BEHAVIORAL HEALTH RESOURCE GUIDE

By

Correctional Behavioral Health Working Group
Coalition of Correctional Health Authorities
American Correctional Association

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Behavioral Health Resource Guide

This Resource Guide offers an introduction to services and processes regarding the delivery of quality mental health and substance abuse treatment within correctional facilities. It is meant as a resource offering basic information and assistance to staff in jails and prisons across the U.S. that are considering, or are in the process of, developing or expanding services to their inmates with behavioral health conditions. It is one of many resources available when learning about behavioral health services within correctional facilities. It is not all inclusive of behavioral health practices or expectations.

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Members of the Correctional Behavioral Health Working Group

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Introduction

The Behavioral Health Resource Guide has been developed by the Correctional Behavioral Health Working Group of the American Correctional Association’s Coalition of Correctional Health Authorities (CCHA) as a tool for your toolbox. It is not all inclusive of behavioral health practices or expectations.

The members of the CCHA are the health authorities from the 50 state departments of correction, the four largest jail systems in the U.S., the District of Columbia and the Federal Bureau of Prisons. The correctional administrator in each jurisdiction appoints his or her CCHA member. It is the person responsible for the health services delivery for the agency and who reports directly to the correctional administrator regarding any health care issues. CCHA was founded on the idea of bringing together the health authorities to network and exchange exemplary practices in professional health care administration, to learn new and improved techniques in quality health care delivery, and to address critical emerging issues.

The mission of the CCHA is to preserve, promote and improve the health and well-being of the correctional population. CCHA is committed to leadership and excellence in correctional health care. CCHA offers members the opportunity to stay connected through educational programs, networking, sharing exemplary practices, identifying issues, solving problems and pioneering new solutions together.

This Resource Guide offers an introduction to current services and processes regarding the delivery of quality mental health and substance abuse treatment within correctional facilities. It is meant to offer basic information and assistance to staff in jails and prisons across the U.S. that are considering, or are in the process of, developing or expanding services to their inmates with behavioral health conditions.

Remember: This document is for informational purposes and is one of many resources available when learning about behavioral health services within correctional facilities.
Assessment/Diagnostic Services

As correctional agencies move toward using evidence-based practices to attain and support safe and secure environments, clinical and psychological assessments become a vital component to achieve success in this endeavor. Practitioners working in correctional settings value the knowledge gleaned from the information and results of assessments of cognitive and adaptive living skills, educational achievement, behavioral traits, suicidality and personality (Desmarais & Singh, 2013). Substance abuse assessments and screenings tools are also valuable, especially in jail settings. Reentry services and release planning benefit greatly by instruments that measure an inmate’s risk of recidivism. Because on average, 50 percent of inmates released from jails or prisons are rearrested and return to detention within three years of release, the ability to identify inmates in greater need of services and at greater risk of recidivism while incarcerated is necessary.

Assessments provide information necessary to understand an inmate’s past and present behavior from a therapeutic perspective, but the results of assessments can also assist custody staff in the determination of housing and optimal living arrangements. Assessments that identify skill strengths and deficits can be used to determine the services and activities that might be valuable for an inmate while incarcerated and can be instrumental in aligning resources with those at highest risk. Assessments can also identify necessary issues that require addressing in regards to their future release and reentry to the community to become more positive, contributing members of society (Lauren, 1997).

Application in Correctional Settings

During the initial intake process, whether to jails or prisons, screening measures are necessary to gather information regarding the mental health status of the inmate and inform decisions as to staffing and programming resources needed. Facilities that offer specialized services for mental health and/or substance abuse disorders depend upon sensitive and informative tools that reliably identify the inmate’s needs and vulnerabilities to make critical classification and housing decisions.

Similarly, tests or assessments can identify areas of an inmate’s interest and can be used to promote their voluntary participation in groups or programs that will reduce idle time and connect inmates to development opportunities while in detention. Pairing an individual with a service that will enhance his/her individual skill set may increase motivation to engage in
positive behavior while incarcerated. For example, matching an illiterate individual with a reading education program can enable him/her to engage more fully in avocational reading; to be able to read and understand admission, legal or medical documentation; or even to read the signs posted around the facility. Likewise, if an individual is experiencing anxiety or depression, an appropriate assessment battery can drive treatment planning to support that individual’s health and well-being while incarcerated and upon their return to the community.

To select the most appropriate and useful assessment tool, it is important to be clear regarding the purpose of the assessment, the type of results sought, and the outcome you are hoping to obtain. Validated assessment measures identify their purpose, utility and administration requirements to include the level of staff education and training required to obtain reliable and meaningful results. Simple screening tools may be administered by officers or bachelor-level clinical staff; forensic and more comprehensive exams, however, may require master- or doctoral-level credentials and training. Given the utility of assessments, some correctional systems have begun to create forensic units with staff that specifically provide the assessment component. Below are some of the most commonly used assessment measures by type.

Examples of Validated Assessment Measures

- **Personality Assessments**
  - Minnesota Multiphasic Personality Inventory (MMPI)
  - Millon Clinical Multiaxial Inventory
  - Personality Assessment Inventory (PAI)
- **Intelligence Tests**
  - Tests of Nonverbal Intelligence (TONI)
  - Wechsler Scales
- **Adaptive Behavior Scales**
  - Vineland Adaptive Behavior Scale
- **Educational Tests**
  - Woodcock-Johnson Test of Cognitive Abilities
- **Substance Abuse Assessments**
  - Texas Christian University (TCU) Screen
  - Addiction Severity Index (ASI)
- **Suicide Risk Assessments**
  - Columbia Suicide Severity Rating Scale
- **Risk Assessment Tools**
  - Level of Service/Case Management Inventory (LS/CMI)
  - Static Risk and Offender Needs Guide (STRONG)
  - Correctional Offender Management Profile for Alternative Sanctions (COMPAS)
  - Suicide Risk Assessment Scale (SRAS)
- **Neuropsychological Tests**
  - Wisconsin Card Sorting Test
  - Memory Assessment Scales
  - Luria-Nebraska Neuropsychological Battery
  - Halstead-Reitan Neuropsychological Battery
Case Study
Romero was diagnosed with paranoid schizophrenia, and his condition was being treated with antipsychotic medication. He was experiencing several negative side effects. Romero volunteered to participate in an assessment program to better understand his treatment options and diagnosis. He underwent cognitive, personality, educational and neuropsychology testing. The comprehensive test battery revealed that Romero had been misdiagnosed. As Romero had previously been diagnosed while under the influence of drugs, he had briefly displayed positive symptoms of schizophrenia, which were drug induced, not organic, in nature. Testing measures indicated that Romero had complex post-traumatic stress disorder (PTSD) and also met criteria for major depressive disorder. The evidence-based, accurate diagnoses altered his medication regime and enhanced his quality of life.

Previous to comprehensive assessment Romero was violent, medication resistant and prone to self-injury. As a result of the assessment process and concomitant education, Romero became medication compliant, completely stopped his self-injurious behaviors and identified realistic strategies to cope with his trauma history and bouts of depression. The combination of educational, cognitive, personality, developmental and neuropsychological assessments enhanced the quality of life for this person and made the work environment safer for officers who worked with Romero. The assessment also provided information that led to the use of evidence-based treatment and rehabilitation strategies for Romero.

Cited Sources


Additional Resources

Cognitive Behavioral Therapy
Cognitive Behavioral Therapy (CBT) is an evidence-based model connecting how an individual’s thoughts influence one’s behavior (NAMI, 2016). Those who have difficulty understanding the consequences of their choices often end up in correctional facilities. CBT affords individuals an opportunity for education and practice of skills that will allow them to better understand how thoughts motivate behavior and inform consequences. Additionally, CBT helps individuals identify and change dysfunctional beliefs, thoughts and patterns of behavior that may contribute to their problems.

Moral Reconation Therapy
Moral Reconation Therapy (MRT) is one of many CBT strategies implemented in the correctional behavioral health field. MRT utilizes education; individual and group counseling; and structured exercises to confront individuals with the consequences of their behavior and decisions on the people and communities around them (Correctional Counseling Inc., 2016) to help alter the client’s thought process and decision making to foster moral development regarding beliefs and reasoning. Studies have suggested that MRT reduces recidivism rates and can be effective with both genders in adult and juvenile populations.

Combination of CBT and Behavioral Therapy
When working with young people, the combination of cognitive therapy and behavioral therapy has been highly beneficial. Among young people, different strategies of CBT have been successful when addressing violence/criminality, substance abuse, teen pregnancy and risky sexual behaviors (Beck, 1999). This therapy combination can also be effective when used with adults.
Practical and Cultural Education Center (PACE)
Landenberger and Lipsey (2005) studied whether CBT strategies were effective in reducing recidivism. PACE (Practical and Cultural Education Center) is a program using CBT-based strategies to reduce potentially harmful sexual behaviors and to address sexual health, such as protective knowledge, attitudes and behaviors about the origins and modes of transmitting HIV/AIDS and teen pregnancy (Landenberger & Lipsey, 2005).

Aggression Replacement Training (ART)
Aggression Replacement Training (ART) is designed to provide individuals with prosocial skills when they are in anger-inducing or negative situations. Additionally, ART aims to teach individuals how to manage their anger impulses through anger control training, acknowledge of others’ perspectives and how to react in anger producing situations (Milkman & Wanberg, 2007).

Reasoning and Rehabilitation
Reasoning and Rehabilitation was developed with the theory that offenders have cognitive and social deficits that have caused their predicament. This program focuses on enhancing self-control, interpersonal problem solving, social perspectives and prosocial attitudes. This program involves different sessions and activities that highlight various skills and learning components (Milkman & Wanberg, 2007).

Relapse Prevention Therapy (RPT)
Relapse Prevention Therapy (RPT) focuses on teaching individuals self-management and self-control over their thoughts and behaviors. This technique focuses on five therapeutic strategies (coping skills, relapse roadmaps, identifying cognitive distortions, lifestyle modification and identifying possible relapses). A vital component is teaching individuals how to anticipate and cope with relapse (Milkman & Wanberg, 2007).

Dialectical Behavior Therapy (DBT)
Dialectical Behavior Therapy (DBT) is a form of cognitive-behavioral therapy that combines behavior therapy with Eastern “mindfulness” (Berzin & Trestman, 2004). Specifically, DBT provides individuals with specific strategies to become aware of how his/her behavior impacts him/her self and the others in the community. This, in turn, teaches the person to remain in the moment and carefully consider choices and actions.

According to Linehan, as cited by Vitacco and Van (2005), the core treatment of DBT centers on emotion regulation, mindfulness, interpersonal effectiveness and distress tolerance. DBT focuses on changing behaviors and developing skills, and promotes responsibility through assignments and groups. Research suggests that DBT is effective with individuals suffering from emotional instability, cognitive disturbance, self-harming behaviors, chronic negative feelings and interpersonal problems (Linehan, et al., 2006). Some of the positive outcomes of DBT include a decrease in violence and recidivism rates for individuals involved in the corrections and the justice system (Vitacco & Van, 2005).

Case Study
Ramon was an individual who had been in and out of jail since he was a teenager. As a child, he was diagnosed with ADHD and had a long-standing history of engaging in impulsive and violent behavior. Ramon has a history of gang involvement and had a nickname of the “action man” because, if given an order, he would act upon it without question. Ramon was moved to the therapeutic CBT unit because he continued to get into fights with competing gang members and his life had recently been threatened.

On the CBT unit, Ramon displayed a high level of energy. He had a tendency to instigate problems and encouraged maladaptive behaviors from others on the unit. The clinician assigned to Ramon began using CBT to help Ramon stop and think about the consequences of his actions before executing anything. This was very challenging for Ramon. However, due to the strong relationship he developed with his clinician, he was motivated to try the useful strategies. In addition, the clinician began to assign Ramon homework that allowed him an opportunity to understand how his impulsive choices in the jail setting negatively influenced outcomes and had applications beyond the jail setting.

Through his clinical work, Ramon learned that by writing about his thoughts, feelings and actions, he was able to calm himself down and make better choices. This strategy was also identified as a talent, as Ramon began to use this coping strategy to create poetry. After five months on the unit, Ramon went from engaging in daily fights with others to zero instances of violent interactions.

Cited Sources


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Medication-Assisted Therapy

Medication-Assisted Therapy (MAT) is an evidence-based medical treatment for substance use disorders that is appropriate for correctional settings. MAT addresses substance use disorders utilizing a combination of medications and behavioral therapy (SAMHSA, 2016). Studies have suggested that when appropriately used, MAT minimizes recidivism and can be an effective way to facilitate recovery from addiction.

While the medications utilized may differ depending upon the addiction being treated, generally, a type of cognitive-behavioral therapy is utilized to support the outcomes achieved with medication administration.

Studies generally support the societal benefits of using MAT for individuals with substance use disorders, particularly those with opioid use disorder (Volkow, Frieden, Hyde & Cha, 2014). With the individual and societal costs of opioid abuse having risen significantly over the past several years, MAT offers a safe and effective way to combat opioid addiction (Volkow et al., 2014; Mohlman, Tanzman, Finison, Pinette & Jones, 2016). Studies suggest MAT increases patient retention in treatment, improves social functioning, reduces risk of infectious disease transmission and reduces risk of criminal activity (Volkow et al., 2014; SAMHSA, 2016).

Application in Correctional Settings

Friedman et al. (2012) highlighted that the most common use of MAT for opiate dependence in correctional facilities includes the use of methadone or buprenorphine. Methadone is in the agonist class; it fully activates opioid receptors. Typically, it is taken once per day to reduce opioid cravings and withdrawal symptoms. The advantage of methadone is that it has high efficacy, but it is highly regulated and may pose a challenge for correctional patients upon release, since early in the treatment course, patients must come to a clinic daily for dosing. Buprenorphine is in the partial agonist class; it activates opioid receptors, but less actively than methadone. Similarly, buprenorphine is taken once a day and serves to relieve cravings and withdrawal symptoms. One advantage is that a prescription can be in place to increase availability and accessibility (Volkow et al., 2014).
**Case Study**
Robert was a 20-year-old male who, upon arriving in the jail’s custody, expressed a history of polysubstance use. Robert explained to a nurse that he frequently used heroin. While in custody, Robert was not immediately involved in treatment for opioid use disorder, nor did he express any interest in that service. During a routine tour, officers noticed that Robert was lying on the floor in his cell with a reduced level of consciousness and slowed breathing, which appeared to be from an opioid overdose. Officers tried to rouse Robert to no avail and immediately called the clinic for a medical emergency. Clinic staff responded quickly and confirmed Robert’s state of unconsciousness and difficulty breathing. Medical staff utilized naloxone (Narcan) which caused Robert to become alert and oriented. Once alert, Robert was transferred to the emergency department, where he could be monitored in an overdose and poisoning unit. After being monitored for 24 hours, Robert was brought back to the facility and entered a program for medically managed withdrawal that would involve routine drug testing, behavioral therapy and induction with methadone. For the remainder of his incarceration, Robert’s treatment plan included his remaining on methadone maintenance to control withdrawal symptoms and cravings, along with cognitive behavioral therapy.

**Cited Sources**


**Additional Resources**


Behavioral Health Resource Guide

**Trauma-Informed Care**

SAMHSA (2014) states that the correctional system is a fertile ground to discuss trauma, both historical events (i.e., abuse, witnessing violence, etc.) and recent traumatic experiences (i.e., arrest, incarceration, losses, etc.) and their effect on both inmates and staff. Typically in the correctional setting we take an “out of sight out of mind” approach toward dealing with trauma, and this approach can cause more harm to those who have been traumatized (SAMHSA, 2014). Well-intentioned professionals often unwittingly engage in behavior that serves as a “trigger” for maladaptive or inappropriate expressions of anger and frustration. This behavior evokes a trauma response in someone who has experienced significant, traumatic life events. Taking the time to explain to an inmate the purpose for procedures can alleviate anxiety and reduce negative incidents.

Trauma is experienced not only by the incarcerated population; it is also seen in correctional staff. A study in 2012 surveyed correctional officers and found 27 percent met the diagnostic criteria for PTSD, which is twice the rate for individuals in other professions (Spinaris and Kellaway, 2012). Therefore it is important for the correctional setting to shift toward a culture of self-care and trauma-informed approaches, not only for the inmates, but also for staff. Helping staff and inmates understand clear boundaries and expectations can reduce potential anxieties for both groups.

**Application in Correctional Settings**

Some of the environmental features of correctional settings that elicit responses from individuals who have experienced trauma include strip-searches; invasion of privacy during cell searches; transitioning from place to place; loud voices and the banging of doors; cell “extractions”; and seclusion (Benedict, 2010). Specifically for women being supervised during sensitive times, such as showering and dressing, supervision by male officers can trigger a “traumatic” response. Research has shown that as high as 90 percent of incarcerated women have experienced trauma in their life before incarceration (Benedict, 2010).

The goal of trauma-informed care is to identify trauma and related symptoms, train staff regarding the impact of trauma, and implement an approach that minimizes the risk of re-traumatization (Miller and Najavits, 2012). This would include acknowledging the role of traumatic experiences in particularly uncooperative and problematic behaviors and thus explaining procedures that might elicit triggers (Belcher-Timme, 2016) (i.e., explaining the
purpose and process before strip searches or transportation). For the inmate, this information can reduce the likelihood of negative behaviors in response to the situations. Additionally, understanding the trauma-informed approach benefits staff because they are more likely to recognize these exaggerated behaviors and respond with appropriate interventions (Belcher-Timme, 2016).

**Case Study**

Alice is a 25-year-old female who has a significant history of self-injurious behavior, including vertical cuts to her wrist, banging her head against windows until bloodied, refusing to take medication, and attacking individuals she perceived as threatening. She had been diagnosed with schizophrenia and had been prescribed Risperdal. In an act of ultimate noncompliance, she began to smear her body with feces before engaging in an attack against staff, or self-injurious behavior. Alice’s first interactions with mental health staff were through bars of a cell in which she remained locked 23 hours a day due to her propensity for violence.

However, in this correctional facility, a new unit was opened that had a trauma-informed focus. Alice was referred to the unit mostly because no one knew what to do with her, not because she was perceived as needing to be in a therapeutic program. However, when staff approached her and asked whether she would be willing to talk about her experiences in jail, Alice agreed. She agreed to move to the therapeutic unit after being informed of the rules and expectations of living in the housing area. Interestingly, she asked over and over again if the unit was going to be “safe” because she was “tired of being abused by officers.”

Alice transitioned to the new unit, participated in all therapeutic activities and began to demonstrate socially appropriate behavior. In therapy, she disclosed that, as a child, her drug-addicted mother had sold her to men for drugs; she had learned that, if she was bloody or covered in feces, people were less likely to rape her or, if she was being raped, it would stop more quickly. Violence had become her strategy to cope with conflict and escape danger. Through working with Alice, it was discovered that when officers approached her quickly and/or using a loud and intense tone of voice, this triggered a trauma response in which Alice felt a need to fight-or-flight. It was realized that this same trigger existed when going to court and when being given directives associated with movement through the facility. It was also determined that strip searches were a highly vulnerable time for Alice. After one month on the unit, Alice’s diagnosis was changed to PTSD. She was taken off the antipsychotic medication and began treatment for trauma and depression. A treatment plan was created that educated officers on how to have appropriate and safe interactions with Alice, taking her trauma history into consideration.

Alice blossomed when she began to participate in art therapy, and she realized that artistic expression helped control her moods, and that she was a very talented artist and could use that talent to make money when she was released. Using a trauma-informed approach helped Alice realize her true potential and allowed her to finish her time in a way that was safe and healthy.

**Cited Sources**


Suicide Prevention Strategies

The Substance Abuse Mental Health Services Administration (SAMHSA) considers suicide to be a major public health problem that causes immeasurable pain and loss to individuals, families and communities nationwide. Suicide is the tenth-leading cause of death in the United States. The national average is 13 per 100,000 individuals, with a suicide occurring approximately every 12.3 seconds (NIMH, 2013). SAMHSA states that, while the causes of suicide are complex and determined by multiple combinations of factors — including mental illness, substance abuse and other significant social stressors — everyone has a role to play in preventing suicide and that efforts must be made to identify and prevent suicide-related behavior.

Suicide prevention efforts seek to

- Reduce factors that increase the risk for suicidal thoughts and behaviors;
- Increases the factors that help strengthen, support and protect individuals from suicide; and
- Provide interventions commensurate with level of risk to prevent self-harm or suicide.

Application in Correctional Settings
Suicide prevention is one of the most critical behavioral health services provided in correctional systems. The Bureau of Justice Statistics reported in 2013, suicide rate in state prisons of 15 per 100,000 inmates and 46 per 100,000 inmates in local jails. Suicide is the leading cause of death in jails and the fourth-leading cause of death in state prisons (Noonan and Ginder, 2014). With these statistics, it is very important that every correctional agency take a serious look at their Suicide Prevention Plan. According to Lindsay M. Hayes, renowned expert on suicide prevention, there are eight critical components in a suicide prevention policy. These eight components are briefly outlined as follows:

1. **Staff Training.** This should include initial training and annual review training for all staff focusing on predisposing factors; high-risk suicide periods; warning signs and symptoms; and referral process when suicide concerns are identified. Additional specialty training is likely to be needed for those with an identified role in the process, such as custody supervisors, medical staff and suicide watch personnel. Regularly scheduled mock suicide exercises are recommended training to help staff become familiar with the
procedures, increase efficiencies in responding, know where the tools (e.g., “cut down knife”) and equipment (e.g., AED, stretcher) are located.

2. Identification/Screening. Suicide risk should be assessed upon admission into a correctional environment and before housing assignment. This screening should include past suicidal ideation/and or attempts, current ideation, threat; prior mental health treatment, hospitalizations, recent significant losses, history of family members/close friends who have attempted or committed suicide, etc. It is particularly important during the screening stage that staff communicate to the inmate the process for accessing help — especially from mental health/medical staff.

3. Communication. It is important that any time an inmate voices suicidal ideations or makes a suicide attempt or self-injurious act, behavioral health staff is notified. Continuity of effective communication regarding suicide risk is important at three levels:
   - Between transporting officers and correctional staff;
   - Between and among medical/mental health staff; and
   - Between staff and the suicidal inmate.

4. Housing. Inmates voicing suicidal ideations or engaging in suicidal behavior require enhanced monitoring, which may include housing conditions. Actively suicidal inmates should never be left in unattended housing (e.g., single celled, restrictive housing, etc.) and most likely will require constant supervision. As suicide risk increases, monitoring should increase commensurately. The offender at risk may be placed on a medical health unit, medical infirmary in close proximity to staff, or placed on suicide watch status. Housing should be a suicide-resistant, protrusion-free cell. Removal of inmate’s clothing as well as physical restraints should be avoided whenever possible and utilized only as a last resort for periods in which inmate is physically engaged in self-destructive behavior.

5. Levels of Supervision. Two levels of supervision are generally recommended for those at heightened risk for suicide; close observation and constant observation.
   - Close observation should be considered for inmates not actively suicidal, but who are expressing suicidal ideation or have a history of self-destructive behavior. Intervals between observations do not exceed 15 minutes.
   - Constant observation is for those offenders deemed to be at high risk of suicide, such as those actively engaging in self-harm, or those whose constellation of symptoms and behaviors suggest imminent self-harm at this level of risk, observation is continuous and uninterrupted.

6. Intervention. Intervention policies should be threefold:
   - All staff in close contact are CPR/first-aid trained.
• All staff responding to attempted suicide should ensure the scene is secure, alert other staff/medical, and initiate life-support measures.
• All staff should not presume an inmate is deceased, but continue lifesaving measures until relieved by arriving medical staff.

All housing units should have appropriate rescue items.

7. Reporting. In the event of a suicide attempt or completed suicide, all appropriate correctional officials should be notified through the chain of security command. Following the incident, the victim’s family should be contacted immediately, as well as outside authorities. All staff interacting with the victim before the incident should submit statements regarding their knowledge of the inmate and the incident.

8. Follow-up/Mortality Review. Every suicide, as well as serious suicide attempt (i.e., requiring hospitalization) should be carefully examined by a mortality review. If resources permit, a mental health professional should provide a psychological autopsy. The mortality review, separate and apart from other formal investigations required to determine cause of death, should include

- Review of circumstances;
- Review of procedures;
- Review of relevant training;
- Review of pertinent medical and mental health services;
- Review of any possible precipitating factors leading up to the suicide; and
- Recommendations for any changes in policy.

Case Study
Travis is a 28-year-old Caucasian male who has both a significant mental health and criminal history since adolescence. His current diagnosis is bipolar disorder, mixed with psychotic features, alcohol dependence in remission in a controlled environment, ADHD by history and antisocial personality disorder. He came to prison in 2008 on aggravated assault and burglary charges, which resulted in placement in maximum security due to his violent, unpredictable behavior complicated by history of gang involvement. His involvement with mental health services has been a combination of medication management and individual therapy as needed. He had been relatively stable and manageable until recently.

One month ago, after he reportedly stopped taking his medications, he stabbed two inmates in his section due to command auditory hallucinations, “The voices told me to do it!” After a period of observation and stabilization on medications in the prison infirmary, he was moved to the Maximum Security Mental Health Section, where he was observed daily by mental health staff along with 15-minute checks by custody staff. However, a week later while officers were completing their checks, they discovered he had partially covered his window and was standing on his sink with a sheet around his neck, threatening suicide. Emergency procedures were activated while both custody and mental health staff attempted “to talk him down,” but he
jumped anyway. Staff quickly entered the cell, removed the sheet, and the inmate was not injured. He has now been moved to the prison’s Acute Mental Health Unit, where the level of observation and treatment now includes 24/7 camera observation, daily visits by MH and 15-minute checks by officers, along with weekly visits by the psychiatrist.

The ability to provide higher levels of observation with 15-minute checks in designated housing areas, immediate staff response and daily mental health contact have been key elements of the facility’s suicide prevention program, which in this case, was instrumental in a successful lifesaving intervention.

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**Additional Resources**


Garvey, K., Penn, J., Campbell, A., Esposito, C., & Spirito, A. (2009). Contracting for safety


Alternatives for the Mentally Ill in Restrictive Housing

A disproportionate number of inmates in restricted housing have a mental illness. Those with mental illness have a difficult time adjusting to their environment and tend to violate rules of the institution, thus receiving disciplinary sanctions that often result in placement in restrictive housing. Some placed in restrictive housing can suffer the effects of social withdrawal, which can be particularly difficult for those with mental illness (Honberg, 2013). Some individuals can develop a mental illness from prolonged segregation. Across the country, correctional organizations have been struggling to appropriately manage inmates with mental illness placed in restrictive housing and those who develop a mental illness while in restrictive housing.

Application in Correctional Settings

In an attempt to improve services and address this issue, many states and local agencies have developed diversion programs. One example is the Therapeutic Diversion Unit (TDU) model established and implemented successfully by the North Carolina Department of Corrections. The purpose of the TDU was to decrease the number of individuals with mental illness who are placed in restrictive housing and, for those who require placement in restrictive housing for safety of self or others, to minimize the time spent in restrictive housing. The TDU was to accomplish this mission through the provision of a comprehensive treatment plan that affords a multidisciplinary approach to behavioral intervention planning and program implementation.

The primary goal of the TDU is to assist individuals with mental illness in developing effective emotional regulation and self-management skills, understanding their symptom presentation and patterns, and to help them prepare for reentry into a less restrictive environment within the prison and, ultimately, successful transition into the community.

Treatment in the TDU is evidence based and utilizes a multidisciplinary approach. The disciplines contributing to the program include psychology, psychiatry, nursing, custody, recreation therapy and unit management. Treatment curriculum focuses on psychological and emotional health, physical well-being, relationship building and social skills development.

Participant response to evidence-based treatment protocols is measured to determine program effectiveness. Outcome measures include multiple assessment and survey instruments administered before treatment and at regular levels throughout the TDU stay. Additional
Initial measures — such as the number of incident reports, self-injurious behavior, and both internal and external hospital admissions — are tracked.

Initially, all inmates on prescribed psychotropic medication residing in restrictive housing are screened to determine admission eligibility into the TDU. Screening includes all types of controlled setting, in addition to disciplinary and administrative restrictive housing. Screening is conducted in a stepwise fashion, beginning with mentally ill offenders who are within one year of release. The second level of screening includes mentally ill offenders who have resided in restrictive housing for greater than one year. Screening priority continues based upon the length of time the mentally ill offender has been housed on a restrictive housing unit.

Another entry point to the TDU may occur during the initial disciplinary process. Mentally ill offenders who receive an incident report for a rules violation will be represented by a behavioral health staff member. In addition to the standard assessment of the offender’s competency and responsibility for the rules infraction, the behavioral health advocate assesses the offender for potential detrimental effects resulting from being confined on a restrictive housing unit. The behavioral health staff member also assesses any potential threat the offender may pose to the safety or security of the institution, based on the current rules infraction and past behavior.

Based upon the above factors, and with input from behavioral health staff, the disciplinary hearing officer (DHO) may elect to impose an alternative sanction, such as a referral to the TDU for therapeutic placement and intervention. The DHO may also elect to impose sanctions other than placement in restrictive housing as allowed by policy. This latter option would be considered if the offense was minor, and the behavioral health staff opines that the offender is stable and not imminently at risk for further negative behavior.

Mentally ill offenders in general population may also be referred to the TDU by a behavioral health provider or treatment team. This option should be considered when a mentally ill offender exhibits signs of instability or difficulty managing their behavior in open population. The TDU is utilized as “diversion” to further mental health decline or engagement in behaviors that might result in an incident report.

Eligibility for TDU placement is determined by a panel of representatives from behavioral health, custody, unit management and nursing. Exclusion criteria includes a history of assaultive behavior, severity of infraction resulting in current sanction, number of infractions over the past 12 months unrelated to a mental illness, history of sexually aggressive behavior, history of subverting or hoarding medication or other significant factors as determined by the screening panel.

Progress and outcome are measured using institutional outcome measures and a variety of validated assessment/outcomes measures, including

- The University of Rhode Island Change Assessment Scale (URICA);
- CBT Skill Acquisition: Challenge Version;
- World Health Organization Disability Assessment Scale (WHODAS 2.0);
- Cross Cutting Symptom Measures;
• Criminal Thinking Scales; and
• Personality Assessment Inventory (PAI).

TDU program participants are provided a minimum of 10 hours out-of-cell, structured therapeutic activity each week. Therapeutic activity includes both individual and group sessions. Additionally, participants are provided 10 hours per week of unstructured activity, including recreation, showering, telephone calls, visitation and leisure time. All out-of-cell therapy is documented in the medical record.

A daily schedule, which includes weekends, is developed for each TDU program participant. Community meetings with all TDU participants occur on a weekly basis. The intention of active participant input is to instill ownership for personal behavior and unit success. The program consists of three phases:

1. Phase 1 — Orientation.
2. Phase 2 — Active Treatment.
3. Phase 3 — Transition.

After successful completion of TDU programming, participants are transitioned to other housing, based on the recommendation of the treatment team. The intent is for participants to continue with programming post-release using interactive journaling as guided by their behavioral health provider.

Case Study
John Smith was diagnosed with schizophrenia. He often withdrew to his cell, exhibited poor hygiene, often had auditory hallucinations and frequently expressed paranoid delusions of others attempting to harm him. Before his acceptance into the TDU, he was in the inpatient institution hospital for these symptoms and was not compliant with his medications or treatment plan. Mr. Smith had been in restrictive housing for three years. After six months in the TDU, he was compliant with all medications and treatment. He had not incurred any infractions, would voluntarily come out of his cell and talk and participate with others, and was able to laugh and joke with both staff and inmates.

Cited Sources
**Additional Resources**


Treatment Mall

The Treatment Mall is a treatment model where programming is in a centralized area for mental health patients. Separate and away from their housing units, patients and staff from multiple units meet for a significant portion of the day. Staff provides a variety of programs and activities, such as recreation therapy, art therapy, stress management, anger management and other educational programs. The facility’s physical and staff resources are pooled and integrated at the mall so that everyone in the inpatient mental health facility has access to a full range of services. Previously, programming had occurred on the individual units, and only the patients on that particular unit were able to participate in the sessions. This Treatment Mall concept was modeled after a state hospital program developed in the 1990s but modified to be in-step with modern psychosocial rehabilitation principles and values. This model facilitates a physical and social environment in which inmates are more likely to become engaged in their personal recovery.

Application in Correctional Settings

North Carolina Department of Public Safety saw an opportunity to develop a program utilizing the Treatment Mall model. A multidisciplinary team consisting of the facility health care administrator, superintendent, mental health director, nursing director, mental health nurse supervisor, quality assurance director, clinical director and a variety of line staff, led by a contract state mental health administrator, developed a six-month plan that outlined the strategy for developing centralized programming in an area of the selected facility that was not being utilized effectively or efficiently. The plan recognized that the scope of the Treatment Mall project would require a dynamic planning strategy that allowed ongoing coordination from every area of the correctional health care facility. The plan included a timeline and a floor plan that projected space utilization. The planning also included time for the unforeseen variables that would emerge in the planning process. Supervisory staff reached out to their subordinates to get volunteers to lead classes.

For patients to participate in the mall, their primary provider wrote a “prescription,” based upon the individual treatment goals for the offender. Inmates were given a choice of classes, including Calm, Cool, and Collected for anger management, Dealing with Anxiety, Reading Rocks, Coping Skills, and Caring for Myself Upon Release. Every morning, staff and patients met in a large conference room labeled Homeroom. In homeroom, patients receive a schedule of the four different classes that have been selected for that day. They rotate through two one-hour long
classes in the morning, break for lunch and return for two additional one-hour classes in the afternoon. At the end of the week, each patient has received 20 hours of out-of-cell, structured activity. Every morning, staff scheduled to lead a group receive a roster of each patient that is scheduled to be in attendance for their session. If the patient is not in attendance at the start of the session, the instructor will notify the correctional officer that is providing supervision. Clinical providers are able to provide spot checks on their patients to ensure that the patient is engaged in his recovery. At the end of the day, each patient safely returns to their housing unit.

While early data have identified a decrease in use of force and restraints, self-injurious behavior and assaults on staff and inmates, the Treatment Mall’s impact on cultural change remains to be measured. What can’t be measured is the positive impact that the rehabilitation has on the patients and the hope they now have as they face their future.

**Case Study**
Jim J. has been diagnosed with bipolar disorder and has a measured IQ of 70. He is a new admission to the inpatient mental health facility. Before his admission, he admitted to medication noncompliance. As part of his intake screening treatment plan, the treating psychiatrist ordered his participation in the facility Treatment Mall focusing on education, managing his emotions and understanding his medications. Initially, Mr. J. had difficulty with basic letter and word recognition. In addition, he was anxious due to the adjustment of his first incarceration. After attending sessions that focused on the letter of the day, the word of the day, and eventually the sentence of the day, in addition to his compliance with medication and participation in yoga, Mr. J. was able to read his medication instructions and had adjusted to the day-to-day operation of his housing unit with minimal infractions.

**Resources**


Reentry describes an array of programming and services designed to assist the incarcerated population as they prepare for release and transition into the community. For many systems, reentry begins at Day One of incarceration as all staff within corrections help to engage the offender in positive, prosocial ways and match programming to need. Release planning represents a distinct component of the broader process of reentry services, focusing on success at the moment of release and in the days and weeks that follow. For example, while the larger reentry services plan may address long-term employment needs by providing training and education while in detention, the release plan would focus on the more short-term need for transitional employment.

Release planning draws upon the assessments, resources and relationships developed during the course of a person’s incarceration and utilizes this foundation to provide practical assistance to the releasing offender. Obtaining housing; health insurance; medication; medical and/or mental health follow-up appointments; and identification — a driver’s license or Social Security card — are examples of the types of assistance provided in a release program. It is important to consider the degree of offender need and plan accordingly, as, for example, individuals with special needs (e.g., dialysis patients and those with mental illness) and individuals who have served long sentences are the most challenging groups to assist in their return to the community.

Reentry/release planning staff supports individuals in multiple ways at pre- and post-release, connecting them to resources that will maintain their freedom and reduce recidivism rates. Research suggests that services that enhance an individual’s housing stability significantly decrease their likelihood to reoffend (Jones & Forman, 2016). Further, Jones and Forman highlight that post-release supervision/mentoring, employment and continued mental health/substance abuse treatment positively influence the chances of an individual’s not reoffending. Ideally, services should be in place before a person’s release into the community. In addition to the coordination and implementation of reentry services, communal support is equally important and vital to the successful reentry and transition into the community.

To assist individuals in securing housing and jobs, staff providing reentry services should be trained on how to increase their effectiveness in delivering the message that release is difficult, and transitioning in the community can be a challenge. One such tool that staff may utilize is motivational interviewing (MI). Motivational interviewing is a person-centered counseling style
that is designed to strengthen an individual’s motivation for and movement toward a specific goal by eliciting and exploring the person’s own reasons for change within an atmosphere of acceptance and compassion. Studies on MI indicate that the practice can be used to improve offender retention in treatment, enhance motivation to change and reduce criminal offending (McMurran, 2009). MI was developed to be a brief intervention that would help people resolve ambivalence and move toward change. Although MI has demonstrated effectiveness as a stand-alone treatment, some persons with limited problem-solving, decision-making and social skills benefit more from a combination of MI techniques and CBT interventions, such as cognitive restructuring and cost benefit analysis (Labrecque, Smith, & Luther, 2015).

New York City and New York State have several innovative reentry programs. The Center for Urban Community Services (CUCS) is one of these programs designed to assist with the transition and return to the community of incarcerated persons. CUCS services both New York City and New York State and assists with post-incarceration housing and supportive services. CUCS also collaborates with a SAMHSA permanent supportive housing unit to assist mental health providers to implement effective housing programs. Rikers Island Single Stop is CUCS’s New York City program that assists men and women with eviction, applying for benefits and legal matters.

Another example of reentry program is the Texas Department of Criminal Justice three-phased Reentry Program, which is done in conjunction with the Texas Correctional Office on Offenders with Medical and Mental Impairments (TCOOMMI). In phase one, offenders are assisted with getting a replacement Social Security card, certified birth certificate and state identification card at the time of release. During phase two, a risk-and-needs assessment is completed to identify those individuals who are at moderate to high risk of reoffending. In phase three, post-release individuals are provided with case management, employment readiness training and employment services.

**Application in Correctional Settings**

The Council of State Governments Justice Center (2014) has outlined a number of practices found to be effective in the planning and implementation of reentry services. The Council of State Governments Justice Center and the National Reentry Resource Center have released a series of user-friendly checklists specifically designed to help executive and legislative policymakers, state corrections administrators, and state reentry coordinators implement these proven strategies in their states.

Research has shown that certain practices and policies can reduce recidivism, including

- **Using risk and need assessments to inform case management.** Research shows that correctional programs with the greatest impact on recidivism sort individuals based on their risk of reoffending. Risk and need assessment tools examine both static factors such as the person’s history and demographics and dynamic or changeable criminogenic needs (also known as criminogenic risk factors) that research has shown to be associated with criminal behavior and that contribute to recidivism. The assessment produces a risk score that allows programs to sort individuals based on risk levels in a consistent and reliable
manner, tailor interventions and prioritize resources for those who are at higher risk of reoffending.

- **Establishing programs that have been shown to reduce recidivism and ensuring they are implemented with fidelity.** While specific approaches may vary across states, programs should be based on the best available science and research. Interventions that address criminogenic risk factors and take into account an individual’s responsivity factors, such as motivation for change, learning styles and mental health needs, are more likely to impact recidivism than those that do not. Programs should also establish desired outcomes and ensure means for measuring progress, such as regular quality assessments and evaluations.

- **Implementing community supervision policies and practices that promote successful reentry.** Improved community supervision that provides greater and varied support and ensures access to services is critical to efforts to reduce recidivism. Supervision conditions and programs should be informed by and reflect an individual’s risk and needs, logically focusing limited resources on those who are assessed to be at higher risk. Parole and probation officers should also have a range of options for swift and certain sanctions and incentives that are proportionate to the event and appropriate for the individual under supervision.

**Case Study**

Antonio, a 50-year-old man, was homeless at the time of his arrest. He was often seen talking to himself, had poor hygiene and tended to act aggressively in response to strangers. He was arrested for stealing and trespassing. Upon intake, he was identified as needing mental health services, such as medication and case management. He was given an opportunity to participate in job skills training through a community-based organization that volunteered in the jail. Before his release, this agency connected Antonio to a substance support therapeutic group, housing services and a health care agency that allowed him to get medical coverage for free. Upon his release, this same organization afforded Antonio an opportunity to obtain a job consistent with the training he received while he was incarcerated. An important element of this successful reentry support was the ability to move Antonio away from those community influences that had negatively influenced his previous decision-making skills. In addition to getting the skills in jail, the commitment of the community to employ this man positively influenced his life.

John, a 19-year-old young adult, has spent most of his teenage years involved in the criminal justice system. He was heavily influenced by his gang and did not engage in many positive activities. During his time in jail, he would often get into fights with other inmates to influence his housing arrangements. He was known to be verbally and physically assaultive to officers. As a result, officers and medical staff were not motivated to interact within John beyond what was absolutely necessary. Eventually, John was moved into a unit with a heavy focus on rehabilitation and programming for young adults. Initially, John was very dismissive of programming and noncompliant with therapy, both of which are important components of the housing unit.

One of the external programs that visited John’s housing unit was a community-based organization that engaged the young adults in playwriting and acting. The young adults were
encouraged to write their own plays and have performances at the completion of the course. It was not until this group started engaging with the young adults that John actively participated in any programming. After weeks of participation in this program, John received recognition for his hard work and the quality of his playwriting. When he completed the program, the organization wrote a letter to the court informing them of John’s progress. Additionally, they stated that once John was released, they would like to honor him with a scholarship to help continue his growth in playwriting.

Cited Sources


Additional Resources
Jail Diversion Programs

Inmates with serious mental illnesses are at a higher risk of reincarceration than those without any mental illness; therefore, it would be better if these individuals could avoid incarceration and receive community-based mental health treatment or be involved in a community-based diversion program (Baillargeon, et. al., 2009). Many local criminal justice systems are looking at programs that will involve both the community health and justice systems to divert these individuals from jails and get them the services they need through the community health services (Cloud and Davis, 2013).

Application in Correctional Setting

Specialized courts — such as drug courts, mental health courts and veteran’s courts — allow participants to receive treatment instead of incarceration. These diversion programs help not only reduce time spent in jail but they decrease re-arrest and help get these individuals connected to the correct community services they need (Steadman and Naples, 2005). Research by Steadman, Morris and Dennis (1995) as shown that to have a successful program, the program needs to have integrated services that involve the correctional system, judicial system and mental health system. The key participants should include judges, mental health professionals, public defendants, probation officers and jail administration who meet regularly to identify those who need these services and develop a specific program that involves the individual from arrest through treatment. One key person involved in this initiative needs to be a case manager, who is the client advocate and plays a role in the evaluation, treatment and monitoring of the client so that the individual can receive the necessary services.

Implementation of such programs can be cost effective, as seen in places like New York City, and Massachusetts, Illinois, and Pennsylvania (Cloud and Davis, 2013). They have been able to show a decrease in expenses regarding the treatment of individuals with mental illnesses in their judicial system, fewer arrests of mentally ill individuals and less need for hospitalization after being arrested. With these savings on the criminal justice side, more resources are available for treatment.
Case Study
Jane, a 35-year-old female, was in the Army for four years and did a tour in Iran before leaving the service. She has had a hard time finding employment and has recently become homeless. She has never been in any legal trouble but has found herself in jail because of an assault case. She was living on the streets and attacked another homeless woman. Jane appears disheveled, with poor hygiene and grooming. When the jailer tried to talk to her upon intake, her answers were illogical, and she appeared to be responding to auditory hallucinations. Jane denied any mental health problems, but having had training in recognizing the symptoms of mental illness, Officer Jones knew something was not right. He immediately contacted the local mental health authority, and Jane was able to be assessed by a psychologist who determined that she needed treatment instead of incarceration. Jane was seen in the Veteran’s Court, where the judge set up a multidisciplinary team made up of a probation officer, mental health professional, public defendant and case manager to work with Jane and make sure she got the services she needed instead of going to jail. Jane is now on medication and has a counselor whom she sees weekly, as well as a case manager who has been able to find her some appropriate housing. Jane has a job interview and has been able to reconnect with her family, as well, because of the help she has received from the Veteran’s Court.

Cited Sources


Veterans Services

Statistics indicate that veterans account for nine of every 100 individuals in U.S. jails and prisons (Hyde, 2011). A 2014 report by the Veterans Affairs (VA) states that the suicide rate among male and female veterans and military service members exceeds the national rate for the general population, accounting for 20 percent of national suicides. Sixty percent of veterans who died by suicide were diagnosed as having a mental health condition. Twenty percent of veterans in substance use treatment were homeless.

For many veterans and service members who suffer from military-related PTSD, part of the complex symptom presentation includes a sense of untreatable brokenness and/or the belief of being non-deserving of healing and/or redemption. These clinical symptoms commonly reinforce the persistence and longevity of PTSD. For these reasons and others, veterans are often seen by their clinicians as being “treatment-resistant.” Many veterans are not willing to help themselves, yet will readily take on a mission to serve others. Many incarcerated veterans have stated their urgent desire to prevent incarceration among non-incarcerated veterans and to promote their healing process.

For a non-incarcerated veteran with a serious mental illness (regardless of prior criminal history and incarceration), the VA offers a variety of community-based services and settings to address specific problems and to promote recovery. Serious mental illnesses (e.g., schizophrenia, depression, bipolar disorder and PTSD) are treated with medications and psychotherapeutic programs proven effective, i.e., “evidence-based,” for the specific mental health disorders. Across programs, the VA also encourages the use of “peer support,” i.e., veterans who have experienced mental illness themselves provide support to fellow veterans experiencing similar issues.

Application in Correctional Settings
The VA uses evidence-based treatments that have been proven to be effective for specific mental health disorders, and services are provided in a variety of settings. These therapeutic programs utilized by VA and tailored to the mental health and substance abuse issues found among veterans can be recreated within a jail or prison environment.

One area that the VA has taken the national lead on is the area of treatment for PTSD. PTSD can occur after a person has a very serious or life threatening, traumatic experience. For veterans, this
life threatening event often occurs during combat. However, other noncombat related events — such as natural disasters, motor vehicle accidents or sexual trauma — can also threaten life and result in PTSD. PTSD symptoms disrupt the person’s daily life as they re-experience the trauma and emotional distancing from other people and feel emotionally numb. Other symptoms of PTSD may include being irritable or quick to anger, trouble sleeping, nightmares, fearfulness or losing interest in things.

Treatments in the VA for PTSD include medications and psychotherapies such as

- **Cognitive Behavioral Therapy (CBT)** to help individuals understand the relationship between thoughts, emotions and behaviors; learn new patterns of thinking; and practice new positive behaviors;

- **Cognitive Processing Therapy (CPT)**, a manualized protocol specifically developed by the Federal Department of Veteran Affairs for PTSD. CPT is a form of CBT that involves correcting negative thought patterns so that memories of trauma don’t interfere with daily life; may also include writing about one’s traumatic experience. CPT conceptualizes PTSD as a disorder of non-recovery, in which a sufferer’s beliefs about the causes and consequences of traumatic events produces strong negative emotions that prevent accurate processing of traumatic memories and emotions resulting from the events. Because emotions are overwhelmingly negative and difficult to cope with, PTSD sufferers are blocked from the natural recovery process by using avoidance of traumatic triggers as a strategy to function in day-to-day living. This limits opportunities to process traumatic experiences and gain more adaptive understanding of them. CPT incorporates trauma-specific cognitive techniques to help individuals with PTSD more accurately appraise these “stuck points” and progress toward recovery. CPT has been proven effective in treating PTSD across a variety of populations, including combat veterans, sexual assault victims, individuals living in a “combat environment” such as destabilized countries with active warfare, and/or incarceration. CPT can be provided in individual and group treatment formats; and

- **Prolonged Exposure (PE) Therapy** to help people reduce fear and anxiety triggered by reminders of the trauma. This is done by confronting or being exposed to trauma reminders in a safe, treatment environment until they are less troubling. Prolonged exposure therapy helps people revisit traumatic memories in a safe environment. In this way, individuals can stop avoiding and reacting to trauma reminders and live their lives more fully in the present with greater freedom from the past. Veterans first remember the trauma by retelling it. Then they slowly become more comfortable with sights, sounds, and smells that remind them of the trauma. They learn to face situations in their current lives that they have been avoiding. The memories and situations become less troubling and interfere less with the person’s daily life.

For anxiety disorders, the VA uses medications and psychotherapies including

- **Cognitive Behavioral Therapy (CBT)** to help individuals understand the relationship between thoughts, emotions and behaviors; learn new patterns of thinking; and practice new positive behaviors (relaxation techniques, using calming tapes to improve sleep, exercising or socializing with friends);
• **Acceptance and Commitment Therapy (ACT)** to help people overcome their struggles with emotional pain and worries. It helps them recognize, commit to and achieve what’s important to them; and
• **Interpersonal Therapy (IPT)** to help people promote positive relationships and resolve relationship problems.

Treatments for substance use disorders include medications to decrease cravings and to ease withdrawal from alcohol and opiates (buprenorphine and methadone can also be used as therapeutic substitutes for illegal drugs), and psychotherapies such as

• **Motivational Enhancement Therapy** to help the individual strengthen his/her commitment to recovery; and
• **Cognitive Behavioral Therapy (CBT)** to help the individual identify the risks for relapse and learn new coping skills to avoid relapse.

In addition to these psychotherapies, the interaction between humans and canines in a prison setting has therapeutic benefits. Studies show that simply petting a canine is proven to increase positive levels of oxytocin, prolactin and dopamine, and decrease harmful cortisol (Yount, et. al., 2013). As a result, this interaction has been proven to lower blood pressure, mean arterial pressure, cardiac stress hormones and subjective pain ratings. Canine programs offer hands-on learning through service to others. Learned skills include communication skills, substance abuse control, mood regulation, vocational skills and the opportunity for participants to earn a certification. Partnerships can be established with canine programs such as local Society for the Prevention of Cruelty to Animals or organizations like New Life K9 with a potentially negotiated no cost to the institution (Yount, et. al., 2012).

**Case Study**
Inmate X is 50 years old and serving a life sentence for murder. He is a veteran and is on a maximum security yard. He has received some mental health services throughout his incarceration due to depression, isolation from any support outside of prison, and thoughts of committing suicide due to a lack of meaning in his life. He takes medication to help with sleep and depressive symptoms. He was recruited to participate in the Canine Program and one of the facility’s first inmate-trainers. Mr. X describes that the first time he was allowed to touch and pet his assigned dog, he nearly cried from the tenderness of being able to engage in touch. He started to feel the enormous responsibility that came with teaching his dog, but also felt pride in the dog’s progress as proof of his effort. He felt, for the first time in prison, that he was permitted to show emotion and that connection was not viewed as a weakness, but as a strength. He started to feel a sense of meaning and purpose in his daily life and the desire to learn something new. As his dog became his companion and relied upon him for daily life within the walls, Mr. X started to feel less depressed and asked to have his medication reduced and eventually discontinued because he slept at night. He no longer had thoughts of wanting to kill himself. He started to create relationships with other inmates that he previously would have been barred from having contact because of their common goal of training the dogs. He started making sure that he programmed in all areas of his prison life because it meant ensuring his spot in participating with the dog program. Mr. X stated that the dog program “changed my life …. I have emotions that I haven’t felt in years … good feelings.”
Cited Sources


Additional Resources

Training

Due to the increasing number of inmates presenting with mental health issues to jail and prison systems, it is imperative that mental health assessment and treatment services be available and provided by qualified, credentialed professionals. In addition, because correctional personnel are the first and principal contact for inmates in any correctional environment, as well as the primary caretakers and supervisors of inmates on an ongoing basis, correctional staff must be aware of the potential signs and symptoms of mental illness and suicidal/self-harming risk behaviors. Further, they need to know the proper first responder response to life-threatening situations.

Training for both mental health care professionals and correctional staff is an important part of ensuring that inmates receive appropriate care while in custody. Appropriate and timely intervention and assistance to mentally ill inmates contributes greatly to maintaining the safety of all inmates and staff in a facility.

The American Correctional Association (ACA) and the National Commission on Correctional Health Care (NCCHC), through their accreditation standards for jails and prisons, clearly establish the need for initial and ongoing training for correctional officers, professional and support staff, including health care employees and contractors. This training includes information related to the supervision of inmates, recognizing signs and symptoms of mental illness/substance abuse, communication with inmates and staff, signs of suicide risk and suicide precautions, along with procedures for suicide prevention and intervention and appropriate referrals to mental health staff.

Application in Correctional Settings
1. ACA’s Correctional Behavioral Health Certification
   ACA has developed the Correctional Behavioral Health Certification (CBHC) program that provides manualized instruction in relevant national standards and guidelines, legal and ethical principles, relevant security regulations, and the role of correctional professionals associated with behavioral health services in jails, prisons, juvenile justice facilities, community corrections, and other correctional facilities operated by special jurisdictions. An examination upon completion of the program ensures the content knowledge base. Eligibility for the CBHC is extended to correctional officers, community corrections officers, and allied behavioral health staff with minimal education, credentials and experience that are associated with the provision of behavioral health services for mentally ill inmates or offenders.
2. National Institute of Corrections’ Crisis Intervention Teams (CIT) Training
In searching for meaningful methods of responding to the needs and challenges presented by the significant population of mentally ill inmates in their systems, some correctional agencies in partnership with stakeholder communities, have implemented Crisis Intervention Teams (CITs). CITs have matured from a street-patrol, first-responder model to new community partnerships with corrections. This team approach incorporates community, front-line law enforcement and corrections agencies in a collaborative effort to address this growing problem. CITs are effective in enhancing correctional staff’s knowledge and skills, aiding administrators in improved management and care for the mentally ill, reducing liability and cost, improving community partnerships for increased access to resources and supports, and increasing safety for all. The 40-hour NIC model includes classroom didactic sessions and scenario-based, role-play exercises.

3. Mental Health First Aid
The Mental Health First Aid curriculum teaches a five-step action plan, known as ALGEE, for use when providing Mental Health First Aid to an individual in crisis:

- **A** — Assess for risk of suicide or harm
- **L** — Listen nonjudgmentally
- **G** — Give reassurance and information
- **E** — Encourage appropriate professional help
- **E** — Encourage self-help and other support strategies

Peer-reviewed studies published in Australia, where the program originated, show that individuals trained in the program

- Grow their knowledge of signs, symptoms and risk factors of mental illnesses and addictions;
- Can identify multiple types of professional and self-help resources for individuals with a mental illness or addiction;
- Increase their confidence in and likelihood to help an individual in distress; and
- Show increased mental wellness themselves.

The program is designed to improve participants’ knowledge and modify their attitudes and perceptions about mental health and related issues, including how to respond to individuals who are experiencing one or more acute mental health crises (i.e., suicidal thoughts and/or behavior, acute stress reaction, panic attacks, and/or acute psychotic behavior) or are in the early stages of one or more chronic mental health problems (i.e., depressive, anxiety, and/or psychotic disorders, which may occur with substance abuse).

After completing the course and passing an examination, participants are certified for three years as a Mental Health First Aider.

**Resources**


National Commission on Correctional Health Care. (2009). Standards for mental health services in correctional facilities. Chicago, IL:
Physical Plant Considerations

In general, housing inmates in correctional institutions presents myriad challenges, the most critical of which is safety. Housing inmates with mental health disorders presents even further difficulties, because their behavior can be unpredictable and impulsive and may include the risk of self-harm or harm to others.

Research by psychologists and architects has found that the design features of the jail/prison environment impacts inmate behavior, the results of therapeutic efforts and the outcome of the correctional experience. For the mentally-ill population in correctional settings, the most therapeutic environments should be as small, “home-like” and “normative” as possible. Recognizing that healing occurs through social interaction and a culture of caring, designs should allow persons to communicate and remain connected with each other, and maintain the inmates’ human dignity.

The impact on staff and inmates of the physical environments of a secure mental health unit should be considered. Research supports that the factors that positively impacts inmate behavior can also improve staff morale and lessen stress in staff.

The concept of creating a “healing environment” should be considered in the interior and exterior design of new facilities and renovation of existing facilities. The types of settings that appear to be most successful in supporting good mental and physical health are

- Enriched with color, art, music, views of nature, opportunities for positive stimulation, etc.;
- “Normative,” allowing patients to maintain as complete a behavioral repertoire as possible; and
- Familiar and meaningful, offering full support to the inmate with opportunities for information, choice and activity within a recognizable, albeit secure, environment.

Specifically, and within security constraints, there should be

- Multipurpose areas and areas for congregating;
• Private areas for confidential treatment services;
• Access to outside space and fresh air;
• Natural and full-spectrum lighting;
• A quiet environment or access to “quiet areas”; and
• Good indoor air quality.

The size and capacity of housing units should be considered, as smaller units allow for visibility and observation of inmates by staff and more frequent communication between staff and inmates. Units for the mentally ill should be continuously staffed and offer direct supervision.

In addition to considerations in the construction and layout of the physical plant, all fixtures (e.g., lighting, equipment) and furniture should be specially designed for the mental health population in order to reduce the possibility of self-harm.

Case Study
The use of segregation in correctional settings has been under scrutiny given the potential psychological and physical effects of restricted conditions of confinement. This is particularly the case with adolescents and young adults. As a means to foster social engagement within the restricted housing environment, facilities have created “treatment pods” as a means to increase group interaction while maintaining the necessary physical separation. Other facilities have used treatment chairs, which allow individuals to be minimally restrained to a desk to maintain separation but that more closely resemble the conditions of a classroom. Some facilities have developed separate units for their inmates with significant mental health issues that have been reconfigured to enhance rehabilitation and create a therapeutic environment. These units have lighter paint on the walls, accessible windows for fresh air, and officers trained specifically to engage with individuals suffering from mental health disorders. The units have an open dayroom setting with tables and areas for congregation scattered throughout. Also, walls have been decorated with positive affirmation statements, and murals have been created by individuals living in the space. Overall, the specialty housing units that focus on addressing mental health have significantly lower incidents of violence and uses of force.

Resources
