# Analysis and Commentary

# An Introduction to Correctional Psychiatry: Part I

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**This article, to be published in three parts, provides an overview of relevant national guidelines/standards for providing mental health services within a correctional setting and describes essential characteristics of a mental health system designed to meet constitutional standards. Part I will provide a brief summary of pertinent epidemiological studies and an introduction to the most widely used national standards/guidelines. Part II will focus on organizational issues within correctional mental health systems, staffing issues, and psychiatric screening/evaluation processes. Part III will address issues pertinent to treatment programs for inmates with serious mental illnesses, confidentiality, involuntary treatment, and management information systems.**

An estimated 1,630,940 persons were incarcerated in prisons and jails within the United States at midyear 1996, which represented a 119 percent increase in the total number of inmates in custody when compared with the correctional population at year end 1985. The total correctional population included 73,607 women, which accounted for 6.3 percent of all prisoners nationwide.[1] Local jails are facilities that hold inmates beyond arraignment, generally for over 48 hours but for less than a year. Local jails are administered by city or county officials. Prisons are correctional facilities in which persons convicted of major crimes or felonies serve their sentences, which are usually in excess of a year. There are six states (Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont) and one commonwealth (Puerto Rico) that have combined jail and prison systems.

Men made up 90 percent of adult jail inmates. White non-Hispanic inmates accounted for 39 percent of the total jail population; black non-Hispanics, 44 percent; and Hispanics, 14 percent. The jail incarceration rate for African Americans was almost six times that among whites. About 94 percent of inmates in prison were men; 48 percent were white, and 51 percent African American.[2]

About six percent of the jail facilities housed more than half of all jail inmates during midyear 1993. Five states (California, Texas, Florida, New York, and Georgia) incarcerated slightly less than half of all local jail inmates. Nearly 30 percent of all inmates in U.S. prisons in

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1995 were incarcerated in California, Texas, and New York.[2, 3]

Studies and clinical experience have consistently indicated that 8 to 19 percent of prisoners have psychiatric disorders that result in significant functional disabilities, and another 15 to 20 percent will require some form of psychiatric intervention during their incarceration.[4, 5] Teplin[6, 7] reported that 9 percent of male, urban jail detainees had a severe mental disorder (schizophrenia or major affective disorder) sometime during their lifetime, with 6 percent having had an episode within two weeks of their arrest. Using the National Institute of Mental Health Diagnostic Interview Schedule-Version III-R (NIMH DIS-III-R) developed for the Epidemiologic Catchment Area Program,[8] Teplin and colleagues[9] studied a randomly selected, stratified sample of 1,272 female arrestees awaiting trial at the Cook County Department of Corrections in Chicago, IL from 1991 to 1993. More than 80 percent of their sample met the criteria for one or more lifetime psychiatric disorders, with 70 percent demonstrating symptoms within six months of the interview. Fifteen percent of the women had symptoms consistent with a diagnosis of a severe mental disorder (schizophrenia/schizophreniform disorder, manic episode, major depressive episode) within six months of their interview. Over one-third of the sample population had a lifetime prevalence of posttraumatic stress disorder, and 70 percent of the women had a history of a substance abuse disorder.[9]

There have been numerous reports and studies about the prevalence of mental disorders among prison inmates.[10–16] Many of these reports and the methodological flaws in such studies are well summarized by Jemelka *et al.*[15] The methodological problems have included vague definitions of mental disorder, lack of standardized procedures and diagnostic criteria, nonrandom samples, and inadequate sample sizes. Steadman *et al.*[17] described the results of a 1996 survey of 3,684 inmates in the New York State prison system that was designed to determine the prevalence of psychiatric and functional disability and service utilization. Their methodology avoided a clinical diagnostic assessment in favor of behaviorally based determinations. Results indicated that 5 percent of their sample was severely psychiatrically disabled, and another 10 percent significantly psychiatrically disabled. Forty-five percent of the severe disability group had no mental health service contacts during the year prior to the study.

Not surprisingly, a very high rate of substance abuse disorders among male prisoners has been frequently reported. A Bureau of Justice Statistics survey[18] found that 62 percent of inmates during 1991 reported regular use of a drug at some time in their lives. High base rates of mental disorders in prison populations, associated with a significant addictive disorder comorbidity, was also found in the NIMH epidemiologic catchment area study.[19] However, it was reported by the U.S. General Accounting Office[20] that state prisons were providing drug treatment to slightly more than 20 percent of inmates with problems of substance abuse. The finding that 71.9 percent of

the institutional population in the NIMH Epidemiologic Catchment Area Program[19] had a lifetime prevalence rate of an alcohol- or other drug-related problem or a mental disorder was more than twice that found in the general community population and included an 82 percent prevalence rate of these disorders among the sampled prison population. The high rate among prisoners was primarily attributable to a very high (72%) lifetime prevalence of substance abuse (56.2% had an alcohol-related disorder and 53.7% had another drug disorder). Other mental disorders were found in 55.7 percent of prisoners.[19] The epidemiologic catchment area study found that the comorbidity of addictive and significant mental disorders were highest in the prison population among inmates who were diagnosed with an antisocial personality disorder, schizophrenia, or a bipolar disorder.

Issues related to mental illness in female inmates within prisons have been less well studied than those related to male prisoners. Daniel *et al.*,[21] using the NIMH DIS-III-R, found high six-month prevalence rates of schizophrenia (7%), major depression (17%), mania (2%), and antisocial personality disorder (29%) among 100 consecutively admitted female offenders to a western U.S. prison. More than 40 percent of women in prisons reported that they had been sexually or physically abused, and 39 percent of all female inmates reported that they had used drugs daily during the month before their offense.[22] Jordan *et al.*[23] found the rates of substance abuse and dependence, antisocial and borderline personality disorders, and mood disorders among women felons in the North Carolina prison system elevated as compared with women in community epidemiologic studies. Their study did not attempt to determine the rates of schizophrenia and manic episodes among the sampled population.

Major problems in identifying and/or providing treatment to prisoners with mental illnesses have been experienced by correctional systems throughout the United States. Efforts to establish adequate mental health systems in prisons were accelerated during the 1970s as a result of successful class action lawsuits. At least one part of the prison system, in 21 states, included a judicially certified class action lawsuit involving the issue of providing adequate mental health services for inmates during 1988.[24]

This article, which will be published in three parts, will provide an overview of relevant national guidelines/standards for providing mental health services within a correctional setting and will describe essential characteristics of a mental health system designed to meet constitutional standards. Treatment pertinent to the developmentally disabled, sex offenders, and inmates with substance abuse problems will not be covered. Issues pertinent to the special needs of women within correctional facilities will be summarized briefly. The role of the mental health professional in providing consultation and training to correctional staff will also be reviewed.

General principles relevant to mental health systems within jails and prisons are described here with attempts made to summarize, when pertinent, differences

between jail and prison mental health systems. Appropriate judgment and flexibility should be used in applying these principles to a specific correctional setting due to the significant differences in various correctional facilities. This article will generally refer to a person within a jail or prison as an "inmate," although such a person within a jail is usually referred to as a "pretrial detainee" unless the person has been convicted and sentenced.

## National Guidelines and Standards

Cohen[25, 26] has described the three essential elements required to establish a constitutionally adequate correctional mental health system as follows: (1) adequate physical resources regarding treatment program space and supplies; (2) 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 (3) adequate access for inmates to the physical and human resources within a reasonable period of time.

The third element, which is an access concept, is emphasized because it helps to define adequacy concerning physical and human resources. These resources are generally adequate if it can be demonstrated that a sufficient number of qualified mental health personnel are available to provide access to evaluation and treatment consistent with contemporary standards of care. Thus, the time frames related to important components of an adequate mental health system such as intake screening and evaluation, response to a crisis or other mental health emergencies, access to diagnosis and appropriate care after the initial reception process, and transfer to a hospital or residential treatment program are important indicators of the adequacy of staffing levels, physical resources, and working relationship between the mental health and correctional staffs.

There are a variety of standards and/or guidelines for correctional health care programs that have been published by national organizations such as the American Bar Association,[27] American Nurses' Association,[28] American Public Health Association,[29] American Psychiatric Association,[30] American Correctional Association,[31] National Institute of Corrections,[32] and National Commission on Correctional Health Care.[33, 34] A useful framework for establishing mental health systems that address the issue of adequate access to treatment are provided by these guidelines and standards. The emphasis varies within these standards and/or guidelines based on the size and type of correctional facility and particular interest/expertise within the organization promulgating such recommendations. Some of these standards are used as partial remedies to class action lawsuits involving mental health care within correctional systems, although they clearly are not determinative of constitutional obligations.

The planning process for providing essential services for the mentally ill in jail is described well by Steadman *et al.*[35] It is often very difficult to implement such services due to physical plant deficiencies in the rapidly increasing jail population.

**Table 1**
**Essential Policies and Procedures for Correctional Mental Health Programs[a]**

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| 1. | Mission and goal |
| 2. | Administrative structure |
| 3. | Staffing (i.e., job descriptions, credentials, and privileging) |
| 4. | Reliable and valid methods for identifying inmates with severe mental illnesses (i.e., receiving screening, intake mental health screening, mental health evaluations) |
| 5. | Treatment programs available |
| 6. | Involuntary treatment including the use of seclusion, restraints, forced medications, and involuntary hospitalization |
| 7. | Other medicolegal issues including informed consent and the right to refuse treatment |
| 8. | Limits of confidentiality during diagnostic and/or treatment sessions with pertinent exceptions described |
| 9. | Mental health record requirements |
| 10. | Quality assurance and/or improvement plan |
| 11. | Training of mental health staff regarding correctional and/or security issues |
| 12. | Formal training of correctional staff regarding mental health issues |
| 13. | Research protocols |

[a] See Reference 4.

The nature of the mental health services offered in jails also varies widely due to the obvious differences in jails, from those having a designated capacity of fewer than 10 inmates to the "megajails" that exist in cities such as New York City, Chicago, New Orleans, and Los Angeles. These megajails have system issues that are more related to prison correctional mental health systems than to the small jail mental health systems that exist in about half of the 3,300 jails in the United States.[36]

Correctional mental health systems within state prisons exhibit a much greater uniformity of structure than jail systems, although diversity is clearly present in these systems. Many state departments of corrections have clearly been attempting to establish correctional health care programs consistent with some set of national guidelines.[24]

The American Medical Association published its first correctional health care standards in 1979. These standards were subsequently revised by the National Commission on Correctional Health Care (NCCHC).[33, 34] The standards for health services in correctional institutions developed by the American Public Health Association (APHA),[29] similar to the NCCHC standards,[33, 34] focus on general health care issues, although they do contain principles specific to mental health services. More specificity concerning correctional mental health services is present in the guidelines developed by a task force within the American Psychiatric Association (APA),[30] which assume compliance with the standards published by the NCCHC.[33, 34]

## Policies and Procedures

Policies and procedures should be developed by health care administrators after receiving input from clinicians. Such input is important because it can increase both the relevance of and the compliance

with the policies and procedures. A policy is an official position of a facility on a particular issue relating to its organizational purpose. A procedure describes in detail how the policy is to be carried out (e.g., see NCCHC standards).[33, 34] Policies and procedures provide important guidelines for the existing health care staff and should be used as an orientation tool for new mental health care staff. Refer to Table 1 for a list of pertinent correctional mental health policies and procedures.

The NCCHC[33, 34] and the APA guidelines[30] provide a useful structure for the development of these policies and procedures. Many of the principles underlying these policies and procedures have characteristics common to noncorrectional mental health systems. Important aspects of these basic principles will be summarized in Parts II and III with an emphasis on issues specific to correctional systems. Part II will focus on organizational and staffing issues and on psychiatric screening of newly admitted inmates to the correctional system. Part III will address issues pertinent to treatment programs for inmates with serious mental illnesses, confidentiality, involuntary treatment, and management information systems.

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