JAIL SUICIDE/MENTAL HEALTH UPDATE

(A joint project of the National Center on Institutions and Alternatives and the National Institute of Corrections, U.S. Department of Justice)

Fall 2007 **Volume 16 • Number 2**

TREATMENT AND REENTRY APPROACHES FOR OFFENDERS WITH CO-OCCURRING DISORDERS

by

Roger H. Peters and Nicole M. Bekman

Introduction

An increasing number of offenders in jail, prison, and community corrections settings have mental health and substance abuse problems. In a recent survey conducted within state prisons, 24% of inmates reported a recent history of mental health problems (Bureau of Justice Statistics, 2006), and prevalence estimates of mental disorders in jails and prisons range from 10 to 15% (Lamb, Weinberger, & Gross, 2004; National GAINS Center, 2004; Teplin, Abram, & McClelland, 1996, 1997). Approximately three-quarters of prisoners have had a diagnosable substance abuse or dependence disorder in their lifetime (Peters, Greenbaum, Edens, Carter, & Ortiz, 1998). Rates of both mental health and substance use disorders among offenders far surpass those found in the general population (Robins & Regier, 1991).

A significant proportion of offenders have co-occurring mental health and substance use disorders (National GAINS Center, 2004), including 80% of probationers sentenced to participate in substance abuse treatment (Hiller, Knight, & Simpson, 1996) and as many as half of female offenders and juvenile detainees (Jordan, Schlenger, Fairbank, & Caddell, 1996; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002). Research indicates that from 72 to 87% of offenders with severe mental disorders have co-occurring substance use disorders (Abram & Teplin, 1991; Abram, Teplin, & McClelland, 2003; Chiles, Cleve, Jemelka, & Trupin, 1990; Bureau of Justice Statistics, 2006).

A number of factors explain the influx of inmates with co-occurring disorders to jails and prisons. These include the closing and "downsizing" of state mental hospitals, adoption of restrictive civil commitment criteria, inadequate access to community support services, widespread availability of relatively cheap and rapidly addicting street drugs, and law enforcement efforts to eliminate drug use and drug-related street crime. Studies examining persons with mental disorders in community settings indicate that having co-occurring disorders increases the risk for community violence and for arrest (Monahan et al., 2001, 2005). Once arrested, persons with co-occurring disorders are more likely to be incarcerated, and once incarcerated, these persons remain in jail significantly longer than other inmates, and are more likely to receive a sentence that involves a period of custody (Bureau of Justice Statistics, 2006; Peters, Sherman, & Osher, in press).

The increasing numbers of offenders with co-occurring mental and substance use disorders has been of great concern to correctional and health care administrators. One significant challenge is that these offenders tend to rapidly cycle between various parts of the criminal justice and social service systems, and are frequently unemployed, homeless, and without financial or social supports (Peters et al., in press). Offenders with co-occurring disorders who are released from correctional settings are not easily placed in traditional residential or other intensive treatment services, and frequently experience difficulty engaging in these services (Chandler, Peters, Field, & Juliano-Bult, 2004). Other potential problems following release include access to medications and psychiatric consultation, affordable housing, transportation, and reinstatement of income supports and entitlements (Osher, Steadman, & Barr, 2002; Weisman, Lamberti, & Price, 2004).

Given the high rates of co-occurring disorders, available treatment services in most correctional settings are inadequate to meet the needs of the vast majority of offenders (National GAINS Center, 2004; Peters, LeVasseur, & Chandler, 2004; Peters & Wexler, 2005). For example, correctional mental health services have grown only nominally in the past decade, despite the tremendous increase in offenders with mental illness who were incarcerated during this period. Moreover, there are few existing specialized co-occurring disorders treatment programs that have been developed in correctional settings (Peters et al., 2004). In recent years, however, several new offender treatment programs have been developed that provide an integrated approach, consistent with evidence-based practices developed in nonjustice settings (Sacks & Ries, 2005). Research indicates that well-coordinated and integrated

INSIDE. . .

services provided in custody and postcustody settings can significantly reduce recidivism among offenders with co-occurring disorders (Sacks, Sacks, McKendrick, Banks, & Stommel, 2004). This chapter explores emerging and innovative approaches for treatment and reentry of offenders who have co-occurring disorders in jails, prisons, and diversion settings. Key areas highlighted in this chapter include evidence-based models of treatment, program features and principles, reentry approaches, and program outcomes. Several challenges to correctional program implementation and funding are also explored, and implications are discussed for policy development and future research.

Correctional Treatment and Reentry Services for Co-Occurring Disorders

Prison Services for Co-Occurring Disorders

In the past, treatment for offenders with co-occurring disorders has been fragmented and typically provided within the constraints of traditional mental health or substance abuse programs. These programs have been characterized by diverse theoretical orientations and approaches toward treatment, variable levels of staff training in co-occurring disorders, and relatively few attempts to provide integrated services (Wexler, 2003). Correctional mental health and substance abuse programs are often housed in separate units, funded through different channels, independently staffed, and typically do not provide specialized services for co-occurring disorders. In many correctional settings, offenders with co-occurring disorders have been excluded from either mental health or substance abuse services because the programs and affiliated staff are only equipped to deal with single disorders. However, there is a growing recognition that this population requires specialized services using an integrated approach, building on evidence-based approaches that have been developed in community settings (Chandler et al., 2004).

Prison-Based Treatment Programs

In a recent national survey (Peters et al., 2004), 20 co-occurring disorders treatment (CDT) programs were identified within 13 state prison systems across the country, as well as 6 additional programs that were being developed. Most of these programs were housed in freestanding treatment units and many were located in prisons designed specifically for inmates who are in need of treatment. The CDT programs surveyed ranged in size from 12 to 320 inmates, and almost all were operating at capacity and had waiting lists. About half of the programs admitted inmates voluntarily, and the length of stay varied from 3 to 24 months. The most common mental disorders treated in these programs included major depression (26%), posttraumatic stress disorder (PTSD) (19%), bipolar disorder (15%), schizophrenia (15%), anxiety disorders (13%) and schizoaffective disorder (6%). Prison inmates treated in CDT programs are often diagnosed with one or more Axis II (personality) and Axis III (medical) disorders, reflecting the need for a structured treatment approach and a comprehensive array of services.

Prison CDT programs generally provide an integrated set of mental health and substance abuse services, an approach that is supported by the research literature (Hills, 2000; Sacks et al., 2004). Most programs provide a structured and intensive treatment environment and use a range of interventions that are based on cognitive–behavioral and social learning models. For example, many of the programs are provided within therapeutic community (TC) settings. Key interventions include psychoeducational skills groups, criminal thinking groups, peer support groups (e.g., AA and NA groups), regular behavioral feedback from peers and staff, individual assignments, behavioral contracts, and role playing and modeling of behaviors.

Prison Reentry Programs

Activities designed to prepare for reentry and transition to the community are particularly important for offenders with co-occurring disorders, and include development of reentry plans, relapse prevention, engagement with ongoing mental health and substance abuse services, and review of housing, transportation, and

NATIONAL STUDY OF JAIL SUICIDES

Through a cooperative agreement with the National Institute of Corrections (NIC), U.S. Justice Department, the National Center on Institutions and Alternatives (NCIA) is currently conducting a national study on jail suicides. The 18-month project, representing the third such national study conducted by NCIA for NIC (e.g., see *And Darkness Closes: A National Study of Jail Suicides* in 1981 and the *National Study of Jail Suicides: Seven Years Later* in 1988), will determine the extent and distribution of jail suicides (i.e., city, county, and police department facilities) during 2005 and 2006, and gather descriptive data on demographic characteristics of each victim, characteristics of the incident, and characteristics of the jail facility which sustained the suicide. NCIA will then develop a report of the findings to be utilized as a resource tool for both jail personnel in expanding their knowledge base, and correctional (as well as mental health and medical) administrators in creating and/or revising policies and training curricula on suicide prevention.

Data provided by individual agencies/facilities will be coded and held in the strictest confidence. Results of the study will be presented in summary fashion, thus preventing the linkage of any data to the particular agency/facility from which the information originated.

Phase 1 surveys were distributed in 2007. Phase 2 surveys will be distributed in early 2008. Both NIC and NCIA would greatly appreciate the cooperation of all agencies/facilities receiving the initial survey request. For further information on the project, please contact Lindsay M. Hayes, Project Director, NCIA, 40 Lantern Lane, Mansfield., MA 02048, (508/337-8806), e-mail: lhayesta@msn.com

employment/vocational needs. Most prison CDT programs feature designated staff (e.g., case managers, transition counselors, outreach workers) who are responsible for linking inmates to community services. These staff often make arrangements for housing, transportation, and employment, and make initial appointments for medical, psychiatric, psychological, and substance abuse services. Some prison CDT programs continue to track offenders once they enter the community, and monitor treatment outcomes. For example, the Community Orientation and Reintegration Program operated by the Pennsylvania Department of Corrections provides supervised prison reentry services for special needs offenders in community corrections centers (Couturier, Maue, & McVey, 2005).

Principles of Prison-Based Programs

Key principles of CDT programs in prisons include the following (Hills, 2000; Peters & Hills, 1997; Peters et al., 2004): (1) early interventions focused on engagement, motivation, and readiness for treatment, (2) a comprehensive approach that addresses mental illness, substance abuse, and criminal thinking and behaviors, (3) tailoring treatment through ongoing assessment of offenders' needs, and (4) continuity of treatment while in custody and postcustody settings. Several treatment modalities have proven effective for this population, including TCs, which have been adapted to provide additional peer and staff support, cognitive–behavioral interventions, relapse prevention, and case management services (Hills, 2000; Sacks et al., 2004).

Several *structural modifications* to prison CDT programs (Peters et al., 2004) include the following:

- Extending the duration of treatment to allow for coverage of new material, and for repetition and overlap of material.
- Developing a highly structured daily treatment schedule.
- Shortening the length of group sessions and other treatment activities.
- Providing an early focus on motivation and treatment engagement.
- Cross-training of treatment staff, program administrators, case managers, security staff, and probation and parole staff in approaches for CDT treatment, supervision, and management.
- Addition of outreach and case management staff who provide prerelease/ transition planning and who track and assist program participants as they return to the community.
- Identification of community treatment agencies/vendors that provide services that are similar and complementary to those offered in prison CDT programs.

Clinical modifications to prison CDT programs include the following:

- Decreasing the amount and intensity of confrontation. Confrontation initiated by staff and peers is used less frequently, and is often replaced by supportive feedback in both individual and group settings.
- Treatment modules and interventions related to medication management, symptom management, and affect regulation.
- Twelve-step groups with a specialized focus on co-occurring disorders, such as Dual Diagnosis Anonymous and Double Trouble groups.
- Treatment groups that address criminal thinking.
- Greater use of supervised study groups, peer mentors, and peer support groups.
- More frequent reinforcement provided for positive behaviors.
- Training staff in techniques to work with participants who have memory problems or cognitive impairment, such as repetition of material and instructions and monitoring to ensure participants' comprehension.
- Review of factors related to co-occurring disorders that may precipitate relapse.

Outcomes of Prison-Based Programs

Several studies have explored outcomes associated with prison-based CDT programs. Sacks et al. (2004) examined the effectiveness of a modified therapeutic community (MTC) in comparison to traditional prison mental health treatment services (MH) for inmates with co-occurring disorders. In this rigorous controlled study conducted within the Colorado prison system, inmates with co-occurring disorders were assigned to one of three levels of treatment: MTC, MH, and MTC plus involvement in postcustody aftercare treatment services, consisting of a 6-month residential TC program in the community. Twelve-month follow-up results indicated that offenders assigned to receive MTC plus aftercare treatment had the lowest rate of reincarceration (5%), followed by those in the MTC group (16%) and the MH group (33%). The MTC plus aftercare group also experienced the lowest rate of arrest for drug-related offenses (30%), in comparison to the MTC group (44%) and the MH group (67%). These findings reveal the cumulative positive effect of specialized CDT treatment received in prison and in the community, following release from prison.

Similar findings were reported from a study of Wisconsin prison inmates with co-occurring disorders, who were either assigned to a specialized TC program or who did not receive the specialized treatment services (Van Stelle & Moberg, 2004). At 3 months following release from prison, the TC participants were significantly more likely to remain abstinent than the comparison sample (63% versus 49%), and were more likely to routinely take their prescribed medications and to be rated as having stable mental health functioning, in comparison to untreated inmates. These outcomes

from prison CDT programs are likely to translate into significant cost savings related to criminal processing and incarceration.

Jail Services for Co-occurring Disorders

As in prisons, there are few specialized treatment programs for inmates with co-occurring disorders in jails, and program services are traditionally provided in either mental health or substance abuse treatment units within the jails. Although all jails are required to provide basic mental health services, most jail programs are frequently understaffed to provide more than screening, stabilization on medications, and routine monitoring (e.g., for suicidal and aggressive behavior, and acute mental health symptoms). Although standards developed by professional correctional and mental health organizations indicate the need for other jail services such as short-term treatment and discharge/release planning, due to the overwhelming numbers of jail inmates with mental and other co-occurring disorders, many do not receive comprehensive services to address these problems (Peters et al., in press; Veysey, Steadman, Morrissey, & Johnsen, 1997).

Jail-Based Treatment Programs

Jail-based treatment programs operate quite differently from those in prison, primarily because of the brevity of incarceration. Rather than providing long-term residential treatment, jail programs for co-occurring disorders often focus on screening and assessment, psychoeducational interventions, linkage with community services, and reentry planning (Hills, 2000). Accurate assessment of co-occurring disorders can provide valuable information regarding the need for treatment, readiness for treatment, and appropriate types of community services that may be mandated by the courts at the time of presentence hearings or at sentencing. Other key services include court liaison, reentry planning, and linkage to community services. Jail programs that are designed for sentenced inmates tend to be longer in duration (typically up to 1 year), and include psychoeducational and peer support groups, interventions designed to increase motivation and engagement in treatment, and transition planning with community agencies. Joint reentry planning with community treatment and supervision agencies can help inmates to meet their legal obligations and to maintain sobriety and involvement in mental health and substance abuse services. Jail inmates with co-occurring disorders also frequently need support to identify sober and safe housing, transportation, employment/vocational services, and to restore eligibility for SSI/SSDI and other benefits.

Principles of Jail-Based Programs

Jail-based treatment programs for inmates with co-occurring disorders are generally organized around four key principles, as described in the following section. These principles tend to guide the process of implementing services across several sequential jail-based program components, including identification, screening, stabilization, assessment and treatment, and reentry.

Focus on Meeting Immediate and Basic Needs: Jail inmates with co-occurring disorders have a variety of acute needs, including stabilization of acute psychological symptoms (e.g., through use of psychotropic medications), detoxification from alcohol and drugs, and suicide screening, prevention, and monitoring. Other urgent needs include treatment of physical illness and injuries, and dental care.

Integrated Delivery of Mental Health and Substance Abuse Services: As indicated previously, integrated or blended treatment for co-occurring disorders is the preferred approach in jails and other correctional settings. These services are most effectively provided in an isolated treatment unit that is geographically separate from other general population housing units. Treatment staff typically include those with experience in both the mental health and substance abuse fields. Staff are frequently cross-trained in techniques for assessment, use of specialized engagement and motivation approaches, and stage-specific treatment interventions for co-occurring disorders.

Preparation for Release: Reentry and transition planning begin following screening and enrollment in jail services, and continue throughout the course of treatment and incarceration.

Collaboration with Community Agencies to Enhance Continuity of Care: In-reach programs are designed to involve community treatment providers and supervision officers in reentry planning activities. Efforts are also made to ensure continuity of benefits and entitlements (e.g., SSI, SSDI, and Medicaid).

Components of Jail-Based Programs

A number of sequential components are included in most jail treatment programs for inmates with co-occurring disorders, and these are described in this section.

Identification and Screening: Jails often provide the initial point of contact and opportunity for assessment and triage following arrest. This creates a unique opportunity to identify co-occurring disorders and needs for specialized services both within and outside the institution. Effective jail systems provide multiple points for identifying co-occurring disorders, including at booking, classification, within mental health and substance abuse treatment units, and through referral by health care staff, correctional officers, or other service providers. In Rensselaer County, New York (Walsh, 2000), a range of jail personnel are tasked with identifying inmates with co-occurring disorders and provide referrals to a Forensic Coordinator. The Forensic Coordinator then reviews the referral information and arranges for a comprehensive assessment by a "MICA coordinator" within the jail.

Stabilization: Jail inmates with co-occurring disorders are often in crisis due to destabilization of their mental disorders, acute intoxication, and related behavioral problems that brought them into contact with law enforcement officers. As a result, these inmates often require emergency services and placement in specialized housing units that allow for close monitoring, ongoing observation, isolation from other inmates, and access to general medical and mental health services. At admission to jail, the focus of interventions is on stabilizing an inmate's physical and psychological condition by providing medication, adequate nutrition, and attending to emergency medical needs. For inmates with co-occurring disorders, both mental health stabilization and detoxification are primary areas of concern. Treatment must be

NOW AVAILABLE:
PUBLIC HEALTH BEHIND BARS: FROM PRISONS TO COMMUNITIES

Projecting correctional facility-based health care into the community arena, *Public Health Behind Bars: From Prisons to Communities* examines the burden of illness in the growing prison population, and analyzes the considerable impact on public health as prisoners are released. More than 40 practitioners, researchers, and scholars in correctional health, mental health, law, and public policy make a timely case for correctional health care that is humane for those incarcerated and beneficial to the communities they reenter. These authors offer affirmative recommendations toward that evolutionary step.

Chapter authors identify the most compelling health problems behind bars (including communicable disease, mental illness, addiction, and suicide), pinpoint systemic barriers to care, and explain how correctional medicine can shift from emergency or crisis care to primary care and prevention. In addition, strategies are outlined that link community health resources to correctional facilities so that prisoners can transition to the community without unnecessarily taxing public resources or falling through the cracks. The introductory chapter ("Thirty Years Since *Estelle v. Gamble*: Looking Forward, Not Wayward") is presented by editor Robert B. Greifinger, followed by offerings divided into the following five sections.

Section 1: Impact of Law and Public Policy on Correctional Populations — "Impact of Incarceration on Community Public Safety and Public Health" (Todd R. Clear), "Litigating for Better Medical Care" (Jon Wool), "Accommodating Disabilities in Jails and Prisons" (R. Samuel Paz), "Growing Older: Challenges of Prison and Reentry for the Aging Population" (Brie Williams and Rita Abraldes), "International Public Health and Corrections: Models of Care and Harm Minimization" (Michael Levy), and "The Medicalization of Execution: Lethal Injection in the United States" (Mark Heath).

Section 2: Communicable Disease — "HIV and Viral Hepatitis in Corrections: A Public Health Opportunity" (Joseph A. Bick), "Prevention of Viral Hepatitis" (Cindy Weinbaum and Karen A. Hennessey), "HIV Prevention: Behavioral Interventions in Correctional Settings" (Barry Zack), "Prevention and Control of Tuberculosis in Correctional Facilities" (Farah M. Parvez), and "Controlling Chlamydia, Gonorrhea, and Syphilis Through Targeted Screening and Treatment in Correctional Settings" (Charlotte K. Kent and Gail A. Bolan).

Section 3: Primary and Secondary Prevention — "Health Promotion in Jails and Prisons: An Alternative Paradigm for Correctional Health Services" (Megha Ramaswamy and Nicholas Freudenberg), "Screening for Public Purpose: Promoting an Evidence-based Approach to Screening of Inmates to Improve the Public Health" (Joshua D. Lee, Marshall W. Fordyce, and Josiah D. Rich), "Written Health Informational Needs for Reentry" (Jeff Mellow), "Reducing Inmate Suicides Through the Mortality Review Process" (Lindsay M. Hayes), "Blinders to Comprehensive Psychiatric Diagnosis in the Correctional System" (Richard L. Grant), "Juvenile Corrections and Public Health Collaborations: Opportunities for Improved Health Outcomes" (Michelle Staples-Horne, Kaiyti Duffy, and Michele T. Rorie), "Female Prisoners and the Case for Gender-Specific Treatment and Reentry Programs" (Andrea F. Balis), and "Building the Case for Oral Health Care for Prisoners: Presenting the Evidence and Calling for Justice" (Henrie M. Treadwell, Mary E. Northridge, and Traci N. Bethea).

Section 4: Tertiary Prevention — "Treatment of Mental Illness in Correctional Settings" (Raymond F. Patterson and Robert B. Greifinger), "Treatment and Reentry Approaches for Offenders with Co-occurring Disorders" (Roger H. Peters and Nicole M. Bekman), and "Pharmacological Treatment of Substance Abuse in Correctional Facilities: Prospects and Barriers to Expanding Access to Evidence-Based Therapy" (R. Douglas Bruce, Duncan Smith-Rohrberg, and Frederick L. Altice).

Section 5: Thinking Forward to Reentry—Reducing Barriers and Building Community Linkages — "Health Research Behind Bars: A Brief Guide to Research in Jails and Prisons (Nicholas Freudenberg), "Reentry Experiences of Men with Health Problems" (Christy A. Visher and Kamala Mallik-Kane), "Providing Transition and Outpatient Services to the Mentally Ill Released from Correctional Institutions" (Steven K. Hoge), "Sexual Predators: Diversion, Civil Commitment, Community Reintegration, Challenges, and Opportunities" (Karen Terry), "Electronic Health Records Systems and Continuity of Care" (Ralph P. Woodward), "Community Health and Public Health Collaborations" (Thomas Lincoln, John R. Miles, and Steve Scheibel), and "Improving the Care for HIV-Infected Prisoners: An Integrated Prison-Release Health Model" (Sandra A. Springer and Frederick L. Altice).

Public Health Behind Bars: From Prisons to Communities was published by Springer Science and Business Media in September 2007 and is available at www.springer.com

coordinated to ensure that there are no adverse effects of combining certain medications with recently ingested alcohol or other drugs, and to monitor detoxification from these substances. Several jails have developed freestanding crisis response teams that serve the entire jail facility by assessing emergency needs for mental health treatment, substance abuse treatment, and close management services, and that provide triage to these services (Steadman & Veysey, 1997).

Assessment: Comprehensive medical and psychosocial assessments are essential elements of jail-based programs for co-occurring disorders, and provide the capability for developing individualized treatment plans based on the offender's unique needs for in-jail and reentry services. Both short- and long-term goals should be considered, with an emphasis on locating services that address needs for housing, transportation, financial support, and treatment following release from jail. For example, in the MISA (Mentally Ill Substance Abuse) treatment program in Beaver County, Pennsylvania (Bell, Jaquette, Sanner, Steele-Smith, & Wald, 2005), assessments help to determine whether inmates will be placed in jail treatment tracks that focus on either drug and alcohol rehabilitation, mental health needs, or co-occurring disorders (through the MISA program).

Integrated Treatment: Effective treatment of co-occurring disorders in jails and other correctional settings requires an integrated approach that addresses both mental and substance use disorders (Osher, 2006). This usually requires staff involvement from both disciplines, and who have experience and training related to both disorders. A phased treatment approach is generally used (Peters et al., 2004; Peters & Wexler, 2005; Sacks & Pearson, 2003) that provides an initial focus on stabilization of acute symptoms, medication consultation, assessment, and enhancing motivation and engagement in treatment. Secondary treatment phases focus on skills development, relapse prevention, involvement with peer supports, and interventions to restructure "criminal thinking." Final treatment phases focus on development of a reentry/transition plan and linkages to community services. In-jail treatment services for inmates with co-occurring disorders include psychiatric consultation and use of psychotropic medications, individual counseling, psychoeducational groups, peer support groups, and other specialized groups that focus on co-occurring disorders. Other specialized individual or group counseling services may be offered, such as those provided by the TAMAR Project in Maryland for female victims of trauma (Russell, 1999) or by the WINGS Program in the Riker's Island jail in New York City that provides support groups and parenting skills classes for female inmates (Sacks & Pearson, 2003).

Unlike prison-based programs, jail programs do not typically feature a lengthy course of treatment, and focus on preparing inmates to effectively engage in services upon their release. One means to encourage rapid engagement in community services is through in-reach of community treatment providers to the jails (Steadman, Fallon, Mireles, Williams, & Aronson, 2005). In-reach activities frequently involve participation in treatment planning, reentry planning, and assessment of eligibility for enrollment in various community treatment programs (e.g., specialized intensive outpatient or residential programs for co-occurring disorders). For example, in Beaver County, Pennsylvania, the MISA program hosts weekly treatment team meetings with community treatment providers, forensic case managers, probation officers, and other community service providers to provide case consultation and to assist in reentry planning (Bell et al., 2005). Cross-training between jail treatment staff, jail correctional staff and administrators, and community treatment and supervision staff also helps to facilitate better communication and problem-solving within jail treatment programs, and to develop consensus regarding reentry needs of inmates who have co-occurring disorders.

Accessing and Restoring Benefits: Individuals with co-occurring disorders who are placed in jails and prisons will generally need to access public assistance and health care benefits (e.g., through SSI and SSDI) once they are released to the community. However, access to these benefits is limited by federal regulations, and these are often suspended or discontinued once an individual is incarcerated. Several state and local initiatives have been implemented to streamline the process of restoring benefits prior to release, and to help encourage rapid engagement in mental health, substance abuse, and other health care services in the community. Key strategies employed by these initiatives are summarized by the Bazelon Center for Mental Health Law (Koyanagi & Blasingame, 2006), and include the following activities:

- Screening for mental illness and prior benefits on entry to prison or jail.
- Suspending rather than terminating inmates' Supplemental Security Income (SSI), Social Security Disability Income (SSDI) and Medicaid benefits.
- Helping inmates to complete applications for enrollment in these programs or for restoration of benefits, and expediting the review and processing of these applications.
- Using Web-based applications.
- Ensuring that inmates have valid IDs prior to release.
- Providing coverage for services and medication after release while applications for benefits are pending.
- Sharing information across correctional and community service agencies.
- Working with the Social Security Administration to coordinate prerelease applications for benefits.

Some jail-based initiatives have led to significant improvements in accessing and restoring benefits, such as the NYC Link program at Riker's Island, in which case workers help file benefit applications on behalf of inmates. One of the first programs designed to facilitate continuity of benefits for jail inmates was developed in Lane County, Oregon, in which SSI/SSDI and Medicaid applications are processed in 1–2 days. Medicaid benefits are sustained for 14 days after placement in jail, and are suspended rather than terminated after this time, to ease the process of reinstatement of benefits upon release (Lipton, 2001; National GAINS Center, 2002).

Reentry/Prerelease Planning: Unlike prison-based programs, reentry planning in jails begins as soon as an inmate is enrolled in treatment services. Reentry services anticipate offenders' needs for basic services and for specialized services related to co-occurring disorders. One key concern following release from jail is providing continuity of mental health services, including ongoing psychiatric monitoring and a supply of medication that will last until follow-up psychiatric consultation can be arranged. To address this issue, jail programs such as the one in Hampden County, Massachusetts, provide inmates with a 30-day prescription and 5-day supply of medications on release (Koyanagi & Blasingame, 2006).

Coordination with community service providers in reentry planning is of vital importance in preventing relapse and recidivism. For inmates with co-occurring disorders, transition services are often instrumental in providing a single point of contact to help with crisis management, appointments with mental health providers, liaison and advocacy with service providers, courts, and community supervision; and to provide monitoring and surveillance for early warning signs of relapse and criminal behavior. One effective model for managing offenders with co-occurring disorders is Assertive Community Treatment (ACT) teams, which provide an interdisciplinary set of staff, case management services, and single point of contact and support for high-risk clients (Lurigio, Fallon, & Dincin, 2000).

In order to effectively facilitate reentry and transition from jail, Osher et al. (2003) have introduced the "APIC" model for planning reentry services. This model provides a practical framework for reentry planning with jail inmates who have co-occurring disorders and multiple service needs, and can be implemented in jails of all sizes, and in settings that feature varying lengths of incarceration and program duration. The APIC model provides a structured approach to accomplish the following key activities:

- **A**ssess the inmate's clinical and social needs, and public safety risks
- **P**lan for treatment and services required to address these needs
- **I**dentify required community and correctional programs responsible
- **C**oordinate the transition plan to ensure execution and avoid gaps in care

The APIC approach is particularly useful for inmates who are incarcerated for brief periods of time (i.e., less than 72 hours), who are eligible for placement in noncustody settings, and who require rapid assessment and triage. The APIC and other reentry planning approaches are most effective if inmates are encouraged to actively participate in the assessment process, identification of services, and implementation of the reentry plan. A reentry "checklist" has been developed to help facilitate implementation of the APIC model (Osher, Steadman, & Barr, 2003), and can assist jail and community treatment and supervision staff to prepare for different components of the transition/reentry plan. The checklist format provides quadruplicate copies to allow dissemination of the reentry plan to jail treatment/medical staff, community service providers, the courts, and the inmate. Key areas addressed in the APIC reentry checklist include:

- Mental health services
- Psychotropic medications
- Housing
- Substance abuse services
- Health care services and benefits
- Income support/benefits
- Food/clothing
- Transportation

Diversion Programs for Co-occurring Disorders

A variety of pre- and postbooking programs have been developed to divert offenders with co-occurring disorders from incarceration, and to expedite access to community treatment and housing (Peters & Matthews, 2002; Steadman, Morris, & Dennis, 1995; Steadman & Naples, 2005). Prebooking diversion programs include specially training law enforcement crisis interventions teams (CIT); postbooking diversion programs include drug courts, mental health courts, and specialized jail-based case management services to provide early identification, court liaison, and triage to community services. The number of diversion programs has increased in recent years (Steadman & Naples, 2005) due in part to assumptions that offenders with mental health and substance abuse problems are more effectively and economically treated and supervised in community settings, and that diversion programs can reduce the pattern of rapid cycling within the treatment, health care, and criminal justice systems.

Several common elements of postbooking diversion programs include: (a) identification of arrestees with co-occurring disorders, (b) screening and assessment for mental and substance use disorders, (c) counseling and discharge planning, (d) use of "boundary-spanning" staff who are versatile in working with the mental health treatment, substance abuse treatment, and criminal justice systems, and (e) referral to community services and/or monitoring following release (Conly, 1999). These programs differ significantly in the location of diversion activities (e.g., in jails, courts, community treatment agencies) and the types of services provided (Broner, Lattimore, Cowell, & Schlenger, 2004).

A wide range of court-based diversion programs have emerged in the past decade, including drug courts, mental health courts, domestic violence courts, community courts, and reentry courts. In the past, many of these programs have been reluctant to admit offenders with co-occurring disorders, due to anticipated high rates of recidivism and to difficulties in treating and managing this population (Peters & Osher, 2004). However, a number of specialized court diversion programs have now emerged to address the needs of offenders with co-occurring disorders. For example, the Treatment Alternatives to the Dually Diagnosed (TADD) program in Brooklyn, New York, provides court-supervised diversion services including identification, screening and assessment, deferred sentencing arrangements, case management, supervision, and court monitoring (Broner, Nguyen, Swern, & Goldfinger, 2003). In some jurisdictions such as Lane County, Oregon, and in Butler County, Ohio, specialized court dockets

have been established for offenders with co-occurring disorders, and operate in a similar fashion to drug courts (Ohio Substance Abuse and Mental Illness Coordinating Center of Excellence, 2002; Peters & Osher, 2004). These programs provide integrated assessment, intensive case management and judicial oversight, specialized dual disorders groups, psychiatric consultation, family involvement, and participation in peer support groups such as "Dual Recovery Anonymous."

Implementing and Sustaining Correctional Services for Co-occurring Disorders

There are several challenges to developing and sustaining co-occurring disorders treatment services in correctional settings (Chandler et al., 2004). As noted previously, mental health and substance abuse services in jails and prisons are often situated in separate programs, provided by different sets of staff or contract vendors, and are typically supported by different funding sources. As a result, it is difficult to generate blended sources of funding, and to promote collaboration between program staff who may not have previously worked together. The emphasis of correctional institutions and programs has traditionally been on punishment and protection of public safety, and rehabilitative programs are often the first to be eliminated in times of budget cuts. Another major challenge is in providing advanced skills training for clinical and supervision staff to work effectively with offenders who have co-occurring disorders. Finally, the absence of reentry services in many jails and prisons prevents effective linkage to the community, and contributes to the risk for relapse and recidivism.

Several resources are available to support the development of correctional programs, services, and research related to co-occurring disorders (Chandler et al., 2004). The National GAINS Center for People with Co-Occurring Disorders in the Justice System provides technical assistance through the TAPA Center for Jail Diversion and the Center for Evidence-Based Programs in the Justice System, and assists in disseminating information related to effective screening, assessment, treatment, supervision, and management of offenders with co-occurring disorders. Diversionary and corrections-based programs for offenders with co-occurring disorders have also been supported in the past through the Center for Mental Health Services (CMHS) Targeted Capacity Expansion (TCE) program (National GAINS Center, 2006), and the Justice and Mental Health Collaboration Program (JMHCP), created by the Mentally Ill Offender Treatment and Crime Reduction Act of 2004 (U.S. Department of Justice, 2006). Both the National Institute of Mental Health (NIMH) and the National Institute on Drug Abuse (NIDA) support research examining treatment approaches for use with offenders who have co-occurring disorders. NIDA's current portfolio of research projects includes the Criminal Justice Drug Abuse Treatment Studies (CJ-DATS) network, which has encouraged exploratory and developmental studies of services and interventions for co-occurring disorders in correctional settings (Fletcher, 2005).

Conclusions and Implications for Policy and Research

Offenders with co-occurring mental health and substance use disorders are being placed in jails, prisons, and other correctional settings in increasing numbers. These individuals are at high risk for recidivism, reincarceration, premature dropout from treatment, homelessness, and a range of other poor outcomes following release from correctional systems (Osher, 2006). Offenders with co-occurring disorders have not fared well in traditional treatment programs or in regular supervision caseloads. Poor outcomes obtained using these approaches are often misattributed to poor motivation, lack of engagement in treatment, skills deficits, and behavioral problems, rather than to the absence of specialized interventions to address both sets of disorders, and the failure to make accommodations for cognitive impairment, motivation level, and effects of mental disorders and medication on problematic behaviors.

Specialized co-occurring disorders treatment programs and supervision caseloads have only recently been developed for correctional populations (Peters et al., 2004). Despite the implementation of several innovative programs in jails, prisons, and diversion settings, there is still a tremendous gap between the need for co-occurring disorders treatment and available services. This gap has been fueled in part by the demand over the past decade for new jail and prison construction, with relatively few resources reserved to upgrade and expand the scope of treatment, reentry, and supervision services. The parallel structure and funding of correctional mental health and substance abuse treatment systems has also discouraged collaborative efforts to develop specialized services for offenders with co-occurring disorders (Chandler et al., 2004). Moreover, staff have not been adequately trained in the past to provide effective interventions for both disorders, and treatment programs have generally reflected a primary focus on one or the other disorder. Finally, management information and data systems in correctional systems are often segmented to capture either mental health or substance abuse information. As a result, correctional administrators are sometimes unaware of the number of offenders who have co-occurring disorders, and may be unable to quantify or justify the need for specialized services.

Specialized co-occurring disorders treatment programs have been successfully implemented in both jails and prisons (Peters et al., 2004, in press). In-custody programs feature a number of structural and clinical modifications. For example, these programs are highly structured, provide an emphasis on motivation and engagement to treatment, follow a phased structure of graduated intensity, and include a significant focus on prerelease planning to address transitional needs for housing, employment, and ongoing treatment. Specialized prison treatment programs are quite comprehensive in scope and are generally of longer duration than those provided in jails. Prison programs provide a range of integrated treatment and peer support activities, and are often situated in long-term residential therapeutic communities. Jail programs are typically less intensive, and focus on stabilization, assessment, access and restoration of benefits, and prerelease planning and reentry needs. In-reach of community treatment and supervision agencies is used by most specialized jail programs to facilitate continuity of services for offenders with co-occurring disorders.

A number of innovative jail-based and court-based diversion programs for offenders with co-occurring disorders have also emerged in recent years (Broner, Lattimore, Cowell, & Schlenger, 2004; Peters & Osher, 2004). Key elements of jail-based diversion

programs include early identification or case finding, assessment, court liaison, and triage and referral to community services. Court-based diversion programs include those located in drug courts, mental health courts, and other alternatives to incarceration programs. In addition, dedicated court dockets and affiliated treatment services have been developed in some jurisdictions for offenders with co-occurring disorders, using some of the same principles and structures that have been operationalized in drug court programs. These programs offer a range of incentives for participation, sanctions for infractions and noncompliance, and involvement in treatment over a sustained period of time. Based on the current discussion and findings, several recommendations may help guide development of effective programs and policies related to co-occurring disorders in correctional settings:

- Planning to develop new correctional services related to co-occurring disorders should be conducted with broad multidisciplinary participation, and using a community systems perspective. Clearly, this population moves rapidly between a number of public health systems (e.g., mental health, substance abuse, emergency health) and the criminal justice system, and consumes vast financial resources in each system. Narrowly crafted programmatic solutions in one setting may temporarily address the needs of this population, but are unlikely to reduce the pattern of relapse, recidivism, and rapid cycling between systems. As a result, communitywide and statewide task forces are needed to address the needs of offenders with co-occurring disorders. These groups should develop strategies for collaborative and interagency funding of specialized services, sharing of information between agencies, identifying and resolving barriers related to service eligibility and access (e.g., changing policies and procedures related to reimbursement for specialized co-occurring disorders services), and implementing long-term and multidisciplinary programmatic interventions, such as Assertive Community Treatment (ACT) teams for offenders with co-occurring disorders.

- Organizations at the state and national/federal level should be tasked with disseminating information regarding evidenced-based and innovative approaches for treatment and reentry of offenders who have co-occurring disorders. These organizations should work closely with courts, local jails, and state correctional authorities to develop strategic planning related to specialized interventions for co-occurring disorders, and to provide incentives for collaboration in this process. These organizations should also work closely with existing groups such as the National GAINS Center for People with Co-Occurring Disorders in the Justice System, the Co-Occurring Center for Excellence (COCE Center), and the Addiction Technology Transfer Centers (ATTCs) to promote training, sharing of key resources (e.g., training curricula, treatment manuals, descriptions of program models, program contact information), identification of programmatic and practice approaches, and prioritization of these approaches for implementation in correctional settings.

WE'RE STILL LOOKING FOR A FEW GOOD PROGRAMS

Future issues of the ***Jail Suicide/Mental Health Update*** will be devoted to exemplary suicide prevention programs operating within correctional facilities throughout the country. Does your facility's suicide prevention policy contain, and do your practices reflect, the following critical elements?

- Intake screening to detect both current and prior suicidal behavior, as well as further and periodic assessment of suicide risk by mental health staff;
- Suicide prevention training for correctional, medical, and mental health staff;
- Levels of communication between outside agencies, among facility staff, and with the suicidal inmate;
- Suicide-resistant, protrusion-free housing of suicidal inmates;
- Levels of supervision for suicidal inmates;
- Timely emergency intervention by correctional and medical personnel following a suicide attempt;
- Provision of critical incident stress debriefing to affected staff and inmates, as well as completion of a multidisciplinary mortality review following an inmate suicide and/or serious suicide attempt; and
- A low rate of inmate suicides for an extended period of time.

If you believe your correctional facility operates an exemplary suicide prevention program, and would like it to be considered as a possible case study in an upcoming issue of the ***Update***, please send copies of your suicide prevention policy, screening/assessment forms utilized to identify suicidal inmates, and total number of suicides and your facility's average daily population for each year from 1997 thru 2006 to:

Lindsay M. Hayes, Project Director
Jail Suicide/Mental Health Update
40 Lantern Lane
Mansfield, MA 02048
(508) 337-8806
Lhayesta@msn.com

- Management information systems (MIS) within treatment and correctional agencies and within state social service and correctional agencies should be modified to capture information regarding offenders with co-occurring disorders. These MIS systems should have the capacity for identifying current and yearly totals of offenders who have co-occurring disorders, diagnoses, living arrangements, medication use, utilization and outcomes of treatment services, use of sanctions and administrative confinement, length of incarceration, reentry needs, placement in reentry or other community services, and outcomes following release from custody.

- Statewide efforts should be developed to track offenders with co-occurring disorders who are released from correctional settings, and to describe their engagement in services, response to services, and rates of hospitalization and criminal recidivism. From these tracking efforts, cost models should be constructed to examine the economic benefits of providing specialized services in jails and prisons, and of specialized reentry services; and the relative costs associated with offenders who are not engaged in institutional or reentry services.

Research examining effective interventions for offenders with co-occurring disorders is in the early stages of development, and much of our knowledge regarding these interventions is drawn from community-based samples involving nonoffenders (Chandler et al., 2004). As such, additional research is needed to identify outcomes in adapting evidence-based community treatment approaches within correctional settings. Preliminary research indicates that specialized institutional and postcustody services independently produce reductions in recidivism and substance abuse among offenders with co-occurring disorders (Sacks et al., 2004). Further work is needed to clarify the contribution of treatment components such as prerelease planning and reentry services, case management, and specialized interdisciplinary treatment teams (e.g., ACT teams) to outcomes obtained with this population.

Existing research examining outcomes related to diversion programs has been equivocal, and has not provided definitive answers regarding program interventions and components that contribute to positive outcomes. Research with offenders who have co-occurring disorders should also examine a wider range of outcomes, including those related to mental health functioning, substance abuse, utilization of services, criminal behavior, incarceration, and costs associated with these outcomes. Controlled studies of treatment interventions are needed that include both male and female offenders, employ large samples, and feature different types of comparison groups (e.g., no treatment, mental health or substance use treatment "as usual," and either custody-based treatment or reentry treatment versus a combined approach).

References

Abram, K.M., & Teplin, L.A. (1991). Co-occurring disorders among mentally ill jail detainees: Implications for public policy. *American Psychologist*, 46, 1036–1045.

Abram, K.M., Teplin, L.A., & McClelland, G.M. (2003). Comorbidity of severe psychiatric disorders and substance use disorders among women in jail. *American Journal of Psychiatry*, 160, 1007–1010.

Bell, A., Jaquette, N., Sanner, D., Steele-Smith, C., & Wald, H. (2005). Treatment of individuals with co-occurring disorders in county jails: The Beaver County, Pennsylvania experience. *Corrections Today*, 67(3), 86–90.

Broner, N., Lattimore, P.K., Cowell, A.J., & Schlenger, W.E. (2004). Effects of diversion on adults with co-occurring mental illness and substance use: Outcomes from a national multi-site study. *Behavioral Sciences and the Law*, 22, 519–542.

Broner, N., Nyugen, H., Swern, A., & Goldfinger, S. (2003). Adapting a substance abuse court diversion model for felony offenders with co-occurring disorders: Initial implementation. *Psychiatric Quarterly*, 74, 361–385.

Bureau of Justice Statistics. (2006). *Special report: Mental health problems of prison and jail inmates*. Washington, DC: U.S. Department of Justice.

Chandler, R.K., Peters, R.H., Field, G., & Juliano-Bult. (2004). Challenges in implementing evidence-based treatment practices for co-occurring disorders in the criminal justice system. *Behavioral Sciences and the Law*, 22, 431–448.

Chiles, J.A., Von Cleve, E., Jemelka, R.P., & Trupin, E.W. (1990). Substance abuse and psychiatric disorders in prison inmates. *Hospital and Community Psychiatry*, 41, 1132–1134.

Conly, C. (1999). *Coordinating community services for mentally ill offenders: Maryland's Community Criminal Justice Treatment Program*. Washington, DC: National Institute of Justice.

Couturier, L., Maue, F., & McVey, C. (2005). Releasing inmates with mental illness and co-occurring disorders into the community. *Corrections Today*, (April), 82–85.

Fletcher, B.W. (2005). National Criminal Justice Drug Abuse Treatment Studies (CJ-DATS): Update and progress. Justice Research and Statistics Association: *The Forum*, 23(3), 5–7.

Hiller, M.L., Knight, K., & Simpson, D. D. (1996). An assessment of comorbid psychological problems in a residential criminal justice drug treatment program. *Psychology of Addictive Behaviors*, 10, 181–189.

Hills, H.A. (2000). *Creating effective treatment programs for persons with co-occurring disorders in the justice system*. Delmar, NY: The National GAINS Center for People with Co-Occurring Disorders in the Justice System.

Jordan, K., Schlenger, W.E., Fairbank, J.A., & Caddell, J. M. (1996). Prevalence of psychiatric disorders among incarcerated women. *Archives of General Psychiatry*, 53, 513–519.

Koyanagi, C., & Blasingame, K. (2006). *Best practices: Access to benefits for prisoners with mental illnesses*. A Bazelon Center Issue Brief. Washington, DC: Bazelon Center for Mental Health Law.

Lamb, H.R., Weinberger, L.E., & Gross, B.H. (2004). Mentally ill persons in the criminal justice system: Some perspectives. *Psychiatric Quarterly*, 75, 107–126.

Lipton, L. (2001). Jail program helps inmates avoid health care gap. *Psychiatric News*, 36(16), 9.

Lurigio, A.J., Fallon, J.R., & Dincin, J. (2000). Helping the mentally ill in jails adjust to community life: A description of a post-release ACT program and its clients. *International Journal of Offender Therapy and Comparative Criminology*, 44, 532–548.

Monahan, J., Steadman, H., Robbins, P., Appelbaum, P., Banks, S., Grisso, T., Heilbrun, K., Mulvey, E., Roth, L., & Silver, E. (2005). An actuarial model of violence risk assessment for persons with mental disorders. *Psychiatric Services*, 56, 810–815.

Monahan, J., Steadman, H., Silver, E., Appelbaum, P., Robbins, P., Mulvey, E., Roth, L., Grisso, T., & Banks, S. (2001). *Rethinking risk assessment: The MacArthur study of mental disorder and violence*. New York: Oxford University Press.

National GAINS Center for People with Co-Occurring Disorders in the Justice System (2002). *Maintaining Medicaid benefits for jail detainees with co-occurring mental health and substance use disorders*. Fact Sheet Series. Delmar, NY.

National GAINS Center for People with Co-Occurring Disorders in the Justice System. (2004). *The prevalence of co-occurring mental illness and substance use disorders in jails*. Fact Sheet Series. Delmar, NY.

National GAINS Center for People with Co-Occurring Disorders in the Justice System. (2006). *Targeted Capacity Expansion initiative for jail diversion programs*. The National GAINS Center for People with Co-Occurring Disorders in the Justice System: http://gainscenter.samhsa.gov/html/tapa/cmhs/overview.asp.

Ohio Substance Abuse and Mental Illness Coordinating Center of Excellence. (2002). *SAMI Matters Newsletter*, 1(2), 1–2. Northfield, Ohio.

Osher, F., Steadman, H.J., & Barr, H. (2002). *A best practice approach to community re-entry from jails for inmates with co-occurring disorders: The APIC model*. Delmar, NY: The National GAINS Center for People with Co-Occurring Disorders in the Justice System.

Osher, F., Steadman, H.J., & Barr, H. (2003). A best practice approach to community reentry from jails for inmates with co-occurring disorders: The APIC Model. *Crime and Delinquency*, 49, 79–96.

Osher, F.C. (2006). *Integrating mental health and substance abuse services for justice involved persons with co-occurring disorders*. Delmar, New York: The National GAINS Center for Systemic Change for Justice-Involved People with Mental Illness.

Peters, R.H., Greenbaum, P.E., Edens, J.F., Carter, C.R., & Ortiz, M.M. (1998). Prevalence of DSM-IV substance abuse and dependence disorders among prison inmates. *American Journal of Drug and Alcohol Abuse*, 24, 573–587.

Peters, R.H., & Hills, H.A. (1997). *Intervention strategies for offenders with co-occurring disorders: What works?* Delmar, NY: The National GAINS Center for People with Co-Occurring Disorders in the Justice System.

Peters, R.H., LeVasseur, M.E., & Chandler, R.K. (2004). Correctional treatment for co-occurring disorders: Results of a national survey. *Behavioral Sciences and the Law*, 22, 563–584.

Peters, R.H., & Matthews, C.O. (2002). Substance abuse treatment programs in prisons and jails. In T.J. Fagan & R.K. Ax (Eds.), *Correctional mental health handbook* (pp. 73–99). Laurel, MD: Sage Publications.

Peters, R.H., Matthews, C.O., & Dvoskin, J.A. (2005). Treatment in prisons and jails. In J.H. Lowinson, P. Ruiz, R.B. Millman, & J.G. Langrod (Eds.), *Substance abuse: A comprehensive textbook* 4th ed., (pp. 707–722). Baltimore: Williams & Wilkins.

Peters, R.H., & Osher, F. (2004). *Co-occurring disorders and specialty courts*. Delmar, NY: National GAINS Center for People with Co-Occurring Disorders in the Justice System and the TAPA Center for Jail Diversion.

Peters, R.H., Sherman, P.B., & Osher, F.C. (in press). Treatment in jails and prison. In K.T. Mueser & D.V. Jeste (Eds.), *Clinical handbook of schizophrenia*. New York: Guilford Press.

Peters, R.H., & Wexler, H.K. (Eds.). (2005). *Substance abuse treatment for adults in the criminal justice system*. Center for Substance Abuse Treatment, Treatment Improvement Protocol (TIP) Series 44. DHHS Publication No. (SMA) 05-4056. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Robins, L.N., & Regier, D.A. (1991). *Psychiatric disorders in America: The Epidemiologic Catchment Area study*. New York: Free Press.

Russell, B. (1999). New approaches to the treatment of women with co-occurring disorders in jails. *American Jails*, March/April, 21–25.

Sacks, S., & Pearson, F.S. (2003). Co-occurring substance use and mental disorders in offenders: Approaches, findings and recommendations. *Federal Probation*, 67(2), 32–39.

Sacks, S., & Ries, R.K. (2005) (Eds). *Substance abuse treatment for persons with co-occurring disorders*. Center for Substance Abuse Treatment, Treatment Improvement Protocol (TIP) Series 42. DHHS Publication No. (SMA) 05-3922. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Sacks, S., Sacks, J.Y., McKendrick, K., Banks, S., & Stommel, J. (2004). Modified TC for MICA offenders: Crime outcomes. *Behavioral Sciences and the Law*, 22, 477–501.

Steadman, H. J., Fallon, J., Mireles, P., Williams, K., & Aronson, L. (2005). *Establishing collaborations with local jails: An edited transcript of the PATH national teleconference sponsored by the Substance Abuse and Mental Health Services Administration (SAMSHA)*. Retrieved on November 15, 2006, from PATH: Projects for Assistance in Transition from Homelessness: http://www.pathprogram.samhsa.gov/tech_assist/default.asp.

Steadman, H.J., Morris, S.M., & Dennis, D.L. (1995). The diversion of mentally ill persons from jails to community-based services: A profile of programs. *American Journal of Public Health*, 85, 1630–1635.

Steadman, H.J., & Naples, M. (2005). Assessing the effectiveness of jail diversion programs for persons with serious mental illness and co-occurring substance use disorders. *Behavioral Sciences and the Law*, 23, 163–170.

Steadman, H.J., & Veysey, B.M. (1997). Providing services for jail inmates with mental disorders. *National Institute of Justice: Research in Brief*, NCJ 162207, 1–10.

Teplin, L.A., Abram, K.M., & McClelland, G.M. (1996). Prevalence of psychiatric disorders among incarcerated women—I. Pretrial jail detainees. *Archives of General Psychiatry*, 53, 505–512.

Teplin, L.A., Abram, K.M., & McClelland, G.M. (1997), Mentally disordered women in jail: Who receives services? *American Journal of Public Health*, 87(4), 604–609.

Teplin, L.A., Abram, K.M., McClelland, G.M., Dulcan, M.D., & Mericle, A.A. (2002). Psychiatric disorders in youth in juvenile detention. *Archives of General Psychiatry*, 59, 1133-1143.

U.S. Department of Justice (2006). *Justice and Mental Health Collaboration Program: FY 2006 competitive grant announcement # BJA-2006-1381*. Retrieved on November

15, 2006, from Bureau of Justice Assistance Programs: http://www.ojp.usdoj.gov/BJA/grant/06MIOsol.pdf.
Van Stelle, K.R., & Moberg, D.P. (2004). Outcome data for MICA clients after participation in an institutional therapeutic community. *Journal of Offender Rehabilitation*, 39, 37-62.
Veysey, B.M., Steadman, H.J., Morrissey, J.P., & Johnsen, M. (1997). In search of the missing linkages: Continuity of care in the U.S. jails. *Behavioral Sciences and the Law*, 15, 383-397.
Walsh, A. (2000). Should jails be messing with mental health or substance abuse? *American Jails*, 14, 60-66.
Weisman, R.L., Lamberti, J.S., & Price, N. (2004). Integrating criminal justice, community healthcare, and support services for adults with severe mental disorders. *Psychiatric Quarterly*, 75, 71-85.
Wexler, H.K. (2003). The promise of prison-based treatment for dually diagnosed inmates. *Journal of Substance Abuse Treatment*, 25, 223-231.

About the Authors

Roger H. Peters, PhD, Department of Mental Health Law and Policy, Louis de la Parte Florida Mental Health Institute, University of South Florida, Tampa, Florida. Nicole M. Bekman, MA, Department of Mental Health Law and Policy, Louis de la Parte Florida Mental Health Institute, University of South Florida, Tampa, Florida.

The above chapter, "Treatment and Reentry Approaches for Offenders with Co-occurring Disorders," appeared in R.B. Greifinger (Ed.), ***Public Health Behind Bars: From Prisons to Communities*** *(2007), (pp. 368-384). New York: Springer Science and Business Media.* ❑

UPDATE
ON THE INTERNET

Recent issues of the ***Jail Suicide/Mental Health Update*** are now available on the Internet at:

www.ncianet.org/suicideprevention

Check us out on the Web!
www.ncianet.org/suicideprevention

Other jail/juvenile suicide prevention and jail mental health resources, including several recent articles by Lindsay M. Hayes, can be found at the following web sites:

www.hhpub.com/journals/crisis/1997
www.nicic.org
www.ncjrs.org/html/ojjdp/jjjnl_2000_4/sui.html
www.cimh.org/publications/publications.cfm
www.omh.state.ny.us/omhweb/forensic/suicide.htm
www.pbstandards.org/ResourceSection.aspx?id=4

LIABILITY AND TELPHONE CORDS

During the early morning hours of December 9, 2002, 23-year-old Bryan Posey was arrested on a charge of assaulting his mother and transported to the Lew Sterrett Central Intake Facility of the Dallas County Sheriff's Department. According to the arrest reports from the Dallas Police Department, Mr. Posey was described as combative with his mother, intoxicated and had been taking drugs (including morphine, Xanax, and speed), had not slept for the past eight days, and was in an irrational and emotional state of mind. Upon entry into the Central Intake Facility, Mr. Posey was frisked and fingerprinted. Although intake officers were required to complete a suicide risk screening form on Mr. Posey, portions of the form were left incomplete. Due to stitches in his hand, Mr. Posey was then seen by the intake nurse who completed another screening form on the inmate. Mr. Posey allegedly answered "yes" to mental health problems ("anger problems"), active wound ("stitched right hand"), and drug use ("smoking pot"). There were conflicting statements from both intake officers and the intake nurse as to whether Mr. Posey was ever questioned regarding suicidal ideation. According to the nurse's notes, Mr. Posey was placed on open "behavior observation" status with a referral to the psychiatrist "for his anger problems."

At approximately 2:35am, Mr. Posey was placed in a male holdover cell which had a telephone. When Mr. Posey apparently began making several harassing telephone calls to his mother, he was moved to another cell which had an inoperable, broken telephone with wires extending from its metal cord. According to the police report, Mr. Posey "was seen by the nurse and was placed in a single cell for his protection due to his irrational state of mind and verbal abuse towards other detainees."

Mr. Posey was periodically observed in the cell by Officer Lynn Looka. At approximately 3:45am, Officer Looka and three trustees entered the cellblock area to deliver meals to the detainees. A few minutes later, a trustee ran out of the male holding area and called for assistance after Mr. Posey was found hanging from the inoperable and broken metal cord of the telephone in his cell. He was removed from the metal cord and laid on the cell floor. Officer Looka and another arriving officer initiated cardiopulmonary resuscitation and were subsequently assisted by the jail nurse. Emergency services personnel were called and subsequently transported Mr. Posey to a local hospital where he was pronounced dead.

Throughout the country, the decision to place a telephone inside a holding cell is primarily done for the convenience and benefit of jail staff in order to avoid escorting detainees and inmates to other locations where a telephone might be located. The location of the telephone inside the holding

cell also increases usage, thereby increasing revenues to the telephone company and presumably the jail system.

It is common knowledge in jail systems throughout the country that corded telephones are dangerous when installed in jail cells because an inmate could utilize the metal cord as a noose and the telephone cradle as an anchor in suicide attempts by hanging (see "A Jail Cell, Two Deaths, and a Telephone Cord," ***Jail Suicide/Mental Health Update***, Winter 2003, Volume 11, Number 4, pp. 1-8). In fact, according to a section of the Texas Commission on Law Enforcement Officer Standards and Education's *Mental Health Peace Officer Training* (1999) on suicide in detention facilities, "The majority of correctional facility suicides are by hanging. A person can die within three minutes by committing suicide using items such as bed sheets, clothing, *telephone cords*, and shoelaces."

As a result of the inherent and foreseeable dangerousness of placing telephones with metal cords inside jail cells, jail administrators are faced with two options: 1) replacing the systems with cordless telephones or 2) prohibiting any type of telephone system inside a jail cell. Cordless telephone systems have been operational in jail facilities throughout the country since at least the early 1990s. Due to the fact that inmates have been known to commit suicide by utilizing the metal cords of the telephones, the primary reason that cordless telephone systems were developed and marketed within jail systems was due to the inherent dangerousness of placing corded telephones inside jail cells.

> I gave orders three years ago that all phone cords would be removed and replaced with the in wall system. After the recent suicide I find that there are still two in the holdovers. Understand me clearly "I WANT ALL PHONES CORDED REPLACED IN THE HOLDOVERS IMMEDIATELY." The cords, as you can see assist in the ability to commit suicide.

There were several examples of Dallas County having knowledge that corded telephones located inside a holding cell were dangerous because of the potential use for suicide by hanging. First, prior to Mr. Posey's suicide, there were at least two other deaths in the Dallas County Jail system in which inmates utilized corded telephones to commit suicide. One suicide occurred in 1993, the other on October 26, 2000 when inmate Charles Williams was found in a holding cell "with a telephone cord wrapped around his neck." Following that death, Edgar McMillan, Chief Deputy and Jail Administrator of the Dallas County Sheriff's Department, ordered that all corded telephones be removed from the holding cells. And most corded telephones were removed, except for two cells, including that housing Mr. Posey.

On January 2, 2003, several weeks after Mr. Posey's death, Chief Deputy McMillan wrote the following e-mail to a subordinate:

> I gave orders three years ago that all phone cords would be removed and replaced with the in wall system. After the recent suicide I find that there are still two in the holdovers. Understand me clearly 'I WANT ALL PHONES CORDED REPLACED IN THE HOLDOVERS IMMEDIATELY.' The cords, as you can see assist in the ability to commit suicide.

Not surprisingly, the family of Bryan Posey filed a lawsuit against Dallas County alleging that the county and its jail staff were both negligent in failing to properly assess their son's suicide risk and in placing him in a cell with a broken, corded telephone. Dallas County filed a motion for summary judgment, arguing there was not sufficient evidence in the case. The motion was denied by the trial court and the case was eventually appealed to the state's Fifth District State Court of Appeals.

On August 28, 2007, the appeals court ruled that evidence presented in the lower court showed jail staff failed to properly assess Mr. Posey's suicide risk during the intake screening process, and that the county had prior knowledge of the inherent dangerousness of corded telephones placed inside jail cells. The appeals court found, in part, that:

> Arguably, a person of ordinary intelligence would anticipate a danger of placing a person with suicidal tendencies in a jail cell with a corded telephone. Thus, the question turns on whether, at this juncture and on this record, the County should have known that Bryan Posey was a suicide risk. The evidence presented to the trial court revealed that the County was aware that corded telephones had been used by inmates to commit suicide. In fact, two inmates committed suicide with corded telephones in the Dallas County Jail in 1993 and 2000. It was the inmate suicide in 2000 that prompted the County to order that all corded telephones be removed and replaced with cordless telephones. All but two telephones had been replaced at the time of Bryan Posey's suicide….The evidence is undisputed that it would be improper to place an inmate with suicidal tendencies in a cell with a corded telephone. The evidence is conflicting on whether County employees properly assessed Bryan Posey's suicide risk. The plaintiffs, through their evidence, have raised a fact issue as to whether the County properly assessed Bryan Posey for his risk of suicide. Accordingly, we conclude the trial court did not err in denying the County's third amended plea to the jurisdiction.

The ruling cleared the way for the case to proceed to trial. Tom Carse, attorney for the Posey family, called the opinion by the Fifth District State Court of Appeals a victory and told *The Dallas Morning News* that he looked forward to presenting evidence to a jury. "The county has stuck its head in the sand for years about the dangers of corded telephones," he said. Bob Schell, chief of the district attorney's civil division, said the county would likely appeal the decision to the state Supreme Court. "We don't agree with that decision and will probably be pursuing further appeals," he told the newspaper. ❑

INMATE SUICIDES UTILIZING TELEPHONE CORDS

The following listing should not be considered comprehensive; it is simply a listing of inmate suicides utilizing telephone cords known to Lindsay M. Hayes from 1990 to the present.

Arizona
Maricopa County Jail, July 1996
Pinal County Detention Center, July 2001
Scottsdale Police Department, September 2003

California
Alameda County Jail, March 2004
Alameda County Jail, October 2003
Alameda County Jail, January 1997
El Dorado County Jail, September 2005
Long Beach City Jail, July 1999
Los Angeles Courthouse Holding Unit, October 2004
San Diego County Jail, February 2000
Santa Clara County Jail, November 1988
Solano County Jail, June 2005
Solano County Jail, February 2004
Tulare County Jail (Bob Wiley Detention Facility), December 2005

Colorado
Jefferson County Jail, December 1990

Florida
Pinellas County Jail, January 2000
Volusia County Correctional Facility, October 1997

Georgia
Cobb County Jail, August 2002
Coweta County Jail, August 2005
Walton County Detention Center, April 2005

Iowa
Marion County Jail, July 2005

Illinois
Coles County Jail, June 2002
Morgan County Detention Center, March 2007
St. Clair County Jail, February 2000
Will County Jail, November 2001

Kansas
Barton County Jail, April 2002
Sedgwick County Detention Facility, April 1994

Kentucky
Boone County Jail, October 2005
Fayette County Jail, June 2004

Louisiana
Rapides Parish Jail, June 2004
St. Tammany Parish Jail, May 2007

Michigan
Berrien County Jail, August 2000
Macomb County Jail, June 2001

Mississippi
Clinton Police Department, December 2000

Missouri
Christian County Jail, August 2000
Independence Police Department, February 2004
St. Clair County Jail, February 2000

New York
Rockland County Jail, April 1998

North Carolina
Orange County Jail, September 2003

Ohio
Cleveland Police Department, August 2006
Mansfield City Jail, January 2004
Mansfield City Jail, May 1999
Portsmouth City Jail, 1995

Oklahoma
Lincoln County Jail, February 2001
Pittsburg County Jail, September 2005
Pushmataha County Jail, December 2000
Stephens County Jail, January 2001

South Carolina
Greenville County Jail, June 2004

Tennessee
Davidson County Jail, November 2005
Hawkins County Jail, August 2004

Texas
Allen Police Department, May 2000
Bandera County Jail, July 1998
Bee County Jail, February 1992
Benbrook Police Department, May 2003
Chambers County Jail, October 2003
Cockrell Hill Police Department, March 2000
Dallas County Jail, December 2002
Dallas County Jail, October 2000
Hardeman County Jail, June 1995
Harrison County Jail, February 1999
Hurst Police Department, April 1998
Johnson County Jail, May 2003
Katy Police Department, June 2001
McLennan County Jail, November 1998
McLennan County Jail, October 1998
New Boston Police Department, February 2000
Pasadena Police Department, October 2000
Port Isabel City Jail, December 1999
Port Isabel City Jail, November 1999
Seagoville Police Department, January 2000
Tarrant County Jail, January 1996
Van Zandt County Jail, May 2007

Virginia
Chesterfield County Jail, August 2007

Washington State
King County Jail, October 1999
Thurston County Jail, January 2007

Wisconsin
Brown County Jail, June 2005

News From Around the Country

Offered below are brief stories regarding inmate suicide, offenders with mental illness, and other related topics that have recently occurred and/or been reported throughout the country.

Mississippi

During the summer of 2007, three inmates were killed and a fourth committed suicide as gang violence erupted in a 1,000-bed segregation unit at the Mississippi State Penitentiary in Parchman. Several corrections officers were fired for alleged gang ties and the warden was transferred. Department of Corrections (DOC) officials confiscated homemade weapons and a semi-automatic handgun in what was supposed to be the state's most secure prison facility. United States Magistrate Judge Jerry A. Davis for the Northern District of Mississippi read about the violence in the infamous "Unit 32" facility in the *Clarion Ledger* newspaper. "I will tell you, over the summer I was worried," Judge Davis said during a court hearing on November 15, 2007. "It caused me some consternation on what could I do and what could the court do."

The court hearing Judge Davis was presiding over involved *Presley v. Epps* (No. 4:05CV148-JAD), a class-action lawsuit filed in 2005 by the American Civil Liberties Union's National Prison Project regarding inadequate classification, use of force, the mental health treatment practices. As acknowledged by DOC officials, Unit 32 was reserved for the "worst of the worst" – death row inmates, escapees, gang members, and inmates who were violence-prone or incapable of following rules. But the ACLU called the living conditions within Unit 32 among the worst of any prison facility in the country. In addition, its experts, including one who helped author the state's new classification system, determined that 80 percent of the inmates in the unit did not need to be locked down 23 hours a day with little chance of programming.

In 2006, the state agreed to settle the lawsuit and, although some corrective action was initiated, the pace was slowed by a breakdown in negotiations and continued poor conditions at Unit 32. The parties returned to Judge Davis's courtroom in April 2007 when he offered to mediate a settlement. The pace of the corrective actions began to pick up. By September 2007, under the leadership of DOC Commissioner Christopher Epps, more than 50 percent of Unit 32's population had been reclassified from administrative segregation to general population, the DOC began to renovate the facility to provide group exercise, recreation, programming and jobs. Many inmates with severe mental illness were also reclassified. Commissioner Epps also temporarily reassigned his deputy commissioner of institutions to Unit 32 in order to solidify management of the facility and quell further violence.

In November 2007, Judge Davis formally approved the "Supplemental Consent Decree on Mental Health Care, Use of Force and Classification," thus ending the lawsuit. Under the agreement, the state agreed to remove all inmates with severe mental illness from Unit 32 and institute "meaningful" mental health treatment for those inmates with less severe illnesses, including a "step-down" housing unit where inmates could receive crisis care and individual therapy. The state also agreed to reform its system of classifying which inmates needed to be held in isolated segregation, limiting that classification only to violent inmates, those engaged in gang activity or escapees. Segregated inmates who were free of serious rule violations and had completed treatment programs would be released from segregation within two years.

Judge Davis said the consent decree had the potential to make the state prison system a model for the rest of the nation. As reported in the *Clarion-Ledger*, Judge Davis told the parties that "I'm just floored completely. This is a tremendous step forward in corrections…..I am willing to hold our corrections system up to anybody." Margaret Winter, associate director of the ACLU National Prison Project, concurred with the court's praise of the DOC efforts. "We think that this is a real landmark and that it stands to make the prison a safer and more humane place not only for the prisoners but also for the staff," she told the *Clarion-Ledger*. "Mississippi is showing some national leadership here that could be followed by other states."

The agreement contains the following seven provisions for mental health treatment:

1) After December 1, 2007, Unit 32 will not be used for long-term housing of prisoners with Severe Mental Illness, other than those on Death Row. For purposes of this Order "long term" means more than 14 days. "Prisoners with Severe Mental Illness" means those with an Axis I diagnosis of a major mental illness (for example Schizophrenia or other psychotic disorder), Bipolar Disorder, Depressive Disorder or other serious Mood Disorder; prisoners who are significantly disabled by mental retardation or an organic brain disorder; and prisoners who are significantly disabled by any other mental disorder (for example, Generalized Anxiety Disorder, Posttraumatic Stress Disorder or any disorder characterized by repetitive self-harm.

2) Prisoners in Unit 32 with Severe Mental Illness requiring inpatient level of care will be housed at East Mississippi Correctional Facility or in another facility where they can receive the full range of appropriate treatment programs and the level of care consistent with their individualized treatment plans. The parties have not reached an accord on whether Defendants will facilitate access by Plaintiffs' lawyers and experts to these facilities for purposes of monitoring; Plaintiffs' motion to compel Defendants to facilitate such access is pending before the Court.

3) Defendants will designate a space at Unit 32 exclusively for use as a Mental Health Step-Down Unit. The Mental Health Step-Down Unit will be used to house

mentally ill prisoners who require an intermediate level of psychiatric care (intermediate between inpatient and outpatient treatment, roughly equivalent to residential treatment and partial hospitalization in the community). These prisoners will be involved in mental health treatment and will not be in administrative segregation status. The care provided will include an individualized multidisciplinary treatment plan, based on an assessment of the patient's needs, and a statement of short- and long-term goals and the methods by which these goals will be pursued. When clinically indicated, and in light of consultation between mental health and security staff, the treatment plan will give patients access to the range of treatment, supportive and rehabilitative services such as individual and group counseling, a range of psychiatric rehabilitation programs and self-help groups) that mental health specialists deem appropriate. The step-down unit will be staffed by at least one full-time psychologist and such other mental health treatment and nursing personnel as are needed. After one year of operation the mental health step-down program at Unit 32 will be re-evaluated for staff and/or location changes.

4) Prisoners in suicidal or other psychiatric crisis will be housed and provided appropriate observation and treatment at Unit 32 in a crisis stabilization area inside the Step-Down Unit. Twenty-four-hour nursing coverage (which may include coverage by the nursing staff at Unit 42) will be available to prisoners in the crisis stabilization area. The prisoners in this area will have out-of-cell time and will participate in individual and group treatment consistent with orders from the supervising psychiatrist. Prisoners will spend no more than fourteen days in the crisis stabilization area, after which they will either be released back to their cells, or to the Mental Health Step-Down Unit, or sent to East Mississippi Correctional Facility, or other housing appropriate for their condition.

5) Defendants will ensure that security staff persons successfully complete a 40-hour training course for working with mentally ill prisoners prior to working in the Mental Health Step-Down Unit. Only those officers successfully trained will be assigned work in the Mental Health Step-Down Unit.

6) Defendants will retain or cause to be retained at least five full-time mental health professionals, with at least masters' degrees in mental health, to provide services to the prisoners housed in Unit 32. Defendants will ensure that at least three such mental health professionals are in place by the time the Court enters this Order; that at least four are in place by January 1, 2008; and that at least five are in place by March 1, 2008. At least one of these full-time mental health professionals shall be a licensed therapeutic mental health clinician, trained in crisis intervention work, with at least a Masters degree.

JAIL MENTAL HEALTH SERVICES INITIATIVE FROM THE NATIONAL INSTITUTE OF CORRECTIONS (JAILS DIVISION)

Nearly 6 to 8 percent of the more than 10 million annual commitments to jails are individuals with severe mental illnesses. Many sheriffs and jail administrators view the challenge of responding to the needs of this population as one of the major issues in jail management. In response, the National Institute of Corrections (NIC) has worked collaboratively with the National Institute of Mental Health for the past several years, and more recently, with the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services to increase and improve these services. As a result of these collaborations, the NIC Jails Division has developed a mental health initiative for jails.

An important component of the initiative is the offering of regional workshops conducted in collaboration with state, regional, and local jurisdictions. The 21-hour regional workshops will be provided upon request to help small and medium-sized jails enhance mental health services and service delivery for inmates. Several jurisdictions in a region can each send a three-person team consisting of a jail administrator, a representative of the jail's community mental health provider, and the person who coordinates mental health services for inmates. Each workshop will include: overview of the problem, planning principles, contract development, leadership and managing change, implementation strategies, staffing and cross-training, and coalition building. The workshops are conducted at the request of a host agency, which is responsible for furnishing the training rooms and equipment. The NIC Jails Division provides two trainers, the curriculum and training materials. Participants are responsible for their own expenses.

In addition to the workshops, the NIC Jails Division's mental health initiative includes the following services:

- **On-site Technical Assistance**: This assistance usually consists of an assessment of a jail system's mental health needs, *but also can be targeted at suicide prevention issues in the jail*;
- **Newsletter**: The NIC Jails Division funds the ***Jail Suicide/Mental Health Update***, a newsletter which is distributed free of charge on a quarterly basis;
- **Information Resources**: The NIC Information Center has compiled a jail mental health information resource order form that contains 22 items. The form is available at the mental health workshops held in Longmont, Colorado and at regional sites. It can also be obtained by calling the Information Center at (800) 877-1461.

For more information on the NIC Jails Division's mental health initiative, on-site technical assistance, and the mental health workshops, contact the agency at (800) 995-6423, or visit their website at: www.nicic.org

7) No later than December 1, 2007, Defendants will ensure that there are least two full-time psychiatrists on site at MSP dedicated exclusively to providing mental health services to prisoners at MSP.

As Judge Davis concluded the hearing in November 2007, he told the DOC Commissioner — "Mr. Epps, there are going to be a lot of folks in Mississippi who think we are coddling prisoners…. They haven't been to 32."

A complete copy of the consent decree in *Presley v. Epps* can be found at: http://www.aclu.org/prison/gen/32735lgl20071113.html

New Jersey

In November 2007, Union County officials agreed to pay $780,000 to the family of a 17-year-old boy who committed suicide in the juvenile detention facility in Elizabeth four years earlier. The death of Eddie Sinclair, Jr. made headlines because he died in an overcrowded, dirty detention center about which officials had repeatedly received warnings from the state to improve conditions. The youth hanged himself on May 10, 2003 by tying a bed sheet to an exposed and broken fire sprinkler that had been ordered removed months earlier.

Yolanda Padilla, the youth's mother, said that the settlement amount from her lawsuit would do little to erase the loss of her son, who had been brought to the Union County Juvenile Detention Center for violating his probation over a stolen bicycle. He died less than 12 hours after being arrested. "I'm just tired," she told the *Newark Star-Ledger*. "I don't think there is any justice, I'm just ready to get it over with." She agreed to settle the wrongful death claim and accept the county's settlement offer for her own peace of mind. "I am not happy about it. (But) it was just lingering on." The family also settled separate lawsuits with Trinitas Hospital and Correctional Health Services Inc., who treated Eddie Sinclair, as well as Siemens Building Technology Inc. and Firemasters, companies involved in the installation of the fire sprinkler head at the facility. Those settlement amounts were confidential. Sebastian D'Elia, spokesman for the county, declined to comment about the specifics of the county's portion of the settlement, and said only that "We want to extend our sympathies to his family. It's an unfortunate incident."

The settlement closes an embarrassing chapter for Union County, which was beset with several years of criticism from at least two state agencies for the poor conditions in which it kept juveniles in the months leading up to Eddie Sinclair's death. The county ignored various state directives to stop the overcrowding which forced three youths to be confined into a single cell, and also resulted in prolonged periods of lock down of up to 18 to 20 hours per day.

Eddie Sinclair's death brought many changes, several forced on Union County by the state Juvenile Justice Commission, which oversees county juvenile detention facilities. The county, for example, had to fumigate for rodents, paint walls and clean grates, as well as limit the population at the facility to 34 beds, the number the Juvenile Justice Commission said it could safely keep in the building. More than a year after the youth's death, the state Office of the Child Advocate also investigated the county's management of the center and criticized facility officials for the deplorable conditions to which Eddie and other juveniles were exposed. As a result of these criticisms, a new detention center is being built which will have a capacity for 76 youth.

Eugene Melody, one of the attorneys who represented the family, said Eddie's death was avoidable. "The settlement in this case should be a bellwether for juvenile detention facilities nationwide to recognize inmates with mental health issues, and provide adequate suicide screening and prevention," he told the *Star-Ledger*. "It's heartbreaking that my kid dies and there is still no juvenile detention center," added Mrs. Padilla. "If the freeholders want to be part of the solution, they have to look at these kids like their own. This could happen to anybody."

Georgia

Mentally ill inmates in Georgia's prison system — many of whom are eventually released — are not getting enough treatment and care, and in some cases are getting worse due to a host of problems outlined in a recently-conducted independent audit. Inmates suffer from a lack of therapy and counseling as a result of insufficient staffing, employee turnover, technological glitches and other concerns, problems that persist in spite of previous audits that sounded the same alarm, the report says.

The consequences are grave, according to an Atlanta human rights law firm tracking the issue. Six mentally ill inmates have either been slain, or killed themselves, since October 2005 at three of the 33 Georgia prisons that care for inmates who need specialized mental health treatment. "From our experience, when you don't have enough mental health professionals to oversee this population, people start dying, people start coming out of prison in body bags," said Sarah Geraghty, a lawyer for the Southern Center for Human Rights.

The report is critical of the "lockdown" of some mentally ill inmates in isolation cells for 23 hours a day, causing them to "clinically deteriorate" or "not clinically improve." Given that roughly 95 percent of inmates are eventually released, it means that thousands of mentally ill criminals return to the street as sick — or sicker — than before. The 37-page audit, obtained by *The Atlanta Journal-Constitution* under the state's Open Records Act, calls the problems "serious" and "systemic."

The health of mentally ill inmates isn't the only issue on the line. Taxpayers could again end up footing the bill for costly litigation related to poor mental health care. The prison system estimates it spent "millions" of dollars complying with a series of consent orders from a 1984 federal class-action lawsuit covering every aspect of prison conditions, including deficiencies in its mental health care system. The system was released from federal supervision in 1998. The threat of another costly federal lawsuit looms large, because the Southern Center for Human Rights — which specializes in prison and jail conditions — has set its sights on mental health care delivery in Georgia prisons.

Department of Corrections officials acknowledge many of the problems cited by correctional health care expert Dr. Jeffrey L.

Metzner, but say some of the most serious results of poor mental health care — violent attacks on inmates and staff — have recently gone down inside of Georgia's prisons even as the number of ill inmates has grown. "There are cracks in the system," said James DeGroot, supervisor of the Department of Corrections' mental health services division. "The system's not broken, but we do have to tend to the infrastructure now stressed by the rapid growth."

DeGroot provided the AJC with numbers of incidents involving mental health inmates that show suicides dropped from 6 in 2005 to 2 in 2006 and one so far in 2007; assaults on prison staff fell from 371 in 2005 to 308 in 2006; assaults among inmates fell from 971 in 2005 to 821 in 2006. The number of homicides, however, has grown. There was one homicide in 2005 and one in 2006 among the mentally ill population. But there have been two slayings of mental health inmates so far in 2007. Five of the alleged perpetrators in this year's homicides were also mental health inmates. Southern Center lawyers are confident they can document at least two more violent deaths among the mental health population, Geraghty said.

DeGroot said the deaths must be put in a broader context. "I don't want to abdicate responsibility for any homicides, suicides or assaults — one is too many," DeGroot said. "But the incidents are relatively low." The report was addressed to Georgia Department of Corrections Commissioner James Donald, who declined an interview request for this article. Metzner, who was paid $10,000 to conduct the audit at the prison system's request, declined comment and deferred questions to the state Department of Corrections.

Robin Graham, whose mentally ill son Bryan was hospitalized following a scuffle with guards, said she has had a difficult time getting proper treatment for him. "They look at them simply as 'they broke the law,' not 'they have a problem,'" said Graham, who has hired a lawyer to look into her son's incident. "And there's hundreds of thousands of cases across the United States of people who have had mental illness and done something [illegal] and are never paid any attention to. Your departments of correction, your police forces, your judicial systems have no clue. Absolutely none."

Prison officials say they are dealing with a potentially volatile, difficult population, some of whom have compounded their illnesses with drug abuse. About 16 percent of the prison population in Georgia receives mental health services. Those services range from routine outpatient treatment — medication and therapy similar to what functioning people in private life get — to hospitalization for the sickest. Inmates with more serious problems are segregated from the general population in mental health wings inside prisons. Thirty-three of the state's prisons and probation detention centers offer mental health services.

The number of mentally ill inmates in Georgia's prisons has surged since 1999, the year after the system was released from the supervision of federal court. But as the population of mentally ill inmates has grown, the amount of professional help provided to them has gone down. In August 1999, there were 132 counselors who provided 2,382 hours of psychiatric and psychological help to 4,425 mentally ill inmates, according to Metzner's report. In December 2006, 188 counselors provided 1,830 hours of care for 8,054 inmates.

Prison officials have been repeatedly warned of the shortcomings. Geraghty, of the human rights group, called the persistent problems "disturbing." "The mental health caseload is skyrocketing and the number of mental health professionals is plummeting."

While under the supervision of the federal courts, the prison system increased staffing levels to make sure mentally ill inmates were cared for. DeGroot said the prison system "began losing ground" in 2000 because of budget cuts. As a result, unlicensed counselors — who are allowed in prison — are not receiving clinical supervision, raising "serious risk management issues," Metzner wrote. Turnover and vacancy rates among mental health staff and correctional officers in prisons are also high. At Chatham County's Coastal State Prison alone, the vacancy rate among guards is about 40 percent, according to the report.

DeGroot said 2006 — the year covered by the most recent Metzner report — was particularly bad because of a spike in the number of sentenced inmates transferred from crowded county jails into the prison system. "We've grown so fast in calendar year '06 that without the staff growing now there are cracks in the infrastructure," DeGroot said.

DeGroot led a tour June 13 for an AJC reporter and photographer of some of the mental health units at Phillips State Prison in north Gwinnett County. The housing units were clean, and most of the inmates appeared calm while participating in therapeutic exercises. Some stared off into space, some held their heads in their hands and some rocked back and forth or twitched nervously. Therapists talked to the inmates about the importance of proper hygiene in one class. In another, a therapist asked a group of mentally ill inmates to name their favorite color and their reason for choosing it. An African-American inmate responded "white." When asked by the therapist why he chose white, he matter-of-factly responded "That's the color I am. I'm just in disguise."

A couple of the inmates who spoke with an AJC reporter said they felt safe and treated well inside the mental health wing by most staff members and guards. They had minor complaints about being forced to take medication, or the occasional surly prison guard.

In contrast, Geraghty of the Southern Center for Human Rights showed the AJC a folder full of photos of mental health inmates who had cut themselves at Phillips State Prison. Some of the inmates had cut their forearms, throats and chests, spilling blood onto their cell floors and uniforms. The photos were gathered during a 2004 lawsuit against the prison system in which the center claimed an "epidemic of self-injury" among mental health inmates at Phillips.

Graham, who had a son at Phillips (he is now at Georgia State Prison in Reidsville), said she's not surprised by the report's findings. "They're basically nonexistent," Graham said of corrections' mental health services. Graham said there were a few mental health personnel who have been helpful to her. But mostly, she felt ignored and kept in the dark about her son's needs. On March 21, her son attacked a female prison guard at Phillips. When asked why, according to a report of the incident, he told authorities "Jesus told him to do it." Graham, who suffers from shizo-affective disorder, landed in an Atlanta hospital with a collapsed lung, cracked ribs and other injuries in the ensuing scuffle with guards

who responded to the attack. Graham, who was serving five years for assaulting a Cobb County police officer, now faces additional criminal charges in Gwinnett.

DeGroot said he doesn't think the prison system's mental health system is in crisis. "We could improve. The staff's hearts, most of them, are in the right place, and doing a good job. I think we're providing help to people who for so long have not received much, if any, help. We're dealing with the most disenfranchised population."

The above article, "Audit on Prison Mental Health Treatment – Inmate Care Declines, Turnover Lack of Therapists Partly to Blame," was written by Carlos Campos, a staff writer for ***The Atlanta Journal-Constitution****, and appeared in the June 23, 2007edition of the newspaper. Copyright 2007,* ***The Atlanta Journal-Constitution****. All rights reserved. Used with permission.*

Florida

According to a recent report from the state's Supreme Court, the legal system is clogged with as many as 125,000 people with mental illness arrested and booked annually into county jails. Some are charged with either misdemeanors or minor felonies that can be attributed to their illnesses. They are typically poor, uninsured, homeless, minorities, and substance abusers. Many languish in jail for months before getting treatment, in violation of state law that dictates a 15-day window. And the treatment they do receive is designed to render them competent to stand trial, not to reintegrate them back into the community. And the cost is enormous — approximately $250 million annually to treat about 1,700 people. That cost is expected to double within the next eight years.

In 2006, the state ranked 12th in the country in spending for forensic mental health services, and since then, spending has dramatically increased, with $16 million in emergency funding and $48 million in annual funding added in the past year. Conversely, the state ranks 48th nationally in terms of overall per capital public mental health spending.

In an effort to comprehensively address the crisis, state Supreme Court Chief Justice Fred Lewis recently hosted an unprecedented forum that brought various state leaders together to unveil a plan to improve the state's mental health system and to better coordinate services provided to people with mental illnesses, including those involved with the criminal justice system. "I think we all recognize," Chief Justice Lewis stated, "that Florida now is stuck in a vicious cycle of inappropriate behavior leading to inappropriate incarceration, again and again. At root, this is an issue about using the wrong tools and the most expensive tools to address human problems and human suffering arising from treatable disease."

The plan, unveiled at the event on November 14, 2007, was part of the work undertaken by a Supreme Court-led task force, one of seven such statewide task forces around the country convened by the Council of State Government (CSG)'s Justice Center and the National GAINS/TAPA Center to improve responses to people with mental illnesses involved with the criminal justice system. The report, *Transforming Florida's Mental Health System: Constructing a Comprehensive and Competent Criminal Justice/ Mental Health/Substance Abuse Treatment System*, recommends the development of a strategy to reduce the state's dependence on forensic mental health beds and to reinvest millions of dollars currently spent on those beds in community-based mental health treatment. Chief Justice Lewis assigned Judge Steve Leifman as the Supreme Court's Special Advisor on Criminal Justice and Mental Health to manage the day-to-day operations of the task force, and Judge Leifman delivered the report's findings and recommendations at the recent forum. Judge Leifman also serves as the co-chair of the national Chief Justices' Criminal Justice/ Mental Health Leadership Initiative, which the CSG Justice Center coordinates in partnership with the GAINS Center. Key elements of the proposed plan include:

- Adoption of innovative financing strategies, designed around principles of managed care, that create incentives to prevent individuals from inappropriately entering the justice systems, and to quickly respond to individuals who do become involved in the justice system.

- Establishment of a multi-tiered level of care classification system targeting individuals at highest risk of institutional involvement in the criminal justice, juvenile justice, and state mental health systems to ensure adequate services in times of acute need when at risk of penetration into institutional levels of care and maximizing limited state resources during periods of relatively stable recovery.

- Creation of a statewide system of limited enrollment, Integrated Specialty Care Networks (ISCNs) under a newly authorized Medicaid state plan option targeting Home and Community Based Services (HCBS) and specifically tailored to serve individuals with SMI/SED who are involved in or at risk of becoming involved in the justice system or other institutional levels of care.

- State certification of local providers and communities for participation in the proposed ISCNs, who demonstrate: 1) The ability to deliver effective, high-quality services across systems of care to individuals at highest risk of becoming involved in the criminal justice system or other institutional levels of care, and 2) On-going, collaborative relationships with state and local criminal justice and community stakeholders that will facilitate early intervention and continuity of care across systems.

- Implementation of strategies targeting community readiness and individuals at highest risk for institutional involvement.

- Establishment of a partnership between the Department of Children and Families and the Agency for Health Care Administration to maximize funding streams and opportunities to serve individuals covered under public entitlement benefits (i.e., Medicaid) as well as those not covered.

- Programs to maximize access to federal entitlement benefits by expediting the application process and increasing initial approval rates for individuals prescreened to be eligible for benefits.

- Strategic, phased in implementation over a six year period to ensure adequate infrastructure development and sustainability.

- Strategic reinvestment of general revenue appropriations currently allocated to the state forensic system into community-based services targeting individuals at risk of criminal justice system involvement.

- Establishment of a Statewide Leadership Group to provide administrative oversight and facilitate technical assistance with the development of state and local plans.

- Implementing strategies and promising practices to maximize enrollment in federally supported entitlement benefits such as Medicaid and Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI).

- Expansion of the Criminal Justice/Mental Health/ Substance Abuse Reinvestment Grant Program to build local and statewide infrastructures.

- Development of local and statewide collaborations.

Implementation of the plan will initially cost approximately $20 million, but the state could also tap into Medicaid money, as well as redirect the $48 million currently being spent for forensic mental health beds that might be needed. Governor Charlie Crist, who also spoke at the event, stated "We have a responsibility to support and care for the most vulnerable among us, and at the same time, ensure the safety of our communities while also being good stewards of taxpayer dollars."

Chief justices in six other states have also been selected to participate in a Chief Justices' Criminal Justice/Mental Health Leadership Initiative and currently receive both funding and technical support from the CSG Justice Center and the GAINS Center. The chief justices in these states, California, Georgia, Missouri, Nevada, Texas, and Vermont, have convened task forces to develop strategies to improve outcomes for people with mental illnesses in the justice system across the state. The Justice Center and GAINS Center anticipate the release of updates on the initiative in the coming months, describing how chief justices in other states can become involved.

A full copy of the 170-page *Transforming Florida's Mental Health System* report can be found at the Florida Supreme Court website: www.floridasupremecourt.org. For more information regarding the Chief Justices' Criminal Justice/Mental Health Leadership Initiative, visit either the Council of State Government's Justice Center website (www.justicecenter.csg.org) or the National GAINS /TAPA Center website (www.gainscenter.samhsa.gov/html). ❑

JAIL SUICIDE/MENTAL HEALTH UPDATE

This technical update, published quarterly, is part of the National Center on Institutions and Alternatives (NCIA)'s continuing efforts to keep state and local officials, individual correctional staff, mental health/ medical personnel, and interested others aware of developments in the field of jail suicide prevention and jail mental health services. Please contact us if you are not on our mailing list. Readers are encouraged to offer opinions and/or submit pertinent materials for inclusion into future issues.

This publication is supported by Cooperative Agreement Award Number 06HI02GJM7 from the National Institute of Corrections (NIC), U.S. Department of Justice. Points of view or opinions stated in this document do not necessarily represent the official position or policies of the U.S. Department of Justice.

Unless otherwise noted, all articles appearing in this newsletter are written by Lindsay M. Hayes, Editor/Project Director.

AVAILABLE JAIL/PRISON/JUVENILE SUICIDE PREVENTION MATERIALS

And Darkness Closes In...National Study of Jail Suicides (1981)
National Study of Jail Suicides: Seven Years Later (1988)
Training Curriculum on Suicide Detection and Prevention in Jails and Lockups—Second Edition (1995)
Curriculum Transparencies—Second Edition (1995)
Prison Suicide: An Overview and Guide to Prevention (1995)
Juvenile Suicide in Confinement: A National Survey (2004)
Jail Suicide/Mental Health Update (Volumes 1-15)

For more information regarding the availability and cost of the above publications, contact either:

Lindsay M. Hayes, Editor/Project Director
National Center on Institutions and Alternatives
40 Lantern Lane
Mansfield, Massachusetts 02048
(508) 337-8806 • (508) 337-3083 (fax)
Web Site: www.ncianet.org/suicideprevention
E-Mail: Lhayesta@msn.com

or

NIC Information Center
791 North Chambers Road
Aurora, Colorado 80011
(800) 877-1461 • (303) 682-0558 (fax)
Web Site: www.nicic.org