movement of inmates within these units is strictly limited which compromises sound confidentiality even further. A few systems have developed "therapeutic holding cells," "therapeutic modules," or "individualized treatment cells," essentially wire-meshed enclosures that may be 2 by 3 feet and 7 feet tall; a patient under special custody conditions can be removed from their cell and interviewed by clinicians in a semi-sound confidential setting. For those inmates who require more intensive mental health services patients might be clustered to enable group therapy. These are some of the most difficult challenges to providing treatment where patients need interventions that would ordinarily be provided on a residential or hospital unit.

Hospital-Level Services

Access to hospital-level mental health services must be provided either within the correctional facility or by agreement with a hospital. Typically, hospital-level services, when outside of the correctional environment, are provided in the local or closest forensic hospital where security measures are in place and staff include the usual array of mental health staff and custody staff for security and management of the units. The process for referral to a hospital level of care is typically instituted by clinical staff within the correctional facility, with an agreed upon approval process for transfer. Transport should be timely because of clinical urgency. The hospital services typically consist of services that are similar to crisis bed and residential services including more out-of-cell time, participation in verbal individual and group psychotherapies, medication management, and access to a greater range of diagnostic tests including psychological testing, neuroimaging, other medical procedures.

Medication Management

Medication administration is a challenge, as psychotropic medications need to be "watch take" for reasons of adherence and prevention of diversion. Another challenge may be the differences between the formulary in the hospital versus the correctional formulary. The same medications that are available at the hospital should be available at the prison. The waiver process for nonformulary medications should be a rapid process without excessive requirements for approval that delays timely access to medically necessary medication. Medical, mental health, and nursing staff need to be sensitive to discontinuity of medication and therapy.

[1]Many States require direct or indirect clinical supervision of nurse practitioners and physician assistants.

Treatment Planning

A comprehensive treatment plan is critical. The clinician who completes the assessment formulates the initial treatment plan. This is a short-term plan. Later, multidisciplinary treatment planning for ongoing treatment is imperative. This latter plan should be timely and well-documented with diagnoses, staff participants, and planned interventions—including interventions to address problematic behaviors, regular updates, and discharge plans. Correctional staff should be involved in psychiatric treatment planning for patients.

Correctional staff include officers and supervisors, but also classification personnel who have access to records and information regarding what restrictions or enhancements are applicable. There may be policies and procedures that limit the participation of correctional staff in the actual treatment planning process. Given that correctional officers are within the facilities 24 hours a day, 7 days a week, their observations and information shared among them are important for the development of an individualized comprehensive treatment plan. Some institutions train and certify officers who work on mental health units, including on HIPAA, to enable a therapeutic mindset.

The treatment plan should be based on the assessment process, but also take into consideration the inmate's length of sentence, security status, and housing. This will allow the development of objectives for the treatment team including goals for the patient to achieve or address for optimal functioning and milestones to demonstrate when the patient is ready for modification of treatment or transfer to a less restrictive level of care. Conversely, when those goals are not reached, the reasons should be documented during treatment plan updates. Examples include non-participation in treatment activities, nonadherence with medication, changes in correctional status, or other factors. The patient should have the treatment plan discussed with him or her, and he or she should sign the treatment plan and be encouraged to comment on any areas where there may be disagreement with the treatment team.

Effective treatment planning begins with the development of policies and procedures designed to govern the treatment planning process. There are several basic requirements for this process to be effective and meet the mental health needs of individual patients:

1. Policies and procedures that define the appropriate content of treatment plans include:
   (a) Identification of presenting symptoms as reported by the inmate.
   (b) Inclusion of collateral information from past records, transfer documents, and observations of officers or others who had access to the detainee/inmate.
2. A complete and appropriate mental status examination, including both the detainee/inmate's self-report and the observations and evaluation of the clinician conducting the examination.
3. Diagnostic impressions according to the *International Statistical Classification of Diseases and Related Health Problems, tenth revision* (ICD-10), or *Diagnostic and Statistical Manual of Mental Disorders, fifth Edition*[2] (DSM-V). A comprehensive assessment should include consideration and inclusion, of all or most of the categories as follows:
   (a) The major mental disorders, substance abuse/dependencies, adjustment to incarceration and life changes, and other potential areas of focus including diagnosis of malingering, when appropriate.
   (b) Identification of personality disorders and developmental disabilities, particularly regarding their impact on the potential adjustment and behavior issues related to correctional confinement.

[2]Some correctional facilities may not have transitioned from ICD-9 or DSM-IV to ICD-10 and DSM-V. Therefore, it may be beneficial to familiarize oneself with the immediately prior versions of both diagnostic classification systems for the purposes of practicing in a correctional setting.

(c) Relevant medical conditions, disorders, or diagnoses, especially if they have direct impact on mental health care.
(d) The stressors that the patient is experiencing that include reasons for the current focus treatment.
(e) Patient's overall level of function, especially in the context of their ability to address their activities of daily living without support and to appropriately interact with others.

While these basic areas of clinical focus are very much in concert with the *Diagnostic and Statistical Manual of Mental Disorders*, *fifth Edition*, they must be applied with particular care in a correctional environment. These categories also align with the axial diagnostic system that was used previously with earlier versions of the DSM. The absolute necessity to identify mental and other disorders that will be the primary focus of attention and to then apply the treatment process to addressing those disorders is essentially the same as it would be in the community, with the exception that there may be particular limitations on what interventions are available in the correctional environment. This applies not only to what are often considered the talking therapies such as individual and group therapy but also to creative arts therapies and other therapeutic interventions. All these interventions are influenced by custodial practice and may prove challenging in areas such as confidentiality, the clinician–patient relationship, and the inclusion of non-clinicians in the treatment planning process. Interventions, particularly group therapies, should take account of the fact that inmates live together and what is said in group often does not stay in group.

Medical diagnoses or problems must be incorporated into treatment planning, because of the potential impact on mental health functioning and for potential drug interactions including second-generation antipsychotic medications, as a prime example.

It is standard correctional practice for clinicians to identify and document the stressor bringing the patient into mental health treatment. Terms such as "criminal justice issues" or "incarceration" are woefully inadequate descriptions of what the inmate may be suffering; simply limiting the descriptors to these categories implies that every "incarcerated" individual should be in mental health treatment based on that stressor alone. In reading the actual descriptions of inmate behavior and inmate reporting of symptoms, it becomes very clear that incarceration may certainly be a concomitant factor, but there is a need for much more comprehensive identification of the specific stressors for an inmate to be a focus of treatment at any given time.

An inmate's overall level of functioning and adaptability in a correctional environment must also be considered in the context of their treatment needs. The "occupation" of an inmate may very well be "inmate," although certainly many inmates are working in shops, as porters, in food service, and other job activities and/or training activities. Educational pursuits vary by facility and the availability of educational opportunities may be limited to obtaining a GED or may include formal classes at some facilities in some systems. Inmates with serious and persistent mental illness may be excluded from work and/or educational activities such that they may not be able to participate based on the errant assumption that their mental illness precludes such participation. Their serious and persistent mental illness may also impact their ability to appropriately address their activities of daily living, for example, personal hygiene, dressing themselves, eating, management of continence, and safe mobility.

Very careful consideration of the inmate's overall level of function, especially in the context of their ability to address their activities of daily living without support and to appropriately interact with others in a correctional environment, should drive the identification of the level of functioning and directly influence treatment decision making and placement.

- Patients who are experiencing severe symptoms of mental illness and unable to function without the availability of 24-hour close clinical support will need crisis intervention services and may require hospitalization.
- Patients with moderate to severe symptoms frequently need residential-level services and accompanying special housing and activities to address their level of functioning.
- Those with mild to no symptoms are most frequently outpatients.
- Patients whose level of function fluctuates based on other factors, including housing location and with whom they are housed.

These factors underscore the need for participation in the treatment planning process by clinical, security, and classification staff to address not only the clinical needs but also the housing and other placement supports. The housing and other placement supports are determined by custody and classification officers with real-time input by mental health staff because of the wide range of mental health and behavioral concerns, including patients with personality disorders, intellectual disabilities/cognitive impairments, and age, gender, and culturally related concerns.

All treatment planning must be based on proper and timely assessment by a professional and qualified clinician. The use of the terms "professional" and "qualified" are included, because in community and hospital practice outside of corrections, states and the federal systems recognize licensure or certification as requirements for clinicians to make independent clinical decisions about diagnosis. Unfortunately, in correctional settings, there are sometimes waivers of such qualifications, and a clinician who is identified as "mental health clinician" without further definition may be placed in a position of assigning diagnoses and developing treatment plans outside their legal scope of practice, without proper qualification and training. Qualifications, privileges, and policies and procedures for clinical personnel must be well-defined.

This does not mean that basic licensure or certification can substitute for appropriate training and experience. For example, physicians are licensed to practice medicine and surgery in most states; however, they may have not practiced in a particular area of expertise for many years. Psychiatrists, for example, are not typically asked to perform general surgery in a prison hospital because they have not engaged in surgical practice since their internships and/or residencies which may have been many years before. Similarly, surgeons should not be in the business of making psychiatric diagnoses when their latest experiences with psychiatric patients may have been during their training years.

While policies and procedures describe the information that should be provided in the treatment plan, the timeliness of the treatment plan becomes the next important factor. Treatment plans should always be based on assessments. Initial treatment plans, which are usually done at the time of the first thorough mental health assessment, may be authored by one clinician as a short-term management strategy until a full, comprehensive treatment plan can be completed. This is usually within the first 3–5 days of the inmate's admission to a facility, after the need was determined through the screening or assessment process. If the assessment determines the detainee or inmate is in need of mental health treatment, there should be: (1) diagnoses; (2) an assigned level of care, for example, outpatient, residential, crisis bed, or hospital; and (3) a management plan to be in effect until the full comprehensive treatment plan has been completed, usually within 14 days.

The comprehensive treatment plan is, indeed, a multidisciplinary treatment plan that requires input from several disciplines including psychiatry, psychology, social work, nursing, and activity/creative arts therapies, plus the presence and participation of custody and classification staff. It is essential for medical staff to be present in specific cases when inmate medical care is involved, such as inmates with chronic pain, seizure disorder, or risk factors for the development of complications related to psychotropic medications, such as metabolic syndrome.

Metabolic syndrome is a constellation of symptoms that has been associated with the use of atypical antipsychotics and includes elevations in glucose, hemoglobin A1c, lipids, and associated weight

gain. The majority of these symptoms are preventable with appropriate monitoring and care. Unless the mental health staff, particularly the psychiatrist, is keenly aware of the inmate's medical status and monitors these parameters via laboratory analysis on a periodic (3–6 month) basis, the development of metabolic syndrome is a serious consequence for patients taking second-generation antipsychotic medication. There are similar risks for inmates on antidepressants and other medications, particularly when used in combination with medications prescribed by non-psychiatric physicians. The American Psychiatric Association Clinical Practice Guidelines for the treatment of schizophrenia and bipolar disorder provide guidance on the standards of care for laboratory and other testing when patients are taking antipsychotic and mood stabilizer medication.

Treatment planning should be timed to the level of care provided to the specific inmate or patient. The frequency of mental health treatment planning following admission and the development of the initial treatment plan should be as follows:

- Inmates in crisis care: every 3–7 days.
- Hospital-level care: Initially within 7 days with weekly to monthly review.
- Inmates in residential or transitional care units: every 3 months.
- Inmates who are outpatients: from 6 to 12 months.

Each of these treatment planning time frames include the development of a comprehensive treatment plan at the first meeting of the treatment team with treatment plan revisions or updates at no longer than the stated frequency, or sooner when there are any significant changes in the inmate's mental status or functioning.

The next most important area is the composition of the treatment team. It should be a multidisciplinary team that includes various clinical and custody staff. There was a time when there were concerns regarding confidentiality of issues discussed in a treatment team meeting and whether correctional officers and other custody staff could be included in those discussions. Confidentiality can be addressed by having custody staff sign confidentiality waivers. They can participate in portions of treatment team meetings concerning observed behaviors, security, limits on transfers, etc. Facilities that do not allow the participation of custody staff, and "hide behind" the concept of not violating confidentiality, are missing an important source of information for effective treatment planning and collaborative service provision.

The treatment plan itself consists of not only descriptions of symptoms reported by the inmate and signs of mental illness as determined by clinical assessment and consultation with custody and nursing, but also diagnoses and specific criteria for addressing the symptoms and signs of mental illness. The process includes the development of a "problem list" that describes in behavioral terms the kinds of signs and symptoms the inmate is exhibiting. For example, auditory hallucinations, suicidal thoughts, lack of socialization with other inmates, and nonadherence with medication are all important behavioral signs and symptoms. Invalid descriptor signs or symptoms include "schizophrenia" or "bipolar disorder" or "personality disorder," because the manifestations of each of these diagnoses may differ from inmate to inmate. The behaviors are the focus of the treatment interventions. True interventions should describe the plan of action, including the assignment of responsibility for executing the plan. Interventions may include: (1) medication, which in most facilities, is prescribed by a psychiatrist and administered by nursing staff, and (2) talking therapies, such as individual and/or group sessions that should be focused on the inmate's mental health signs and symptoms rather than simply being "round robin" groups comprised of whichever inmates feel like participating that day. The latter is an unacceptable way of conducting group therapy. The treatment planning process not only should assign patients to specific groups but also should review whether group participation has been meaningful and effective in addressing the patient's mental health needs. Other interventions include suicide watch or suicide precautions, placement in a crisis or residential bed, or placement in outpatient services.

The intensity of services decreases with the reduction of the level of care. Inmates who are in hospital crisis beds experience the least involvement with other prison activities; inmates in outpatient are in "general population" and, therefore, may have recreational and other activities with inmates who do not have mental illness. These factors should be very seriously considered in determining not only the level of care, but more specifically what interventions are available and at what frequency the interventions will be provided at each level of care.

The interventions should be provided to address specific objectives. For example, if the problem "hearing voices telling him to harm himself" is addressed by interventions including medication, verbal therapy, and housing in a crisis bed unit to prevent harm to himself, including suicide precautions, the objective should be to reduce the impact of the voices and reduce the likelihood of harm to self. When these objectives have been met, based on the interventions provided, then the problem may indeed be resolved or improved to the extent that a crisis bed is no longer necessary. When the treatment plan identifies a specific problem with specific interventions and objectives, the discharge plan from crisis bed is also being developed. Therefore, the discharge plan should include where the inmate is to go next, which may be to a residential treatment unit or to outpatient services, as a less restrictive environment than hospital or crisis bed services.

Conversely, if the objective of reducing the impact of the voices and reducing the likelihood of harm to self is not met in a crisis bed, then transfer to a higher level of care (hospital) may be the most appropriate intervention. If the inmate is already in a hospital, maintaining the inmate may be the appropriate intervention if the objective of reducing the impact of voices and harm to self has not been achieved. This is just one example of an identified problem with associated interventions to address that problem and the specified objectives to be met by that intervention.

Overall, the short- and long-term goals should also be identified in the treatment plan, which is a compilation of all of the objectives. In the short term, the objectives, if achieved, may result in a decrease in the level of care and, if not achieved, may result in a change to either a higher level of care or maintenance of the inmate at the same level of care.

In the treatment planning process, it is not infrequent to read in medical records the impressions by clinical staff that an inmate is "manipulative" or "malingering." Unfortunately, this occurs with the suggestion that because an inmate is manipulative or malingering, they are excluded from having legitimate mental illness. Manipulation and mental illness are not mutually exclusive. In correctional environments, our experience is that some inmates attempt to control or otherwise influence their environment by reporting they have mental illness, particularly suicidality, or by disruptive/offensive behaviors, such as smearing feces or "gassing," that is, throwing bodily fluids on staff.

One of the crucial questions to be asked by any clinician evaluating an inmate for the presence or absence of mental illness or the presence or absence of malingering or manipulative behavior is to ask the inmate "what do you want?" or "what are you trying to achieve by this behavior?" Although these may seem to be simple questions, they frequently are not asked of the inmate (lest the inmate "control" the situation), and a struggle between the inmate and facility staff including clinicians and custody staff can occur. This kind of "struggle" may result in "upping the ante" with accelerated disruptive or self-destructive behavior to achieve unexpressed goals.

With careful interviewing, inmates tend to acknowledge that they are attempting to influence their conditions of confinement for reasons other than true suicidality or even serious symptoms of mental illness, such as hallucinations and delusions. For such a dialogue to occur, there must be an effective and useful relationship between clinical and custody staff. Unfortunately, to return an inmate to the very same conditions that they are attempting to avoid by manipulating staff or malingering illness can result in more serious attempts to change that environment or change their placement in it and greater morbidity and mortality and/or increased risks to staff.

We strongly encourage clinicians and custody staff to step back and rethink whether "manipulative" and "malingering" behaviors and statements may be adaptive—at least for some prisoners—and consider alternatives to restrictions and punishments. We also encourage clinicians to reconsider the differential diagnosis and approach to care. For example, inmates may report clearly malingered hallucinations, but if a clinician explores further, they may discover the inmate actually has post-traumatic stress disorder—a commonly missed diagnosis in correctional populations—and that the patient lied in an attempt to obtain psychotropic medication to relieve nightmare-induced insomnia.

Step 6: Discharge Planning and Aftercare

Patients with serious and persistent mental illnesses should have a discharge plan providing community-based services on reentry. The community-based services should include an evaluation and assessment of the inmate's mental health needs at the time of discharge, with transitional care focused on disease management and social support.

In jails, while initial treatment planning may occur when the inmate is assessed, with "bridge orders" of medication, the assessment process may not be fully realized until up to 14 days into the incarceration. A high proportion of jail inmates will have bonded out or been released prior to the development of a treatment plan or an appropriate discharge plan. When detainees in the jail are in treatment, a comprehensive multidisciplinary treatment plan should be completed, and a discharge plan should be initiated on the supposition that the detainee will require treatment for a year or possibly 2 years when released to a prison or to the community. The collaboration between correctional practitioners and community providers is a critical component of successful treatment.

In prisons, discharge planning is frequently based on level-of-care determinations and length of incarcerations. For patients who are on a higher level of care, the treatment planning generally focuses on what interventions are necessary to meet objectives for them to move to a lower level of care or remain stable. When those objectives are met, the discharge plan should be updated by the sending facility staff and reviewed in detail and incorporated into the treatment planning process by the receiving staff. In those instances where patients are serving long sentences, it is important to remember that these sentences do come to term. For condemned inmates who will most probably die in prison, treatment services should address their changing mental health needs.

The provision of discharge summaries to identified clinicians in the community, with scheduled appointments and adequate medications to bridge the period between release and the appointment, is vital for continuity of mental health care for inmates to have a reasonable chance of successful reentry to the community. In Chap. 30 on transition to community outpatient services for the mentally ill released from correctional institutions, Dr. Steven Hoge provides an excellent description of some of the challenges and mechanisms for success in providing appropriate discharge and transition planning.

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