

Care of the Mentally Ill in Prisons: Challenges and Solutions

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So, where did all the [state hospital] patients go?—
Emanuel Tanay, MD¹

Jails and prisons have become the mental asylums of the
21st Century—CNN²

The United States has the highest rate of adult incarceration among the developed countries, with 2.2 million currently in jails and prisons. Those with mental disorders have been increasingly incarcerated during the past three decades, probably as a result of the deinstitutionalization of the state mental health system. Correctional institutions have become the *de facto* state hospitals, and there are more seriously and persistently mentally ill in prisons than in all state hospitals in the United States.

A systematic review of 62 surveys of the incarcerated population from 12 Western countries³ showed that, among the men, 3.7 percent had psychotic illness, 10 percent major depression, and 65 percent a personality disorder, including 47 percent with antisocial personality disorder. Among the women, 4 percent had psychosis, 12 percent major depression, and 42 percent a personality disorder. In addition, a significant number suffered from anxiety disorders, including post-traumatic stress disorder (PTSD), organic disorders, short- and long-term sequelae of traumatic brain injury (TBI), suicidal behaviors, distress associated with all forms of abuse, attention deficit hyperactivity disorder (ADHD), and other developmental disorders, including mental retardation

and Asperger's syndrome. Most of the incarcerated were economically disadvantaged and poorly educated with inadequate or no vocational and employment skills. Approximately 70 percent had primary or comorbid substance abuse disorders.

Owing to the lack of widespread utilization of diversion programs such as mental health and drug courts at the front end of the criminal justice process, more people with these morbidities are entering prisons than ever before. At the back end, about 50 percent reenter prisons within three years of release (a phenomenon known as recycling), because of inadequate treatment and rehabilitation in the community. Systematic programs linking released mentally ill offenders to state mental health programs are few and far between. The immediate post-release period is particularly risky for suicide and other causes of death.⁴

A recent study (2006) by the U.S. Department of Justice⁵ found that more than half of all prison and jail inmates have a mental health problem compared with 11 percent of the general population, yet only one in three prison inmates and one in six jail inmates receive any form of mental health treatment.

Questions

Are our prisons' rehabilitative services set up to provide comprehensive mental health and psychiatric programs to deal with the increasing population with such severe psychopathology and impairment? Shouldn't standards of care of psychiatric disorders be respected in the correctional setting as they are in other community provider settings? Shouldn't in-

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mates have access to the same standard of treatment consistent with the principle of equivalence?

Shouldn't access to specialized diagnostic procedures and assessment protocols, including general and neuropsychological testing, be available and applied to identify neuropsychiatric and behavioral consequences of brain injury and other organic disorders? Are states willing to allocate sufficient budget and manpower resources to meet the needs of mentally ill and substance abusing offenders? Are legislators and administrators willing to take a serious look at the criminal justice process to determine how to refer mentally ill arrestees and offenders to various treatment programs?

Although the answers to these questions are relevant and critical to the overall care of this multimorbid population, this editorial focuses on select key aspects of care within the prisons.

Privatization

Historically, the departments of corrections, employing their own staff and clinics, directly administered mental health and medical care to offenders. Because of ever-increasing health care costs, staff expense, lack of qualified health care professionals to work in prisons, lack of visionary correctional leadership (with exceptions), and ever-increasing litigation, more and more states have privatized the mental health and medical services. Although the first system privatized was Rikers Island in 1973,⁶ the rate of privatization escalated beginning in the late 1980s, and the trend is continuing. About 25 states and several large urban jails contract with private vendors for correctional health care services. Currently, states such as Oklahoma, Connecticut, and Texas use medical schools exclusively, while Georgia uses medical schools for medical care and contracts with a private mental health vendor for mental health services. New Jersey contracts with a medical school for mental health and with a large private vendor for medical care. Other contractors range from small private vendors for mental health services with various agreements for staffing and services to large private correctional health care companies providing both medical and mental health care.

There are no studies to indicate which model is best suited to deliver adequate, reasonable, and cost-effective mental health and psychiatric services in correctional systems: services directly provided by the state; large private vendors providing both med-

ical and mental health services; separate small or large specialist mental health vendors; public medical institutions exclusively; or medical school-private vendor partnership. Appelbaum *et al.*⁶ have delineated the advantages of the university-state-corporation partnership in Massachusetts. In this model, the state correctional program receives enhanced quality of services, recruitment of high-quality professionals and expansion of training programs, while the medical school expands its revenue source while providing much needed public service as well as opportunities to engage in correctional research.⁶

The profit motive may trump quality and compromise ethics standards and practice. Profit-oriented service providers tend to keep certain key staff positions unfilled or partially filled and encourage less expensive treatment approaches and medications, potentially jeopardizing patient care. Although the experience of private vendors indicates that they are more successful in recruiting professionals, including psychiatrists and psychologists, the correctional system still lags behind other provider systems in attracting qualified personnel.

How can the competing profit motives of the vendors and the expectations of the correctional system be reconciled? The foundation for this reconciliation begins very early with the state's design of the request for proposal (RFP), which must encompass the emerging trends in mental health and the criminal justice process, offender management, and research and development of new psychotropic agents. Departments of corrections should develop operational and performance criteria and benchmarks for evaluating vendor compliance. Conducting regular objective and impartial audits with well-designed and valid audit tools would hold the vendors accountable and at the same time help them to take timely corrective action. Once the contract is awarded to a service provider, such entities become full partners with the state. Open communication between the state and the service providers is essential. Key elements of success include establishing credibility and trust. This element should be mutual, in that both entities respect what is agreed on and do not deviate from the established contractual expectations and compliance indicators. Appelbaum *et al.*⁶ reported, and this author concurs, that the contractor must be willing to work within the budget but at the same time provide quality service, practice within accepted community standards, train correctional staff in han-

dling the most difficult patients and work within the context of the primary mission of the correctional system.

Acute Care Services

Compared with the public, offenders may seem less cooperative, less appealing, and even less “human.” Yet U.S. courts have clearly established that prisoners have a constitutional right to receive medical and mental health care that meets minimum standards (*Ruiz v. Estelle*⁷) with no underlying distinction between the rights to medical care for physical illness and its psychological counterpart (*Bowring v. Godwin*⁸). Clinical services are to be provided in the inherently coercive system of prisons without compromising its missions and the providers’ ethics standards, which is at the very least, extremely challenging.

Treatment challenges and problems caused by the increasing prevalence of the seriously and persistently mentally ill in prisons are here to stay. What then is the best setting in which to provide the care? We must look at the scenario of developing acute care psychiatric units in prisons by shifting state funds to departments of corrections from departments of mental health. Many departments of corrections have agreements with state departments of mental health for providing acute care. This approach creates expenses associated with the transfer of offenders back and forth and security concerns, as well as interdepartmental conflicts and communication problems inherent in the difference between handling offenders and handling patients. Conflicts generally involve admission criteria, level and type of care, formulary differences, limitations of what each system can and cannot do regarding supportive and ancillary therapies, and access to medical records. Furthermore, conflicts may also arise in the area of handling conduct violations when the offender returns to prison. The advantages of acute care psychiatric units in prisons include creating a therapeutic milieu consistent with the correctional mission; safe and proper implementation of specialized treatments, such as involuntary medication administration consistent with *Washington v. Harper* criteria⁹ for the gravely disabled offender who is noncompliant; and proper implementation of therapeutic restraints and seclusion.

The Open Formulary Versus Restricted Formulary Controversy

Pharmaceutical costs are a significant component of the overall mental health care costs in corrections, and they generally increase about 15 to 20 percent annually. As a result, prescription drugs often become the target of aggressive cost-cutting by private health care providers. A commonly used tactic to control cost is to establish a restricted formulary of older generation psychotropics and generic agents that are less expensive and then insist that the psychiatrist preferentially prescribe medications from this restricted formulary instead of the newer, generally more expensive medications that are often included in the nonformulary list. Control and cost-containment measures are mediated via a concurrent nonformulary review process that is time consuming both for the psychiatrist provider and the psychiatrist reviewer. The reviewer who is employed by the service provider organization is placed in a situation in which he or she must manage the psychopharmacologic practice consistent with accepted standards while trying to control costs to make a profit, sometimes at the expense of quality care.

Newer medications improve the quality of life of offenders. More importantly, they help to reduce overall health care costs by reducing long-term hospitalization, emergency admissions to psychiatric units, and indirect costs associated with transportation of offenders to DMH facilities. According to the “Massachusetts Biotechnology Council White Paper Executive Summary”¹⁰ on drug costs:

[G]iven that prescription drug costs (10%) are a fraction of health care spending in the U.S. (compared with hospital and physician care: 32 v. 22% respectively), targeting pharmaceuticals to restrain health care cost is questionable as a significant saving mechanism and may in fact cost the health care system dollars if it involves restricting access [Ref. 10, p 5].

The irony that cost-saving measures can in fact increase the cost of care may be true of the correctional system as well.

Instituting practice parameters and guidelines for prescription practice, stringent peer review, and proper quality-assurance activities, including monitoring long- and short-term side effects should be the preferred method of cost stabilization and control.

Suicide Prevention in Prisons

Suicide is the third leading cause of death in U.S. state and federal prisons, exceeded only by natural causes and AIDS. Comprehensive suicide-prevention programs in prisons are of increasing importance to mental health professionals, correctional administrators, health care providers, legislators, attorneys, and others as they seek to rehabilitate offenders and avoid the multimillion-dollar lawsuits that often arise from inmate suicides.

A comprehensive review of national and international research clearly demonstrates that inmate suicide arises from a complex array of inter-related and self-reinforcing risk factors.¹¹ These risk factors include mental illness, substance abuse, prior serious suicide attempts, chronic stresses of incarceration (i.e., family separation, solitary confinement, intimidation, and victimization), acute psychosocial stressors (i.e., parole setback, death of a loved one, rape), and staff errors or oversights.

Responsibility for suicide prevention in corrections has traditionally been placed squarely on mental health staff. Experience has shown that their efforts may be doomed to failure in the absence of adequate support and involvement of administrators and custodial staff. These correctional employees have joint responsibility for ensuring the health and safety of prison inmates, and they are increasingly held liable, individually and collectively, when they fail in this duty. Best practice in suicide prevention, outlined in the World Health Organization's updated resource guide,¹² calls for a state-of-the-art collaborative effort of administrators, medical and mental health clinicians, and custodial staff to identify at-risk inmates and intervene appropriately.

Medication Treatment for Substance Abuse

Inmates being released from prison are particularly vulnerable to serious relapse from the effects of drugs and alcohol within the first month of release.⁴ While in prison, most inmates receive minimal medical treatment for substance abuse, except for detoxification. Long-term relapse prevention is limited to self-help groups, like Alcoholics Anonymous, and therapeutic communities.

The overt acute symptoms of withdrawal dissipate within a few days of incarceration. Upon release, substance-abusing offenders return to a cue-rich envi-

ronment of past drug use that can trigger a powerful rekindling of the addiction. This familiar environment results in the manifestation of physical symptoms similar to acute withdrawal, known as conditioned abstinence, first observed by Abraham Wikler.¹³ Conditioned abstinence can occur even before release, when patients recall past drug use, and has been shown in laboratory studies in which exposure of former drug users to drug paraphernalia triggered intense cravings akin to acute drug withdrawal, even though patients had not used drugs for months.

Offenders with an established history of drug or alcohol abuse should be treated with anti-craving and relapse-prevention medications two to four weeks before release, and the medication regimen should be continued 30 to 60 days after release. Although there are no medications that treat cocaine, methamphetamine, and marijuana abuse, medications such as naltrexone¹⁴ and acamprosate are effective for opioids and alcohol. Naltrexone tablets and the recently approved monthly injection may be well-suited to the correctional setting, unlike methadone. Naltrexone is likely to generate less controversy and problems because it has virtually no potential for abuse or diversion. The availability of newer pharmacotherapy agents to treat addictions ranging from smoking to alcoholism should be aggressively utilized to reduce the unacceptable rate of recidivism.

Conclusions

Innovative and comprehensive treatment programs in prisons, coupled with state-of-the-art diversionary measures for mentally ill arrestees and prisoner community reentry programs, must be pursued to prevent a high rate of recidivism and morbidity of prisoners and to facilitate their adjustment in the community.

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