Current Issues in Correctional Psychiatry

Jeffrey L. Metzner, M.D.
Clinical Professor of Psychiatry
University of Colorado School of Medicine

Long standing issues

- Physical plant problems
- Staffing allocations
- Access issues

Three essential elements required to establish a constitutionally adequate correctional mental health system are as follows:

- Adequate physical resources regarding treatment program space and supplies;

- Adequate human resources concerning numbers of properly trained and/or experienced mental health staff who will identify and/or provide treatment to inmates with serious mental illnesses; and

- Adequate access for inmates to the physical and human resources within a reasonable period of time (Cohen 1993).

Cohen F: Captives' legal right to mental health care. Law and Psychology Review. 1993; 17:1-39.

Standards and/or guidelines for correctional health care programs

- American Psychiatric Association
- American Public Health Association
- National Institute of Corrections,
- National Commission on Correctional Health Care
- American Nurses Association
- Association of Correctional Psychologists

APA Guidelines (2000)

- "The fundamental policy goal for correctional mental health care is to provide the same level of mental health services to each patient in the criminal justice process that ***should*** be available in the community."

Important Principle

- Security classification does not determine treatment need (e.g., level of care). It often determines how the LOC will be implemented.

Levels of care

- Treatment need is generally independent of security status, with some exceptions.
- Exceptions include effect of conditions of confinement on the inmate's mental health, especially in locked down settings.

- Assuming that the inmates have been properly classified, the decision regarding the nature of the security required during treatment should be a collaborative one, involving attention to both custody and therapeutic concerns.

- Unquestionably, the safety of staff and inmates is the highest priority, and the ultimate responsibility for institutional safety falls on the institutional warden or equivalent. When there is good interdisciplinary communication, it is easier to accommodate both interests. Ultimately, good treatment enhances institutional security, and vice versa.

Essential Components of a Comprehensive Mental Health System

- crisis intervention program, with infirmary beds for short-term treatment (usually less than 10 days) available,

- acute care program,

- a chronic care program and/or special needs unit (housing unit(s) within the correctional setting for inmates with chronic mental illness who do not require inpatient treatment but do require a therapeutic milieu due to their inability to function adequately within the general population),

- outpatient treatment services,

- consultation services (consulting with the prison's management team and/or providing training of correctional officers and program staff),
- suicide prevention program,
- discharge/transfer planning, including services for inmates in need of further treatment at the time of transfer to another institution or discharged to the community.

Evolving issues

- Mental health issues relevant to lockdown units (e.g., segregation, disciplinary, supermax, etc.).
- Mental health input into the disciplinary process.
- Discharge plans for inmates with serious mental illness (will review if time permits).

Evolving issues (which will not be addressed in this talk)

- Management of the inmate with inappropriate sexual behaviors (e.g., indecent exposure).
- Special Needs of Female Inmates
- Research ethics (see IOM report- http://books.nap.edu/catalog/11692.html)

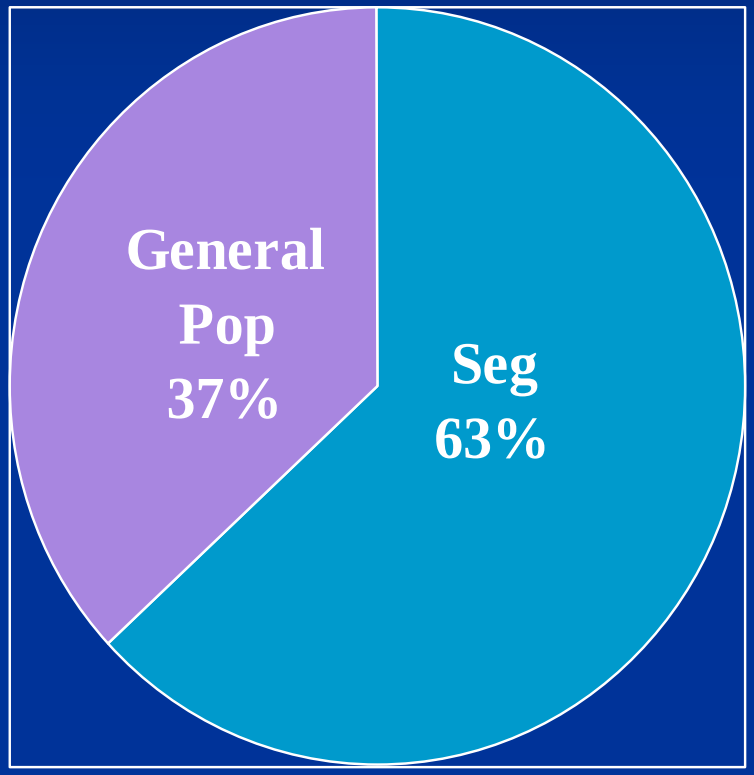
Evolving issues con’t (will not be addressed in this talk)

- Quality Improvement Systems
- Management Information Systems
- Substance Abuse Treatment

The major problems relevant to the mentally ill in segregation involve issues related to the following:

- Definition of mental illness
- Duration of confinement in segregation
- Conditions of confinement
- Clinical assessment of the above 3 factors

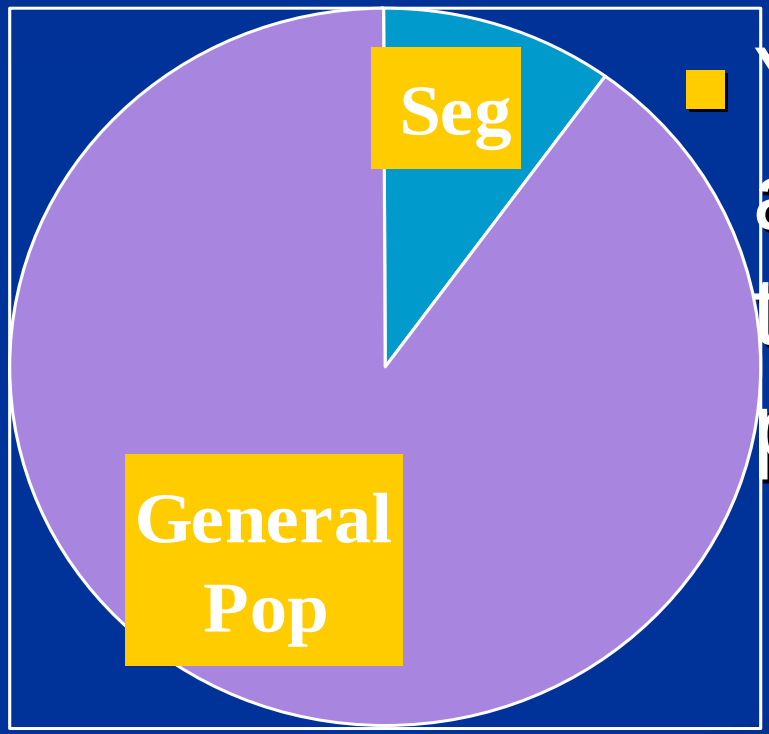
Segregation Housing



- More than half of prison suicides occur in segregation units

Federal Bureau of Prisons Study (1983-1997)

Segregation Housing (cont.)



- Yet segregation accounts for less than10% of prison beds

Reminder: Re: Malingering

- Malingering a mental illness and having a serious mental illness in a correctional setting are not mutually exclusive.

- Warning sign: diagnosis of SMI changed to malingering and/or a personality disorder.

Manipulation and Suicide

- Manipulation and true suicidal impulses can co-exist (the presence of manipulation does not rule out suicide risk).

- Overt manipulation may actually be a risk factor for suicide in the long term.

Guidelines and models

- APA task force report: *Psychiatric Services in Jails and Prisons* (2nd edition, 2000)
- National Commission on Correctional Health Care
- American Correctional Association
- Court cases (*Madrid; Coleman; Dunn; Jones ' El, et al. v. Berge,)*

Mental health issues relevant to lockdown units

- The standard of care appears to now a require a health screening process either prior to or within a short period of time following an inmate's admission to a segregation unit for purposes of assessing suicide risk factors, medical/psychiatric care needs and healthcare contraindications to segregation placement.

- Inmates must receive any mental health services that are deemed essential, their segregation status notwithstanding.

- Institutions should provide for regular rounds by a qualified mental health clinician in all segregation housing areas. During these rounds, each inmate should be briefly visited, to assess any emerging problem. The clinician should communicate with segregation security staff in order to identify any inmate who appears to be showing signs of mental deterioration or psychological problems

- These rounds in segregation allow mental health professionals to detect psychological deterioration much earlier, and prevent the more severe exacerbations of psychoses, depression, or anxiety that can cause the most severe discomfort to inmates and disruption to the correctional environment.

Segregation inmates, who are known to have serious mental health needs:

- Must be assessed on a regular basis by qualified mental health practitioners, to identify and respond to emerging crises at the earliest possible moment.

Access issues

- Mental health referral process (timeliness of response—internal mail process, etc.)
- Cellfront versus out of cell contact
- Sound versus visual privacy
- Availability of escort officers

For those inmates assessed to need a residential level of care,

- The specialized mental health program should offer at least ten to fifteen hours per week of out-of-cell structured therapeutic activities in addition to at least another ten hours per week of unstructured exercise or recreation time.

Residential treatment LOC in lockdown units

- Implementation of such a program is logistically very difficult and expensive due to the need for increased correctional officer staffing in order to comply with security regulations and construction related to needed programming space.

Controversies surrounding these treatment guidelines:

- The use of metal enclosures that are designed to allow inmates to participate in group psychosocial therapeutic activities while physically separated from other inmates and staff.
- Amount of out-of-cell structured and unstructured time.
- Psychological effects of lockdown units

The recommendation of 10-15 hours of structured therapeutic activities

- Based on experience with six large correctional systems involved in systemwide class action litigation that focused on the adequacy of the mental health system.
- It is meant only as a guideline, due to the variability in the conditions of confinement in supermax prisons across the county, and the varying needs and capabilities of inmates with serious mental illness.

- Institutional conditions include the nature of the physical plant, staffing, security practices, access to televisions and radios, group recreational yard, duration of confinement, allowable property, educational and program opportunities.

- The intention is to provide enough healthy social interaction for treatment purposes as well as to prevent a person with a serious and disabling mental illness from potentially getting worse because of the absence of normal social interaction.

Impact of long-term segregation upon psychological functioning

- The literature is sparse.
- There are few if any adequate scientific studies concerning the impact of locking an inmate in an isolated cell for an average of 23 hours per day with limited human interaction, minimal or no programming, and in an environment that is designed to exert maximum control over the individual.

- There is general consensus among clinicians that placement of inmates with serious mental illnesses in these settings is contraindicated because many of these inmates' psychiatric conditions will clinically deteriorate or not improve.

- In other words, many inmates with serious mental illnesses are harmed when placed in a supermax setting, especially if they are not given access to necessary psychological and psychiatric care.

- Less clear and more controversial is the psychological impact of long term confinement on inmates who do not have pre-existing mental illness.

- Despite claims to the contrary, it is not currently clear whether, how often, and under what circumstances such confinement causes persons to develop serious mental illness (e.g., psychotic symptoms, disabling depressive or anxiety disorders, etc.)

- The literature, in addition to being sparse, provides conflicting perspectives on this question.

References

- Metzner JL and Dvoskin JA: An Overview of Correctional Psychiatry. Psychiatric Clinics N Am , 29: 761-772, 2006
- Glancy G. The psychiatric aspects of solitary confinement. Victims and Offenders. 2006; 1:361-368.
- Haney C. Mental health issues in long-term solitary and “supermax” confinement. Crime & Delinquency 2003; (49):124-156.
- Grassian S. Psychopathological effects of solitary confinement. American Journal of Psychiatry 1983; (140):1450-1454.

- Mental health clinicians working in such facilities report that it is not uncommon to observe many inmates, who do not have pre-existing serious mental disorders, to develop irritability, anxiety and other dysphoric symptoms when housed in these units for long periods of time.

- This is consistent with the finding that many non-mentally ill inmates in supermax settings respond favorably to weekly (or more frequent) rounds by mental health clinicians for monitoring purposes, especially when provided with copies of crossword puzzles, reading materials or simply friendly conversation.

- Claims that long-term segregation necessarily causes particular kinds of psychological harm, often described as being scientifically proven, have been published and presented in journals and educational meetings, and verbalized via testimony.

- Most of these claims significantly overstate what is known about the psychological impact of long term supermax confinement, especially on inmates who do not have pre-existing mental illness.

- It should be acknowledged that many of these advocates have made a significant contribution to improving mental health services in correctional facilities, in part, by raising these issues. However, we believe that the long term psychological effects of such environments are not known, and that the basis for such claims lacks scientific support.

Colorado Study

- The broad purpose of the project is to evaluate the psychological effects of long-term solitary confinement on offenders, particularly those with mental illness.

- Will compare the impact of solitary confinement against the general prison setting and a mental health prison facility

- Will assess whether offenders with mental illness decompensate differentially from those who are not mentally ill.

Mental health input into the disciplinary process

- While formal evaluations are not required, however, mental health input into disciplinary proceedings is recommend for three reasons.
- First, it allows consideration of an inmate's competency to proceed at the hearing.
- Second, it allows for consideration of the inmate's culpability and thus the appropriateness of the punishment.

- Finally, mental health input allows identification of those inmates whose mental illness would make the same segregation punishment more unpleasant than it was intended to be.

- Except for a very useful article by Krelstein little else has been written about mental health clinicians providing input into the disciplinary process, especially when inmates with serious mental illnesses have committed a rule infraction.

(Krelstein M. The role of mental health in the inmate disciplinary process: A national survey. J Am Acad Psychiatry Law. 2002; 30:488–96)

- It is useful for mental health staff to be notified when caseload inmates receive serious (i.e., major) rule violations because their actions leading to the violations are often clinically significant.

- A procedure should be in place that results in timely notification to mental health staff of such occurrences, which should facilitate mental health input to the disciplinary process, when indicated, relevant to issues of competency to proceed with the disciplinary hearing, mitigating factors, and dispositional recommendations.

- Mental health staff should also be available to the disciplinary hearing officers for consultation purposes, when a non-caseload inmate appears to be demonstrating symptoms of a serious mental illness.

- Major versus minor infractions

- Recommend that the mental health input into the disciplinary process not address issues related to responsibility (e.g., the equivalent of an insanity plea).

- Clinicians providing mental health input into the disciplinary process need special training relevant to such assessments and that hearing officers also need training on how to use such information obtained from the mental health clinicians.

- An ongoing training and quality improvement process should occur relevant to this area due to the frequent changes in hearing officers and rotation of clinicians to other program areas.

Discharge planning

- An essential component of mental health treatment
- The process of planning and arranging for a patient with mental illness to continue to receive an appropriate level of treatment after discharge from the care of his or her current provider

The extent of discharge planning services that should be provided to an inmate depends on a variety of factors including

- the nature and severity of the inmate's mental illness,
- the scope of mental health services provided to the inmate during incarceration, and
- the inmate's ability to function on his or her own after discharge.

Obstacles to effective transition to the community

- Homelessness
- Symptoms associated with mental illness
  - Denial
  - Socialization skill deficits
  - Cognitive deficits

- Lack of financial resources and barriers to obtaining entitlements
- Co-morbid substance use disorders.
- The mental health treatment system is frequently difficult to access.

Adequate discharge planning includes:

- creating a written service plan that identifies the needs of the inmate and the appropriate resources available to him or her upon release,

- referring and linking (facilitating the connection of) inmates to community-based mental health services,

- providing inmates with a temporary supply of medication when clinically appropriate,
- referring and/or linking inmates to appropriate available housing if they are likely to be homeless after their release, and
- assisting the inmate in obtaining necessary financial benefits.

Release from Prison — A High Risk of Death for Former Inmates (Binswanger et al. N Engl JMed 356;2 January 11, 2007)

- During the first 2 weeks after release, the risk of death among former inmates was 12.7 times that among other state residents, with a markedly elevated relative risk of death from drug overdose.

- The leading causes of death among former inmates were drug overdose, cardiovascular disease, homicide, and suicide.

California POC study

- After controlling for background characteristics, it was found that receiving a prerelease assessment by a social worker was associated with a 90 percent increase in the odds of attending a parole outpatient clinic at least once following release from prison.

- In turn, parolees who attended a clinic following release from prison were 37 percent less likely to be returned to prison within 12 months than were parolees who did not attend one. Similar trends were found when predicting how long parolees remained out of prison.

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