An Introduction to Correctional Psychiatry: Part III

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This article, which is the last of three parts, provides an overview of relevant national guidelines/standards for providing mental health services within a correctional setting and describes essential characteristics of mental health systems designed to meet constitutional standards. Part III addresses issues pertinent to treatment programs for inmates with serious mental illnesses; confidentiality; involuntary treatment; quality assurance; management information systems; and research.

Part III of this article addresses treatment programs offered to inmates in correctional facilities with a focus on providing mental health services for inmates with serious mental illnesses. Issues pertinent to involuntary treatment, confidentiality, quality assurance, management information systems, and research will also be briefly summarized.

Treatment Programs

The guidelines developed by the American Psychiatric Association (APA)[1] define mental health treatment as the use of a variety of mental health therapies, biological as well as psychological, to alleviate symptoms of mental disorders that significantly interfere with an inmate's ability to function in a particular criminal justice environment. Mental health treatment in a correctional setting, as in the community, should also be available for purposes of alleviating symptoms of mental disorder associated with present distress (a painful symptom or syndrome) or with a significantly increased risk of suffering death, pain, or significant impairment. Generally accepted mental health practices and institutional requirements provide the structure for treatment, which should be approached in a multidisciplinary and eclectic manner. A comprehensive system should include the components listed in Table 1.

Mental health treatment available to inmates in jails is often limited by the short stay and the size of the facility. Treatment generally emphasizes prescription of psychotropic medications or crisis intervention services, which may include transfer to special housing units, special observation, and brief psychotherapy. Some longer-term verbal therapies may be available to inmates with lengthier pretrial confinements or sentences. The essential mental health services for a jail population in-

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Table 1
Essential Components of a Comprehensive Mental Health System

1. Crisis intervention program, with infirmary beds for short-term treatment (usually less than 10 days) available
2. Acute care program
3. 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)
4. Outpatient treatment services
5. Consultation services (consulting with the prison's management team and/or providing training of correctional officers and program staff)
6. 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[1, 9]

clude access to inpatient psychiatric beds, seven-day-a-week mental health coverage; availability of a full range of psychotropic medications that are prescribed and monitored by a psychiatrist; appropriate nursing coverage in any medical/mental health area; and procedures, developed and monitored by psychiatrists and nurses, to ensure that psychotropic medications are distributed by qualified medical personnel whenever possible.[1]

It is often not cost effective for smaller jails to hire their own mental health staff. Mental health services can often be purchased on a contract basis from local mental health centers or from private practitioners on a regularly scheduled consulting basis. Inpatient mental health services can often be obtained through the forensic division of the state hospital system following successful negotiations with the Department of Mental Health or an equivalent state agency.

Prison mental health systems should provide a comprehensive system of mental health care, as described in Table 1. The importance of a chronic care program for inmates with serious mental illnesses has become increasingly recognized as an essential component of such a system.[2] A 1993 report by the American Correctional Association Task Force on Offenders with Special Needs summarized 202 programs from several provinces in Canada and 39 states in the United States.[3] These programs included in-house correctional programs and community-based programs for offenders with mental illness, emotional disturbance, mental retardation, substance abuse problems, and sex-offending behavior.

Specialized Programs for Inmates with Serious Mental Illness

The correctional mental health literature is sparse concerning descriptions of chronic care programs (often known as a residential treatment unit, intermediate care unit, supportive living unit, special needs unit, psychiatric services unit, or protective environment) for inmates with serious mentally illnesses. Inmates appropriate for these units generally have had significant difficulty functioning in a general population environment due to symptoms related to their serious mental disorders.

These special living areas are generally designed to house 30 to 50 inmates per housing unit, which allows staffing to be

done in a cost-effective fashion. Adequate office space (preferably unit staff offices or offices close to the unit), storage rooms for charts, office and program supplies and equipment (e.g., blackboards/audiovisual materials), and wall-mounted TV/video equipment are necessary components of these units. Adequate numbers of individual and group rooms for programming activities are essential. Indoor and outdoor recreational space will be required as will ample day room space. Art and/or music therapy are very useful adjuncts to the treatment program. The ability to provide meals on the unit can be very helpful. Attention should also be placed on having adequate shower facilities and janitor's closets.[4]

The unit should be designed to enable adequate observation of inmates from the nurses' office and the correctional officers' station. Space needs to be available within the unit for a treatment room for sick call purposes, crash carts, medication carts, and a medication room. Designated cells for close observation and/or restraints need to be close to the nursing and/or correctional officers' station. Central air conditioning or the ability to maintain reasonable room temperature, adequate ventilation, and proper acoustics (to decrease the noise level in the treatment/housing areas) are important environmental conditions that should exist.

The size of the unit and security classification levels of the inmates will be significant factors in determining the staffing for such units. The necessary staff includes a psychiatrist, nurses, activity therapists, clerk, and other mental health professionals (e.g., psychologists, social workers, mental health technicians) to provide the necessary treatment services. A typical intermediate care unit in the New York Department of Corrections, described by Condelli *et al.*,[5] served 60 inmates and was staffed by a .5 full-time equivalent (FTE) psychiatrist and three to five other full-time mental health specialists (e.g., psychologist, nurse, social worker, occupational/recreational therapist). The importance of a good working relationship between the mental health staff and correctional officers on these units cannot be overemphasized. It is recommended that the mental health director of such a unit have significant input regarding the selection of correctional officers assigned to the unit. Having at least a six-month rotation for the correctional officers on the unit will facilitate development of a treatment team concept.

Morgan *et al.*[6] studied the adjustment to prison life by individuals with schizophrenia and compared their adaptation with a control group that had no known mental illness and were matched for age, race, sex, most serious crime, and security level. The outcome variables studied were number of infractions, number of "lock-ups," days in lock-up, ability to obtain a job in prison, and ability to obtain release from prison. Lock-up meant that an individual was restricted to his cell except to shower twice a week, obtain needed medical assistance, and during one hour of recreation per day. Lock-up could also occur in special administrative segregation cells. Inmates with schizophrenia had more trouble adapting to prison life than the control group, based

on all outcome variables studied. They were less able to successfully negotiate the complexity of the prison environment, which resulted in an increased number of prison rule infractions and consequently more time spent both in lock-up and in prison.

Condelli *et al.*[5] studied whether there was a reduction in disruptive and harmful behaviors, as well as in the correctional restrictions and mental health services used to address those behaviors, among inmates in the New York prison system who had been admitted to an intermediate care program (ICP) for inmates with psychiatric disorders. These ICPs included milieu therapy, individual and group therapy, psychotropic medications, recreational therapy, task and skills training, educational instruction, vocational instruction, and crisis intervention. Significant reductions were found in various serious infractions of rules, suicide attempts, correctional discipline, as well as in the use of crisis care, seclusion, and hospitalization.

The need for specialized programs for inmates with serious mental illnesses in correctional settings has also been recognized by the APA. The APA practice guideline for the treatment of patients with schizophrenia recommends that individuals with schizophrenia receive appropriate treatment including psychotropic medications and psychosocial and rehabilitative interventions. The practice guidelines further state that "persons with schizophrenia should generally not be placed in 23-hour/day lockdown for behaviors that directly result from the schizophrenia because a) such an intervention is not likely to reduce the risk of the behaviors in question and b) such an intervention is likely to exacerbate the schizophrenic symptoms that are responsible for the behavior."[7]

Treatment Modalities

Psychotropic medications are an important treatment modality within correctional mental health systems. The development of protocols for the use of mood-stabilizing medications such as lithium, carbamazepine, and divalproex sodium help to assure the appropriate use of psychotropic medications. The use of addicting sedative-hypnotics and antianxiety medications is strongly discouraged within a correctional setting due to the potential for substance abuse. Relaxation techniques and tricyclic antidepressants are often useful treatment options for inmates with sleep problems or anxiety disorders. Serotonin-selective reuptake inhibitors (SSRI) antidepressants and the newer antipsychotic medications (e.g., risperidone, olanzapine) are increasingly recognized as cost-effective treatment options.

Individual outpatient psychotherapy is often limited to crisis intervention, except for supportive psychotherapy for inmates with serious mental illnesses, due to limited resources. However, infrequent but regular (i.e., monthly) psychotherapy sessions are often useful for inmates with severe behavioral disorders. Group psychotherapy is generally considered the most cost-effective form of treatment within a prison setting.

Therapy Issues

An excellent synopsis of the inmate experience is provided by Roth,[8] who provides a summary of the power and control issues that are dominant within a correctional environment. Various institutional rules and practices that involve strip searches, non-contact visits, yard time, shower time, and administrative (or punitive) segregation, are often made for security purposes, but their implementation may reflect control issue dynamics between correctional staff and inmates. Attempts will often be made by both inmates and correctional staff to engage the mental health clinician as an ally in these power struggles, especially within administrative segregation units. A reasonable response by the mental health clinician will be facilitated by an understanding of the institutional organization and the inmates' social system. The mental health clinician's credibility will often be enhanced by acknowledging a limited ability to change the system when responding to these struggles.[8, 9] Other common therapy issues include stresses related to institutional life and overcrowding, poor living conditions, lack of meaningful work, violence, sexual exploitation, and weakening of the inmate's usual affectional ties.[8]

Inmates often seek psychiatric treatment because of requirements established by the classification committee and/or parole board as a condition for consideration for transfer and/or release. This type of treatment, which usually involves substance abuse or sex offender treatment programs, is generally referred to as correctional rehabilitative treatment although it is often provided by mental health services. The effectiveness of correctional rehabilitation treatment remains controversial, despite studies indicating that effectiveness depends on what is delivered to whom in particular settings.[10] Treatment programs for sex offenders often decrease the availability of already limited mental health resources for inmates with serious mental illnesses.[11]

Inmates with personality disorders, including antisocial personality disorder, may benefit from time-limited crisis intervention therapy, which should use a straightforward, consistent, present-day approach. Attempts should not be made to provide treatment designed to result in significant personality changes, due to limited resources available and questionable outcomes.[9] However, the mental health clinician can effect an improvement within the correctional environment that may increase opportunities for the individual growth of the "normal offender."[8]

There have been fewer studies concerning issues pertinent to mental illness in female than male inmates. However, it is clear that there is a need for treatment programs for female inmates that focus on issues related to sexual abuse, affective disorders, and substance abuse.[12, 13] Ackerman[14] described many topics of concern pertinent to women incarcerated in jail; these are summarized in Table 2.

Treatment Planning

A treatment plan, which is a series of written statements specifying a particular course of therapy and the roles of the qualified health care personnel in carry-

Table 2
Issues Pertinent to Mental Health Treatment for Women[14]

1.	Grief and misery they have caused their parents/grandparents
2.	Restrictive telephone hours
3.	Fear that employers and others will find out they are in jail and that they will lose their jobs
4.	Frustration in trying to stay off drugs
5.	Fear of contracting AIDS
6.	Depressive feelings
7.	Dislike and fear of guards
8.	Fear of "going crazy"
9.	Dislike of jail food
10.	Fear of lesbian advances in jail
11.	Fear of bunk-mates who have been accused of violent crimes
12.	Explaining to their children/adolescents why they are in jail
13.	Lack of physical contact with their children and families
14.	Jail clothing
15.	Lack of long range goal planning
16.	Long wait until they go to court and other related legal issues
17.	Future job placement problems
18.	Fear of being sent to prison
19.	Unfairness of the bond system
20.	Staying in contact with women met in jail while not violating probation
21.	Fear of old friends who may once again getting them into trouble
22.	Being able to earn a living for their family
23.	Divorce proceedings against them while in jail
24.	Custody proceedings against them, while in jail, regarding minor children
25.	Disgust with their lives
26.	Physical problems they feel are recurrent and debilitating

ing it out, should be developed and periodically reviewed for inmates receiving mental health services. It is an individualized, typically multidisciplinarily generated statement of short- and long-term goals as well as the methods by which these goals will be pursued.[15, 16]

The APA guidelines place an emphasis on discharge/transfer planning for inmates receiving mental health services at the time of a transfer to another institution or discharge to the community, to facilitate continuity of care. Case management services, which are an integral part of discharge/transfer planning, include the following: (1) appointment arranged with mental health agencies for all mentally ill inmates or a specific subgroup such as those receiving psychotropic medication; (2) referrals arranged for inmates with a variety of mental health problems; (3) notification of reception centers at state prisons; and (4) arrangements made with hometown pharmacies to have prescriptions renewed.[1]

Informed Consent and Involuntary Treatment

Inmates generally have a right to refuse evaluation and treatment without disciplinary action or punishment. Basic principles of informed consent apply to inmates receiving treatment in correctional settings, although the inherently coercive setting of a correctional facility requires specific sensitivity to the element of "voluntariness." Policies and procedures concerning the right to refuse treatment should conform with the rules and procedures of the jurisdiction in which the facility is located.[9]

Use of involuntary psychotropic medications, seclusion and/or restraints should be governed by rules, regulations, and laws applicable to the specific jurisdiction. The

health care staff should not participate in the nonmedical restraint of inmates except for monitoring their health status.[1, 15–17] A U.S. Supreme Court decision, *Washington v. Harper*,[18] defines circumstances that must exist before the state may administer antipsychotic medications to an inmate against his or her will. *Vitek v. Jones*[19] defines the required due process protection that needs to be followed when an inmate is involuntarily transferred to a psychiatric hospital setting.

Confidentiality

The standards/guidelines of the American Public Health Association[17] and the National Commission on Correctional Health Care (NCCHC)[15, 16] essentially require full confidentiality of all information obtained during the course of treatment although exceptions are clearly described. These exceptions to confidentiality include times when the inmate (1) is suicidal, (2) is dangerous to others, or (3) presents a clear and present risk of escape or of creating internal disorder or a riot.

The APA guidelines[1] take a more practical approach to the issue of confidentiality. For example, these guidelines recognize that information is generally released concerning administration of psychotropic medication in the housing unit, situations that involve transfers to special units for observation and/or treatment, and other circumstances that are essential to providing adequate treatment to the inmate. It is very important that the clinician be familiar with state laws, rules, and regulations relevant to the issue of confidentiality. For example, parole boards in some states have access to an inmate's health care record without obtaining informed consent from the inmate. The APA guidelines emphasize that written policies concerning confidentiality should be developed and explained to the inmate as part of the informed consent process. In general, because of the frequent exceptions to maintaining confidentiality, it is recommended that the inmate be informed that there are frequent occasions when confidentiality will not be maintained, but the clinician will use his/her judgment regarding the nature of the information to be released.[9]

The mental health records may be part of the general medical chart or may be kept in a separate mental health chart. These records should be kept under secure conditions, separate from custody records, and access to such records should be controlled by the health authority consistent with the pertinent local, state, and federal law.[15, 16]

Quality Assurance/Quality Improvement

NCCHC[15, 16] standards require a comprehensive quality improvement (QI) program that involves a multidisciplinary quality improvement committee of health care providers who meet regularly with correctional administrators to design QI monitoring activities and to review the results. Many mental health systems within prisons have been slow to develop a QI program and have varying levels of sophistication concerning an ongoing quality assurance (QA) plan. The Joint Commission on Accreditation of Healthcare Organizations[20] has provided a useful publication for providing guidance to

organizations that are in transition from QA to QI programs.

Management Information Systems

The medical and correctional literature has contained little about computerized management information systems for correctional mental health care programs. However, state systems are increasingly developing management information systems that provide information concerning medication prescriptions, psychiatric diagnosis, level of functional impairments, level of mental health care provided, and routine demographic data. A system-wide management information system should be developed that will help to efficiently generate evaluation reports on facilities and programs and establish routine monitors for utilization review and patient care. Many QI activities are significantly facilitated by the use of a management information system.[9]

Research

Policies and procedures consistent with ethical, medical, legal, and regulatory standards for human research should be developed to encourage and allow for research within correctional settings. The Code of Federal Regulations provides the necessary framework for the participation of prisoners in studies of the possible causes, effects, and processes of incarceration, as well as research that is designed with the reasonable probability to improve the health and well-being of the subject[15, 16,21]

Summary

The correctional system in the United States has demonstrated an overwhelming increase in the number of persons being incarcerated during the past decade. Many of these inmates will require mental health treatment during their stay in either a jail or prison setting. The development of national guidelines and standards concerning correctional mental health care and successful class action suits relevant to providing such care have accelerated the development of more adequate mental health systems within U.S. correctional settings, the essential elements of which have been summarized in this three-part paper.

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