

Academic-Correctional Partnership: Connecticut's Mental Health Services Program

By Robert L. Trestman

According to the Bureau of Justice Statistics, the total number of individuals incarcerated on any given day in U.S. jails and prisons has exceeded 2.1 million. Of critical importance to this societal shift, 97 percent of these individuals will return to the community at the end of their sentences, BJS calculates.

Complicating this picture is the fact that the correctional population has far more illnesses than the average population. In terms of chronic general medical illness, 4.8 percent have diabetes,¹ 3 percent of women and 1.9 percent of men are estimated to be HIV-positive² and 31 percent have hepatitis C.³ In addition, 29 percent actively abuse or were addicted to illicit drugs prior to incarceration.⁴ These factors, and more, have strained corrections' capacity to deliver adequate care, and constitute a major challenge to the field's ability to address these overlapping public health, public safety and health care concerns.⁵

One area in particular that has become a focus of concern is the disproportionate number of incarcerated mentally ill individuals. U.S. jails and prisons have become a substantial source of public psychiatric services for individuals with serious and persistent mental illnesses.⁶ During 2003, more than 750,000 individuals with serious mental illness were incarcerated. The largest mental health treatment centers in the country are jails. Los Angeles County, Cook County, Ill., and Riker's Island in New York each house more than 15,000 inmates, of which more than 2,500 receive mental health treatment on any given day.

The situation is similar in Connecticut. About 14 percent of the inmates incarcerated in the state's jails and prisons in December 2004 were in active treatment for mental illness, and an additional 29 percent have a history of prior treatment. According to the Connecticut Department of Corrections, between 2 percent and 3 percent meet criteria for severe and persistent mental illness.

In this context, local, state and federal jurisdictions have been forced to look for ways to handle the growing proportion of inmates with mental illness. Until such a time when alternatives to incarceration are adequate in scope and number, the corrections field is forced to develop effective strategies to cope with substantial numbers of incarcerated mentally ill individuals.

Why Are More Mentally Ill People Behind Bars?

Moving the mentally ill from hospitals to services in the community, or deinstitutionalization, is widely considered a contributing factor for the placement of mentally ill individuals in the criminal justice system.⁷ Deinstitutionalization was a response to the concern that grew in the nation in the late 1950s and 1960s over the long-term warehousing of the mentally ill in substandard state hospitals.

However, deinstitutionalization was often poorly implemented. This had clear consequences: more mentally ill out in communities that were poorly equipped to serve them. The very nature of many mental illnesses — that may, at least episodically, include emotional instability and impulsive behavior — increased sufferers' risks for incarceration. This became the unintended consequence of the public's increasingly strong desire for improved safety in the 1980s and 1990s, with increasing arrests for illicit substance use, longer sentences and more common use of mandatory sentencing guidelines.⁸

The Legal Framework and Service Delivery Issues

In 1976, the U.S. Supreme Court ruled in the landmark case *Estelle v. Gamble* (429 U.S. 97, 1976) that prison officials cannot be indifferent to inmates' medical needs. Federal and state rulings since then have interpreted the law to require both medical and psychiatric care and have developed various criteria for care. In its recent guidelines for psychiatric

services in jails and prisons, the American Psychiatry Association outlines three basic types of services: screening, referral and evaluation; treatment; and discharge planning.

These basic services must be provided to the mentally ill in both prisons and jails. The different environments, of course, call for different approaches. Prisons, where individuals are confined for sentences generally lasting a year or more, require a global service delivery approach including outpatient through inpatient levels of care. Jails, where individuals are held while awaiting trial or while serving a sentence (typically of one year or less), have a high turnover rate and a significant proportion of people are held for short periods of time. The jail environment is one where the care delivery approach may appropriately emulate that of a comprehensive emergency room, with the emphasis on assessment and crisis intervention. In both environments, there must be a real focus on linkage with community mental health care providers, to promote continuity of care on admission, and with community aftercare services, to ensure that gains made by inmates while in the correctional environment last after they are discharged.

The Role for Academic Health Centers

Both the jail and the prison environments provide academic health centers the opportunity to provide, in an integrated fashion, the broad scope of services that might not be readily available to the severe and persistently mentally ill individuals in the community.⁹

Specifically, academics can bring to bear multiple tools including awareness of state-of-the-art clinical assessment and intervention; research skills to examine service delivery methods to ensure continuing improvements; and a commitment to training the next generation of clinicians.

Each level of care, from triage and screening to ambulatory treatment to structured residential programs, requires adaptation from community models. There has been very little research done to determine the effectiveness of these models when used in a correctional environment. Clearly, academics can and should play a role in that research.

Individuals are under considerable stress in the correctional environment. Potential strategies for reducing and handling that stress require the development of situationally appropriate programs of distress and behavior management. Several potentially relevant evidence-based treatments have been developed for community settings; a role for academics lies in tailoring appropriate programs specifically to the correctional environment.

Quality assurance and quality improvement initiatives are an expanding component of any health care delivery system. Helping to build coherent programs in a correctional environment may lead to the opportunities for generalizable knowledge in the form of published data that can guide the field to improved care, more efficient service delivery and better outcomes.

Education is a key component to maintaining the clinical sophistication and acumen of the mental health care staff. Inherent in academia is the role of education and the capacity for continuing medical education. Additionally, with work force development opportunities linking the training of different disciplines — social work, psychology, medicine, psychiatry — can help to build a solid foundation for recruiting the next generation of well-trained and dedicated clinicians.

The University of Connecticut Health Center Experience

In 1996, the Connecticut DOC approached the University of Connecticut Health Center about assuming the provision of all health services for those under its jurisdiction. In response, the health center proposed the Correctional Managed Health Care (CMHC) program. In 1997, CMHC was officially established and the health center began assuming the DOC's existing health care programs. The final transfer of approximately 560 employees from the state's 20 correctional institutions took place in November 1997. Total assumption of the program, including pharmacy and laboratory, was completed in December 1997. Since then, the health center has become the provider of health care and mental health services to the incarcerated population of the state of Connecticut, one of six states in the nation with a combined or integrated jail and prison system. Through CMHC, the health center has developed a comprehensive health care delivery system for the Connecticut DOC. The program has all of the operational characteristics of a staff-model HMO.

Training the Next Generation of Clinicians

The health center has established several programs that rotate students and fellows through the DOC. For example, candidates for a master's degree in social work from the University of Connecticut School of Social Work hold internships at DOC facilities. Health center medical students may select a clinical psychiatry rotation at a correctional institution for men or for women. Students participate in initial evaluations, crisis management, ongoing ambulatory care and inpatient care under the supervision of a faculty member. Psychiatry residents in the third postgraduate year and addiction psychiatry fellows participate in faculty-supervised clinics in several prison and jail facilities. By exposing young professionals to the environment, the health center faculty is informing them of the opportunities of, and need for, clinical care provision and research in the correctional environment.

One academic model that has been adopted is the case conferences on particular patients. These conferences bring additional staff and a focused attention to a particular case with the goal of improving the delivery of care and the outcome for the patient. It also makes it clear that expectations for care delivery are high and that caregivers will cooperate and assist each other to promote treatment improvements.

The health center and CMHC staff have held regularly scheduled mental health conferences for all mental health staff in correctional facilities around the state. The conference format provides intensive sessions in key areas of mental health care delivery geared specifically to the correctional environment. It is structured so physicians get continuing medical education credits and other mental health professionals earn continuing education credits. The program has focused on topics with direct and current relevance to the correctional setting, including depression in a correctional setting, HIV and co-occurring mental illness, severe personality disorders, substance abuse and co-occurring mental illness, and malingering. The conferences create opportunities for staff development and research and have helped to recruit and involve highly qualified clinicians who otherwise might not have been interested in working in

Potential strategies for reducing and handling that stress require the development of situationally appropriate programs of distress and behavior management.

the correctional environment. By investing energy, supporting staff development, creating and supporting research initiatives, and bringing students into the correctional environment, it is CMHC's goal to help raise the standards of mental health care in Connecticut's prisons and jails.

Bringing Additional Resources

Since establishing CMHC, the health center has worked closely with the DOC to develop mutually agreeable research programs that support the mission of both organizations. The health center has also brought additional resources to the work by obtaining federal grants. A grant from the National Institute of Justice has funded the development of a gender-specific, race- and ethnicity-sensitive screening tool for the recognition of mental illness upon admission into jail. This validated, sensitive and specific tool is brief and may set a national standard for the nation's 3,500 jails.¹⁰ The study is directly relevant to the needs of the correctional environment and arises from a collaborative research agenda. Behavioral problems resulting from symptoms of severe mental illness often lead to potentially dangerous security and management problems during incarceration.¹¹

A second project funded by the NIJ seeks to adapt dialectical behavior therapy to prison settings. Dialectical behavior therapy is a successful evidence-based treatment program designed for the community treatment of individuals with disorders of emotion regulation, impulse control, anger management and/or interpersonal relationships.¹² As these same problems are frequently central to the issues of the incarcerated mentally ill, and directly overlap with the mission of DOC for institutional and community safety and security, this initiative has been fully supported by all stakeholders. Behavioral problems due to the symptoms of severe mental illness also can lead to a failure in community readjustment after release and a return to crime and further costly involvement with the correctional system.

These projects, plus others not mentioned here, represent the beginning of the Center for Correctional Mental Health Services Research, an ongoing collaboration between the DOC, CMHC and the University of Connecticut Health Center's Department of Psychiatry.

Collaborating for Improvement

By virtue of their combined interest and expertise in clinical care, teaching and research, academic health centers are ideally suited to provide the care required by the mentally ill in the nation's prisons and jails. It is a collaboration that benefits all stakeholders: the inmate who is a patient, the custodial organization, the community and the academic health centers.

The inmate stands to benefit from improved, evidenced-based care delivery linked to outcomes and provided by highly motivated and educated clinicians and their students. The custodial organization will benefit because appropriate treatment of the mentally ill is directly supportive of its mission to provide public and institutional safety. The community is interested in receiving back, from incarceration, citizens who are healthier and more likely to

be productive members of society. Once again, effective treatment of mental illness works to further that interest.

The partnership of the Connecticut DOC and the University of Connecticut Health Center is consistent with models evolving in other states of academic-correctional contracting¹³ and moves closer toward a model of close collaboration that promotes both public health and public safety.¹⁴ Given the current state of affairs, the greatest public good is likely to come from academic medical centers assuming greater responsibility for the care of the incarcerated mentally ill.

ENDNOTES

¹ American Diabetes Association. 2004. Diabetes management in correctional institutions. *Diabetes Care*, 27(1):S114-S121.

² Maruschak, L.M. 2004. *HIV in prisons and jails, 2002*. Washington, D.C.: Bureau of Justice Statistics, U.S. Department of Justice, Office of Justice Programs.

³ Beck, A.J. and L.M. Maruschak. 2004. *Hepatitis testing and treatment in state prisons*. Washington, D.C.: Bureau of Justice Statistics.

⁴ Bureau of Justice Statistics. 2002. *Criminal offenders statistics*. Washington, D.C.: Bureau of Justice Statistics.

⁵ Anno, J.B. 2001. *Correctional health care: Guidelines for the management of an adequate delivery system*. Chicago: National Commission on Correctional Health Care.

⁶ Metzner J. 1998. An introduction to correctional psychiatry: Part III. *Journal of the American Academy of Psychiatry and the Law*, 26(1): 107-115.

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

⁷ Lamb, H.R. and L.E. Weinberger 1998.

⁸ American College of Physicians, National Commission on Correctional Health Care. 1992.

The crisis in correctional health care: The impact of the National Drug Control Strategy on correctional health services. *Annals of Internal Medicine*, 117(1):71-77.

⁹ Appelbaum, K.L., T.D. Manning and J.D. Noonan. 2002. A university-state-corporation partnership for providing correctional mental health services. *Psychiatric Services*, 53(2):185-189.

Raimer, B.G. and J.D. Stobo. 2004. Health care delivery in the Texas prison system: The role of academic medicine. *Journal of the American Medical Association*, 292(4):485-489.

Kendig, N.E. 2004. Correctional health care systems and collaboration with academic medicine. *Journal of the American Medical Association*, 292(4):501-503.

¹⁰ Ford, J.D., R.L. Trestman, V. Hogan and W. Zhang. (under review). Development and initial validation of a brief screening tool to identify newly incarcerated women and men with undetected psychiatric disorders. *Psychological Assessment*.

¹¹ Metzner, J. 1998.

¹² Koerner, K. and M. Linehan. 2000. Research on dialectical behavior therapy for patients with borderline personality disorder. *Psychiatric Clinics of North America*, 23(1):51-67.

¹³ Appelbaum, K.L., T.D. Manning and J.D. Noonan. 2002.

Raimer, B.G. and J.D. Stobo. 2004.

¹⁴ Kendig, N.E. 2004.

Robert L. Trestman, Ph.D., M.D., is a professor in the Department of Psychiatry at the University of Connecticut Health Center.

... the greatest public good is likely to come from academic medical centers assuming greater responsibility for the care of the incarcerated mentally ill.

