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Best Practices in Mental Health at Corrections Facilities

Abstract

Police, court personnel, and correctional staff interact with, stabilize, and treat more persons with mental illness than any other system in America—making criminal justice agencies the largest mental health provider in the United States. Yet a wide gap exists between the training of corrections staff and the enormous responsibility they have for day-to-day management of mental health issues. To narrow this gap in jail and prison settings, the best practices include training programs, screening procedures, communication between staff, and good documentation. Quality mental health services help maintain security by reducing inmate and staff stress levels and helping to facilitate offender participation in rehabilitative programming. They increase the likelihood of successful reintegration of mentally ill offenders into the community by promoting adequate community based mental health care follow-up, thereby contributing to reduced recidivism. By following these best practices, correctional organizations can also reduce the likelihood of expensive civil litigation or other legal actions that can result from inadequate correctional mental health services.

Keywords

Buffalo, Health, Equality/Civil Rights, Disability, Criminal Justice, Incarceration, General, Policy Brief, PPG, PDF

Best Practices in Mental Health at Corrections Facilities

Sahil Jain

Introduction

Police, court personnel, and correctional staff interact with, stabilize, and treat more persons with mental illness than any other system in America—making criminal justice agencies the largest mental health provider in the United States. Yet a wide gap exists between the training of corrections staff and the enormous responsibility they have for day-to-day management of mental health issues. To narrow this gap in jail and prison settings, the best practices include training programs, screening procedures, communication between staff, and good documentation.

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Jail Suicides: Screening and Assessment

Jail suicides usually involve young, highly traumatized, alcohol-compromised individuals, often first offenders, detained in settings with little screening for suicide risk, insufficient training of staff, and limited supervision of the

detainees. A national study of jail suicides found that

- 89 percent were not screened for suicidal behavior at booking,
- 51 percent of the deaths occurred in the first 24 hours of incarceration, and
- 48 percent of those who committed suicide while or after being intoxicated died within the first 3 hours of their stays.

The first 24 hours of detention are the most dangerous with regard to suicide. For this reason, the screening process is vital. If an inmate is identified from the beginning as a suicide risk, mentally ill, or a drug user, then he or she can receive the appropriate treatment or supervision immediately, which in turn can prevent impulse suicides.¹

The purpose of assessment is to identify mental health problems or potential mental health problems and evaluate the need for treatment, as well as to identify inmates who are likely to

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be a danger to themselves or others. Without proper mental health staff and procedures in place, inmates' mental health issues may not be addressed and are in danger of being improperly diagnosed and treated.

Toward a Multi-Dimensional Approach

Putting people in one or more individual diagnostic categories—each with its own treatment regimen—has been the traditional assessment method for local jails. This is problematic as it may produce a fragmented treatment strategy that treats problems in isolation rather than in their totality. A multidimensional approach, which can address several problems at once, allows for more individualized and holistic treatment.

For example, a substance abuse program may not be equipped to address the needs of a schizophrenic individual, and the providers treating schizophrenia may not offer treatment programs for substance abusers. A multi-dimensional approach also allows the clinician to measure treatment success incrementally rather than dichotomously (i.e., meets the diagnostic criteria or does not).²

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Protocols and Checklists

Inmates with potential mental health issues should always be assessed by a trained mental health professional as soon as possible. If one is not readily available, correctional officers must be adequately trained to identify inmates with suicide risk. Correctional officers interact with inmates and observe their behaviors 24 hours a day, making officers often the first to observe conduct and demeanor that may connote mental illness.

Suicide checklists are an important part of a comprehensive assessment and suicide prevention plan for a number of reasons. First, they provide the intake officer with structured questions on areas of concern that need to be covered. Second, when there is little time available to conduct screening, they act as a memory aid for busy intake staff. Third, they facilitate communication between officers and locations within the institution and, finally, they provide legal documentation that an inmate was screened for suicidal risk upon entrance into the facility and, again, as conditions changed.

Correctional staff should be prepared to talk with inmates about special housing, activities, medication and behavioral programs. Each of these activities has the dual benefits of improving the quality of mental health services provided and reducing stress on the staff and inmates.

Ongoing Observation and Processes

To be effective, suicide prevention must involve ongoing observation. A management process must be established with clearly articulated policies and procedures outlining responsibilities for placement, continued supervision, and mental health intervention for inmates who are considered to be at high risk of suicide. Correctional staff must be trained to be vigilant during the inmate's entire period of incarceration. Procedures that can be taken include:

1. Routine checks to watch for indications of suicidal intent or mental illness, such as crying, insomnia, sluggishness, extreme restlessness or pacing up and down; sudden changes in mood, eating habits or sleep; divestment such as giving away personal possessions; loss of interest in activities or relationships; refusal to take medication or a request for an increased dose of medication.

2. Conversations with an inmate around the time of sentencing or other critical periods (such as the death of a family member or divorce) to identify feelings of hopelessness or suicidal intent.
3. Supervision of visits with family or friends to identify disputes or problems that emerge during the visit. Families should be encouraged to notify officers if they fear that their relative may harbor suicidal wishes.

Seclusion and Segregation

Inmates in isolation, seclusion, or administrative segregation account for a disproportionate number of suicides. Enforced physical isolation can be a frightening experience for a person who already feels alienated, and can cause individuals who had not previously attempted or even threatened suicide to take their own lives. Assaultive individuals who are physically secluded may turn their aggression upon themselves and commit suicide. This points to the importance of understanding the individual needs of the mentally ill inmates and the danger of separating them from human contacts.

A report by Human Rights Watch in 2003 argued that segregation increases the risk of suicide for all inmates, especially the mentally ill.

A lengthy report by Human Rights Watch in 2003 argued that segregation increases the risk of suicide for all inmates, especially for the mentally ill. Mentally ill inmates often see this process as punishment, and to avoid it they may keep their thoughts to themselves, including suicidal ideation, which increases their chances of suicide because they fear seeking out help.

Placing an inmate suspected to be at risk of suicide in a dormitory or shared cell may

significantly reduce the risk of suicide, particularly when the placement is with sympathetic cellmates. In some facilities, social support is provided through the use of specially trained inmate “buddies.” Family visits may also be used as a means to foster social support as well as to provide information about the inmate’s health.³

One should note, however, that mentally ill inmates often have greater difficulties socializing with inmates, and this deficit can have harmful consequences, including victimization and acting out behavior. Therefore, they may benefit from less socialization or more structured socialization. Therefore, inmates with severe mental illnesses should be placed under careful monitoring and counseling concerning medications by psychiatrists and nurses. Psycho-educational classes such as anger management and chemical dependency should be offered with a low-stress social setting in place for mentally ailing inmates.

Safe Cells

Structurally, correctional facilities can reduce inmate and supervision stress levels by retrofitting cells into “safer cells.” In a safer cell, all the corners are rounded, the pipes are covered, the light fittings are modified, and a safe ventilator is used instead of windows that open and that could, therefore, be used to attach a ligature.⁴

Problem Areas

Correctional facilities are often stressful environments for both inmates and correctional officers. This in turn can be the cause and result of several environmental and operational deficiencies that might contribute to suicide such as:

1. Inadequate or unavailable psychological services at initial intake and during incarceration;

2. Poor communication among staff;
3. Perception among staff that self-injurious behavior is a means of manipulation;
4. Basic elements of the institutional environment that constrain personal efficacy and control;
5. Limited staff training and direction in suicide prevention;
6. Limited staff direction to respond to suicide incidents; and
7. Investigations after a suicide that are directed primarily towards establishing an appropriate response by staff without the accompanying thorough investigation of the causes of the suicide.

support; routine visual checks and constant observation for more seriously suicidal inmates; and appropriate use of restraints.

5. Development of sufficient internal resources or links to external community-based mental health services to ensure access to mental health professionals when required for further evaluation and treatment.
6. A strategy for debriefing when a suicide occurs to identify ways of improving suicide detection, monitoring, and management.

In order to fully address inmate health and mental health needs, correctional facilities will need to forge strong links with community-based programs.

Six Essential Practices

There are six essential practices for suicide prevention in correctional facilities.

1. A training program (including refreshers) for correctional staff to help them recognize suicidal inmates and respond appropriately to inmates in suicidal crises.
2. Procedures to screen inmates systematically upon their arrival at the facility and throughout their stay in order to identify those who may be at high risk.
3. A mechanism to maintain communication between staff members regarding high-risk inmates.
4. Written procedures which outline minimum requirements for housing high-risk inmates; provision of social

In order to fully address inmate health and mental health needs, correctional facilities will need to forge strong links with community-based programs. This means that criminal justice, mental health, and health systems must be linked for the task of suicide prevention in correctional settings. Depending on the location, this may require multi-agency cooperative service arrangements with general hospitals, emergency services, psychiatric facilities, community mental health programs, and addiction programs.

Mental health programs and interventions that exist can achieve positive results, but after the inmate is released a system must be put into place to continue to guide and aid the individual if we are to minimize the recidivism of mentally ill inmates.

¹ Pompili, M., Lester, D., Innamorati, M., Del Casale, A., Girardi, P., Ferracuti, S., et al. (2009). Preventing suicide in jails and prisons: Suggestions from experience with psychiatric inpatients. *Journal of Forensic Sciences*, 54(5), 1155-1162.

² Standards for psychology services in jails, prisons, correctional facilities, and agencies: International Association for Correctional and Forensic Psychology (2010). *Criminal Justice and Behavior*, 37(7), 749-808.

³ Adams, K. (2008). Managing mentally ill inmates in prisons. *Criminal Justice and Behavior*, 35(8), 913-927.

⁴ Ax, R. (2007). Innovations in correctional assessment and treatment. *Criminal Justice and Behavior*, 34(7), 893-905.

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