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THE INTERFACE OF MENTAL HEALTH AND THE REALITIES OF THE CORRECTIONAL SYSTEM

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There is little argument that our nation's prison system has a disproportionately high rate of offenders who are diagnosed with mental illness.¹ The estimates for the rate of offenders in United States prison systems with mental illness ranges from 15% to 20%,² but can be as

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1. Etienne Benson, *Rehabilitate or Punish?*, MONITOR ON PSYCHOL., July/Aug. 2003, at 46, 46-47, available at <http://www.apa.org/monitor/julaug03/rehab.aspx>.

2. *Id.*

high as between 16% and 56% in some states.³ To illustrate these conservative percentages, if a prison had a total offender population of 40,000, between 6,000 and 8,000 of those offenders would suffer from mental illness, and that range is a more conservative estimate.⁴ With such large numbers of offenders suffering from mental illness, which is defined by the National Alliance on Mental Illness as medical conditions that disrupt a person's thinking, feeling, mood, ability to relate to others, and daily functioning,⁵ the prison system is being forced to alter its primary mission as a punitive setting. Such prison reforms occur within the larger context of the judicial system's movement toward restorative justice, which includes the creation of specialized drug courts and mental health courts with alternative sentencing options to better promote behavioral change in offenders.⁶ These judicial system reforms, although not available in many communities, have laid the groundwork for a changed attitude toward mental health reforms in prison. Restorative justice has increased attention to new paradigms for considering social, addiction, and mental health factors in how society structures the criminal justice system.⁷

Because of the large number of mentally ill offenders and the constitutionally mandated requirement to provide treatment for their mental illnesses, the prison system must accommodate various therapeutic philosophies and settings, such as behavioral modification units, subacute units, residential treatment units, and crisis care units.⁸ This is further complicated as the field of mental health has begun defining subsets of the mentally ill population and creating terminology such as Serious and Persistent Mental Illness (SPMI) and Seriously Mentally Ill (SMI).⁹ With no universally accepted definition of these subsets, the prison system is placed in an uncomfortable and unwelcome state of confusion. Most prison systems have adopted clear black and white concepts: "A always equals B; B always requires C." However, it is imperative that prisons adopt an integrated-sys-

3. Christine M. Sarteschi, *Mentally Ill Offenders Involved with the U.S. Criminal Justice System: A Synthesis*, SAGE OPEN, July–Sept. 2013, at 1, 1.

4. See Benson, *supra* note 1, at 46–47.

5. *Mental Health Conditions*, NAT'L ALLIANCE ON MENTAL ILLNESS, <http://www.nami.org/Learn-More/Mental-Health-Conditions> (last visited Mar. 14, 2015).

6. Mark A. Small & Robin Kimbrough-Melton, Essay, *Rethinking Justice*, 20 BEHAV. SCI. & L. 309, 309–14 (2002).

7. *Id.* at 309.

8. U.S. CONST. amend. VIII; *Brown v. Plata*, 131 S. Ct. 1910, 1928 (2011); *Estelle v. Gamble*, 429 U.S. 97, 103 (1976).

9. See generally MINDY J. VANDERLOO & ROBERT P. BUTTERS, TREATING OFFENDERS WITH MENTAL ILLNESS: A REVIEW OF THE LITERATURE 2–5 (2012), available at <http://ucjc.utah.edu/wp-content/uploads/MIO-butters-6-30-12-FINAL.pdf>.

tems approach marked by subjectivity and flexibility to effectively and safely manage mentally ill offenders due to the inherent complexity of their adaptive functioning deficits.

Despite the lack of a universal definition or agreement on terminology for the subset of mentally ill inmates, several states, such as Indiana, Oklahoma, and Massachusetts, have some shared agreement on which disorders make up SPMI/SMI, including psychotic disorders, delusional disorders, mood disorders, and anxiety disorders.¹⁰ Still, there are differing opinions as to whether personality-disordered individuals should be included in this designation. For the purpose of our discussion here, let us include personality disorders and use the term SMI because it better illustrates the need to alter the approach used by the prison system for these individuals. As is the case in most state-operated departments of corrections, the programmatic budget—which not only includes medical and mental health services, but also educational and vocational services—has been scaled back to accommodate overall fiscal realities of the state. What has not decreased is the number of individuals entering the prison system. Statistical data collected between 2000 and 2005 indicate that among state and federal correctional facilities, the offender population increased by 10%.¹¹ That 10% translates to approximately 63,000 more offenders in state and federal systems compared to the 2000 census data on correctional facilities.¹² If we assume conservatively that 15% to 20% of offenders would be mentally ill, then 9,450 to 12,600 of those individuals entering the system were mentally ill.¹³ While the percentage of the mentally ill population that will be designated SMI can vary, there is some indication that between 6% and 8% of those individuals will have a serious psychiatric illness.¹⁴ These numbers are particularly troubling because between 2000 and 2005, “the number of inmates incarcerated in state and federal facilities rose 10%, nearly [three] times faster than the number of employees” working in those

10. *E.g.*, 440 IND. ADMIN. CODE 8-2-2 (2015); MASS. DEP'T OF CORRECTIONS, POLICY NO. 103 DOC 650 (2015), available at <http://www.mass.gov/eopss/docs/doc/policies/650.pdf>; *Mental Health Services*, OKLA. DEPARTMENT OF CORRECTIONS, http://www.ok.gov/doc/Organization/Administrative_Operations/Health_Services/Mental_Health_Services/ (last visited May 15, 2015).

11. JAMES J. STEPHAN, BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, NCJ 222182, CENSUS OF STATE AND FEDERAL CORRECTIONAL FACILITIES, 2005, at 5 (2008).

12. E. ANN CARSON & DANIELA GOLINELLI, BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, NCJ 243920, PRISONERS IN 2012: TRENDS IN ADMISSIONS AND RELEASES, 1991–2012, at 3 (2014).

13. See Benson, *supra* note 1, at 46–47.

14. MENTAL ILLNESS IN AMERICA'S PRISONS 161 tbl.1 (Henry J. Steadman & Joseph J. Cocozza eds., 1993), available at <https://www.ncjrs.gov/pdffiles1/Digitization/151849NCJRS.pdf>.

facilities.¹⁵ If the number of offenders has increased and the number of staff has not increased proportionately, there is imbalance, which leads to deficient service delivery.

The inherently isolating nature of prisons may actually exacerbate mental illness symptoms. Consider that high quality partnership and extended family relationships have a buffering effect on depressive symptoms among midlife adults, but are not a buffering factor for anxiety.¹⁶ Incarceration creates a physical barrier to building or maintaining high-quality relationships because access and confinement factors limit the nature and duration of interactions. Given the fact that prisons cut off or severely limit family support, incarceration of SMI offenders requires an effective mental health system to enable such offenders to thrive.

In order to guard against an ineffective mental health service delivery system in prisons, effective policies and procedures must be in place that specify the service delivery model. This system must take into account the training needs and culture building necessary to create a more individualized and flexible response to mentally ill offenders' social functioning and ability to comply with institutional rules and social demands. At its core, an effective mental health delivery system screens, refers, evaluates, designates, and continuously improves the quality of its service delivery at all levels. All offenders entering into the correctional system must be screened at intake for the potential risk of suicide and any indication of mental health concerns or mental illness. Initial screening is vital because it becomes the launching platform for future service delivery within the prison system. Effective screening influences housing, security designation, mental health designation, referrals, and countless other processes.

Mental health screenings are supposed to detect the potential for mental health concerns. Screening, follow-up assessment, and treatment is needed to maintain prison safety, especially given the moderating role of anxiety in physical aggression among impulsive persons.¹⁷ Such screens should not be intended to diagnosis or provide in-depth assessment, as that will occur on referral for mental health services.

The screening step is one of the first steps that can flag a problem or potential problem. Developing a system of referral by correctional

15. STEPHAN, *supra* note 11, at 5.

16. Judith A. Crowell et al., *Partnership and Extended Family Relationship Quality Moderate Associations Between Lifetime Psychiatric Diagnoses and Current Depressive Symptoms in Midlife*, 33 J. SOC. & CLINICAL PSYCHOL. 612, 622-24 (2014).

17. Joshua Hatfield & Chris S. Dula, *Impulsivity and Physical Aggression: Examining the Moderating Role of Anxiety*, 127 AM. J. PSYCHOL. 233, 239-41 (2014).

officers and other nonmental health professionals is another crucial means of flagging potential mental health issues, as these staff members act as a first point of contact with the offender. Effective and timely communication of mental health concerns that arise before and after screening guards against oversight of mental health needs, as the volume of offenders processed at arrival to the system may be high due to the insufficiently growing staff-to-offender ratio.¹⁸ An adequate referral system is also crucial because common offender characteristics may pose a challenge to identifying mental illness at the time of screening, including general mistrust of authority figures and commonplace disorientation to the unique social pressure of prison for first-time inmates.

The mental health evaluation is an in-depth process that takes a comprehensive look at the person. This process includes, but is not limited to, assessing the person's psychological, developmental, and social histories, along with her current mental status, in order to formulate a current diagnosis and establish an individualized treatment plan. The goal of a mental health evaluation is to obtain a comprehensive picture of the person so that a diagnosis and treatment course can be formulated. Mental health evaluations must continue to occur as the person progresses through treatment to ensure her needs are continuously being met.

Offenders often transfer to several different facilities within a state system, making up-to-date treatment plans imperative to ensure continuity of care. Offenders who have adapted well to the structure, services, and cultural environment of one facility may have difficulty adapting to changes in these factors between facilities, especially after a transfer between facilities of differing security levels. Mentally ill offenders' ability to adapt may be strained by changes in availability of mental health, rehabilitation, vocational, and educational programming. Change in the level of freedom of movement and out-of-cell time across facilities also poses a challenge for mentally ill offenders who have difficulty coping with social isolation. Some offenders benefit from a highly structured and lower stimulus environment, which may pose problems for their ability to thrive in lower security-level settings with freer movement, less correctional officer direction, and decreased monitoring. Institutions with less programming involvement will leave SMI offenders with fewer opportunities for staff to witness decompensation and provide early referral to the mental health department. In essence, SMI offenders are at risk of remaining

18. STEPHAN, *supra* note 11, at 5.

“off the radar” regardless of adaption when they have less involvement in programs.

Having an effective Quality Assurance (QA) process in place is essential for any correctional mental health system. QA is designed to find ways to improve clinical processes, enhance resource allocations, improve continuing professional educational training opportunities for staff, and improve overall offender satisfaction with mental health services. This process, above all others, allows the prison system to show evidence that its mental health service delivery system is functioning well and is sufficiently integrated within the larger correctional system to provide effective treatment. An effective QA process may be difficult to implement in some systems, because it will require staffing and resource allocation. This is a full-time process that must be allowed to run its course. Further, there must be a commitment on the agency’s part to support the improvement recommendations that flow out of the QA process. Without such support and commitment, the QA process cannot be effective.

As has been illustrated, the offender population—specifically the mental health population and its SMI subset—has a tremendous impact on the entire correctional system. In future discussions, we will take a more comprehensive look into the basic core components of an effective mental health delivery system.