Our Part in the Evolution of Correctional Mental Health Care

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I am a general, forensic, and correctional psychiatrist and have spent decades involved in direct care and administrative services. I have provided consultation to secure hospitals and correctional facilities (jails and prisons). State and federal courts in various jurisdictions have appointed me to assess, evaluate, and opine regarding the mental health care provided within correctional institutions, often specifically relative to compliance with constitutional standards. These standards are based on provisions of the Eighth and Fourteenth amendments to the Constitution and relevant case law.[1–5]

In this editorial, I provide a brief review of several aspects of the evolution and dynamics of providing mental health care to prisoners. I apprise the reader of challenges faced by state and county governments, correctional administrators and supervisors, correctional officers and deputies, medical and nursing staff, and prisoners, as well as mental health monitors and experts working to improve the health care provided in correctional facilities. I encourage psychiatrists and other health care professionals to consider the need for adequate mental health care "behind the walls" and to appreciate the challenges and rewards of this career choice.

My postresidency career in general, forensic, and correctional psychiatry began in 1981, when I served as staff forensic psychiatrist for two pretrial units at Saint Elizabeths Hospital in Washington, DC, and began a solo private practice. I progressed through the Saint Elizabeths Hospital system to become Director of Forensic Services and Commissioner of Mental Health for the District of Columbia. I conducted competency and criminal responsibility evaluations for detainees referred by the courts and risk assessments for conditional release determinations for insanity acquittees. My private practice in general and forensic psychiatry included direct service to secure psychiatric hospitals and correctional facilities. I served as a psychiatric expert and monitor assessing the mental health services provided to detainees, inmates, and hospital patients in secure facilities. I have also been retained by plaintiff and defense attorneys on individual cases to opine whether a specific suicide was foreseeable or preventable, or both.

As clinicians, our mission and responsibilities have been markedly different from those frequently expressed as the custodial and operational mission and responsibilities of correctional staff. Clinicians are focused on the health care needs of the individual and with implementing necessary treatment interventions in the least restrictive environment possible. Historically, corrections professionals have maintained control of the correctional environment through a combination of custody and confinement, using officially sanctioned or unofficially administered force that includes long periods of segregation and physical and chemical restraints, in some cases administered as punishment. Current correctional mission and vision statements frequently combine one or more of the following responsibilities: public safety; custody and confinement; safety for staff and inmates; a humane and rehabilitative environment;

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stewardship, including professional excellence, official responsibility and self-sufficiency; positive re-entry of offenders into society; and reduction of victimization.

There have been significant changes over time in some jurisdictions, but there is much work to be done. One compelling area for change has been in the use of segregation and physical and chemical restraints as substitutes for the treatment needs of inmates with mental illness. The use of segregation historically has meant prolonged isolation for hours, months to years, and even for life. At present, court decisions require more humane conditions, including limitations on the time individuals can be housed in segregation and requirements for out-of-cell time. Consistent with most of my colleagues who assess and monitor mental health care in penal institutions, I believe that the use of segregation, particularly for those prisoners with serious mental illness, does not benefit the individual and may be harmful, antitherapeutic, and damaging.[6–10] Many organizations have expressed viewpoints regarding the prolonged isolation and segregation of prisoners. These include the World Health Organization,[11] the Congressional Quarterly (CQ) Research Report on Solitary Confinement,[7] the American Psychiatric Association,[10] the American Academy of Psychiatry and Law,[6] and the Society of Correctional Physicians.[12] Their commentaries condemn prolonged uses of segregation and isolation for prisoners generally and for those with mental illness specifically and provide examples of the harms that include injury and death.[9,13,14]

History

Beginning with the Community Mental Health Services Act in 1963,[15] several changes began to evolve regarding state mental hospital systems across the country. There was a reduction in hospital populations and hospital beds based on the premise that many patients could be released and maintained in communities with appropriate supports. As a result, hospitals decreased in size, and the criteria for admission became more stringent for individuals admitted voluntarily for brief periods or for those civilly committed for extended periods. Although there are some success stories regarding the evolution of community services, by and large the anticipated substitution and replacement for state hospital beds by adequate community services for individuals with mental illness did not keep pace with the need.[16,17] Estimates and data published by the Treatment Advisory Center indicate that, based on a ratio of 50 psychiatric hospital beds per 100,000 people, all U.S. states and territories incarcerate more individuals with serious mental illness in jails and prisons than are treated in free-world psychiatric hospitals.[18]

Accordingly, many have referred to the "deinstitutionalization" of the State hospital systems as "transinstitutionalization" to correctional institutions and homelessness on the streets for individuals with serious mental illness in need of treatment. The Bureau of Justice Statistics (BJS) published data in 2016 that included estimates in 2014 that there were approximately 744,600 prisoners in jails and 1,561,500 prisoners in prisons, for a total number of individuals incarcerated in jails and prisons of 2,234,400, adjusted for offenders with multiple correctional statuses.[19–21] The BJS further reported that 14 percent of men in prisons compared with 20 percent of women in prisons and 26 percent of men in jails compared with 32 percent of women in jails met the threshold of serious psychological distress in the month before the survey in 2011–2012.[21,22] A survey conducted by the Marshall Project in 2011–2012 reported that 40.8 percent of incarcerated males and 67.9 percent of incarcerated females reported a history of a diagnosed mental condition.[23]

In addition to the number of individuals who have been incarcerated in U.S. correctional facilities, the Pew Report entitled, "Jails: Inadvertent Health Care Providers," published in January 2018, reported that during 2015, the latest year for which data were available, there were 10.9 million admissions to jails and other lockups for individuals awaiting trial or serving sentence (Greifinger R: personal communication, September 10, 2012). These numbers highlight the need to provide mental health services in jails and lockups that keep pace with a high turnover of individuals, rather than services based on the number of beds in each facility.

Owing in part to the mandatory sentencing of individuals convicted of drug-related offenses and the proliferation of three-strikes laws requiring mandatory sentences and longer lengths of stay in many state and the federal systems, the increase in prisoner populations has included the need for ongoing mental health services and for expansion of the medical and mental health services offered to the increasing geriatric population of the nation's prison systems.[24]

The need to provide medical and mental health services for juveniles convicted before the age of 18 and sentenced to adult facilities has also increased. The establishment and implementation of the Prison Rape Elimination Act (PREA) of 2003 has resulted in the obligation to separate prisoners younger than 18 from adult prisoners.[25] Individuals with intellectual disabilities also may require specialized housing and services.

There are differences in the availability of adequate mental health services provided to male versus female prisoners. Progress has been made in some systems in providing a continuum of mental health care for male prisoners. Such care ranges from hospital-level mental health services to residential and transitional housing, to outpatient services for those individuals who are able to be maintained in general populations with appropriate mental health and medical supports. However, the same is not true in many systems for female prisoners. For calendar year 2016, the number of women incarcerated in the nation's jails and prisons, as reported by the Bureau of Justice Statistics, was 102,300 in jails and 111,422 in prisons.[19,20] The number and percentage of women in the nation's correctional facilities are substantially lower than those of men. Still, it is common to find deficiencies in the continuum of mental health care for women.

Discussion

The increase in the number of prisoners with serious mental illness or behavioral difficulties in correctional facilities has highlighted the need for adequate medical and mental health care, as most jails and prisons were not initially designed nor intended to meet such needs. They are not adequately funded to provide medical and mental health services for large and diverse populations. Correctional systems and facilities have struggled to make the necessary changes to provide services and to comply with legal requirements.

Many of the changes in the availability and planning for mental health services have come as the result of legal actions.[26] Individual and class-action lawsuits have shown the inadequacy of institutional mental health care, and courts have mandated that constitutionally adequate mental health services be provided to those with mental illness. Case law, including *Estelle v. Gamble*[3] and *Bowring v. Godwin*,[4] is notable for decisions mandating that constitutionally adequate medical and mental health care be provided to incarcerated individuals. In *Farmer v. Brennan*,[5] the U.S. Supreme Court held that:

> A prison official cannot be found liable under the Eighth Amendment for denying an inmate humane conditions of confinement unless the official knows of and disregards an excessive risk to inmate health or safety; the official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists and he must also draw that inference [Ref. 5].

The Department of Justice Special Litigation Section implemented the Civil Rights of Institutionalized Persons Act (CRIPA), enacted in 1997.[27] Areas of investigation have included conditions of confinement; use of segregation (isolation), force, and restraints; inadequate medical or mental health services; and suicide prevention. The conditions of confinement are usually the major obstacle to providing constitutionally adequate mental health services within any correctional facility or system.[7,9] This problem applies not only to adequate correctional staffing and housing in the segregated population versus the general one but also to the availability of acute (hospital-level) mental health care; residential care; medical services; including infirmaries and hospital care; and the environmental conditions in facilities, on any given unit, including sanitation, food service, out-of-cell time, and recreational activities.

The term "adequate mental health services" is frequently used both positively and negatively to define what is necessary. Adequate mental health services include not only the continuum of care for those with diagnosed serious mental illness,[28,29] but also services for other prisoners with transient or less serious mental illness or conditions, intellectual disability, personality disorders, substance use disorders, sexual paraphilias, and behavioral management needs and for victims of assault. The behavior of some individuals is described as malingering and manipulative, although clinicians involved in the provision of health care and assessment and monitoring of medical and mental health care may describe some of these behaviors as "adaptive." (Greifinger R: personal communication, September 10, 2012). In some instances, the concerns expressed by prisoners are for their safety or the reality of prison politics in the population. Consequently, the prisoner may report or demonstrate mental health symptoms, including suicidality or self-injurious behaviors, as a protective adaptation.

There are certainly prisoners who attempt to use mental health services for other than treatment reasons, including obtaining drugs and gaining access to staff and other prisoners with the intention of harming them. The collaboration of clinical and security staff in determining the most appropriate treatment and behavioral management of prisoners displaying these behaviors is the first step to an effective management approach.

In my experience as a mental health provider, administrator, and monitor, the responses to implementing constitutionally required changes have varied widely. Some states and counties have embraced the review of their services, policies and procedures, training, supervision, and mental health care. Others have resisted the interventions and requirements that result from court-ordered settlement agreements, consent judgments, and other legal requirements for the establishment and maintenance of such services. The highest level of federal intervention has come in the form of federal receiverships that transfer the financial and governing authority from the state or county to a federally appointed receiver who assumes the duties and responsibilities of the highest authority for that system or jurisdiction. The hiring of monitors, special masters, and receivers carries costs that are borne by the state or jurisdiction, in addition to the costs necessary to provide the remedies required by the settlement agreement, consent judgment, receivership, and other court orders.

Many jurisdictions have determined that the most appropriate way to comply with court-ordered staffing requirements is to hire or reassign the necessary mental health staff within their correctional facilities; collaborate with the mental health authority of the state or county to provide services within the correctional facilities; engage the services of private for-profit mental health and medical providers to deliver the services, again usually within the correctional facilities; and engage the local hospitals' emergency departments to provide services, particularly acute care, to prisoners. The staffing determinations are not only necessary for mental health staff including psychiatrists, psychologists, social workers, counselors, activities therapists, and other qualified mental health professionals (QMHPs). They also include the medical and nursing services that are essential for a comprehensive mental health program.

An adequate number of qualified correctional officers and deputies is essential for observing and providing security for mental health assessment and treatment services. The services include escorting inmates to and from the necessary services and, in some systems, monitoring and supervising prisoners who have been placed on various forms of suicide precautions. Training of correctional staff and supervisors is necessary to support the mental health program.

Historically, when Department of Justice investigations and civil class-action lawsuits have resulted in court-approved or court-ordered state or federal oversight by way of settlement agreements, consent judgements, or receiverships, the jurisdictional authority, usually county or state, is the focus of review and analysis for improvement. Although the courts' specific requirements for improvements may include health care concerns, the contractual for-profit providers of these services were not usually subject to court sanctions.[26] However, the landscape is changing, as reflected in an article published by the Marshall Project in which court-ordered fines were sometimes levied against contractual provider companies for failure to provide adequate medical, mental health, and consultative (specialty) services in a timely manner.[30]

In some instances, the local authorities have embraced the oversight from either state or federal court monitors, as it may be the most effective and immediate way for them to receive budgetary enhancements for not only their medical, nursing, and mental health staffing, but also their correctional and operations staffing, to support implementation of the necessary mental health programs.

Maintaining control and custody in correctional facilities requires responses by corrections staff to disorderly, disruptive, threatening, or dangerous behaviors and statements. Correctional **s**ystems struggle with how to apply, govern, and document appropriate uses of force, even more so when a prisoner has suspected or known mental illness. When mental health services are not available and even when they are available, segregation or the planned use of force, including physical and chemical restraints, may be the first response. Having collaboration and consultation with and input from mental health staff regarding facility use-of-force policies and procedures and, when possible, having a mental health professional present during such an event, may reduce the use of segregation or physical and chemical restraints. These steps may also lessen the likelihood of placing the prisoner and staff at serious risk. For individuals

with untreated or undertreated serious mental illness, the use of force can increase the risk of harm to the inmate, including suicide, self-injurious behavior, or complication of medical conditions, and poses a risk of injury to staff.

Some interventions that we may be accustomed to in hospital environments, such as the use of emergency and long-term involuntary medications or specific medications with high abuse potential, may not be available in certain correctional facilities. This may result from the lack of adequate support such as psychiatric, medical, nursing, and correctional staff, or they may be prohibited by state law. Medication management in corrections is especially challenging in segregation units, as medications may be administered through food ports, compromising direct observation and perhaps contributing to hoarding medications for self-harm and contraband exchange with other prisoners, among other adverse effects.

Human suffering and a higher percentage of completed prisoner suicides occur in segregation or single cells.[14,31] Thus, the use of segregation has been a major focus of litigation and has in some systems resulted in limitation or elimination of segregation of prisoners with mental illness. Some publications have argued that the risk of suicide in correctional facilities is increased when prisoners are isolated.[14,32]

A major challenge for psychiatrists and other health care professionals when assessing or monitoring correctional systems is to identify and document the components necessary for an effective and adequate suicide prevention program. The approach to providing adequate suicide prevention and management varies. Some facilities and systems determine that monitoring and supervision of prisoners on suicide precautions should be conducted by correctional staff. Others have these services provided by nursing personnel; civilian, student, or inmate observers; or "camera watches" in which inmates are observed by centrally located officers or deputies who are looking at monitors, rather than having direct human observation and monitoring at the cell front.

An effective suicide prevention and management program, including necessary policies and procedures, is essential for mental health care in correctional facilities. The fundamentals for such programs have been well described in several articles and include appropriate policies and procedures, staffing, staff training and supervision, observation and monitoring, physical plant suicide resistant cells, emergency response, documentation, and quality management reviews.[32–34]

Table 1 Suicide Rates in United States Correctional Facilities

Year	Jails	Prisons
2005	39	17
2006	36	17
2007	36	16
2008	29	15
2009	41	15
2010	42	16
2011	43	14
2012	40	16
2013	46	15
2014	50	20

Data are number of deaths per 100,000 inmates.
Source: U.S. Department of Justice, Bureau of Justice Statistics, 2016 (Refs. 33, 34).

The BJS published data on the annual suicide rates in jails and prisons from 2005 through 2014,[33,34] measured in number of suicides per 100,000 population (Table 1). According to the National Institute of Mental Health, the annual suicide rate in the United States outside of jails and prisons has increased from 11.5/100,000 to 13/100,000 from 1999 through 2014.[35]

Another challenge to be confronted in correctional facilities is the need for adequate policies and procedures that address discharge planning and transition to the community. When I became involved in correctional psychiatry, I began to understand that mental health personnel working in jails and prisons are frequently unaware that an individual is to be released because of good-time credits or other reductions in sentence. Adequate discharge planning is critical because of the recidivism rate of individuals who have been in correctional environments; those who required mental health services while incarcerated sometimes return because their mental health has deteriorated. There are models for discharge planning and transition to communities that emphasize the need for prerelease mental health and substance use treatment, medication adherence, risk reduction, identification of triggers, transitional case management, and identification and consultation with community providers, as well as the pursuit of social entitlements and housing.[36,37]

Traditional clinical training and updates on cultural competence should be enhanced by on-the-job exposure and formal training in the dynamics of prison politics: prisoner social relationships with one another and officers; their affiliations, such as gangs

and other groups; and the perceptions and practices of correctional staff. Culturally competent practice in correctional settings should consider not only cultural identity, but also the person's beliefs about the criminal justice system and mental illness, relationship with the clinician, and participation in treatment planning.[31]

For prisoners with mental illness, the illness may limit coping strategies, and symptoms may lead to unnecessary confrontations by and with other prisoners and staff and may be seen as a weakness, thus making them more vulnerable.[38]

Conclusions

There is a continuum of assessment and care necessary for any correctional system to be successful in meeting the mental health treatment needs of its population. A primary principle in assessing correctional facilities is based on the need to take into account not only the available resources, but also the safety and security requirements within those facilities. These considerations may require systems to bring the inmate to treatment or bring treatment to the inmate, which requires creative thinking by the clinician and collaboration with correctional administration and on-line officers and deputies, to facilitate access to care for the prisoner and reporting of behavioral problems.

The Ethics Guidelines for the Practice of Forensic Psychiatry of the American Academy of Psychiatry and the Law[39] provide suggestions for ethical practice. They include confidentiality, consent, honesty and striving for objectivity, and qualifications. These principles are very helpful for psychiatrists who practice in or monitor correctional settings and must consider ethics-related obligations in the context of conditions of confinement. Collaboration with correctional administrators and staff is necessary to provide assessment and treatment in as safe and secure an environment as possible.

When appointed by the court as a monitor or psychiatric expert, the responsibilities are not to provide treatment in a doctor–patient relationship but rather to serve jurisprudence, with emphasis on our role as consultants. In this function, we are responsible and accountable to the court, and our duties are in the service of jurisprudence's use of our professional training and experience to assess implementation and compliance with court-ordered constitutionally adequate mental health care.

As practitioners and monitors, we are not only useful and important, but absolutely necessary, as we attempt to address the medical and mental health needs of the incarcerated members of our communities and to provide information to the courts and others to facilitate adequate mental health care for prisoners in safe and secure environments, followed by their transition to free communities.

The evaluation in correctional facilities and systems of the adherence to constitutional requirements to provide adequate medical and mental health care has progressed with varying success. Managers and clinicians working in correctional systems and facilities should contemplate the needs of their systems. They should consider restructuring the provision of health care services to meet constitutional requirements and community standards: to ensure adequate provision of the necessary resources, including staff, physical plant, and support services; to assure an adequate management system, including electronic health care records and management information systems; to identify opportunities and challenges in implementation of responses; to incorporate the use of outside consultants as needed; and, as required, to engage court-appointed monitors and experts to serve the needs of jurisprudence and the correctional communities. The letter may include prisoners, staff families, and the communities to which nearly all prisoners return.

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