QUESTIONS AND ANSWERS
NIC Videoconference: Jail Inmates with Mental Illness: A Community Problem
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Part 1. Questions from participants

Is there a process for the use of deferred prosecution? (i.e., no formal court action if deferred prosecution agreement signed by inmate and attorney as long as the inmate complies with the stipulations of the agreement, i.e., take meds, make appointments with the MH case manager in the community, etc.)

Deferred prosecution can be an excellent strategy for diverting people from having to go through the whole criminal justice process when the person, through some equitably/equally applied risk assessment measure, seems unlikely to commit a similar offense in the future. As to its appropriate use with persons with mental illnesses, I think it is important to avoid using a devise designed to manage people in the criminal justice system with people who should not be in the criminal justice system at all. Further, some of the expectations involved in deferred prosecution agreements may be set ups for those with mental illnesses – things like mandating medications, mandating counseling appointments and/or housing conditions, without a method of taking into consideration their own perspectives towards these mandates – and may work to ignore or undermine the dignity and self-determination of those persons.

Can you provide information regarding experience or data as to the use of Community Case Management and the impact on recidivism? Discuss the benefits (if any) of attempting medication management for "revolving door" inmates (not compliant before admission to the jail and a definite pattern of non-compliance upon return to the community).

If medications are indicated and the person is willing, after the appropriate diagnosis is made and education given, to take these medications, then of course medication management may be beneficial. If, however, you are talking about involuntary medications, this is a whole area of treatment that has constitutionally based civil rights and human rights implications. Just because someone is "revolving door" doesn't mean that they have achieved that status on their own. I would ask whether they are revolving door clients because of some systemic failure – how does the local community mental health provider pursue this client? Have attempts been made at education, at different methods of intervention and treatment, at securing stable housing, and at providing medications that have minimal side effects? What exactly is "non-compliant" and who has defined this person as being such?

Unfortunately, higher than ideal caseloads, poor salaries, staffing deficiencies, and the convenience of incarceration often make law enforcement/criminal justice interventions the expedient ways of managing challenging people. In the end, however, we all pay for

quick solution – not just fiscally, but in perpetuating the stigma against mental illness; reinforcing the image of the jail as being the place that always has a bed, always has the open door; and supporting the "out of sight, out of mind" phenomenon that in many ways keeps our government and our communities from really engaging with and tacking the problems of the "revolving door" inmates.

The use of special conditions of release should be utilized as a tool for people who are typically noncompliant. You could examine the types of medications being prescribed. Are they the newer medications that have fewer side effects? Although these medications are higher in cost, in the long run, the costs would be less. In addition, it would be beneficial for the prisoner to be linked to wrap-around services such as mobile treatment, assertive community treatment, and/or a homeless provider so that multiple agencies can remain in contact with the prisoner and hopefully break the incarceration cycle.

Is isolation past the need for protection/safety/security issues in the same category as chemical restraint/physical restraint?

This is a complex question that requires a much more complex answer than what you'll receive here. It is always best to consult with your county and/or institutional attorney about the appropriateness of your procedures for isolation and "punishment."

If you are asking whether you can isolate for punishment, the answer is it depends. You of course cannot punish someone just for being in jail. An inmate can be "punished" after an appropriate administrative procedure (that affords due process protections), if that person has violated a clearly articulated institutional rule. Isolation cannot be used to punish someone simply for the sake of punishment. It can be used if it is deemed imperative to the security of the institution and/or the safety of inmates/staff.

Chemical restraints and physical restraints cannot be used to punish, period. These can only be used if there is an immediate threat to the inmate's safety, others' safety, and/or the security of the facility and/or the public.

More than just isolation and restraints are required for those in need of treatment. Liability issues would be similar for excessive use of isolation.

Due to the change in funding a large amount of clients are ending up in jail facilities. What's the difference in cost between a mental institution vs. a prison, and how are these costs covered?

Community treatment alternatives should be less costly than expensive jail stays. There is no hard data available because costs vary state-to-state.

Since community mental health providers cannot use federal benefits to provide treatment/care management while a person is in jail, how do most states pay for the "coordinated" effort by mental health? Sometimes there is a period of time between

jail discharge and when medical benefits are available. How is MH treatment provided and paid for during that period?

While the person is incarcerated, the jail pays for health and mental health services (which includes a social worker to do discharge planning as well as medications). In Maryland, the state and local county governments pay for case management services for in the jails. These case managers can follow the person both in the jail and upon discharge.

Can jails medicate against the will of the inmate when the inmate is displaying difficult behavior?

No. In and outside of jail, involuntary medications are inappropriate methods of controlling "difficult behavior." You should seek the advice of your county/facility attorney re when medication can be forced and the (onerous) procedures that must be followed prior to forcing medications.

The real issue here is one all of us can imagine … in fact, most of us would fit into the category of having "difficult behavior" from time to time. How would you like to be medicated for getting angry, being assertive, having a bad day? Remember the movie the Stepford Wives – where women were involuntarily medicated simply because their husbands wanted the "perfect" wives? When we talk about forcing medications for behavior problems, we are suggesting that someone else's idea of what is "good" and "bad" behavior will control. This is not a good idea under any circumstances or in any setting.

This is determined on a state-by-state basis. See the Washington v. Harper prison case (see www.findlaw.com) for reference material. The findings in the case are adequate to be adopted in other states.

How do you approach a situation where the inmate is demonstrating mental health characteristics, but the mental health staff classifies the inmate as having "behavioral problems"?

Jails are responsible for having competent mental health staff. If we have competent mental health staff, we need to rely on their advice and deal with the behavioral problems via appropriate security measures, e.g., restriction of privileges, lock down, restraint devices, etc., as appropriate to the situation and as required to maintain security.

It might be helpful to establish policies and procedures that encourage a multi-disciplinary approach to classification. Consider using case reviews to discuss challenging cases. Mental health staff should consider that they might occasionally be wrong on some of their assessments. Therefore, the opinions and experience of the correctional staff should tapped for their knowledge of the inmate.

There are problems of perception and definition inherent in this dilemma. Mental health staff are indicating one thing; security another. In these cases, a "team" case planning/case management approach might work. Include in the team key representatives from mental health, security, classification, administration, medical, and/or programs. Confidentiality agreements can be signed so that needed information (that required to make an effective plan) can be shared between the team members. The first item on the agenda is to share perceptions – how are mental health staff defining the problems? Why does security staff see these problems as "mental health" problems? In the end, you want to come up with a behaviorally based management plan – what can be done to modify/shape this person's behavior as opposed to changing their mental condition (which is generally more difficult to do and to measure outcomes).

What success has there been with the mental health courts in diverting seriously mentally ill persons from incarceration by keeping them in the community?

You will get different answers to this question depending on whom you talk to. Here is mine: I have two problems with mental health courts. First, generally speaking, no new services are produced as a result of the initiation of these courts. While they may work to divert persons with mental illnesses from the jail and/or criminal justice system, they do so by directing that they be seen and cared for through the use of existing mental health resources. Second, I think both the jails and the mental health systems need to think twice before handing over such authority to the courts. Judges are not the experts on diagnosing, treating, and managing persons with mental disorders – why would we want to put them in the center of the decision making process? While I appreciate some judges willingness to be involved in the dilemma of more and more persons with mental illnesses coming into our jails, I think their involvement should have no more weight or bearing on the solution to this problem than that of the jail administrator, the mental health director, or the individual him- or herself.

How have mental health courts affected jail crowding?

The jury is still out on this one in terms of the numbers of persons with mental illnesses. I would guess, however, that jail overcrowding in general has not been affected…and I would also say that alleviation or reduction in jail overcrowding is not an appropriate outcome to expect from mental health courts.

As a Community Based Correctional Facility we are now faced with the challenge of creating a program to habilitate the criminal offenders with serious mental health illnesses. Where does a facility begin developing a treatment plan to help this population? What are some major goals to focus on?

I am assuming that you have some funding to support you in fulfilling this mandate. I don't have any magical answers for you, but I would encourage you to make this a collaborative effort with your community mental health and health providers, using consumer and family input as well. The jail and the community corrections agencies are but two service providers in a community of service providers. If you are to help

habilitate offenders with serious mental illnesses, the input of the other service providers in your community is imperative.

You are right in thinking that goals/objectives need to be set so that you have a focus and a mission. You will want to secure a good, shared definition of "habilitation." Be realistic – habilitation does not necessary imply cure or even treatment. It may imply "optimum functioning" and to determine this, you necessarily need everyone's ideas.

Don't think that you have to single-handedly find the answer to the questions/dilemmas with which we are all struggling. The NIC Information Center has program descriptions from jails in other parts of the country which may be helpful to you. And, I know there is no shortage of creative thinking right there in your own community. The emphasis should be on engaging with and/or treating people in multiple milieus…including the jail, the community corrections center, the community mental health center, in vocational rehabilitation programs, schools, sheltered workshops, and so on.

What is your experience with the privatization of care? Since our area jail has adopted this method for fiscal challenges, quality of care has gone down. Mentally ill individuals come into the jail unable to get the medications they are willing to take. Sometimes, after receiving requested treatment at a Forensic Psychiatric setting, they still experience a lapse of time before getting the prescribed medications.

My experience is with contracted medical and mental health services, not with the privatization of a jail facility. The requirements for the care of inmates with mental illness are the same whether provided by contractors or otherwise. Contracts must ensure that mental health treatment meets the community standards of care.

Our jail has an average daily population of 900 inmates. We have one M.D., one nurse practitioner, five nurses, and seven medical techs. We have no psychologist or psychiatrist. I continue care, or diagnose and treat mentally ill people. (I am an internist). The county commission claims the county cannot afford a full time psychologist and a part time psychiatrist. Is the jail violating the constitutional rights of inmates by not providing a psychologist? Is there a national standard of care for a jail of this size in terms of what level of staffing should be in place?

I suggest you look at the Estelle v. Gamble case (www.findlaw.com). The APA, APH and correctional commission have set standards for care. In addition, the correctional mental health report addresses this issue.

There are no "national standards of care" for staffing for mental health programs, and though I am sure others would disagree with me, I resist the idea of setting either recommended or mandatory staffing levels. We in jails certainly don't want to be hemmed in by standards not applied in the community mental health systems.

You are in a tough position and some psychiatrists, I suspect, would encourage you to resist prescribing a psychiatric regimen of treatment. Probably not surprising to you, I

would not automatically jump to this conclusion. Instead, I would ask if there are psychiatrists around your area who are available to provide services to the jail. The size of your jail population suggests you are in a metropolitan area, so medical schools and/or psychiatry clinics might be useful agencies from which to seek staff.

Another alternative is for you to attend special CME classes that pertain to psychiatric diagnosis and treatment with psychiatric medications. These may suffice in terms of your practice in the jail, especially if there are no psychiatrists willing to answer the jail's call for assistance. You should, of course, check this out with your state AMA board.

Finally, think about other credentialed professionals who might be able to provide psychiatric services, such as certified nurse practitioners, social workers, other masters level mental health professionals – professionals who, under state regulations, can diagnose and treat (though not necessarily prescribe medications for) persons with various kinds of mental illnesses.

What is the best initial assessment tool to determine need for treatment and medication – keeping in mind that we are limited to a "self reporting" perspective?

There is no such thing as the "best" initial assessment tool. I have never seen a tool that I thought was perfect, but I have seen some that I have liked. A combination of direct questions – and training for officers and/or health personnel who will ask those questions in how to do so with empathy and a show of concern – and observational terms which can be circled or checked if they apply, seems most advisable. Also, though it may be hard to believe, self-report is not as unreliable as one might think. Many, many studies are based on self-report and in fact, there are research reports which support the use and validity of self-report measures.

Are there any thoughts or plans to form a treatment review committee within the jails to assess the need for providing medication to someone who may not have enough judgment or insight to consent to taking medications which are beneficial to their well-being?

Inmates cannot be medicated without their consent, except under certain extreme emergency conditions. Any such committee would be constrained to working within applicable legal processes which apply to these emergency situations only.

There are several red herrings in your question. First, when is not enough judgment or insight, not enough? This is tough, and it is a slippery slope as well. Who would make that judgment and what would their credentials need to be? Also, how would you define the circumstances where medications might be "beneficial to their well-being"? You cannot limit that to symptoms which "may" make them dangerous because the standard for forced medication is that the person is dangerous.

As I have suggested to others writing about this topic of forced medication, I would encourage you to talk with your county or facility attorney to determine what options

exist for ensuring the appropriate level of review, one that affords the inmate(s) all of their due process protections, when involuntary medications need to be considered after other attempts to ensure the safety of the individual and/or security of the institution have failed.

Consider forming a review panel (similar to those in state hospitals) to determine the client's need for medication. (See the Washington v. Harper prison case at www.findlaw.com).

Who takes responsibility for release planning and follow-up services in your respective parts of the country – the mental health system or the criminal justice system?

In several jurisdictions in Maryland, the criminal justice system takes the lead in discharge planning where a social worker in the jails/prisons develops the discharge plans. The social worker's salary is typically paid for through the DOC budget. However, the state and local mental health authority also provide funding for discharge planners. These people work to provide pre-booking diversion as well as discharge planning and community follow-up.

When studying jurisdictions, have any statistics been gathered that indicate the degree of participation of stakeholders in the default problem? Any breakdowns in relation to city, county being dumped on more than others? Have any tools been developed to engage stakeholders, to heighten participation of stakeholders?

I suggest that you begin by calling a meeting and inviting the stakeholders to attend. Then quarterly meetings could be held to review the delivery of services and explore ways to collaborate between systems. Next pursue the development of Memorandum of Understandings. This can build on the themes already established in the quarterly meetings. Another less formal, but highly productive meeting can be to bring together systems for clinical case reviews. In Baltimore County, a meeting called the Vulnerable Adult Assistance Network (VAAN) meets monthly to review challenging cases which cross multiple systems. This could include a client who has been arrested several times (police and jail staff are represented), has a substance abuse issues (the substance abuse authority attends), has trash in the yard (so zoning is included), has been emergency petitioned several times (so mental health attends), etc. Collectively a treatment plan that addresses multiple system problems is developed. This has been a very effective mechanism to bring together stakeholders in an informal, but productive way.

The Canadian Mental Health Association publishes a manual regarding mobilizing community resources to care for persons with mental illnesses. I did not read this manual in any kind of comprehensive sense, but you might check out resources like this to help you think about organizing your own method of stakeholder engagement.

What direction should a facility pursue when community agencies limit their intervention when referring cases?

Go talk to them. Explore the issues and possible areas for mutual goals and cooperative involvement. They will probably not come to you; the jail administrator will have to take the initiative.
I suggest that the directors of agencies should be contacted and either a memorandum of understanding signed or agreements made to collaborate/facilitate discharge planning. If the directors are the problem, then the local mental health authority should be asked to intervene.

Continuity of care was addressed several times. Specifically, how can services be better delivered to inmates and true continuity of care established for inmates who are ineligible for benefits while in custody? If the individual who is now incarcerated has not been formerly identified as being mentally ill, they often have a long waiting period (up to 120 days) for social security, medical assistance/access, etc. We often encounter individuals who have been misdiagnosed for years in the community until brought to prison where there is long-term 24/7 observation and care.

Many times, what we are experiencing in the prisons are the results of medication non-compliance and decompensation. Due to this, the mentally ill individual's behavior becomes more apparent and they are identified by law enforcement and brought back to prison. The prison mental health professions assist the individual in becoming stable through medication and counseling and they are released and the cycle begins again.

This is exactly the situation in which I am presently stuck.. If there is an answer, I am convinced that it will come only through the jail and community mental health working together to the common goal of achieving true continuity of care. Neither entity can solve it alone.

Because of the high cost of jails, I am also convinced that continuity of care can be a less costly approach than the on again/off again cycle you describe. If this is true, then what it will take is for the jail and community mental health professionals to develop new and/or creative approaches to provide for continuity within the existing mutual resources of both systems. Is it really less expensive for the community to keep these individuals in jail? I don't think so. Or, is a reallocation of existing resources to some creative approaches likely to be more cost efficient.

Part 2. Resources

Sheriff Gayle Ray discussed a Mental Health Court they have in their county/state. Where can I obtain more information on this?

The Bureau of Justice Assistance (BJA) has published a document on the subject of mental health courts, titled Emerging Judicial Strategies for the Mentally Ill in the Criminal Caseload: Mental Health Courts. You can download it from the NCJRS website

at www.ncjrs.org/pdffiles1/bja/182504.pdf. A number of jurisdictions have information available on the web. Searching under Mental Health Courts will allow you to view a number of reports from around the country. Or, contact the NIC Information Center for assistance.

Margaret Severson advised that in July she will be releasing a report on suicide/suicide screening. Will that report be posted on your web site? If not, how can I obtain a copy of that report?

The final report is due on July 1, 2002 to the National Institute of Justice. NIJ staff will determine how the findings and the report itself will be disseminated. Look for our findings in upcoming professional journals as well.

The panel also mentioned the Mental Illness Crime Reduction Act. Where can I obtain a copy of that act?

Try the National Alliance for the Mentally Ill – their website at *www.nami.org* has an section with releases on all the pertinent legislation pending that affects individuals with mental illness.