Managing Mental Illness in Prison Task Force

Findings and Recommendations
October 2004

Oregon Department of Corrections

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Preface and Acknowledgements

Oregon State Penitentiary was established in 1866 for the purpose of housing offenders away from the general citizenry. There are 12,733 inmates within the Oregon corrections system at the time of this writing. At about the same time, the first state mental hospital, the Oregon State Hospital in Salem, was opened in 1883 with the admission of 320 patients. The first legislative authorization for the construction of the hospital was passed on October 25, 1880. Before construction of the state mental hospital, Oregonians with mental illness were cared for in a private mental hospital in Portland at state expense.

There has been an increase in mental illness in prison. Twelve to fifty percent (12-50%) of the population experiences some form of mental or emotional problem. There are greater obstacles for the inmate with mental illness and for those in the general prison population, for who are charged with maintaining security within the prisons, and for those who would provide care and treatment for the inmate with mental illness. This brings us to the focus of this report.

By Executive Order dated October 8, 2003, Governor Kulongoski appointed a **Governor's Mental Health Task Force** to address specific issues related to the delivery of mental health services to Oregonians. In their report, *Governor's Mental Health Task Force Report*, September 2004, the authors identify short-term actions as well as long-term strategies to improve the lives of Oregonians with mental illness.

The Oregon Department of Corrections **Managing Mental Illness in Prison Task Force** goes on further to examine the aspects of how to effectively manage the mentally ill once they enter the corrections system. Historically, prison structures were not equipped to treat the mentally ill. Rather, corrections systems were organized along the lines of restraining the criminally inclined and protecting the outside population. To successfully fulfill the charter of the Oregon Accountability Model, the Department of Corrections must adapt.

This Task Force identifies the issues, supply findings, and provide recommendations for action. The Task Force wishes to acknowledge those who have contributed their talent, time and effort to the project.

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Introduction

On May 4, 2004, Oregon Department of Corrections' Director, Max Williams, chartered this Task Force to examine current practices and procedures relating to the management of behavior of the mentally ill within the Oregon prison system. Task Force members were appointed by the Director and included experts in mental health and in corrections institutions management from both within the DOC and from outside, including DOC Chief of Security and representatives from DOC Counseling Treatment Services, Oregon State Hospital, Oregon Jail Managers Association, Oregon Advocacy Center (OAC), National Alliance for the Mentally Ill (NAMI), Oregon Mental Health Addiction Services (OMHAS), DOC Health Services, American Federation of State, County and Municipal Employees (AFSCME) and the Association of Oregon Corrections Employees (AOCE).

The Mission of the Task Force was to identify prison practices and policy that result in safe and effective behavior management of inmates with mental illness; to affirm current DOC practices consistent with national corrections standards and best practices; and to recommend changes to align DOC practices, policy and rules with those standards and best practices identified. (Refer to Appendix B for the MMIP Task Force Charter.)

Members of the Task Force have invested more than 600 hours combined, extending over 5 months in meetings and active discussion, to produce this thorough body of work. During this time the Task Force operated using the following principles:

- Keeping people safe; inmates with mental illness, other inmates, staff and the community.
- Rehabilitation and recovery.
- Crisis stabilization is vital.
- The least restrictive environment.

Executive Summary

The 2004 DOC Managing Mental Illness in Prison (MMIP) Task Force has prepared a report that identifies issues of concern in DOC's mental health system, additional findings, and offers numerous recommendations to reflect a comprehensive approach to mental health treatment programming. This includes change in systems, procedures, policy and rules to work more effectively with DOC's population inmates with mental illness.

Primary Recommendation:

This Summary examines the overarching recommendation to structure the DOC Mental Health service delivery model to meet the needs of inmates with mental illness, rather than being driven by facilities or infrastructure.

The MMIP Task Force reviewed the September 2004 Governor's Mental Health Task Force report and has aligned with their recommendation, "*the Department of Corrections, OMHAS, the PSRB, and representatives of local law enforcement and mental health authorities must evaluate the possibility of creating a single forensic mental health facility to house and provide integrated services to individuals who cannot safely be treated in community settings.*" This recommendation is consistent with the service delivery model the Task Force proposed in this report.

Other recommendations in this Task Force report relate to:

- Inmate housing assignments
- Increased availability for Mental Health services
- Improved internal communications
- Intake mental health assessments
- Oregon Medicaid eligibility
- Improved systems through automation
- DOC staff training relative to mental health services
- Change in policy and rules
- Bazelon Center model law strategies
- Recruitment and retention of health professionals
- Clinical, cultural and gender competence
- Suicide prevention

Funding:

The Task Force took into consideration the current department budget situation and funding realities within Oregon state government. Although some recommendations require additional mental health staffing and resources, a projected cost to the Department has not been included.

Findings

Findings, Facts and Practices

The Task Force views the identification of the following mental illness-related issues as a beginning step to facilitate important change in the way the Department provides housing and services to its mentally ill population. Recommended changes to housing and services will not only provide better care for inmates but, equally important, is expected to reduce behavioral issues encountered with the population of inmates with mental illness.

The Task Force reviewed the Department of Corrections (DOC) policy, rules, procedures and processes. In addition, the Task Force also reviewed policies and processes of the Office of Mental Health and Addiction Services (OMHAS) and Oregon State Hospital (OSH) as well as those of other states and standards established by National Institute of Corrections (NIC), Department of Justice, and National Commission on Correctional Health Care (NCCHC). DOC processes for Intake and the mental health evaluation were reviewed in depth.

DOC Facts

As of October 28, 2004 the DOC inmate population was 12,733 and includes the following:

Type of Population	Number of Inmates
Men	11,789
Women	944
Total Inmates with Mental Health Needs	5,162
Receive Mental Health Services	3,000
Severely and Persistently Mentally Ill	1623
Developmental Disabilities	290

According to DOC Research Unit, there are a total of 2602 inmates who are age 46 and older. This number is expected to increase dramatically over the next 5 years. Of these inmates, there are 434 who are age 61 and older.

DOC Findings and Practices

1. Intake Center Process

Incarceration begins at the Coffee Creek Correctional Facility (CCCF) Intake Center. The Intake assessment is a 21-day process and includes the identification of: custody level, security threat groups, inmate relationship conflicts, educational needs, criminogenic risk assessment, substance abuse needs and vocational needs for the inmate. An initial mental health screening is conducted by a Health Services nurse within the first 24 hours of incarceration. The Personality Assessment Inventory (PAI) is typically administered to inmates with adequate reading skills within 48 hours. A face-to-face clinical evaluation is conducted on all inmates who have a history of mental illness, on those coming into the system already on mental health medications, those with elevated PAI scores, those inmates who because of their reading score were unable to take the PAI, and those who have either self-referred or have been referred by other staff. Inmates are also screened for developmental disabilities (DD) and substance abuse. Inmates are assigned a specific "A" code to indicate level of mental health needs and services necessary. DD inmates are assigned a "G" code.

2. Community Impact on the Intake Process

Most often, significant medical and mental health information about the inmate is not made available to DOC by the community. Limited mental health and behavioral information is received from the County jails. This can have serious consequences for the inmate with mental illness and DOC staff, prior to completing the 21-day Intake process.

3. Interruption of the 21-Day Intake Process

A flaw in the Intake process happens when an interruption of the initial assessment occurs due to inadequate bed space or a rule infraction by the inmate, which forces transfer to another facility with a special housing unit. In July 2004, five percent (5%) of the individual inmate assessments at Intake were interrupted. There is no formal process for completing the assessments after the interruption.

4. Mental Health Services to Inmates

Mental health services are provided to inmates based upon a continuum of care. Depending upon diagnosis and acuity level, an inmate with mental illness may receive services such as individual treatment, group treatment, medication and case management services. Case management includes coordination of services based on need for special housing, a treatment plan, special work

assignments, and regular follow-up appointments. (Refer to Appendix C Allocation of Mental Health Services.)

5. Mental Health Credentials and Line of Authority

Counseling and Treatment Services (CTS) uses a broad range of professional mental health staff, and has a clear line of responsibility among its mental health professionals. Currently clinical supervision is provided on an intermittent basis within DOC institutions due to inadequate resources.

6. CTS Mental Health Clinical Staff Credentials

CTS experiences significant recruitment and retention issues for rural Oregon prisons. Urban and rural prisons have a noticeable difference in CTS staff credentials

- Minimum qualifications for employment as a DOC Mental Health Specialist or DD Case Managers are a Bachelor's degree plus two years of experience, or a Master's degree plus one year of experience.
- Although not a requirement, the sixty percent (60%) of CTS Mental Health Specialists and DD Case Managers hold either a Master's or a Doctorate degree.
- No one practices outside the scope of their skills or licensure.
- Ninety-five percent (95%) CTS contracted providers hold either a Master's or a Doctorate degree and are licensed to practice by the State of Oregon.
- Psychiatrists, Psychiatric Nurse Practitioners, and Registered Nurses utilized by DOC are licensed by the State of Oregon.
- All CTS Student Interns are pursuing Doctoral degrees.

7. Crisis Management

The Task Force finds the DOC Mental Health On-call System experiences occasional gaps within some institutions due to lack of adequate resources. These gaps most often occur after regular hours and on weekends when there are no mental health providers on site. Primary issues identified are:

- On-call requests for assistance that do not receive a response (primarily due to technical difficulties with pagers);
- Security, CTS and Health Services are the disciplines involved in crisis management of inmates. At times, one or all may have conflicting priorities regarding a given inmate that can result in disagreement and complicate the outcomes related to housing and level of supervision.

8. Medication Management

Staff recognizes the issue of medication management as critical to inmate and staff safety. Management of this population requires a great deal of medication, which results in high costs and a significant amount of staff resources to

dispense, administer and monitor, despite innovative and cost saving practices such as: bulk purchase of medications, evidence based prescribing practices, decrease in polypharmacy and self administered medication.

- Some of the larger DOC institutions have over 600 inmates receiving mental health related medications.
- Dispensing and recording medications is a manual Health Services process with no formal mechanism to ensure that medications are dispensed. This is significant because of the difficulty in tracking treatment compliance and/or medication availability.
- A DOC Prescriber may have more than 450 inmates to manage at one facility. This constitutes a tremendous workload issue for the Prescribers, and impacts good prescribing practices.
- Research demonstrates that evidence based prescribing practices should contribute substantially to improved individualized clinical care as well as cost effectiveness. DOC Health Services has begun this process and should be encouraged to continue and expand it.

9. Housing and Special Needs Population

If the inmate is in crisis or needs acute care, DOC addresses the inmate need by channeling these inmates through a Special Management Unit (SMU) at Oregon State Penitentiary, Snake River Correctional Institution or Coffee Creek Correctional Facility. DOC cannot currently meet the care level necessary for inmates leaving the SMU or for those simply needing a less restrictive level of care.

Inmates transitioning out of SMU go directly to general population (GP). DOC has no alternative housing units to provide intermediate or transitional care prior to sending an inmate with mental illness to GP. Returning these inmates to GP does not provide the supervision or transition planning necessary to allow for a prevention of immediate complications inherent in the GP living environment. A sheltered environment would reduce risk of victimization, decrease the suicide potential and allow for better medication and behavior monitoring.

- A national correctional standard for the number of SMU beds is 30 beds for every 1000 inmates. This translates into more than 360 SMU beds to serve DOC's 12,733 inmates. Currently, DOC is ranked 49 out of 50 in the nation for the number of SMU beds available.
- DOC houses its most severe and persistent inmates with mental illness in SMU. DOC operates three SMU units with a combined total of 72 beds located at Oregon State Penitentiary (OSP), Coffee Creek Correctional Facility (CCCF), and Snake River Correctional Institute (SRCI).
- DOC operates a COPE day-treatment program with 64 beds in GP, located at Eastern Oregon Correctional Institute (EOCI).
- DOC operates a Bridgepoint dual diagnosis (co-occurring disorders) day-treatment program with 50 beds in GP, at Columbia River Correctional Institute.

- DOC operates an IN FOCUS dual diagnosis (co-occurring disorders) day-treatment program with 54 beds in GP, at CCCF.
- Thirty to forty-five percent (30-45%) of the more severe mentally ill population in DOC is housed in the most restrictive security units, Intensive Management Unit (IMU) and Disciplinary Segregation Unit (DSU). There are no alternatives or system in place to house and treat inmates with both mental illness and significant disciplinary problems.
- SMU focuses on crisis stabilization through intensive treatment, assessment, and medication administration, both voluntary and involuntary.
- Inmates are referred to SMU when they become a danger to themselves or to others, or are unable to manage their activities of daily living.
- Limited alternatives to administrative segregation bed needs leads to the use of SMU beds for temporary housing of inmates with non-mental health related issues.
- A limited number of beds at two of the larger institutions, OSP and SRCI, are primarily used as an informal step-down unit. These units are mixed with inmates who do not have mental illness, and are not staffed with specially trained personnel.
- Inmates with mental illness are moved frequently without regard for their need for treatment programming.
- There are inadequate resources within the prisons to manage and serve inmates with mental illness in GP. For example, every week, Mental Health Intake assessments identify one new inmate who demonstrates the need for SMU related services.
- DOC Research Unit indicates that the number of inmates 46 years of age and older will increase by 73 percent (73%) during the next five years. Additionally, 30 percent (30%) of the current 434 inmates who now exceed 60 years of age are expected to develop dementia sometime during their incarceration. DOC must plan future services for the aging population.
- Eighty percent (80%) of inmates with mental illness have a co-occurring disorder of substance abuse, alcohol or drug. The Department's current organizational structure separates A & D services from mental health services, thereby creating a significant disadvantage to inmates with mental illness and co-occurring substance abuse disorders.

10. Disciplinary Process

- DOC Research Unit indicates that inmates with the greatest mental health needs are twice as likely to receive a disciplinary report (DR) than those inmates without a mental health need. Inmates with mental health needs averaged 2.4 DR's during the last 12 –month period; those without mental health needs averaged 1.1 DR's.
- Security staff is consciously working to recognize the impact of mental illness on an inmate's behavior. However, there is a need for more training and formalized mechanisms for communication between Security staff, Mental Health Program staff and Medical staff. For example, some DOC staff use inappropriate and derogatory language regarding mental health and inmates with mental illness.

11. Transition and Release Planning

Critical aspects of good release planning are a connection to housing, medication, community services and employment. Release planning begins six months prior to the inmates' scheduled date of release into the community. The Case Manager works closely with the inmate to identify community and social services, share appropriate information, and psychological preparation. While the department supplies the transitioning inmate with a 30-day supply of medication upon release, there is likely to be no services beyond that point. The Task Force finds that it is common for an inmate to experience an unknown gap between an inmates' supply of medication and the inmates' eligibility determination for Oregon Health Plan prescription benefits. Aftercare is critical for the successful reintegration to the community and the long-term benefit of lower recidivism and revocations.

12. Counseling and Treatment Services

- Community staffing standards for a Prescriber caseload are 250 patients. DOC's Prescriber caseloads average 350 inmates.
- National standards for a Mental Health Case Manager caseload are 80 inmates. DOC's Mental Health Case Manager caseloads average 110 inmates.
- Due to inadequate numbers of Case Managers, not all inmates with mental illness have a treatment plan. This compounds difficulties when Mental Health professionals respond to an after-hour call to support necessary treatment decisions.
- Mental Health treatment programs should be placed where recruitment and retention of qualified mental health professionals can be expected to be available.

13. Internal DOC Communication

Effective internal communication, among work units and institutions, is a key factor and must be considered an essential 'common thread' by the department. The Task Force finds that inmate information derived from history and assessment, when used effectively, can decrease incidents of violence, self-harm, disciplinary incidents and staff injuries. The Task Force also found that the unusual incident report process poses a number of barriers to communication.

- When there is relevant information to be shared, there is no consistent information to relay to relevant staff.
- Informal and occasional inaccurate information is frequently shared among relative and non-relevant staff.
- Transferring an inmate after hours or over a weekend creates problems that demonstrate a need for improved communication between the respective

institutions. (E.g., medications don't arrive, transportation schedule is not communicated.)

- Transfer of inmate records, both criminal, medical and CTS does not happen in a consistent or timely manner.

14. DOC Staff Training

- Oregon Accountability Model (OAM) training and education are producing steady progress in how DOC staff work with and manage those inmates with mental illness in prison.
- DOC provides limited mental health training for Security staff working in SMU.
- DSU and IMU have a forty percent (40%) mentally ill population and their staffs receive no mental health training, and thus are at a disadvantage.
- There is insufficient training to that address confidentiality. The Task Force identified significant staff confusion regarding both confidentiality and HIPAA.
- Current levels of behavioral management training are not sufficient.
- Security staff is far more willing to involve mental health staff in assessing needs, identifying interventions and managing suicidal inmates than ever before. However, Security staff requires more training to appropriately recognize situations that may be appropriate to involve mental health staff.
- The need for expanded training in New Employee Orientation and In-Service was deemed paramount to program success.

15. DOC Policy, Rules and Procedures

It is clear to this Task Force that staff members have significant concerns about what information can and cannot be shared.

- DOC has not adequately addressed department policy specific to confidentiality.
- The Suicide Prevention rule directs the CTS Administrator to conduct a review process following a suicide. The report identifies security concerns which are then shared with the appropriate security administration. Confidential clinical issues are shared in a peer review process, which includes medical and mental health administration.
- There are separate work units who develop their own procedures that may conflict with DOC policy. This creates staff confusion when applying the Department rule or policy.

16. Review or Audit Mechanism

DOC currently has a satisfactory mental health audit mechanism in place. The NCCHC annual accreditation reviews mental health issues as a part of Health Services standard. Therefore, the Task Force will offer no recommendations for change at this time.

The MMIP Task Force Charter identified a need for an ongoing audit mechanism as a necessary component of a quality program for behavioral management of inmates with mental illness. It was determined that the rigorous accreditation program currently provided by the National Commission on Correctional Health Care (NCCHC) fulfills this requirement. NCCHC is also recognized by the National Institute of Corrections for their work with the mentally ill

Established in the 1970's, NCCHC accreditation is a process of external peer review in which NCCHC, a private, not-for-profit organization, grants public recognition to correctional institutions that meet its nationally accepted *Standards for Health Services*. Through the accreditation process, NCCHC renders a professional judgment regarding health services provided and assists correctional facilities in their continued improvement.

Developed by experts from the professions of health, law and corrections, separate standards exist for health care delivery in jails, prisons, and juvenile detention and confinement facilities. The areas covered by the *Standards* include:

- Facility governance and administration
- Maintaining a safe and healthy environment
- Personnel and training
- Health care services support
- Inmate care and treatment
- Health promotion and disease prevention
- Special inmate needs and services
- Health records
- Medical-legal issues

The annual Accreditation Review is an on-site, facility-by-facility audit conducted by health professionals experienced in correctional health care, and includes a comprehensive review of medical documents and policies and procedures; interviews with health staff, correctional officers and inmates; and a tour of each facility.

17. Suicide Prevention

Recognizing the verbal and behavioral cues that indicate suicide risk is critical to early intervention and successful suicide prevention. To that end, a suitable suicide prevention program is built upon having properly trained correctional staff, adequate housing, good communication, proper staffing standards, and clear policies and procedures.

At present:

- DOC institutional staff training has improved awareness of verbal and behavioral warning signs for suicide. Additionally, staff must exhibit competence in suicide prevention to satisfy NCCHC standards.

- The use of Safety Smocks is a commonly recognized and accepted practice throughout correctional facilities across the country, mainly generated by the need to ensure the safety and security of the suicidal inmate. In a community environment a person who is actively suicidal would normally be hospitalized and receive one to one observation rather than isolated and given a Safety Smock. The use of Safety Smocks in DOC could be minimized through one-on-one observation; however one-on-one observations for all actively suicidal inmates would require additional staffing.

18. Translation Services

Language translation for those inmates who speak little or no English is insufficient for mental health assessments. Effective assessment of these inmates requires qualified professional staff that has 'clinical cultural competence.' Hearing impairments are also a concern.

Task Force Recommendations

Overview

In considering the mission to identify practices and policies that result in safe and effective behavior management of inmates with mental illness, the MMIP Task Force reviewed a large number of policies and practices and made specific and detailed suggestions for their improvement. We would be remiss in not mentioning that there are other mental health management issues beyond the scope of this Task Force implied in our mission that DOC should consider in setting its course for the future.

As we know, there is a steady increase in the number of inmates with mental illness. DOC has responded to this increase generally, by augmenting and enhancing existing mental health services within the existing institutional structure. Inmates in need of *hospital-level* services are housed in a Special Management Unit (SMU); inmates with less-acute conditions receive mental health services in the general, *community–level* population (some attend specialty programs). While this approach has been successful in many ways, it contains some gaps and weaknesses.

While DOC has the equivalent of *hospital-level* and *community-level* care, it is missing a *mid-level* equivalent of the group home or community facility. In a community mental health system, these settings are used for individuals who are disabled to the point that they cannot safely negotiate the world at large, but do not need *hospital-level* service. It appears that many inmates who fit into this *mid-level* description may end up in Disciplinary Segregation Unit (DSU) for long periods of time. Others may be housed in DOC facilities that are remotely located and have access to few mental health professionals. Some may be effectively denied access to vocational and other rehabilitative services due to their disabilities.

The Governor's Mental Health Task Force report recommendations:

> The Department of Corrections, OMHAS, the PSRB, and representatives of local law enforcement and mental health authorities must evaluate the possibility of creating a single forensic mental health facility to house and provide integrated services to individuals who cannot safely be treated in community settings.

This recommendation is an invitation for DOC to begin a study of how it may restructure its mental health services and facilities to more effectively treat and house inmates who need *hospital-level* and *mid-level* care housing and access to mental health professionals and programs that are not currently available.

The NIC has multiple recommendations located in Appendix E. Correctional Best Practices are located in Appendix F.

A Comprehensive Behavior Management Approach

The following recommendations reflect a comprehensive approach to behavioral management treatment programming. All references to mental health treatment programs refer to general education, employment and housing. Substance abuse also plays a role in this approach, as 78 percent (78%) of the total DOC inmate population is diagnosed with a form of substance abuse. Of those 78 percent (78%), 30 percent (30%) have a *co-occurring disorder;* a diagnosable mental disorder combined with a substance abuse disorder.

MMIP Task Force Recommendations:

1. **Explore with OMHAS and PSRB, an option to create a common facility and treatment program for inmates with the most severe mental illness.**

    - As stated previously, this is a recommendation from the Governor's Mental Health Task Force that we support.
    - This exploration should include and not be limited to: resource and staffing issues, informed consent to treatment, use of physically managing inmate and client behavior, involuntary administration of psychotropic medications, and use of therapeutic restraints.
    - DOC should research effective design options, staffing and resource costs for a forensic or *Hospital Level* facility and its inclusion in future construction plans.
    - This research should include a review of Michigan's forensic institute model; operated under the Michigan Department of Corrections and funded through Michigan's state hospital.

2. **Create a four-tiered inmate housing assignment system as described below:**

    - General Population: Provide the least restrictive treatment environment.
    - Step-Down Unit: Serve long term inmates who cannot be managed safely in GP, and need a more protected environment with no need for a higher level of treatment. Population examples include the Developmentally Disabled (DD), inmates with organic brain trauma and those with mental illnesses that are chronic and debilitating but stable.
    - Transitional Unit: Serve inmates who are stable and coming out of Hospital level or those inmates prior to moving into Hospital level; and need to be program defined for closer monitoring and/or ongoing intensive treatment. DOC current Special Management Units would be integrated into this level and used specifically for short-term crisis management.
    - Hospital Level Unit: Serve inmates in need of intense treatment resources for acute care.

This system would allow:

- Mental Health services to be program or treatment driven, rather than facility driven by bed availability.
- Utilization of a *continuum of care model;* the ability to move inmates with mental illness through different stages of care and treatment.
- Creation and maintenance of the least restrictive environment for each level of the inmate population.
- Day treatment programming to divert inmates with mental illness from SMU and IMU.
- Appropriate educational services, employment availability and behavioral services (i.e. Cog) for a *special needs* population.
- The combining of *special needs* programs and housing within facilities in the future.

3. Create Transition housing units in facilities with SMU's as well as formal DOC Step-Down housing units within various institutions.

Resource Implications: With the ever-growing number of mentally ill and behaviorally challenged inmates entering DOC, the need for additional special management beds will be evident. SMU and IMU beds are expensive to utilize for inmates who fit into the transition-type and/or long-term alternative housing need categories. Transition and Step-Down Units would be more meaningful, efficient, and cost-effective alternatives for inmates needing more intensive treatment than can be provided in general population.

For example:
The following staffing level integrates the needs of mental health, substance abuse, and behavior management service delivery. The Mental Health staff needed to manage a 216-bed Step-Down unit is:

- One Program Director
- Four Case Managers
- One Psychiatric Prescriber
- One Behavior Specialist
- Two Substance Abuse Specialists
- Two Support Staff

Special Housing Beds

Bed Type	Current DOC Beds Available	Recommended Special Housing Beds	Difference in Current & Recommended
Hospital Level	72 (SMU)	360	288
Transitional	none	100	100
Step-Down	64	500	436

This will clearly have budget and staffing implications that are somewhat dependent upon the system of delivery. Hospital level and Transitional staffing have not been identified.

The total number of developmentally disabled inmates is approaching 300. The total number of inmates with the serious mental illness is nearly 1700. Statewide, DOC currently has a number of informal units that house close to 400 inmates that are not adequately staffed or officially designated, but relatively successful. A total of 500 Step-Down beds are necessary statewide, and could provide appropriate longer term alternative housing for the developmentally disabled and the more severely mentally ill.

The cost savings for having Transitional units would include reduced SMU stays (approximately $500 per day), transportation costs associated with multiple transfers, decreased DSU and IMU housing associated costs, reduced medical expenses related to staff and inmate physical/sexual assaults, lawsuits associated with inadequate care of the most severely mentally ill and developmentally disabled, costs associated with suicide attempts, less staff overtime due to emergencies (more stable environment), and cost savings associated with reduced recidivism.

Policy Implications: Creating Mental Health Transition units at OSP, CCCF, and SRCI institutions would accommodate the more intensive treatment needs of inmates releasing from SMU's or prevention from the need for SMU level care. This type of unit(s) would not be for long-term use, but transition from a crisis (SMU) to step-down or to outpatient units to provide the safe transitional environment so necessary to this type of inmate. The unit would be designed to deliver specialized programs, group therapy, provide medication management, and deliver skill development programming on the unit. It would keep these inmates out of the general population where inmates are, in reality, always there to "push these inmates' buttons." It would provide for close monitoring supervision, as well as supported employment and education.

There is also, however, a serious need for long term beds for those inmates not transitioning but vulnerable because of their chronic mental illness or cognitive deficiencies. A step-down unit could accommodate a mixture of inmate population needs, including those with developmental disabilities, neurological impairment, and those inmates with chronic and debilitating problems related to their mental illness within a day treatment-type program. Along with mental health services, the unit would address co-occurring substance abuse problems, education, and supported employment.

Public Safety Impact: Providing the inmates with the level of care based on their level of need offers them the opportunity to develop the skills needed to transition within the correctional environment and upon release to the community.

System Impact: This model is in keeping with the Oregon Accountability Model. It provides staff with the training to work in a team environment, dedicated to assist inmates to become better able to face challenges within the correctional environment and community.

Creating a safer environment in which these inmates can function is one of DOC's major responsibilities. The potential for preventing suicide attempts, preventing

weaker inmates from being victimized and teaching skills to function within a highly charged environment is imperative.

Recommendation: The increased number of mentally and developmentally challenged inmates incarcerated in the system dramatically necessitates the need for additional special housing.

Communities and DOC staff, as well as inmate families have a right to be confident in the knowledge that inmates are in a safe, monitored, learning environment appropriate to their needs. This has the potential to reduce the risk of these inmates being preyed upon, or them preying upon others.

(Refer to Appendix H - A Criminal Justice System and the Mentally Ill process describing the flow of inmates throughout the DOC system.) Note that the *Hospital Level* is currently DOC SMU, which is also residential treatment and crisis management. When the *Hospital* performs the acute care, current DOC SMU's then become *Transitional* (residential) level care.

4. Increase Mental Health Case Management services for all DOC institutions.

- This is a significant strategy for crisis intervention.
- Newly developed department programs and policy change implementation have caused Mental Health Case Managers to experience a documented 20 percent increase in essential duties. This increase in duties greatly reduces a Case Managers' time to proactively plan which allows only enough time to react to urgent situations. This in turn, creates safety concerns and promotes staff burnout and retention issues.

Implementation Option A: Staff institutions with Mental Health Case Managers for two shifts, seven days per week. *This option assumes the current housing standard driven by available bed space rather than program need.*

Impact: This option would require employing six additional Mental Health Case Managers and two support staff. An increase in Security appropriate staffing patterns is likely, and should be determined by each institution. Recruiting Mental Health professionals and retention may be an obstacle to this option.

Cost: $444,437 projected for 2005-2007 biennium; does not include Security staffing.

Implementation Option B: Adopt an expanded on-call protocol by which Mental Health Case Managers would be available to their respective institutions for after-hour and weekend emergencies. This would be an addition to the current on-call system, which is handled through Health Services Nurse Practitioners.

Impact: Probable increase in penalty pay.

5. Communication, Standardization and Information Technology

- Develop an automated C*lassification and Transfer* program that includes different levels of approval and notification filters to be completed prior to approving and sending a Request for Transfer (Form 1206) to the Transport Unit for action. This type of programming would support an appropriate housing assignment of all special case factors such as mental health, medical, security threat groups and conflicts.
- Institutions currently develop internal procedures as to who can enter transfer requests and who can access transport information. It is recommended that institutions adopt standardized procedures to enhance the necessary flow of information regarding the movement of inmates with mental illness. This would result in fewer crises and an increase in effective use of CTS staff time for both the sending and receiving institution.
- Standardized information technology should be available to all staff, throughout the Department of Corrections. Including automated treatment and behavior plans, computer access for officers on every tier (read only authority for certain mental health sections); electronic medical records, access to transfer information, and automated tracking of medication compliance. Standardized access to, and maintenance of behavior and treatment plans would provide Security staff with pertinent information when needed.
- Facilitate continuous improvement of service delivery to inmates by creating an on-going and formalized communication among the three disciplines of Security, Medical and CTS. Examples of an interactive communication structure may be mini-in-service sessions, cross functional staff meetings, workshops, teambuilding, etc.
- Revise and automate the Unusual Incident Report process. The current paper system poses a number of barriers to communication. It is recommended that the process be automated to include electronic filing at all locations and a notification system to provide an alert to key personnel when an incident occurs that may require immediate review or action. Key personnel should include notification to CTS.

6. Avoid interruptions in the Intake Mental Health assessment. Create a process to ensure completion of the mental health assessment during intake.

- Identify a number of Disciplinary Segregation Unit (DSU) beds within the Intake Center to allow inmates to continue in their assessment process and avoid being sent out prematurely due to rule infractions.
- Minimize inmate transfers that occur after hours and on weekends.
- Develop a plan to manage those inmates that require suicide precautions at the Intake Center, in the same manner in which other institutions manage suicidal inmates, in accordance with the OAR 291-076 -Suicide Prevention.
- Create a back-up process.

7. **State of Oregon develop effective release planning for inmates with mental illness including adequate housing, community mental health services, medication and access to any state or federal benefits to which they are entitled. (Refer to Appendix I Bazelon Center Building Bridges and Model Law.)**

8. **Automate a medication tracking and management system for use by DOC Health Services and CTS.**

   Consider cooperation and collaboration with OYA and the OMHAS state operated facilities to look at common problems related to technology in prescribing, dispensing, record keeping, and monitoring medications.

9. **Provide adequate staffing for CTS clinical supervision within DOC institutions.**

10. **Provide mandatory confidentiality training to all employees and contract staff once every two years.**

    - Provide Officer(s) in Charge (OIC) with confidentiality training specific to crisis intervention and assisting on-call professionals with confidential mental health information.
    - New Employee Orientation (NEO) should include confidentiality training to identify appropriate boundaries and describe the minimum confidential information necessary to perform an assigned task.
    - Include confidentiality policy and or language in all institution specific employee orientations.
    - Highlight confidentiality policy in all Human Resource new employee packets.

11. **Provide mandatory mental health training to all staffs.**

    Behavior management of inmates with mental illness training must be completed before working in a segregation unit.

12. **Eliminate inmate access to razor blades.**

    Currently, razor blades are the number one choice for self harm instruments among inmates.

13. **Consider re-funding the position of liaison between DOC and OMHAS.**

    This position would support the Governor's Mental Health Task Force recommendation for exploring the option of "a single forensic mental health facility to house and provide integrated services to individuals who cannot safely

be treated in community settings." Additionally, the positions should coordinate the state accreditation of mental health programs in prisons, providing more credibility and scrutiny to DOC Mental Health programs.

The projected cost of one Principal Executive Manager D for the 05-07 biennium is $ 133,990.

14. Enhance mental health services by sequencing the Workforce Development (WFD) Cognitive restructuring program as part of the cognitive behavioral treatment.

These services add to the integration of mental health treatment modalities with behavioral and cognitive modalities, providing a much needed and comprehensive continuum of mental health care.

15. Revise DOC policy and OAR's as follows:

- All DOC operational policy should have consistent definitions and language in the beginning section of each policy.
- Definitions should be clear, inclusive and operationally defined (e.g., suicide watch, close observation, moderate observation, low-risk precautions).
- Definitions should include the following components:
    - Operational description (what it looks like);
    - Description of requirements and/or qualifications (e.g., necessary employee certifications or licenses);
    - Identify specific behaviors and specific outcomes related to the described behaviors (e.g., an inmate qualifies for suicide watch by cutting himself);
    - Qualification or description of behavior to be removed from consequences or results or earlier behaviors (e.g., how an inmate becomes eligible for removal from suicide watch, and who makes the decision);
    - Identify the Mental Health staff who perform the assessment and release, and further treatment;
    - Identify who is qualified to make decisions by rule;
    - Exercise awareness of staff liability.
- Utilize NCCHC definitions for Qualified Health Care Professionals and Qualified Mental Health Professionals.
- All existing CTS and Health Services policy should be integrated to appropriately represent common policy for the department. (Example: integrate Health Services P-G-04 and CTS MH E-1 – Emergent and Urgent Access to Mental Health Consultation Procedure to become a DOC policy that describes how and when to access mental health services within the department.)
- Revise OAR 291 Division 011 – Segregation (Disciplinary) to reflect the following changes:
    - Add language to section 0064(1*)* "be temporarily deprived of any service or…" *not to include Mental Health services and Health services*.

- Clarify language in sections 080(6), 050(5) (A) and 030(6) related to "*qualified MH/Health care professional*" by using the NCCHC definition.
- Define individual provider titles within the policy.
- Add the NCCHC definition for *Qualified Mental Health Professional* to rule.
- Change current language in section 080(12) "*OIC will consider,"* to indicate an immediate response by the OIC.
- Reflect the NCCHC mental health standard for accreditation.
- Revise policy to require staff mental health training prior to staff working in all DOC segregation units.

- Revise OAR 291 Division 013 – Use of Force**.** Planned use of force with regard to inmates with mental illness should be governed by consultation with a Mental Health professional. This policy should describe the planned use of force strategies that are and are not acceptable for use with inmates with mental illness.
- Revise OAR 291 Division 105 – Prohibited Inmate Conduct and Processing Disciplinary Actions to reflect the following changes:
  - Change current language in section 0066(9), "the hearings officer *may"* to "the hearings officer *shall.*"
  - Add language to section 0072 (5) (B) "Mental Health professional will help determine appropriate method of holding inmate accountable." Clinically based advice should be given consideration during the disciplinary process. Mental health information provided for this reason should become part of the final order document. Also, within appropriate confidentiality rules, the final determination available to appropriate Security and or Transfer staff.
- Revise OAR 291 Division 071 – Therapeutic Restraints (Use of) to reflect the following changes:
  - Eliminate conflicting language; revise this policy to be consistent with Division 013 Use of Force language and integrate NIC standards.
  - Specific language regarding releasing inmate from restraints should be consistent with the Division 013 Use of Force language to the same end.
  - The DOC Policy Group should consider the types of restraints used, location, and the resources available to supervise the use of therapeutic restraints in a correctional environment.
  - Consider changing the terminology *therapeutic restraints,* as its use may be outdated in the mental health field. Use of soft restraints is for the means of *emergency intervention* and not for therapeutic purposes.
- Revise OAR 291 Division 076 –Suicide Prevention in Correctional Facilities to reflect the following changes:
  - Integrate all CTS functional unit Suicide Prevention related procedures into one DOC policy. This policy should have a single focus and administrative rule that governs the response to an attempted inmate suicide.
  - Add a clear set of definitions that identifies specific staff and their respective tasks to be accomplished.
  - Describe specific suicide prevention measures used.

- Identify the timeliness of assessment, clearly designating that inmates must receive the services needed at the time they are needed. Receipt of needed services should not be based upon a fixed period of time.

- Create a DOC Confidentiality policy that includes clear language regarding the appropriate application of HIPPA as it applies to DOC. Policy should include internal and external use of confidentiality.
- DOC Security and CTS coordinate an in-depth revision of OAR 291-048-0170 - Provision of Basic Services and Programs.

16. Develop a pool of qualified medical and mental health professionals who have clinical cultural and gender competence. Designate this pool as a shared resource with OMHAS and the Mental Health community. This should include hearing impairments.

17. Develop effective recruitment and retention strategies for future vacancies; giving close attention to facilities in rural areas.

This process should include identification of existing barriers and solutions for the current challenges experienced with CTS recruitment and retention.

18. Identify Bazelon Center strategies for inmates with mental illness that can be implemented without additional legislation.

This should include pre-release planning and strategies specifically for the mentally ill population.

19. Develop a joint process with county jails and local area community providers to make available significant medical, mental health and behavioral information regarding individual offenders upon their incarceration with DOC.

Appendix

Appendix A: Glossary of Terms

The following terms as used within this report are defined as follows:

Assessment

An assessment is the process of examination or evaluation. Its focus is information gathering that includes an interview and a review of existing records. It can include the administration of specialized instruments or tests and is conducted to identify those inmates who may require a particular intervention or treatment. The assessment ascertains the specific nature and severity of the mental health and/or substance abuse treatment needs as well as includes recommendations for treatment.

Case Manager

CTS mental health specialist.

Developmental Disability

This term refers to a severe and pervasive impairment in several areas of development: reciprocal social interaction skills, communication skills, or the presence of stereotyped behavior, interest, and activities. These disorders are usually evident in the first years of life and are often associated with some degree of mental retardation. The essential feature of mental retardation is a significant sub average general intellectual functioning that is accompanied by significant limitations in adaptive functioning in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, and use of community resources, self-direction, functional academic skills, work, leisure, health, and safety. The onset must occur before the age of 18 years. Significantly sub-average intellectual functioning is defined as an IQ score of about 70 or below. Mental retardation would not be diagnosed in an individual with an IQ below 70 if there are no significant deficits or impairments in adaptive functioning.

GAF

The Global Assessment of Functioning (GAF) Scale is a system used by to indicate an individual's psychological and occupational functioning on a scale designed to measure overall severity of psychiatric disturbance. The GAF scale may be particularly useful in tracking the clinical progress of individuals in global terms, using a single measure.

G codes

G-1: An inmate that has been assessed for developmental disabilities, including cognitive and adaptive functioning, and has been determined to have no need for ongoing case management services.

G-2: An inmate that has an IQ 79 or below with impairment in adaptive functioning.

G-3: An inmate with an IQ below 70 with significant impairment in adaptive functioning.

Mental Health Professional

Employee or contractor qualified to provide mental health services.

Mental Illness

The American Law Institute Test from Model Penal Code, 1962 defines mental illness as: 1) a person is not responsible for his/her criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity to appreciate the criminality of his conduct or to conform his/her conduct to the requirements of the law, and 2) the terms "mental disease or defect" do not include an abnormality manifested only by repeated criminal or otherwise anti-social conduct. For the purpose of clinical practice, the operational definition of mental illness is the presence of a diagnosable severe and persistent mental disorder according to the DSM-IV TR.

Mental Illness Code Classifications

A-codes:

A system of classification to determine the allocation of mental health resources provided to inmates. A-codes also provide information to other corrections staff about an inmate's need for services. A-codes are:

A-0: Assigned to an inmate who has been assessed by a CTS treatment provider and does not meet criteria for a diagnosis that requires mental health services.

A-1: Assigned to an inmate who has been assessed by a CTS treatment provider and, based on diagnosis along with mild acuity, does not meet criteria for mental health services.

A-1R: Assigned to an inmate who has been assessed by a CTS treatment provider and meets diagnostic criteria for a code of A-1 and is prescribed psychotropic medications by a CTS prescriber or the inmate's acuity level is assessed as moderate or severe. The inmate will be restricted to institutions where mental health services are available.

A-2: Assigned to an inmate who has been assessed by a CTS treatment provider and meets diagnostic criteria for a high level of need for mental health services. The inmate will be restricted to institutions where mental health services are available.

A-3: Assigned to an inmate who has been assessed by a CTS treatment provider and meets diagnostic criteria for the highest level of need for mental health services. The inmate will be restricted to institutions where mental health services are available.

*As of September 2004, approximately 1290 A1-R inmates resided within Oregon prisons.

*A2 classified inmates obtain Case Management contact regularly, from weekly to every 120 days, depending upon GAF score. As of September 2004 approximately 910 A2 inmates resided within Oregon prisons.

*A3 classified inmates receive Case Management contact regularly, from weekly to every 90 days, depending upon GAF score. As of September 2004, approximately 713 A3 classified inmates resided within Oregon prisons.

Prescribing Practitioner

A licensed psychiatrist or psychiatric nurse practitioner.

Qualified Health Care Professional

As defined by NCCHC (National Commission on Correctional Health Care) , *Qualified Health Care Professional* includes physicians, physician assistants, nurses, nurse practitioners, dentists, mental health professionals and others who by virtue of their education, credentials and experience are permitted by law to evaluate and care for patients.

Qualified Mental Health Professional

As defined by NCCHC (National Commission on Correctional Health Care), *Qualified Mental Health Professional* includes psychiatrists, psychologists, psychiatric social workers, psychiatric nurses and others who by virtue of their education, credentials and experience are permitted by law to evaluate and care for the mental health needs of patients.

Screening

A screening is a preliminary appraisal to both determine the existence of a disorder and/or the need for a more in-depth evaluation.

Treatment Provider

A mental health professional or prescribing practitioner as defined above.

Appendix B: Task Force Charter

MANAGING MENTAL ILLNESS IN PRISON
TASK FORCE CHARTER

Mission

The mission of the task force is to identify the Department of Corrections (DOC) practices and polices that result in *safe and effective behavior management of inmates with mental illness*. (To avoid duplication with other work groups and initiatives, the group will not address mental health treatment programs in prison.) The work group is chartered to:

- Review current DOC policies and practices related to the management of behavior for inmates with mental illness
- Review current DOC policies and practices related to the use of disciplinary procedures with for inmates with mental illness
- Review and analyze behavior management and disciplinary procedures used in the mental health system and in other incarcerative settings, including use of restraints.
- Review collaboration between divisions with regard to management of inmates with mental illness.
- Review level of staffing and credentials of mental health staffing.
- Request and review recommendations from the National Institute of Corrections.
- Endorse current practices that represent the best practices in the safe and effective behavioral management of inmates with mental illness
- Identify needed changes in current practices
- Recommend new or changed practices as appropriate
- Recommend an ongoing audit mechanism that provides for annual review of behavioral management practices.

Deliverable

The task force will produce a report identifying the prison practices and polices that are most likely to result in safe and effective behavior management of inmates with mental illness, affirming current DOC practices that are consistent with these best practices, and recommending specific changes as needed to bring the DOC practices and policies into alignment with the identified best practices.

Timeline

The task force will complete its work by October 1, 2004.

Members

Members are appointed by the Director of the Department of Corrections. Membership will include experts in mental health and in corrections institutions management from both within the DOC and from outside, including DOC Chief of Security and representatives from DOC Corrections Treatment Services, Oregon State Hospital, Oregon Jail Managers Association, Oregon Advocacy Center, National Alliance for the Mentally Ill, and AFSCME.

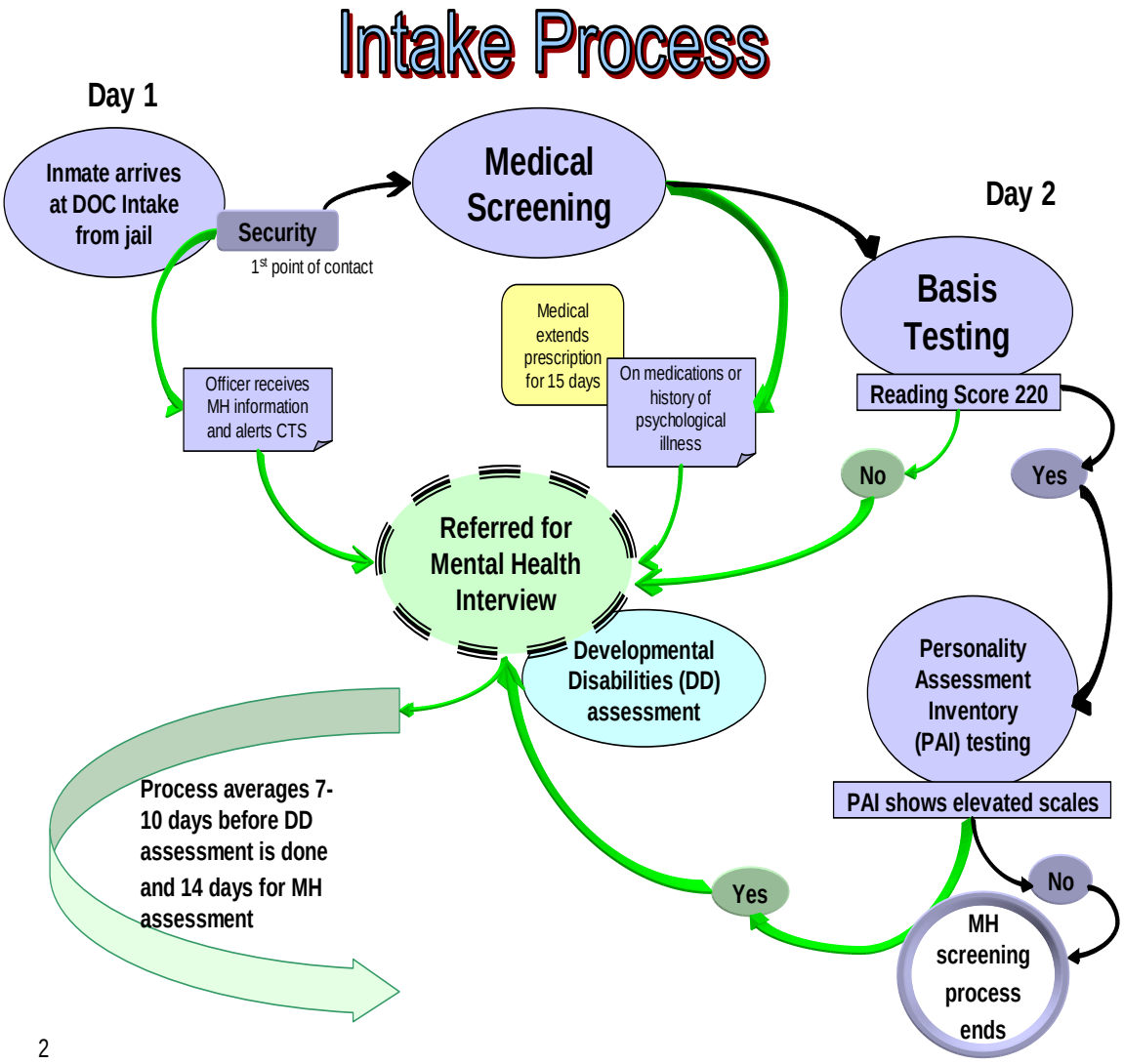
Appendix C: Allocation of Mental Health Services

Allocation of MH Services based on A-code and Acuity level

	Mild (GAF=61-100)	Moderate (GAF=31-60)	Severe (GAF= 01-30)
A-3	Case mgmt contact at least every 90 days Group	Case mgmt contact at least every 30 days Group Individual	Case mgmt contact at least weekly Group Individual
A-2	Case mgmt contact at least every 120 days Group	Case mgmt contact at least every 60 days Group Individual	Case mgmt contact at least weekly Group Individual
A-1R	Prescriber only if referred through case mgr	Prescriber only if referred through case mgr Group	Prescriber only if referred through case mgr Group Individual
A-1	No services		

5

Appendix D: Intake Process



Appendix E: NIC Recommendations

The following reflects recommendations from *Effective Prison Mental Health Services, Guidelines to Expand and Improve Treatment, 2004 Edition* by the National Institute of Corrections and U.S. Department of Justice. For additional information, refer to www.nicic.org.

1. Introduction

Since the early 1990's, more and more adults with serious mental illness have become involved in the criminal justice system. Prisons, in particular, have undergone a dramatic transformation, housing a growing population of inmates with serious mental disorders. The U.S. Department of Justice estimates that 16 percent of all inmates in state prisons have mental illness (Ditton, 1999).

Historically, correctional facilities have been unprepared to provide mental health services. They typically have not had the physical facilities, staff, staff training, or clinical resources to necessary to meet the needs of inmates with serious mental illness. Yet the courts have made it abundantly clear that correctional facilities are legally and constitutionally required to provide adequate mental health services for the inmates in their custody.

It is important for prison officials to understand the severity and scope of mental illness in their populations and how to treat mental disorders effectively. These issues have important implications for humane and effective facility operation, maintaining safety for inmates and staff, and avoiding litigation.

Challenges

The high numbers of people with serious mental health problems entering prison present significant challenges. Adults with mental illness often enter prison with histories of chronic health problems, unemployment, homelessness, transient behavior, financial instability, and high-risk behaviors. Typically, they do not have health coverage, and they lack the supportive, positive, and enduring relationships that contribute to emotional health and stability (McVey, 2001). While incarcerated, inmates with mental illness often need housing and services different from those offered to other inmates. They may need extra medical attention, treatment, medication, security, suicide precautions, special programming, rehabilitative services, case management, or transition services. Due to their illness, they may need to be housed in units with higher staffing ratios. Many prison officials find themselves balancing the needs of inmates against the costs of the special services.

Many inmates with mental illness have difficulty adapting to the structure, routine, and social milieu of prisons. Some become overly passive, withdrawn, and dependent (Jemelka, Trupin, and Childes, 1989). Others act out their illness in antisocial ways. Infractions are primary indicator of prison adjustment and may ultimately affect classification and release decisions. Judgments about what behaviors are tolerable or are allowed as manifestations of illness, therefore, are

important ones (Jemelka, Trupin, and Childes, 1989). Prisons should avoid penalizing inmates for infractions that are a direct result of their mental disorder.

Challenges in caring for inmates with mental illness may be summarized by the following:

- Determining whom and how to treat.
  Prison staff must be trained to recognize the signs of serious mental disorders and substance abuse, monitor the entire prison population for signs of emerging problems, and distinguish acute and serious conditions form less serious ones.

- Managing inmate behavior and symptoms.
  Prison administrators must often increase levels of staffing to house inmates with mental disorders safely and humanely because these inmates often have a disruptive effect in a prison environment. The Bureau of Justice Statistics found that people with mental illness were twice as likely as other prisoners to be involved in a fight (Ditton, 1999).

- Recognizing the negative effects of the prison environment on mental health.
  Overcrowding, the lack of privacy, temperature and noise levels, victimization, and other environmental conditions in prisons can easily exacerbate the symptoms of mental illness for some people. The prison environment itself can contribute to increased suicide and the inability of inmates with serious mental illness to adjust.

- Understanding inmates' difficulties in adjusting to institutional life.
  Inmates with mental disorders generally have a more complicated adaptation to prison as measured by rule violations and incidents of misconduct. Serious mental illnesses are stress sensitive; changes in housing, staffing and routine may bring about an adverse reaction. Misunderstanding an inmate's aberrant behavior can turn a minor incident into a serious situation (Morgan, Edwards, and Faulkner, 1993).

- Determining the need for special services.
  Many adults with mental illness enter the prison system with histories of problems such as victimization, co-occurring substance abuse, chronic health conditions, or violence. Many inmates with mental illness, especially women, have histories of trauma and abuse prior to entering prisons; others are victimized while incarcerated.

- Addressing chronic care programs and special needs housing.
  Inmates with chronic mental illness and a growing number of geriatric inmates pose special challenges. Special programs and housing units, when designed appropriately, can reduce serious rule infractions, suicide attempts, correctional discipline, seclusion, hospitalization and the need for crisis intervention.

2. Mental Health Screening and Assessment

Implementing effective screening and assessment practices help maintain an optimal level of safety and security for staff, inmates and the public. The process of identifying and evaluating this subpopulation of inmates consistent with national standards and guidelines is outlined below.

Offenders entering into the state prison system should be screened for mental health disorders for both clinical and legal reasons. Screening and assessment for mental illness:

- Identify those at risk for injuring themselves and others.
- Determine whether the inmate is capable of functioning in the prison.
- Determine whether the inmate should be transferred to a mental health facility.
- Determine whether the inmate can benefit from treatment at the prison (Ogloff, Roesch, and Hart, 1993).

Standards for screening and assessment developed by several national organizations suggest that, as with other acute medical conditions, mental health and substance abuse issues need to be identified immediately on entry into a correctional facility. Significant stressors encountered in adjusting to the prison environment can be particularly problematic for those who have a preexisting psychiatric condition. The sooner individuals can be identified, the sooner treatment providers working in the correctional setting can intervene to help them adapt to the environment. This helps the facility maximize security, maintain its operational routine, and make the prison safer for staff and inmates (Dvoskin and Steadman, 1989). Adequate screening and follow-up procedures help the offender with mental health or substance abuse problems function better and have the potential to reduce inmate suicide (NIC, 1995), violence, and other predatory behaviors (Cohen and Dvoskin, 1992).

Useful guidelines for mental health screenings have been developed by the American Psychiatric Association (APA) and the National Commission on Correctional Health Care (NCCHC) (Metzner, 1993). APA recommends that a mental health screening be conducted at the time of admission to the prison. Following the initial screening, APA recommends a more detailed, thorough intake mental health screening be conducted. APA's guidelines also recommends that any inmate identified by these screenings as having a mental illness or disability be referred to an appropriately trained mental health professional for a more comprehensive mental health professional for a more comprehensive mental health examination or assessment. This assessment should take place within 24 hours of receiving the referral from the screener.

NCCHC also has developed standards for two levels of mental health screenings in prisons. The first is recommended to take place immediately, within 2 hours upon arrival, and to be completed by qualified health care personnel.

The second level of screening is a post-admission mental health evaluation (closer to an assessment). It is recommended that this evaluation occur within 14

days of admission to the prison and be completed only by qualified mental health personnel. This mental health evaluation should include a structured interview that inquires into the inmate's history and current status.

Co-occurring Disorders

Screenings and assessments in criminal justice settings ought to address issues related to mental health, substance abuse and the interaction between the two (Peters and Bartoi, 1997). The screening approach used to identify mental health and substance abuse conditions should be integrated; that is, if either a mental health or substance abuse disorder is detected, the other should immediately be screened for as well. The prevalence of co-occurring substance abuse and mental health disorders is especially high in the prison population. An estimated 13 percent of the prison population has both a serious mental illness and a co-occurring substance abuse disorder (National GAINS Center, 1997), and 23 to 56 percent of inmates in general population who have a diagnosable mental disorder also have a substance abuse disorder (Regier et al., 1990).

Screening and Assessment of Women Offenders

The screening and assessment of female inmates is particularly significant given the growing numbers of women in state prisons and the higher incidence of mental illness and substance abuse disorders when compared with male inmates (Bureau of Justice Statistics, 1999). An estimated 19 percent of female jail detainees are diagnosed with schizophrenia, bipolar disorder, or major depression compared with 9 percent of male detainees (Teplin, 1994; Teplin, Abram, and McClelland, 1996). A history of prior physical or sexual abuse is reported by 30 percent of mentally ill male inmates and 78 percent of female inmates (Bureau of Justice Statistics, 1999).

Screening and assessment of women offenders, therefore, need to be particularly sensitive to the presence of mood symptoms, depression and anxiety symptoms which can have significant impact on the way these women relate to others and on the safety and the security of the facility."

3. Problems in Screening and Assessment

Problems identified by NIC relating to screening and assessment for mental health are as follows:

- Determining how to screen and the methods to use remains challenging.
- Mental health professionals who choose to work in prisons are in short supply.
- Many people with serious mental illness do not acknowledge they have it or do not want other inmates or staff to know they have it.
- Some inmates do not have a preexisting mental condition when they enter prison but develop significant psychiatric problems as a result of incarceration.
- Inmates with mental illness who stand out and cause problems quickly get attention. Those who are quietly psychotic or depressed are harder to recognize.

- Suicide is an additional risk in correctional settings, and inmates with mental illness are at particularly high risk.
- Suicide is the third leading cause of death in prison (Hayes, 1999), and almost all suicide attempts committed in prisons are by people diagnosed with major psychiatric disorders (Bonner, 2000).
- There is a high incidence of borderline intelligence and mental retardation in the prison population. An inmate's inability to think abstractly and lack of verbal skills may inhibit his or her ability to put common symptoms and feelings into words that adequately convey a sense of what is happening.
- Cultural differences play a role in the diagnostic process.

4. Mental Health Treatment

A number of court rulings affirm that prison inmates are entitled to mental health care equal to that available in the community. Yet, few if any prisons are able to offer a comprehensive array of mental health services for all inmates who may require or request them. Limitations of mental health staff and resources force most prison officials to prioritize inmates with the most severe impairments and dangerous and disruptive symptoms. Inmates with adjustment disorders and less severe mental health problems may wait lengthy periods for treatment or get no treatment at all.

Ruiz v. Estelle (1980) established the minimum components needed to deliver adequate mental health treatment in prison, including the use of trained mental health professionals in sufficient numbers to identify and treat inmates who are mentally ill (Metzner, 1993).

National Standards and Guidelines

Although the courts do not mandate the use of any particular mental health service delivery model, they do expect correctional facilities to maintain policies and procedures that will reduce needless suffering and allow access to needed services (Cohen and Dvoskin, 1992).

American Psychiatric Association

The APA guidelines (APA, 2000) recommend that a variety of biological and psychological therapies be available to treat mental health disorders that significantly interfere with an inmate's ability to function in prison. Treatment should be multidisciplinary, eclectic, and consistent with generally accepted mental health practices and institutional requirements. APA's guidelines require the following components be available:

- A crisis intervention program with infirmary beds available for short-term treatment (less than 10 days).
- An acute care program (inpatient treatment for inmates with significant psychiatric symptoms that interfere with their ability to care for themselves).
- A chronic care program (a special housing unit for inmates with a chronic mental illness who do not need acute inpatient care but cannot function adequately within general population).

- Outpatient treatment services.
- Consultation services (including consultation with other prison officials and departments ant the training of officers and program staff).
- Discharge/transfer planning (including both transfer to other institutions and release to the community.

NCCHC

APA's guidelines were designed to be used in conjunction with the standards developed by the NCCHC (Anno, 2000). In addition to issues of care and treatment, NCCHC standards address administrative and personnel issues, support services, special needs and services, health records, and medical-legal issues. Care and treatment issues stipulated by NCCHN include the following:

- Inmates must be screened for mental health problems by a qualified health professional within 2 hours of admission.
- Inmates must be informed within 24 hours of arrival of the types of mental health services available and how to access them.
- Inmates must have a health appraisal within 7 days of arrival that includes taking a history of any prior mental health problems, hospitalizations, psychotropic medications, suicide attempts, and alcohol and other drug abuse.
- Inmates must receive a mental health evaluation within 14 days of arrival that includes a complete mental health history and current mental status and screening for mental retardation and other developmental disabilities.
- Treatment plans must be created for inmates who are identified as having serious mental health needs and who are developmentally disabled.
- Inmates should be seen by a qualified professional within 48 hours of a request for non-emergency mental health services (72 hours on a weekend).
- Prison procedures must address psychiatric emergencies and suicide attempts.
- Mental health treatment should occur in private (except for high security risks) and with respect for the offender's dignity and feelings.

Metzner (1993) has integrated several sets of national guidelines and recommends the following 13 policy and procedural issues be addressed in the development of a prison's comprehensive mental health system:

- A mission and goals.
- Administrative structure.
- Staffing (e.g., personnel, credentialing, job descriptions).
- Reliable and valid methods for identifying inmates with severe mental illness.
- Treatment programs available to inmates.
- Involuntary treatment, including the use of seclusion, restraints, forced medications, and involuntary hospitalizations.
- Medical/legal issues, including informed consent and the right to refuse treatment.
- Confidentiality.
- Mental health record requirements.
- A quality assurance and improvement plan.

- The training of mental health staff regarding correctional and security issues.
- The formal training of correctional staff regarding mental health issues.
- Research protocols involving human subjects.

Informed Consent and the Right to Refuse Mental Health Treatment

Although APA, NCCHC, and other guidelines exist to ensure that offenders receive adequate mental health treatment, the right of inmates to refuse mental health treatment also must be addressed by policies and procedures in prison settings. This right to refuse treatment is inherent in the notion of informed consent, which NCCHC (1999) defines as:
"...the agreement by a patient to a treatment, examination, or procedure after the patient receives the material facts about the nature, consequences, and risks of the proposed treatment, examination, or procedure, and the alternatives to it."

There are exceptions to the need for informed consent. When inmates with mental illness pose an imminent danger to themselves or others, they can be treated despite their refusal. These exceptions should be clearly delineated in written procedures.

Mental Health Staffing

Guidelines and standards from national organizations (including NCCHC) do not stipulate how many or what type (i.e., from which discipline) of mental health or substance abuse professionals should be employed by each prison. They recommend only that there be qualified mental health professionals at sufficient levels to ensure that inmates can receive the treatment equal to contemporary standards or care (Metzner, 1993). Very little empirical data exist to help administrators select a particular staffing model for providing mental health services to inmates (Rice and Harris, 1993; Dvoskin and Patterson, 1998). The numbers and types of mental health care providers required at any particular facility depend on the number of inmates being treated, the particular needs of those inmates being treated, the particular needs of those inmates, and the scope of services being offered (NCCHC, 1999). It is recommended, however, that the professionals providing mental health and substance abuse services meet the state licensure, certification, and registration requirements necessary to practice outside of the prison setting so as not to compromise the quality of care provided to inmates (NCCHC, 1999).

Treatment Planning

Regardless of the specific treatment or setting where services are delivered, and individualized treatment plan is essential to the provision of prison-based mental health services. The plan includes a series of written statements that address key components of the inmate's mental health issues and treatment (Metzner et al., 1998). A treatment plan should include:

- An objective description of the problems the inmate faces as a result of mental illness.
- An objective description of short- and long-term goals of treatment.

- The types of therapeutic interventions that will be used to achieve those goals and how often they will be delivered.
- The providers who will deliver the treatment.

Treatment plans also can address interventions or activities to be provided by non-mental health staff that can be critical in helping inmates with mental illness function adequately and provide relief from symptoms. These interventions and activities may include attending school or vocational programs, recreational activities, family visits, and work assignments (Metzner et al., 1998).

Crisis Intervention

Offenders who require long-term mental health interventions and treatment are generally seen in residential units or at outpatient clinics. There are times, however, when emergency interventions for crisis situations must be provided to inmates who may or may not be receiving mental health services on a regular basis. Crisis intervention is needed when inmates' mental illnesses make them dangerous to themselves or others or leave them unable to adequately care for themselves. Most often, this is the result of an acute suicidal depression or an acute exacerbation of psychosis (Cohen and Dvoskin, 1992).

On these occasions, the success of the crisis intervention in preventing further psychiatric decompensation (the appearance or exacerbation of a mental disorder due to the failure of defense mechanisms) and in protecting the inmate and others depends on the timely response by staff and the ability to provide the necessary services, including access to:

- Mental health screening and assessment.
- Psychotropic medications.
- Supportive psychotherapy.
- Crisis stabilization beds.

Long-term mental health treatment may or may not follow these crisis intervention services. At times, it is a crisis situation that first brings an inmate into contact with mental health staff. This may be true for several reasons: the inmate's initial screening and assessment did not reveal mental illness, the inmate's mental illness was in remission prior to the crisis, or the illness developed while incarcerated (Cohen and Dvoskin, 1992).

Case Management

Case management was first developed in the 1960's and 1970's as a way to help those with mental illness access the social and health services they need to function on a day-to-day basis in the community (Chamberlain and Rapp, 1991). The traditional functions performed by Case Managers working with adults with mental illness are:

- Assessment of the offender's needs.
- Planning services to meet the needs identified through assessment.
- Advocating for the offender's needs.
- Linking offenders to the services identified by service planning.

- Monitoring the offender's progress in achieving the objectives detailed in the service plan.

In correctional settings, Case Managers may be assigned to inmates who have mental health disorders, alcohol or drug abuse disorders, or both (co-occurring disorders). In a prison, the community comprises the general, or open, population housing units and the various departments and programs that deliver services to offenders. The Case Manager may need to broker between both correctional administrative systems (e.g., security, classification, housing) and treatment-oriented services and programs (e.g., education, vocation, health/medical, mental health, and alcohol and drug abuse services).

It is increasingly recognized that interventions with inmates who have mental illness need more intense involvement and that the relationship between the Case Manager and inmate should be emphasized. Case mangers report that informal counseling with their clients is a vital component to their relationship. With appropriate education and training, Case Managers can provide treatment in the form of counseling and psychotherapy.

Requiring that case manages be properly trained mental health professionals is consistent with national guidelines that recommend that the training and competence of the qualified mental health personnel employed in correctional facilities be equal to community standards (APA, 2000; NCCHC, 1999).

To avoid conflict in roles, clinicians who provide mental health treatment in forensic settings should not also provide correctional services. Effective case management:

Mentally ill offenders are best managed by an identified Mental Health Case Manager who is responsible for activating and monitoring a continuum of treatment and classification services to a caseload of mentally ill offenders. The purpose of this approach is to monitor each offender's individualized mental health treatment plan, and to regularly evaluate the adequacy and appropriateness of the plan, making modifications where necessary. Effective case management will ensure consistency of service delivery, and will monitor mentally ill offenders' progress, including changes in levels of functioning and treatment needs. (Jemelka, Rahman, and Trupin (1993).

Staff Training

Prison-based Case Managers working with inmates with mental illness should possess, at minimum, the skills needed by any successful prison staff member, including correctional officers (Rice and Harris, 1993).

Studies suggest that staffs who are most likely to succeed with correctional or mentally disordered offender populations are those who use authority to enforce rules but in a non-confrontational manner, who model prosocial (and anti-criminal) attitudes and behaviors, and who are at the same time emphatic and interpersonally skilled.

Line correctional staffs assigned to work with inmates with mental illness are best prepared for this role if they receive the same training as direct care workers in psychiatric hospitals (Hafemeister, 1998). Correctional officers can be highly effective when they are trained to:

- Understand that simply listening and talking to inmates with mental illness may resolve crisis.
- Understand that frequent contact by staff, even brief contacts, can help calm confused and anxious inmates.
- Provide accurate information about the institution and how to access mental health services to inmates.
- Observe and record inmate behavior.
- Receive and relay inmate requests for assistance from mental health staff.
- Consult with mental health staff about mental issues.
- Monitor inmates who take psychotropic medications for compliance and side effects.
- Identify the early signs and symptoms of mental illness and implement suicide prevention (Hafemeister, 1998).

Basic training for all correctional staff should therefore include the following information:

- How to recognize the early signs and symptoms of serious mental illness and suicide.
- The nature and effects of psychotropic medications.
- The mental health services available in the prison.
- How and when to make referrals to mental health services (Cohen and Dvoskin, 1992).

Case Managers should demonstrate the ability to:

- Establish rapport with inmates.
- Educate inmates about the institution and its mental health services.
- Link inmates to other services and departments.
- Link inmates to community services on release.
- Prepare treatment plans.

Co-occurring Disorders

Of the 16 percent of state prison inmates with a mental illness, 59 percent reported using alcohol or drugs at the time of their offense, and 34 percent have a history of alcohol dependence (Bureau of Justice Statistics, 1999). The term *co-occurring disorders* is defined within this context as those inmates who have a severe and persistent mental illness and a substance use disorder.

There are three models of treatment commonly used for delivery of service to inmates with co-occurring disorders: *parallel, sequential, or integrated* treatment. Both *parallel* and *sequential* treatment approaches may be adequate for offenders with less severe co-occurring disorders. The *integrated* model, calling for a single professional or team of professionals trained in both mental

health and substance abuse providing comprehensive treatment to address both disorders simultaneously, is most effective for inmates with severe persistent mental illness.

5. Use of Seclusion, Segregation and Restraints

Finding safe, humane, and non-punitive methods for handling inmates who are experiencing the symptoms of mental illness is an ongoing challenge for prison administrators. The nature of serious mental illness may create major problems for managing the behavior of these inmates. Some symptoms of serious mental illness may result in inmates' committing disciplinary infractions. Prison administrators must work to maintain order in their facilities but must also work to avoid penalizing inmates with mental illness for behavior that results directly from their illness. Inmates with mental disorders who do not fully comprehend the rules or who are unable to control their behavior often get into trouble and are punished even when they clearly have diminished responsibility, comprehension, or self-control (Faiver, 1998).

The American Psychiatric Association (APA) has expressed concern that inmates who have difficulty understanding or adhering to institutional rules as a result of their mental illness will find their way into segregation units unnecessarily in prisons with inadequate mental health services (APA, 2000). Solitary confinement or extended segregation may cause extreme stress for a mentally ill person and can promote decompensation and exacerbate the illness (Faiver, 1998).

As do other inmates, offenders with mental illness violate institutional rules and commit infractions that would normally result in discipline, including segregation and confinement. Although administrators must ensure that such behaviors trigger appropriate consequences, caution must also be taken because segregation for mentally ill offenders can severely exacerbate their psychiatric symptoms. Segregation may be so anxiety provoking for some that they may go to extreme lengths to avoid it, including threatening or attempting suicide (Hafemeister, 1998). Given that offenders with mental illness will at times be placed in administrative or disciplinary segregation, mental health staff should be readily available onsite to identify inmates who are experiencing significant psychological problems and to provide an adequate level of services.

NCCHC standard specifically stipulated that health care must continue to be made available inmates in segregation (Anno, 2000). Routine checks must be made by health staff at least three times a week for inmates in administrative segregation and daily for inmates in disciplinary segregation. Although the NCCHC standards do not address the frequency with which mental health staff should visit inmates in segregation, the APA has recommended that they make the rounds of segregated inmates at least weekly to check their mental status (Anno, 2000; APA, 2000). Anyone needing further evaluation or treatment should be referred for follow-up interventions and seen in an appropriate clinical setting.

APA recommends that, when inmates are in segregation for any reason, mental health staff should make a special effort to assess and address serious mental health needs because of the stressful nature of segregated housing.
Meeting Mental Health Needs in Segregated Housing:

- Inmates should not be confined in segregated housing units solely because they exhibit symptoms of mental illness.
- Segregated inmates must continue to receive any mental health services that mental health staff determines essential.
- Inmates in current, severe psychiatric crisis, including but not limited to acute psychosis and suicidal depression, should be removed from segregation until they are able to psychologically tolerate segregation.
- Inmates who have been identified as having serious mental health needs, especially those with severe and persistent mental illness, must be assessed regularly by mental health staff to identify and respond to any crises as soon as possible.

Unlike the NCCHC, the APA specifically recommends that mental health staff conduct regularly scheduled rounds in all segregation units and have contact with every inmate. APA also states that mental health staff needs to communicate with security staff to help identify offenders who show signs of decompensation.

Use of Seclusion and Restraints

Both seclusion and mechanical devices that restrain are used at times to protect mentally ill offenders from harming themselves and others. Because of the high potential for misuse of these devices (i.e., to control or punish an inmate rather than as a therapeutic intervention), specific and well-articulated policies and procedures must be in place to govern who can use them and under what conditions. When restraints are used for therapeutic interventions by health and mental health staff, NCCHC standards stipulate certain requirements (Anno, 2000):

- The facility must have written policies and procedures governing their use.
- Only soft restraints may be employed.
- Only a physician or other health provider permitted by law may order restraints or seclusion.
- Health staff may only use restraints or seclusion as part of a treatment regime and not for disciplinary or custody reasons.
- Any single order for restraints or seclusion cannot exceed 12 hours.
- Inmates in restraints or seclusion must be checked at least every 15 minutes.

APA recommends that staff consider that many inmates, especially women, may have suffered from a history of abuse and trauma and may be re-traumatized when secluded and restrained (APA, 2000). They recommend that the treatment team work together with the inmate to use other methods to manage behavior, such as talking the person down and understanding what is really going on.

The new American Correctional Association (ACA) standards for health care (ACA, 2001) also stipulate that correctional institutions have policies and

procedures that address the use of restraints for psychiatric reasons. These policies and procedures must include:

- The conditions under which restraints may be applied;
- The types of restraints allowed;
- The staff qualified to decide when they are to be used because less restrictive measures would not be successful;
- The length of time they can be applied;
- Documentation of efforts for less restrictive alternatives as soon as possible; and
- An after-incident review.

Although ACA guidelines state that all of these issues must be addressed, the specific details are left up to the organization to determine.

6. Suicide Prevention

Perhaps nothing is more tragic and unsettling for prison staff and inmates than the suicide of an inmate. This event can shake an institution and leave anxiety and anger in the minds of both staff and inmates for a considerable length of time. It is important for prison administrators to adopt the most effective standards and procedures to prevent suicides and manage suicidal inmates. Staff must be equipped to identify inmates who are at risk so they can intervene and prevent this tragedy.

Suicide remains a leading cause of death for prison inmates, ranking third among all deaths that occur in prisons (Bureau of Justice Statistics, 1993). *Prison Suicide: An Overview and Guide to Prevention* (NIC, 1995) contains the most current data on prison suicide and its prevention, including a report on a 10-year survey of prison suicides conducted by the National Center on Institutions and Alternatives (NCIA) from 1984 through 1993. Important findings of this survey include the following:

- Suicides in prisons occurred at the rate of 21 per 100,000 inmates per year.
- Suicides in general population occurred at the rate of 12.2 per 100,000 people per year.
- Prison suicide rates gradually and steadily declined throughout the country from 1985 through 1993.

Hayes (NIC, 1995) reviewed local, state, and federal studies on prison suicides and found common characteristics among prison inmates who successfully completed suicides. These risk factors for prison suicides include:

- The presence of significant mental illness.
- A prior history of suicide attempts.
- Having a lengthy sentence (20 years or more).
- Being 31 to 40 years of age (which is older than the age of most jail inmates who successfully complete suicides).
- Having institutional problems (e.g. being in protective custody).
- Being housed in a segregated or isolated housing unit.

- Being male.

One of the most important and consistent findings in suicide prevention research is the strong correlation between segregation and successful suicide.

Overwhelmingly consistent research shows that isolation should be avoided whenever possible. NIC has stated, "Whether its use is disciplinary or observational, isolation can pose a special threat to inmates who have limited abilities to cope with frustration." (NIC 1995, p. 7).

Suicidal Gestures and Manipulations

Prison administrators and correctional staff must differentiate those inmates who are genuinely distressed to the point where suicide has become a legitimate option in their minds from inmates who threaten suicide or make suicidal gestures (e.g., superficial cuts to wrists) to effect some change in their situation.

Regardless of the motivation, it is a serious mistake for prison officials to ignore inmates and their para-suicidal (intentionally self-harmful) behaviors for fear of reinforcing the manipulation. Further, it is even more egregious for inmates to be punished and isolated as a consequence. It is common for inmates who manipulated their situation by these threats or gestures to escalate their behavior in an attempt to achieve their goal and, in so doing, to die either accidentally or by miscalculating how the staff will respond (NIC, 1995).

In the final analysis, all correctional staff shares the responsibility for preventing inmate suicide. The challenge for the correctional administrators is to provide staff the training and resources that put them in the best possible situation to help at-risk and hopeless inmates whenever possible and prevent this type of tragedy from occurring.

National Commission on Correctional Health Care

NCCHC standards (1999) require a written suicide prevention plan. NCCHC also suggests 11 essential components for such a program:

- Identification. Initial screening should include observation and interview data related to an inmate's potential suicide risk.
- Training. All staff should be trained to recognize verbal and behavioral cues that indicate suicide risk.
- Assessment. A qualified mental health professional should designate the inmate's level of suicide risk.
- Monitoring. The facility should develop a procedure for monitoring at-risk inmates that includes regular and documented supervision.
- Housing. Suicidal inmates should not be isolated unless under constant supervision. When constant supervision cannot be maintained, the inmate should be housed with another inmate or in a dormitory and checked every 10-15 minutes.
- Referral. Procedures should be developed for referring inmates who are at risk for suicide or have attempted suicide to mental health staff.

- Communication. Effective communication must take place between correctional and health staff about an inmate's status.
- Intervention. Staff should develop procedures on how to handle a suicide attempt in progress (e.g., first aid measures and how to cut down a hanging inmate.)
- Notification. Procedures for notifying family, prison administrators, and other outside authorities regarding potential, attempted, or completed suicides should be developed.
- Reporting. Staff should document in detail all potential, attempted, or completed suicides.
- Review. The facility should perform administrative and medical reviews of completed suicides.

NCCHC also provides recommendations for the assessment, housing, and observation of suicidal inmates through a level system that allows for a more individualized approach to the problem of suicidal potential and behavior:

- Level 1. Inmates who have recently attempted suicide should be observed continuously in a safe and protected room.
- Level 2. Inmates at high risk for suicide based on current mental status and history should be placed in a safe and protected room and observed every 5-10 minutes.
- Level 3. Inmates at moderate risk (e.g., coming off level 1 or 2) should be observed by staff every 10 minutes when awake and every 30 minutes when asleep.
- Level 4. Inmates who have a significant risk history and could become severely depressed or suicidal should be observed every 30 minutes when awake or asleep.

7. Treating Women Offenders

The characteristics of women offenders differ from those of men. And the number of women in prison is on the rise. Some research indicates that between the years 1984 and 1999, the number of incarcerated women increased by 273 percent (Gilliard and Beck, 1996).

Women offenders are a diverse group. Many represent ethnic minorities, have had significant academic or educational difficulties, are survivors of child maltreatment or domestic violence have histories of substance abuse, and suffer from a sexually transmitted disease or other chronic health condition. Often, their involvement in the justice system exacerbates the difficulties they face due to their traumatic histories. The often punitive culture within the justice system may trigger a reliving of past traumatic events, which may cause them to present with symptoms associated with posttraumatic stress disorder.

Women inmates represent about 10 percent of the total criminal justice population and have higher rates of mental illness than men (Gilliard and Beck, 1996). Women involved in the criminal justice system are more likely than men to enter because of drug-related charges. According to the Bureau of Justice of

Statistics, almost half of the women in prison reported committing their offense under the influence of drugs or alcohol.

Women Offenders with Histories of Victimization

On average, half of women in prison report histories of physical or sexual abuse at some point in their lives (Greenfield and Snell, 1999). Seventy-three percent of those who reported having an emotional condition had been sexually or physically abused. Women who have been abused may have difficulty dealing with restraints, seclusion, and searches, which they may perceive as dangerous or threatening and which may result in retraumatization.

Many women with histories of trauma have been diagnosed with co-occurring mental health and substance abuse disorders. Treatment methodologies must focus on both the residual effects of the trauma and the women's subsequent mental health and substance abuse issues.

Promising Practices for Women Offenders

Due to the prevalence of co-occurring substance abuse and mental health disorders among women victims of violence, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) conducted the Women, Co-Occurring Disorders and Violence Study in partnership with its Center for Mental Health Services, Center for Substance Abuse Treatment, and Center for Substance Abuse Prevention. The study's goal was to identify promising practices for the treatment of women with co-occurring disorders who also have histories of violence. Although the study did not address treatment during incarceration, the attributes of successful treatments that address the specific needs of women with both co-occurring disorders and histories of violence can and should be applied to all systems that provide intervention to women, including the justice system.

The SAMHSA study reported that treatment for women with co-occurring conditions and histories of violence works best when it contains the following four components:

- Focus on each individual woman's strengths. A woman with co-occurring disorders and a history of victimization has within her certain strengths that should be acknowledged and addressed during treatment.
- Acknowledge a woman's role as a parent. Treatment provided to mothers with co-occurring disorders and histories of violence should acknowledge their roles as parents and incorporate maternal themes within individual and group therapies.
- Improve interactions between the parent and child.
- Use a comprehensive approach to coordinate specific types of treatment for the mother and her children. Attention should be paid to mothers' struggles with issues of shame and guilt, which can exacerbate their mental health problems.

Using a Comprehensive Treatment Approach

The SAMHSA study recommends that the following should be considered to provide women with co-occurring disorders and histories of violence the treatment that addresses their unique needs:

- Issues of trauma, mental illness, and substance abuse should be interwoven to better integrate treatment.
- Treatment should be tailored to the developmental needs of each woman and the age of her children.
- Issues relating to historical involvement with other systems should be addressed; for example, custody, previous mental health and substance abuse treatment, and primary health history.

The overarching justification for integrating issues of parenting, mental illness, trauma, substance abuse, and violence into treatment is to improve outcomes for incarcerated women and their children. It is assumed that when mothers' needs are addressed, their children, consequently, will be affected. If the issues of substance abuse, mental illness, co-occurring disorders, trauma and violence, and maternal-child relationships are addressed during incarceration, there may be increased opportunities for women to be successfully integrated into their communities and reunited with their families.

8. Treatment of Special Needs Populations

Several subpopulations within the prison are often referred to as "special populations" because they require a level of care or specialized services not required by other groups. These groups sometimes include adults with serious mental health disorders, as well as offenders with mental retardation, violent offenders, sex offenders and geriatric offenders.

Overcrowding, the lack of privacy, temperature and noise levels, victimization, and other environmental conditions in prisons can easily exacerbate the symptoms of mental illness for some people. In fact, the prison environment itself can contribute to increased suicide and the inability of inmates with serious mental illness to adjust. Environmental factors can also elicit significant adjustment reactions from inmates who may not have had a previous diagnosis but who become ill while incarcerated.

The vulnerability of inmates with mental illness to abuse by other inmates and their tendency to accumulate disciplinary sanctions for disruptive behavior may more often result in placing offenders with mental illness in protective segregation or isolation. Segregated placements address some environmental problems and create others. Administrative segregation, for example, can have substantial psychological consequences for an inmate with depression or schizophrenia (Reid, 2000). Isolation can increase symptoms for many people. Placing inmates in higher security settings may also limit their access to privileges, programs, work release assignments, and early parole (DiCataldo, Greer, and Profit, 1995).

NIC also reports that effectiveness of specialized mental health units for the care of inmates with serious mental illness, and who are unable to cope with participating in daily activities with the general population, but who are not in need of hospital-level care has been demonstrated in numerous prison systems (Wilkinson, 2000).

Specialized mental health units generally reduce the number of institutional crises and management problems and improve the quality of life for impaired inmates. These units have moderate costs, which are more than offset by the decrease in the use of inpatient psychiatric care and improvements in institutional safety and security (Haddad, 1999).

Inmates with Mental Retardation

Individuals with mental retardation have "significantly sub-average intellectual functioning" and other indicators of impaired functioning that occurred prior to the age of 18.

Prison staff may experience challenges with these inmates for a variety of reasons. Inmates with mental retardation may experience one or more of the following:

- Difficulty in comprehending and responding to instructions. This can be counteracted by using clear, simple language and giving the person adequate time to respond.
- Low frustration tolerance. This may lead to excited behaviors or inappropriate verbalizations/speech. Persons who can calmly redirect the individual may need to intervene.
- Impulsivity. Difficulty controlling impulsive behaviors and positive or negative affect may cause the individual to behave impulsively.

When violence occurs, it may be the result of limited communication skills, a sense of being threatened, misinterpreted social cues, or flawed concrete logic (believing that acting in a violent fashion was the only reasonable solution to the situation) (Day and Berney, 2001).

Prison staff must take extra care to make certain that inmates with mental retardation are not ridiculed or preyed on by other offenders. Inmates with mental retardation should be observed frequently so that these issues may be addressed.

Treatment of Older Adults

NIC uses the term "geriatric" for inmates who are 50 years of age or older. This fairly liberal categorization is suggested because of the higher "biological age" of the inmate population due to higher rates of smoking, poor nutrition, lower socioeconomic status, and limited access to prior health care (APA, 2000). The high-risk behaviors inmates commonly engage in have resulted in appraised medical ages 5 to 10 years older than their chronological ages (McVey, 2001).

Longer sentences and increased curtailment of parole have made older offenders the fastest growing population in state prisons (Ortiz, 2000). Older offenders are also the most expensive group to house and maintain, largely due to their physical and mental impairments. Data from several sources suggest that the cost of medical care for elderly prisoners is almost three times the average cost for the general population (Faiver, 1998).

Other important issues in the treatment of older adult inmate populations include their:

- Physical vulnerabilities when housed with aggressive, younger adults.
- Potential lack of connection to other inmates.
- Greater rates of successful suicides.
- Increased risk for death during their tern of incarceration.
- Greater difficulty in adapting to prison (APA, 2000).

All these vulnerabilities can exacerbate underlying psychiatric disorders.

Hopelessness and despair are common as older male and female offenders gradually lose contact with their families and face long prison sentences. Elderly offenders' losses progress slowly over time, contributing to grief. Specially trained staff may be needed in prison settings to identify and treat geriatric health and mental health problems and to prevent suicide attempts. Treatment of both mental health and substance abuse problems must be individualized to meet the needs of these offenders (Maue, 2001).

Because many have aged out of the workforce, this population has special programming needs and significant issues regarding discharge planning, sex-offender counseling, long-term housing, medical costs for chronic conditions and hospice care.

9. Continuity of Care

Ensuring continuity of care for offenders with mental illness is a significant challenge for prison officials. As a rule, community providers and prison officials do not communicate or exchange records when a person enters the prison system or during incarceration. The lack of continuity and communication works considerable hardships on offenders with mental illness. Without good coordination between community and institutional programs, the offender's disorder, anxiety, or both are likely to weaken any gains made earlier in treatment and trigger a relapse (Field, 1998).

Continuity of care is "required for admission to transfer or release from the facility (ACA, 2001). This includes sharing appropriate information between community-based providers and prisons.

One of the most significant issues facing people with serious mental illness when they are released from prison is their ability to continue their psychotropic medication.

Appendix F: Correctional Best Practices

Inmates with Mental Illness
Dr. Arthur Tolan, Non-practicing physician
Marvin D. Fickle, M.D.

Mentally Ill Persons in Prison
According to the US Department of Justice *Mental Health Treatment of Inmates and Prisoners* July 1999 study

1. **Statistics**

   A 1999 US Department of Justice study found:

   - An estimated 16.2% of state prison inmates and probationers are mentally ill.
   - Homeless in the year prior to incarceration in state prison: 20.1% mentally ill vs. 8.8% other
   - Physical or sexual abuse prior to incarceration in state prison: 36.9% mentally ill vs. 15.2% other
   - History of alcohol dependence prior to incarceration in state prison: 34.4% mentally ill vs. 22.4% other
   - Sentences for all offenses in state prison: 171 months mentally ill vs. 159 months other

   Oregon Department of Corrections

   From 1998 through July 2002, DOC had over 11% of population with severe and persistently mentally illness. (Numbers show an increase.)

   As of July 2004 DOC had:

   - 28.8 % of total inmate population = A-1 & A1-R
   - 11.6% of total inmate population = A-2 & A-3 (Severe and persistent group)
   - 23.2% of total inmate population on meds (R,2,3)

2. **Oregon Statutes (1999)**

   - 161.365 Procedure for determining issue of fitness to proceed.
     1. Whenever the court has reason to doubt the defendant's fitness to proceed by reason of incapacity as defined in ORS 161.360, the court may call to its assistance in reaching its decision any witness and may appoint a psychiatrist or psychologist to examine the defendant and advise the court.
     2. If the court determines the assistance of a psychiatrist or psychologist would be helpful, the court may order the defendant to be committed to a state mental hospital designated by the Mental Health and Developmental Disability Services Division for the purpose of an examination for a period not exceeding 30 days.

- 161.370 Determination of fitness; effect of finding of unfitness; proceedings if fitness regained; pretrial objections by defense counsel.
    1. When the defendant's fitness to proceed is drawn in question, the issue shall be determined by the court. If neither the prosecuting attorney nor counsel for the defendant contests the finding of the report filed by a psychiatrist or psychologist under ORS 161.365, the court may make the determination on the basis of such report. If the finding is contested, the court shall hold a hearing on the issue. If the report is received in evidence upon such hearing, the party who contests the finding thereof shall have the right to summon and to cross-examine any psychiatrist or psychologist who submitted the report and to offer evidence upon the issue. Other evidence regarding the defendant's fitness to proceed may be introduced by either party.
    2. If the court determines that the defendant lacks fitness to proceed, the proceeding against the defendant shall be suspended, except as provided in subsection (13) of this section, and the court shall commit the defendant to the custody of the superintendent of a state mental hospital or other treatment facility designated by the Mental Health and Developmental Disability Services Division or shall release the defendant on supervision for so long as such unfitness shall endure.
- 161.295 Effect of mental disease or defect; guilty except for insanity.
    1. A person is guilty except for insanity if, as a result of mental disease or defect at the time of engaging in criminal conduct, the person lacks substantial capacity either to appreciate the criminality of the conduct or to conform the conduct to the requirements of law.
    2. As used in chapter 743, Oregon Laws 1971, the terms "mental disease or defect" do not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct, nor do they include any abnormality constituting solely a personality disorder. [1971 c.743 s.36; 1983 c.800 s.1]

3. Criminal Justice/Mental Health Consensus Project - Findings & Best Practices

- **Receiving and Intake of Sentenced Inmates**

    1. Incorporate screening for mental illness and referral to mental health services into the existing receiving / admission protocol by integrating into the process a screening instrument along with observations by those charged with booking newly received inmates into the receiving / admission process.
    2. Ensure consistency of screening protocols within correctional system by using the same screening instrument at all facilities statewide and training facility staff in their use.
    3. Develop a system of triage to ensure that follow-up responses to the screening results reflect the immediacy of the inmate's needs.
    4. Evaluate periodically the effectiveness of the screening instrument employed, as well as the mental health assessment and mental health evaluation protocols.

5. Conduct a comprehensive mental health evaluation of every inmate flagged as having significant mental health issues during the professional mental health assessment process.

- **Development of Treatment Plans, Assignment to Programs, and Classification/Housing Decisions**

1. Include the most appropriate psychotherapeutic medications in prison and county correctional institution formularies.
2. Develop and adopt jointly standardized clinical decision protocols (i.e., Algorithms) that are based upon research conducted on a national level.
3. Require, at a minimum, that (1) mental health-specific case management services and (2) effective, research-based behavioral and counseling interventions accompany the use of medication.
4. Develop and provide programs for inmates with co-occurring disorders.
5. Facilitate access to professional psychiatric services by using telepsychiatry in systems where inmates are distributed across a large geographical area or in locations where there is a shortage of psychiatric service providers.
6. Review mental health services provided to ensure that they are evidenced-based.
7. Ensure the cultural competency of all programs for inmates with mental illness.
8. Provide mental health treatment and services that are gender-specific.
9. Recognize the distinct programming needs of special populations with mental illness, such as the elderly, the developmentally disabled, those with chronic medical problems, substance abusers, and sex offenders.
10. Develop graduated housing options for inmates with mental illness that ensure the safety of staff and inmates and prepare inmates, when appropriate, for transition from specialized housing to general population units.
11. Provide disciplinary hearing officers with the proper orientation and training to make informed decisions about offenders with mental illness.
12. Ensure continuity of services when inmates are transferred to a different facility.
13. Require appropriate staff to review mental health information received with the transferred inmate and to respond accordingly.
14. Identify appropriate technology and protocols for the development of an electronic patient records system.

- **Subsequent Referral for Screening and Mental Health Evaluations**

1. Reassesses periodically the mental health status of inmates who are at the highest risk of showing signs of mental illness.
2. Conduct brief mental health assessments upon request of an inmate or by referral from any staff person.
3. Minimize the stigma that staff and inmates may harbor regarding mental illness.

- **Release Decision**

    1. Develop guidelines regarding release decisions that address issues unique to inmates with mental illness, and consult with mental health professionals during the decision-making process.
    2. Develop protocols to share information and resources among parole agencies, departments of corrections, and mental health organizations.
    3. Establish special conditions of release that are realistic, relevant, and research-based to address the risks and needs of parolees with mental illness.
    4. Ensure that the releasing authority can identify and obtain access to community-based programs and resources adequate to support the treatment and successful community reintegration of parolees with mental illness and that such programs and resources are available in the communities to which parolees return.
    5. Train parole board members to increase their knowledge of the risks/needs of persons with mental illness and factors that mitigate that risk so release decisions and special conditions can be determined appropriately.

- **Development of Transition Plan**

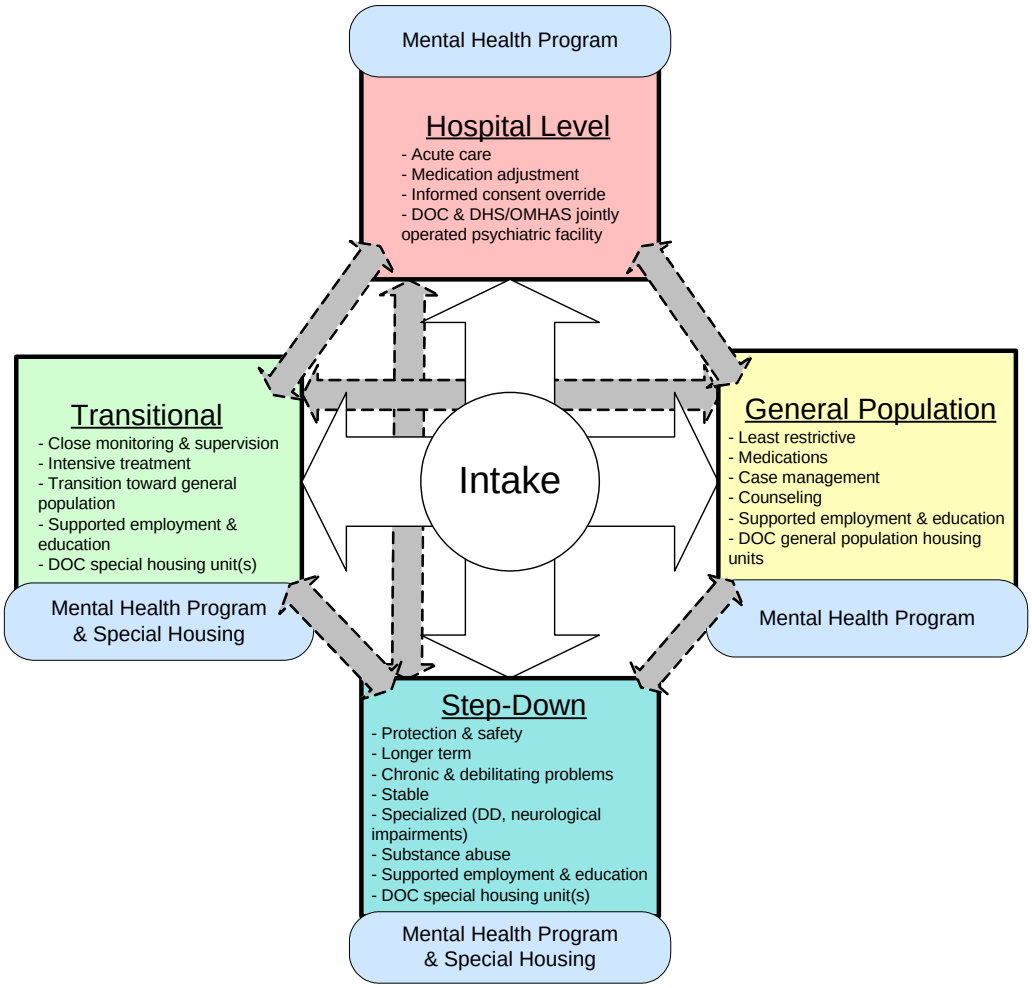
    1. Identify transition planners in each institution and charge them with coordinating a case management process, which incorporates representatives of institutional corrections, community corrections, social service agencies, and community-based mental health providers.
    2. Involve all relevant agents and individuals who will assist in carrying out the transition plan, including family members, in its development.
    3. Take steps to ensure that the inmate's release from secure housing to the community progresses in a gradual sequence of planned steps.
    4. Develop a transition plan that includes the inmate's assignment to a community-based provider whose resources and assets are consistent with the needs and strengths of the inmate.
    5. Integrate housing support services into the transition plan and provide releasees with mental illness an arrangement for safe housing or at a minimum, shelter.
    6. Make arrangements for at least a week's supply of important medications, along with refillable prescriptions, to be provided to inmates at the point of release.
    7. Develop a process to ensure that inmates eligible for public benefits receive them immediately upon their release.
    8. Notify the victim before the offender is released from prison, consistent with the requirements of the state's law or constitution, prior to release.
    9. Monitor the inmate closely in the days approaching release and modify the discharge plan when appropriate.
    10. Provide enhanced discharge planning, including extensive coordination with the community treatment provider, to ensure continued case management for inmates with mental illness who will complete their sentence in prison.

Appendix G: Proposed Mental Health Service Delivery Model

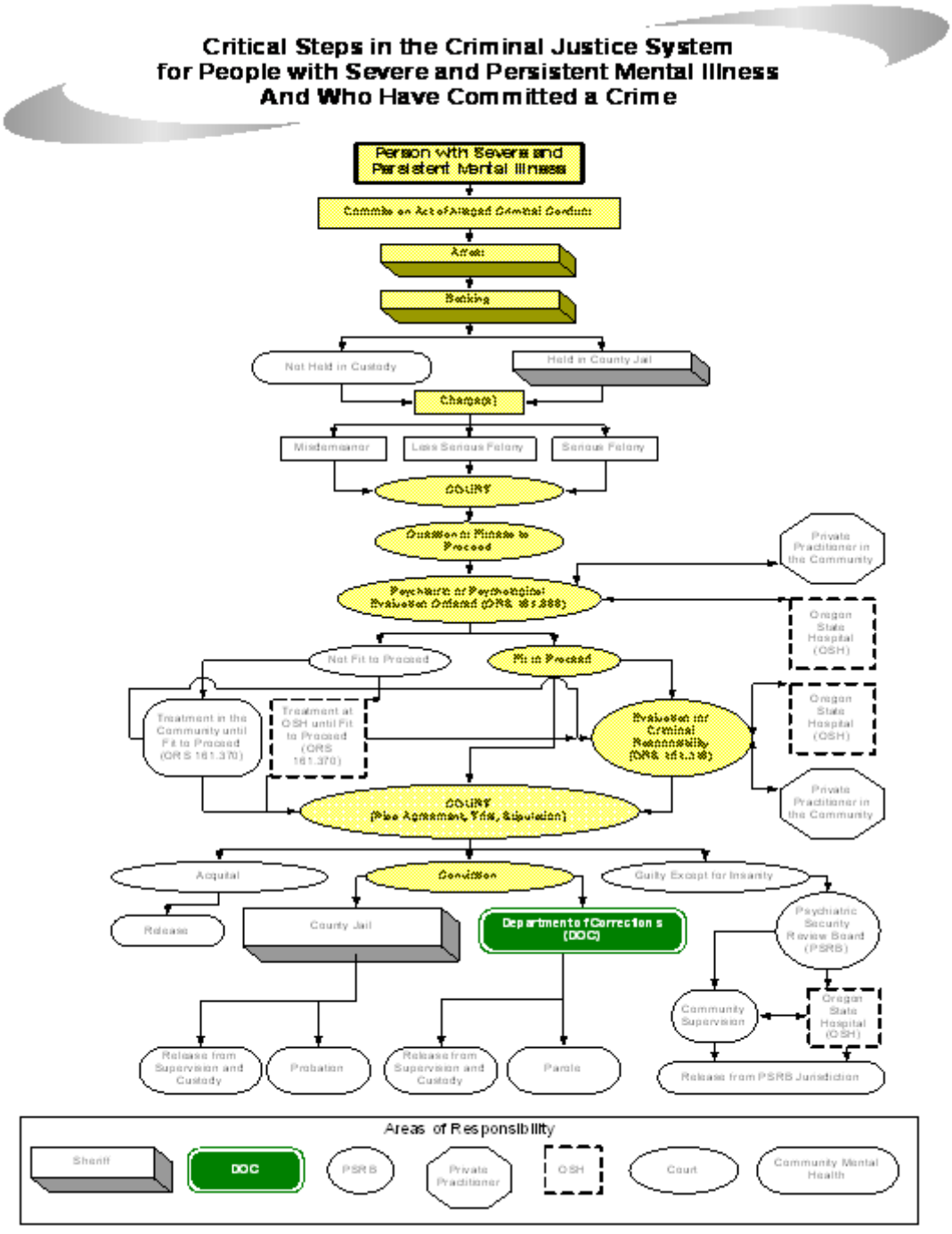
Managing Mental Illness in Prison Task Force

Recommendation for Improved Mental Health Care

And Behavioral Management of Inmates with Mental Illness



Appendix H: Criminal Justice System and Persons with Mental Illness



Narrative – Criminal Justice System and the Mentally Ill:

The flowchart, shown on the previous page, was developed by the Workgroup on Criminal Justice Issues from the Governor's Mental Health Task Force, maps the pathways that can be taken by a person with a mental illness who is accused of committing a crime in Oregon.

The first determination that must be made in such cases is whether the person is able to cooperate with counsel. If not fit to cooperate with counsel, the person is committed to community mental health treatment or secure treatment at the state hospital. Once able to proceed, the court must determine whether the person is guilty of the alleged crime and, if guilty, whether the person was responsible at the time of the crime.

If a person with a mental illness is guilty of a crime and responsible, the sanction is probation, a county jail sentence, or a prison sentence. Severity of the crime, history of any other criminal conduct, and sentencing guidelines determine the sentence.

If a person with a mental illness is found guilty of a crime but as the result of mental disease or defect lacks substantial capacity either to appreciate the criminality of the conduct or to conform the conduct to the requirements of the law, the legal outcome is guilty except for insanity. The person then is placed under the jurisdiction of the Psychiatric Security Review Board (PSRB). The PSRB can place the person in a supervised community setting or in the state hospital. The criteria for placement include seriousness of the crime, past history of criminal conduct, and mental health status.

The main criterion for releasing persons with mental illnesses from secure settings (jail, prison, or state hospital) is public safety. Before release, that fundamental criterion must be satisfied or the person must have served the limit of required time. There is an additional criterion for persons committed to the state hospital, namely, the person's mental illness must be in satisfactory clinical remission. If a person's full sentence has not been completed at release, that person in the community remains under the supervision of the Board of Parole and Post-Prison Supervision or the PSRB.

These different pathways for persons who have a mental illness and are accused of a crime can be seen in the accompanying flowchart. Public safety is the primary purpose of the systems described here. The availability of mental health services for these individuals while incarcerated or in the community varies significantly from setting to setting.

Appendix I: Bazelon Center for Mental Health Law – *Building Bridges*

Building Bridges: An Act to Reduce Recidivism by Improving Access to Benefits for Individuals with Psychiatric Disabilities upon Release from Incarceration

For additional information, see www.bazelon.org.

As the number of people with psychiatric disabilities in jails and prisons continues to rise, prison officials, state lawmakers and mental health advocates have become increasingly concerned about the effect of this trend on inmates, staff and state budgets. *Building Bridges* offers states a strategy to reduce recidivism and help recently released inmates with psychiatric disabilities successfully transition to community life.

Section-by-Section Summary

Article I
Sets out findings and explains the purposes of the bill. When released from jail or prison, individuals with psychiatric disabilities often lack access to critical services and supports such as health and mental health care, housing, education and employment or income support. As a result, many become trapped in a cycle of destitution, deterioration, rearrest and re-incarceration. Although federal entitlement programs offer income support and health care coverage, individuals released from incarceration seldom have timely access to these benefits. The Act directs state and local agencies to adopt policies and procedures that enable individuals with psychiatric disabilities, upon release, to be enrolled or reinstated in these programs, receive needed services speedily and establish connections to the community-based mental health system prior to release. By thus promoting the successful community re-entry of inmates with psychiatric disabilities, the Act will enhance public safety and offer taxpayers relief from the fiscal burdens imposed by avoidable recidivism.

Article II
Defines terms used in the bill.

Article III
Establishes state policy to facilitate suspension, rather than termination, of federal benefits when an individual with psychiatric disabilities is incarcerated and to enable speedy restoration of benefits upon the individual's release.

Article IV
Establishes state policy to assist inmates with psychiatric disabilities who are not on eligibility rolls for federal entitlements in applying, while incarcerated, to receive benefits upon release. Requires the Medicaid agency to set up procedures for receiving Medicaid applications and reviewing them within 14 days and enrolling eligible individuals on suspended status while incarcerated. Mandates that correctional agencies identify inmates who are likely to be eligible for Medicaid and/or disability benefits, ask them if they wish to apply and ensure that applications are filed well in advance of their release.

Article V
Requires correctional agencies to negotiate Pre-Release Agreements with the Social

Security Administration and to arrange for competent and experienced staff to assist inmates with psychiatric disabilities in applying for federal disability benefits prior to their release.

Article VI
Creates a bridge program for released inmates whose applications for federal benefits are pending. Requires the state Medicaid agency to provide a temporary Medicaid card and cover services for up to six (6) months or until an individual is determined ineligible. Designates a state agency to provide temporary income support for up to six (6) months to individuals with psychiatric disabilities who have applied for but are not receiving SSI or SSDI upon release. Provides for the state to claim federal reimbursement of benefits provided to the individual and prohibits the recovery of any costs from an individual who is found ineligible for federal entitlements.

Article VII
Requires correctional agencies to arrange for the issue of a photo identification card that does not disclose the individual's incarceration.

Article VIII
Requires access to medically necessary mental health services for inmates both while incarcerated and upon release. Assigns this responsibility to the state corrections agency for individuals in prison who have psychiatric disabilities, to the state juvenile corrections agency for individuals in juvenile corrections facilities, and to the state mental health agency for inmates in jails or juvenile detention facilities. Mandates the provision of an adequate temporary supply of medication upon an inmate's release and requires the state mental health agency to provide case management services well in advance of an inmate's release to help arrange for shelter, services and supports and assist with benefit applications.

Article IX
Requires the state Medicaid agency to seek federal approval of amendments to the state Medicaid plan that may be necessary to implement this legislation.

Article X
Appropriates funding to implement the Act.

Article XI
Sets dates when the various articles will take effect.

Bazelon Center for Mental Health - Model Law

Article I: Findings and Purpose

A. Findings

The Legislature finds and declares that:

1. When released from incarceration, adults and juveniles with psychiatric disabilities often lack access to mental health services, stable housing, employment or other income and education. Obtaining food and other necessities can be a problem. Without basic supports, many needlessly become trapped in a cycle of destitution, deterioration, re-arrest and re-incarceration.

2. Upon release, individuals with psychiatric disabilities need basic services and supports to enable them to transition successfully to community life. Existing federal programs, such as Medicaid, Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI), provide health care coverage and income support to people with psychiatric disabilities. Often, however, individuals released from incarceration are not enrolled in these programs or their enrollment is unreasonably delayed.

3. Legislative action is required to aid individuals with psychiatric disabilities in maintaining their eligibility for federal benefit programs during incarceration and, upon release, to enable them to access federal benefit programs for which they are eligible and temporary health care coverage and income when federal benefits are not immediately available.

4. Legislative action is also required to ensure that, upon release, individuals with psychiatric disabilities are connected to the community-based mental health system.

5. Providing access to mental health care and income support for individuals with psychiatric disabilities upon their release will promote successful community re-entry, enhance public safety and provide relief to taxpayers from fiscal burdens imposed by avoidable recidivism.

B. Purpose

The purpose of this Act is to facilitate the community reintegration of adults and juveniles with psychiatric disabilities upon release from jail, prison, detention centers or other correctional facilities and to enhance public safety and provide cost-effective care by enabling such individuals to receive benefits speedily upon their release from incarceration. It directs [identify state and local agencies] to adopt policies and procedures that enable individuals with psychiatric disabilities, upon release from incarceration, to:

1. Participate in federal benefit programs for which they qualify;

2. Be speedily reinstated or enrolled in federal health insurance and income support programs for which they are eligible;

3. Obtain temporary health care coverage and income support while receipt of federal benefits is pending; and

4. Receive mental health services, including case management, medications and substance abuse services.

This Act also provides funds for costs associated with its implementation.

Article II: Definitions

1. “Case management” means [see state law and policy]

2. “Correctional agency” means an agency of state or local government responsible for overseeing the operation of one or more correctional institutions, including juvenile justice facilities.

3. “Correctional institution” means a jail, prison, juvenile corrections facility, juvenile detention facility or other detention facility operated by a state or local correctional agency that qualifies as a public institution under 42 Code of Federal Regulations (C.F.R.) § 435.1009.

4. “Enrolled in the SSI program” means (a) currently eligible, as determined by the Social Security Administration pursuant to SSI program rules and (b) on eligibility rolls, even if cash benefits are currently suspended.

5. “Enrolled in the SSDI program” means (a) currently eligible, as determined by the Social Security Administration pursuant to SSDI program rules and (b) on eligibility rolls, even if cash benefits are currently suspended.

6. “Federal benefit programs” refers to Medicaid, Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI).

7. “Incarcerated” means confined in a correctional institution.

8. “Individuals with psychiatric disabilities” includes (a) adults with serious mental illnesses, as defined in [state law or policy], and (b) juveniles with emotional/behavioral disturbances or emotional disorders, as defined in [state law or policy].

9. “Inmates” refers to incarcerated individuals with psychiatric disabilities.

10. “Likely to be eligible” individuals means individuals with psychiatric disabilities (a) whose enrollment in the Medicaid, SSI or SSDI program was terminated during their incarceration; (b) who were enrolled in the Medicaid, SSI or SSDI program at any time during the five years prior to their incarceration; or (c) who were not previously enrolled, but who are likely to meet eligibility criteria for the Medicaid, SSI, or SSDI programs upon their release from incarceration.

11. “Medicaid eligibility category” refers to all existing eligibility categories established in the state Medicaid plan

12. “Medicaid eligibility through SSI” means that an individual is eligible to participate in the Medicaid program by virtue of enrollment in the SSI program.

13. “Mental health services” means [see state law and policy]. It includes substance abuse services.

14. “Parent” means a parent, guardian or individual acting in the role of parent (e.g., grandparent raising a child).

15. “Pre-Release Agreement” means a formal agreement with the Social Security Administration (SSA) under which a correctional agency and SSA will work collaboratively to ensure that applications for SSI and SSDI by inmates are speedily handled by SSA.

16. “SSI” means the Supplemental Security Income program, a federal income support program for people with disabilities and low incomes, provided under Title XVI of the Social Security Act.

17. “SSDI” means the Social Security Disability Income program, a federal income support program, provided under Title II of the Social Security Act, for individuals with disabilities who have worked and paid Social Security taxes.

18. “Suspend” Medicaid coverage means to place an individual’s Medicaid eligibility in an inactive status such that (a) the individual remains eligible for Medicaid and continues on the state rolls but (b) Medicaid benefits are not payable for services furnished (e.g., during incarceration).

19. “Suspend” SSI or SSDI eligibility means to stop cash payments due to incarceration.

Article III: Suspension of Eligibility Upon Incarceration and Restoration Upon Release

A. State Policy
It shall be the policy of [State] to facilitate, to the full extent permitted by federal law:

1. The suspension rather than termination of federal benefits when an individual with psychiatric disabilities is incarcerated, and

2. Speedy restoration of benefits upon the individual’s release.

B. Medicaid
The [Medicaid agency] shall adopt regulations or policies ensuring that:

1. When an individual with psychiatric disabilities enrolled in the Medicaid program is incarcerated,

a. The individual’s eligibility for Medicaid will be suspended rather than terminated, and will remain suspended rather than terminated for as long as is permitted by federal law; and

b. The individual shall not be terminated from the Medicaid program unless [Medicaid agency] determines that the individual (i) no longer meets the Medicaid eligibility criteria under which they had qualified and (ii) is not eligible for Medicaid under any other Medicaid eligibility category.

2. When an individual whose Medicaid eligibility is suspended is released from incarceration, the individual’s Medicaid eligibility will be fully restored on the day of release unless and until the [Medicaid agency] determines that the individual is no longer eligible for Medicaid.

C. Federal Disability Benefits
[Correctional agencies] shall seek to ensure the speedy restoration of benefits of inmates with psychiatric disabilities whose eligibility for SSI or SSDI has been suspended during incarceration. These agencies shall seek to ensure that cash benefits under SSI and SSDI are reinstated in the month of release. To this end, these agencies shall:

1. Identify inmates with psychiatric disabilities whose SSI or SSDI was suspended during incarceration, and ask them if they wish to receive benefits when released, and

2. For those who wish to receive benefits, ensure that (i) applications for reinstatement of SSI or SSDI upon release are filed on their behalf as soon as possible following suspension, and (ii) all applicants for reinstatement leave the correctional institution with a copy of the application.

Article IV: Applications for Inmates with Psychiatric Disabilities Terminated from or Not Enrolled in Federal Benefit Programs

A. State Policy
It shall be the policy of [State] to assist inmates with psychiatric disabilities whose eligibility for SSI, SSDI or Medicaid benefits was terminated while incarcerated or who were not receiving benefits at the time they were incarcerated to apply, while incarcerated, to receive benefits upon release.

B. Medicaid

1. The [Medicaid agency] shall:

a. Establish procedures for receiving Medicaid applications on behalf of incarcerated individuals with psychiatric disabilities in anticipation of their release.

b. Expeditiously review such applications and, to the extent practicable, complete its review before the individual is released. All reviews shall be completed within fourteen (14) days of the application's receipt.

2. The review process shall assess whether the individual is presently eligible to be enrolled in the Medicaid program or is likely to be Medicaid eligible upon release.

a. If the individual is eligible to be enrolled while incarcerated, the individual will be enrolled but placed on suspended status. The individual will be provided a Medicaid card, entitling the individual to receive benefits effective upon his or her release.

b. If the individual is not eligible to be enrolled in Medicaid while incarcerated but is likely to be eligible for Medicaid upon release, the individual will be enrolled in the temporary Medicaid eligibility program described in Article VI. B., but on suspended status pending release. The individual will be provided a Medicaid card, entitling the individual to receive benefits under the temporary Medicaid eligibility program effective upon his or her release.

3. To facilitate enrollment in Medicaid, [correctional agencies] shall:

a. Identify inmates with psychiatric disabilities who are likely to be eligible for Medicaid while incarcerated or upon release, and ask them if they wish to receive benefits when released, and

b. For those who wish to receive benefits, ensure that (i) applications for Medicaid are filed, to the extent practicable, well in advance of release and, if possible, at least ninety (90) days before release, and (ii) all applicants for these benefits leave the correctional institution with a copy of the application.

C. Disability Benefits
[Correctional agencies] shall seek to ensure that inmates with psychiatric disabilities begin to receive SSI and SSDI cash benefits for which they are eligible in the month following release. To this end, these agencies shall:

1. Identify inmates with psychiatric disabilities who are likely to be eligible for SSI or SSDI upon release and ask them if they wish to receive benefits when released, and

2. For those who wish to receive benefits, ensure that applications are filed on their behalf prior to release and, to the extent practicable, at least ninety (90) days before release, and that they leave jail or prison with a copy of the application.

Article V: Facilitating Applications for Benefits

A. State Policy
It shall be the policy of [State] for correctional agencies to enter into Pre-Release Agreements with the Social Security Administration and to otherwise facilitate participation by inmates with psychiatric disabilities in federal benefit programs upon their release from incarceration

B. Negotiating Pre-Release Agreements with Social Security Administration

1. [Correctional agencies] shall use their best efforts to negotiate Pre-Release Agreements with the Social Security Administration that will ensure:

a. Speedy consideration by the Social Security Administration of new applications for and applications for reinstatement of SSI or SSDI on behalf of individuals with psychiatric disabilities, and that

b. The Social Security Administration is informed of the expected and actual release dates of individuals with psychiatric disabilities whose applications have been approved or are pending.

2. Once negotiated, each agreement shall be implemented as soon as practicable.

C. Application Assistance

1. Competent staff familiar with the characteristics of successful SSI, SSDI and Medicaid applications shall ensure that proper applications are filed and updated as needed. These staff will, among other things:

a. With applicants' assistance, complete required forms for applicants with psychiatric disabilities;

b. With applicants' consent, secure medical and other information required to support applications; and

c. Submit applications to the appropriate agency office.

These staff may be provided through contracts with local mental health agencies or providers.

2. With the applicant's permission, a copy of each application shall be provided to a family member designated by the applicant and to any mental health case manager who will work with the individual upon release. Permission to provide a copy to a parent is not required in the case of minors under the age of 16.

Article VI: Bridge Programs

A. State Policy
It shall be the policy of [State] to offer individuals with psychiatric disabilities temporary

Medicaid eligibility and temporary income support when released from incarceration while their applications for federal benefits are pending.
[Medicaid agency] will administer the temporary Medicaid eligibility program, and [state agency] will administer the temporary income support program.

B. Temporary Medicaid Card

1. An individual with psychiatric disabilities shall be qualified to receive a temporary Medicaid card upon release from incarceration if:

a. The individual is not receiving Medicaid-funded services;

b. The individual is likely to be eligible for Medicaid; and

c. An application for SSI or Medicaid was filed on his or her behalf while the individual was incarcerated or within three (3) months after the individual's release.

2. An individual with a psychiatric disability may apply for a temporary Medicaid card while incarcerated or within three (3) months after release. Application may be made by submission to the [Medicaid agency] of an application for Medicaid, a copy of an application for SSI submitted on the individual's behalf or other documentation deemed suitable by the [Medicaid agency].

3. Within fourteen (14) days of submission of the application, the [Medicaid agency] will determine whether the individual is qualified to receive a temporary Medicaid card and, if so, will immediately issue a temporary Medicaid card to the individual. If the individual is incarcerated, the card will entitle the individual to receive benefits under the temporary Medicaid program effective upon his or her release. If the individual has already been released, the card will be effective immediately.

4. If found qualified for a temporary Medicaid card, the individual is entitled to receive covered Medicaid services from certified Medicaid providers for a period of six (6) months. For individuals found qualified while incarcerated, the six (6) months begins upon release. For individuals found qualified after release, the six (6) months begins on the date of that determination. The six (6) month term may be renewed at the option of the [Medicaid agency].

5. A temporary Medicaid card shall be void if, prior to the end of a six (6) month term, it is determined that:

a. The individual is not eligible for the SSI program, and

b. The individual is not eligible for Medicaid under any other Medicaid eligibility category.

6. To the extent permitted by federal law, the state may claim reimbursement under the Medicaid program for payments made for care provided to an individual to whom a temporary Medicaid card has been issued. The state may not recoup any costs from the individual, including if the individual is found ineligible for Medicaid.

C. Temporary Income Support

1. An individual with a psychiatric disability shall be qualified for temporary income support upon release from incarceration if:

a. The individual is not receiving SSI or SSDI;

b. The individual is likely to be eligible for SSI or SSDI, and

c. An application for SSI or SSDI was filed on his or her behalf while the individual was incarcerated or within three (3) months after the individual's release.

2. An individual with a psychiatric disability may apply for temporary income support while incarcerated or within three (3) months after release. Application may be made by submitting to the [responsible agency] a copy of an application for SSI or SSDI benefits, or other documentation deemed suitable by the [responsible agency]. Within fourteen (14) days of submission of the application, the [responsible agency] will determine whether the individual is qualified to receive temporary income support.

3. Temporary income support shall be paid monthly in an amount equal to the [basic SSI payment in the state]. Payments will be made for a period of six (6) months. For individuals found qualified while incarcerated, the six (6) months begins upon release. For individuals found qualified after release, the six (6) months begins on the date of that determination. The six (6) month term may be renewed at the option of the [responsible agency]. Payments may be terminated before the end of a six (6) month term if the Social Security Administration makes a final determination that the individual is not eligible to receive the federal benefits for which the individual applied.

4. To the extent permitted by federal law, the state may recoup the temporary income support from SSI or SSDI back benefits issued by the Social Security Administration. The state may not otherwise recoup any payments of temporary income support from the individual, including if the individual is found ineligible for SSI or SSDI.

Article VII: Photo Identification

[Correctional agencies] shall arrange for adults and emancipated youth with psychiatric disabilities to have photo identification when they are released from incarceration. [Correctional agencies] will ensure that inmates who lack photo identification are issued a photo identification card before or immediately upon release. The photo identification card will not disclose the individual's incarceration or criminal record. It will list an address other than a correctional facility

Article VIII: Access to Services

A. State Policy
It is [State's] policy that inmates have access to mental health services while incarcerated and upon release, as provided below.

1. For individuals in prison who have psychiatric disabilities, the [state corrections agency] shall be responsible for the provision of mental health services.

2. For individuals in juvenile corrections facilities who have psychiatric disabilities, the [state juvenile corrections agency] shall be responsible for the provision of mental health services.

3. For individuals in jail or juvenile detention facilities who have psychiatric disabilities, the [state mental health agency] shall be responsible for the provision of mental health services.

4. The [state mental health agency] shall be responsible for the provision of the case management services described in (C.) below.

These agencies may arrange for services to be provided through contracts with community mental health agencies or community mental health providers.

B. Mental Health Services

1. While incarcerated, individuals with psychiatric disabilities shall have access to medically necessary mental health services, including substance abuse and crisis services.

2. At the time of their release, individuals with psychiatric disabilities shall be provided a fourteen (14) day supply of the psychiatric medications they were taking prior to release.

3. Individuals with psychiatric disabilities shall be given access upon release to Medicaid-covered services as provided in Articles III, IV and VI.

C. Case Management Services

1. To aid their transition to community living, the [state mental health agency] shall provide to incarcerated individuals with psychiatric disabilities case management services well in advance of their release, to the extent practicable, and if possible, at least ninety (90) days before release.

2. The case manager shall work with the individual to identify services and supports that the individual desires and needs upon return to community living. As desired by the individual, the case manager will:

a. Help arrange for needed shelter, mental health services including substance abuse services and other supports to be provided to the individual upon release; and

b. Help the individual access federal benefit programs upon release, including, as needed, by updating benefit applications.

Article IX: State Medicaid Plan

If implementation of any regulation or policy anticipated by this Act requires an amendment to the state Medicaid plan, the [Medicaid agency] shall use its best efforts to obtain federal approval of the amendment.

Article X: Funding

A total of $_____ is appropriated for implementation of this Act, as follows:

1. $_____ to [Medicaid agency] for implementation of Articles III, IV and VI;

2. $_____ to [corrections agencies] for implementation of Articles III, IV, V, VII and VIII;

3. $_____ to [responsible state agency] for implementation of Article VI.C; and

4. $_____ to [state mental health agency] for implementation of Article VIII.

Article XI: Effective Dates

1. Articles III, IV and VII become effective _____ days after enactment. The [Medicaid agency] will adopt the policies and procedures required by Articles III and IV within _____ days after

enactment. These deadlines shall be extended as needed pending federal approval of any necessary amendment to [state's] Medicaid plan.

2. Correctional agencies] will use their best efforts to conclude negotiations with the Social Security Administration, pursuant to Article V, within _____ days after enactment.

3. The temporary health insurance and income support programs described in Article VI will be implemented within _____days after enactment.

4. Article VIII will be implemented within _____ days after enactment.