Reducing Risk and Responding to Mental Health Needs: Kentucky's New System of Care

By Connie Milligan and Ray Sabbatine

Imagine a simple solution to some of America's detention centers' most complex problems, a solution that involves a system of care that would reduce suicide and expand mental health services, and would not increase cost to the jails. That was the task and the accomplishment of the Kentucky Jail Mental Health Crisis Network. After the first year of implementation, the data appear to show that this new network of services, fully funded by legislative action through an increase in court cost, is reducing suicides and increasing service connections.

Why was this needed? In 2002, the *Louisville Courier Journal* did an investigative report on 17 suicides and two deaths in restraints that had occurred in Kentucky jails in the previous 30 months.[1] The articles highlighted the disconnect between proper risk assessment and the appropriate delivery of services. It was clear that detention center personnel were being asked to provide services to a population they little understood without the training and skills to manage them, while mental health professionals were not adequately involved.

Kentucky legislators took notice of the problem, and during the 2002 legislative session, four hours of mental health training was mandated for all detention center personnel. The authors, who were involved in the development and the delivery of that training, heard from the jailers that, although the training was helpful, it was not a substitute for

actual services. In 2003, the authors began to develop a consultation service — the Telephonic Triage program — and piloted it in five jails. It was clear from the outcomes of the pilot program that the jails needed a more comprehensive service delivery system. Because of limited local and state resources for new jail services, legislative funding was sought for the program in 2004. With the passage of the legislation and more than a year of implementation across the state, Kentucky has a new program that takes a different approach to solving a problem that plagues detention centers across the nation.

The solution, implemented by legislative action in 2004, is a new statewide program that involves a four-step process to clearly define protocols for integrating mental health services into the state detention centers.[2] It includes the use of two standardized detention center risk-screening instruments; a telephonic triage to assess the level of mental health risk; recommended management protocols defined for each risk level; and follow-up services provided by the regional community mental health boards.

The goals of this program are to identify suicide and/or acute mental health symptoms, reduce self-harm and suicide in jails, provide a secondary level of assessment by a licensed mental health professional, and to increase possible diversion and treatment.

Rationale for Kentucky's Solution

In Kentucky, most of the 86 jails are in rural areas, are governed by local fiscal courts, and have difficulty accessing and affording services. In many areas, the use of criminal charges and jail time has become the most frequent solution for difficult social problems that would be better served by extensive professional involvement. This includes behavioral problems related to mental illness, suicidal behavior, domestic violence and substance abuse. Alternatives such as court diversion programs and extensive treatment programs are unavailable in rural areas. Although some of the larger detention centers have contracts for mental health services, most small to medium-size jails are dependent upon limited medical staff for risk assessment. Thus, the day-to-day management decisions and response to these complex behavioral problems are left to officers. Staff discretion in caring for and responding to people with mental illness and/or who are suicidal can pose tremendous risk. It becomes clear that the more those decisions are taken out of the hands of staff who are not trained or considered mental health experts, the better.

According to the National Institute of Corrections, objective jail classification "is considered one of the most important management tools for jail administrators and criminal justice system planners." It helps ensure consistency in assessing and responding to the risk and needs of individuals by offering clear protocols and a consistent nonsubjective model for decision-making. It helps ensure safe housing, management and response to the highest risk people. A classification system used in Lexington Fayette County Detention Center resulted in the detention center experiencing a dramatic reduction in suicides, from 10 in a 13-year period to none in the 12 years after classification was implemented. Kentucky's program has been developed based on the lessons learned from this experience.

The protocols for the program are built on the basic tenants of a good classification system and integrate most of the key components that Lindsay Hayes, project director of the National Center of Institutions and Alternatives, has promoted for the reduction of suicide in jails.[3] It includes standardized screening instruments, telephonic triage, jail-management protocols and mental health follow up.

Standardized Screening Instruments

The success of this program is dependent on the detention center's use of reliable and standardized screening instruments. The two questionnaires developed for this program have no more than 20 yes-or-no questions that reduce the booking/screening officer's role in making judgment calls. The yes answers have prompts on who to notify if risk is present.

The first instrument is given to the arresting officer. It has been noted in Kentucky, and is certainly true across the country, that numerous deaths have occurred because critical information was not provided by the arresting officer. Three questions related to behavioral indicators of suicide, mental illness or negative reactions to the charge are immediate prompts for a call to the Telephonic Triage Line (described below).

The second instrument is given to the arrestee by the booking/screening officer. Again, the questions are limited to those that simply identify risk and need. The five questions that are flags for a call to the Triage Line include a serious mental health problem that needs attention; a history of psychiatric hospitalization in the past year; history of a suicide attempt; current suicidal thinking; and a severe reaction to the charge that may result in self-harming behavior. Additional yes answers to the questions related to substance abuse, mental retardation and acquired brain injury are also reviewed during the Telephonic Triage.

During the training, detention center personnel are instructed to supplement the intake and booking questionnaires with additional processes to identify risk at any time during incarceration. This includes an alert file on people with previous high-risk status, officer observation of mental health or suicide risk, individual requests for services, and an automatic reassessment of risk when the legal status changes for the worse. Therefore, this program recommends that six different methods of identifying risk and need be used by detention center personnel.

Telephonic Triage Line

The toll-free Telephonic Triage Line offers 24-hour response by a licensed mental health professional who uses a research-based mental health and suicide risk-assessment instrument. This instrument was developed with consultation from a technical resource provider from NIC. A positive answer to any of the mental health and suicide flags on the screening instrument (or from other methods of identification) prompts an immediate call to the 24-hour toll-free Triage Line.

The intent of the triage is to identify a level of risk related to current and potential symptoms of suicide and mental illness. The risk level corresponds to clear protocols for

detention center management and follow-up services. Because the service is offered telephonically, it is not intended to be a psychosocial or diagnostic assessment. The triage is a guided interview with the detention center officer and also includes direct conversation with the individual in question. It included questions in the following categories: risk related to the charge, risk related to substance abuse withdrawal or overdose, risk related to suicide and risk related to symptoms of mental illness in four diagnostic categories. Additional factors also are considered and include history of hospitalization and treatment, substance abuse, post-traumatic stress disorder, victimization, mental retardation/ developmental disabilities and acquired brain injury. Each one of the data variables is defined in a data dictionary so that the mental health professionals and the detention center personnel can be consistent in their interpretation of terms.

The Telephonic Triage information is scaled at three points in the triage process: the risk related to the charge, the risk related to suicide (including current substance use risk), and a final risk level that integrates suicide and the mental illness variables. The final level of risk is tightly defined with protocols to guide the clinicians' determination and is labeled critical, high, moderate or low. The risk assignment also includes recommendations for additional follow-up services that include a face-to-face follow-up visit by a local mental health professional, civil commitment to a psychiatric facility or referral for a competency evaluation. The triage clinician e-mails or faxes the completed triage assessment to the detention center and the follow-up clinician, and makes calls as needed for follow up.

Jail Management Protocols

The Telephonic Triage summary risk level is tied to suggested detention center risk-management protocols. These protocols represent the best practice standards in the industry and integrate typical detention center standards and classification program recommendations. For each clinical risk level, the detention center is guided on housing, level of supervision, property, clothing and food. Again, it ties the mental health risk back to appropriate, safe and humane detention center management.

The clinical risk levels' management techniques encourage the detention centers to implement new best practice protocols. For instance, the critical risk level is reserved for when an individual is actively trying to take his or her life. Four-point restraints are no longer acceptable because of the high safety risks they pose. At the high-risk level, safe or single-cell housing is used along with frequent and staggered supervision (instead of the standard 20-minute observation in most detention center protocols). This type of supervision ensures that someone on a suicide watch does not find opportunity for an attempt. Suicide smocks are recommended instead of paper jumpsuits. The only property allowed is a suicide blanket. Finger foods are recommended. At the moderate risk level, the individual can be in general housing but will receive individualized observation to determine if he or she develops symptoms that need further assessment. The low-risk level indicates that the individual can be housed in general population.

Follow-Up Mental Health Consultation

The final innovation of this program is the funding for the regional community mental health center boards to provide 24-hour coverage for detention center emergency follow-up response. The result is now a tight system of response that has trained clinicians on 24-hour call to respond to detention center emergencies as identified during the Telephonic Triage.

Mental health follow-up is defined as a consultation service to those individuals with acute risk for suicide or mental illness. It is a mandatory response for people assessed at the critical level of risk and required for those with acute symptoms at a high level of risk. To ensure consistency in response across the state, time frames are established for each level of risk. Critical level of risk requires a three-hour response time; high level, a 12-hour response time; and moderate level, a next business day, or as needed response time.

Clinicians conduct an assessment to determine if the triage risk assessment and the corresponding risk-management protocols should be maintained, reduced or increased. In addition, the clinician determines if other services are needed, makes consultation recommendations and initiates the legal process for diversion to hospitals, or in some circumstances, for conditional release, dependent on outpatient follow up. Most important, the clinician becomes an important ally to the people with mental illness and a consultant for risk management to the detention center staff. Staff in both agencies are now being cross trained.

Program Results

In the first year of implementation, there was 88 percent participation among Kentucky detention centers, with more still requesting training and entry into the program. The data are showing some interesting results.

Of the 5,500 triages completed in the first year, it is estimated that they represent 7 percent of the bookings. This is consistent with data from national clinical studies that suggested 6 percent to 16 percent of individuals in city or county detention centers have mental illness.[4]

The data provide an interesting profile of the people with suicidal and mental illness risk factors who are incarcerated in Kentucky jails:

- A high percentage of people (64 percent) have relatively minor misdemeanor charges;
- The relatively low number of people who are at risk related to their charge (12 percent) actually pose some of the highest risk for self-harm;
- Suicidal risk represents a great concern to the jails. It is present in 65 percent of the people triaged, with high- to critical-risk protocols needed in 35 percent of the cases;
- The high rate of previous psychiatric hospitalization (30 percent during the past year and 16 percent in the past six months) confirms what is known anecdotally: Many of these people are falling through the cracks of an unsuccessful cycle of hospitalization, failed outpatient treatment follow up, and arrest on relatively minor misdemeanor charges;

- The rate of concurrent substance use problems is 38 percent lower than expected;
- Seventy-seven percent have mental health symptoms, a greater rate than in the general population; and
- High risk is not being over-identified: A low number of people are at the critical level of risk (0.5 percent) and 32 percent are at high risk.

According to Kentucky Justice Cabinet officials, the jail self-report of in-custody suicides indicates that the suicide rate in Kentucky jails has been significantly reduced since the inception of the program. The 17 deaths by suicide that were reported from 2000 to 2002 have been reduced to one from 2003 to 2005 in jails participating in the state Jail Mental Health Crisis Network. The program appears to be accomplishing one of its significant goals.

Observations from clinical staff include recognition that this is important work, and the previous barriers between jails and mental health agencies have been reduced by a new spirit of collaboration and cross-training. Problem-solving continues. Issues being discussed include how to increase pre-arraignment and post-arraignment diversion through collaboration with pretrial release officers and the courts, and increasing in-facility treatment options. The clear cycle of recidivism suggests new treatment options must be considered.

The new Kentucky Jail Mental Health Crisis Network is bringing mental health services to the detention centers, increasing the cross-training in both professions and reducing the rate of suicide in Kentucky jails. The detention centers now have statewide best practice protocols that reduce their risk and provide better options for people with mental illness or suicide risk. The triage process, follow up and tight protocols reduce the staffing outlay for managing risk and provide good consultation. It is a program that has clear potential for future development.

ENDNOTES

[1] Adams, J. 2002. Locked in suffering: KY jails and the mentally ill, a four-part series. *Louisville Courier-Journal*, Feb. 24-March 3.

[2] Kentucky Revised Statues. 2004. HB 157 SCS(2), create a new section of KRS chapter 21, KRS 441 and KRS 23A and 24A.

[3] Hayes, L. 2003. Jail suicide and liability and policy assessment and development services. National Center on Institutes and Alternatives. Available at www.ncianet.org/cjjsl.cfm.

Crawford, M. 2005. Attitude, communication can prevent suicide. Nov-Dec 2005, CorrectionalNews.com.

[4] Lamb, R. and L. Weinberger. 1998. Persons with severe mental illness in jails and prisons, a review. *Psychiatric Services*, 49 (April):483-492.

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