PROVISION OF MENTAL HEALTH CARE IN PRISONS

Special Issues in Corrections *February 2001*

LIS, Inc.

U.S. Department of Justice
National Institute of Corrections
Information Center
Longmont, Colorado

National Institute of Corrections

Morris L. Thigpen
Director

Susan M. Hunter
Chief, Prisons Division

Madeline Ortiz
Correctional Program Specialist

National Institute of Corrections
Prisons Division
320 First Street N.W.
Washington, D.C. 20534
(800) 995-6423
(202) 307-3106

NIC Information Center
1860 Industrial Circle
Longmont, Colorado 80501
(800) 877-1461
(303) 682-0213
http://www.nicic.org

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Introduction

In July 1999, the U.S. Bureau of Justice Statistics reported that more than 250,000 jail and prison inmates—16% of the incarcerated population—currently had or were known to have had a major mental illness. A 1999 review of prevalence data by Emil Pinta ("The Prevalence of Serious Mental Disorders Among U.S. Prisoners," *Correctional Mental Health Report* 1(3), September/October 1999) found estimates of 7.6% to 36.5% of prison inmates having narrowly defined serious mental disorders, with an average of 14.7% having such disorders within the past year. (These figures do not include data from female-only studies. Prevalence among women inmates has been found to be about twice as high as for incarcerated men.)

Based on these indicators and on data gathered through the present study, it is evident that most U.S. prison populations include significant numbers of inmates who enter the system with mental health needs. Some of these inmates must be housed and cared for separately for short or long periods, while others function acceptably in the general population. An inmate's previously recognized mental health issues may be exacerbated in the stressful environment of the prison, or an inmate may first be diagnosed with a mental health problem while incarcerated.

While many inmates may present a management problem, it is important to note that difficulty in managing certain inmates may be the result of underlying personality disorders, such as abnormal aggression levels or an inability to bond normally with other people. When such a factor is diagnosed, an inmate may receive treatment such as medications or counseling. If the behavior pattern were not recognized as a mental health issue, however, the inmate could be placed in segregation without treatment and possibly leave custody in worse mental condition than when he or she entered the prison system.

This study sought to examine the extent to which corrections agencies acknowledge the needs of, and provide for mental health care for, not only their acutely or severely mentally ill inmates but also those with lower levels of disturbance. To explore this and other questions about prison mental health services, NIC distributed a survey in December 1999 to departments of corrections (DOCs) in state, territorial, and federal government settings. Responses were received from 49 states, the Federal Bureau of Prisons (BOP), the Correctional Service Canada, Guam, and Puerto Rico. About half of the DOC respondents were directors of mental health or psychiatric services, and respondents in another 11 agencies were mental health clinicians. Respondents in the remaining agencies included medical directors, wardens, and researchers.

Study findings suggest great diversity in the management and treatment provided to inmates with mental health care needs. In general, whatever the agency's overall philosophy of care, corrections agencies devote more mental health resources to inmates who meet pre-determined criteria of mental illness or major mental health care need than to those who have lesser needs.

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Numbers of Inmates Needing Mental Health Care

Data gathered through this project support the idea that deinstitutionalization of mentally ill persons in the broader community may have shifted some of the responsibility for their care to corrections agencies.

- DOC respondents from 25 states, the BOP, and Puerto Rico reported that their agencies have kept records over the last 10 years which document an increase in their populations needing mental health care. (See Table 1, page 3.)
- In four DOCs, recorded data show no increase in the proportion of mentally ill inmates.

The remaining state DOCs lack data on changes in their populations with mental illness. Respondents in three (3) agencies said they had anecdotal evidence of an increase but no hard data. Some respondents noted that their agencies have only recently developed, or are in the process of developing, data management systems that provide the ability to track mental health needs and services.

Eighteen (18) DOC respondents identified the specific indicators used to document the increase. (See Table 1, page 3.) Examples include:

- The number of inmates classified at specific psychological grades or mental health ratings;
- The number of inmates requiring placement in special units or mental health facilities;
- The number of inmates for whom psychotropic medications are prescribed;
- The number of inmates with major mental illnesses;
- The number of inmates to whom the DOC provides mental health services of all kinds; and
- The number of incident reports involving inmates affected by mental illness or disorders.

Rates of increase cannot be compared from agency to agency because of the variety of tracking measures used. However, it is clear that many DOCs have been experiencing major increases in their numbers of inmates with mental illnesses. According to data provided, inmates with mental illness or mental health needs make up 10% or more of the prison population in seven states.

Approaches to Identifying and Providing Services to Mentally Ill Populations

Survey responses suggest that most DOCs rely on a variety of staff positions to identify inmates with mental illness. Identification commonly takes place during the intake process. In many agencies and institutions, intake screening is a multi-stage process in which the initial screening is done by non-psychologists, including nurses, counselors, physicians, or social workers. Inmates identified as needing additional mental health assessment are then referred to psychologists, psychiatrists, or a mental health team for a further evaluation of their needs and assignment to housing and services.

To explore the question of needs and service matching, NIC's survey asked respondents whether their agencies make an operational distinction between inmates with mental illnesses and inmates with other mental health needs. Respondents were asked to explain the nature of the distinction, if any.

- Sixteen (16) DOC respondents said no such operational distinction is made. Mental health care is provided to all inmates as needs are identified.
- The remaining 33 agencies indicated that they do make some type of operational distinction. Respondents described a range of approaches to distinguishing levels of need for mental health care among the inmates they house.

Table 1. Reported Increases in Mental Illness Among Prison Populations

	Indicator	Period		Increase Observed
		From	To	
Alaska	Annual review of mental health staff caseload	1980s	1999	Increase; data not available
California	Number of inmates to whom mental health is provided	1991	1999	3.3% increase; currently, 17,000 inmates, 11.2% of population
Colorado	Number of inmates with major mental illness	1996	1999	From approx. 600 to 1,200 inmates. Currently, nearly 10% of the inmate population
Connecticut	Number of inmates with mental health ratings of 3 to 5	1991	1999	From 5.2% to 12.3% of population
Delaware	Numbers of inmates on psychotropic medication, in infirmary setting for mental health reasons, and requiring placement in Crisis Care Unit	n/a	n/a	Increase; data not available
Florida	Inmates with psychological grade S2 to S5	1993	1999	From 7.9% to 14.4% of population
Georgia	Percentages of inmates receiving mental health services	1996	1999	From 9% to 12% of population
Idaho	Number of inmates on psychotropic medication	1998	1999	From 463 to 638 (38% increase)
Illinois	(Not identified)	n/a	n/a	Increase; data not available
Iowa	Percentage of inmates on psychotropic medication	1995	1999	From 4% to 8% of population
	Percentage of inmates receiving psychiatric consultations	1995	1999	From 1,573 to 4,316 consultations (274% increase)
Kansas	Percentage of inmates receiving psychotropic medication	1995	1999	From 7.5% to 12.5%
	Number of initial mental health screenings	1995	1999	From 16.7% to 30.3%
	Number of crisis placements	1995	1999	36.1 % increase
	Number of transfers to Larned facility	1995	1999	98% increase
Kentucky	Use of psychotropic medication, Seriously Mentally Ill bed demand, content of Extraordinary Occurrence Reports, and recently collected data	n/a	n/a	"Up significantly"; data not available
Massachusetts	Proportion of inmates with mental illness	1994	1999	"Significant" increase among female inmates, "lesser" increase among males; data not available
Montana	Number of screenings and referrals; use of services	n/a	n/a	Increase; data not available
New Hampshire	(Not identified)	n/a	n/a	Increase; data not available
New York	Size of mentally ill population; now reviewing data on population proportion and acuity levels.	n/a	n/a	Increase; data not available
North Dakota	Proportion of inmates on psychotropic medication	n/a	n/a	Increase; data not available. Now at 20% of population
Ohio	(Not identified)	n/a	n/a	Increase; data not available
Oklahoma	(Not identified)	n/a	n/a	Increase; data not available
Oregon	Proportion of population who have mental illness	1996	1999	From 13.6% to about 15%
Tennessee	(Not identified)	n/a	n/a	Increase; data not available
Vermont	(Not identified)	n/a	n/a	Increase; data not available
West Virginia	Number of inmates receiving psychotropic medication	n/a	n/a	Increase; data not available
U.S. BOP	(Not identified)	n/a	n/a	Increase; data not available
Puerto Rico	Number of inmates referred for mental health services	1993	1999	Increase; data not available

Distinguishing inmates' need for services. A majority of DOCs (28 state DOCs and the BOP) reported that they use assessment findings to make a formal determination of which inmates are considered mentally ill. This determination then makes it possible for the inmate to receive specific types of housing, programming, and management that are not available to inmates who have lesser degrees of mental disorder.

Respondents described the following approaches for determining levels of need:

- Seven (7) state DOCs, the BOP, and the Correctional Service Canada use the American Psychiatric Association's DSM-IV diagnostic classifications to define mental illness among those being assessed, which in turn determines treatment and service levels. An Axis I diagnosis of a clinical disorder is commonly required for the inmate to be considered mentally ill. In three DOCs, inmates with an Axis II diagnosis of personality disorder along with a low General Ability to Function (GAF) score also may be considered to have a mental illness.

- In eight (8) state DOCs, inmates are considered mentally ill if their assessments result in a particular designation, such as "chronically mentally ill", "severely mentally ill", "seriously disturbed," or "seriously and persistently mentally ill." Inmates who do not receive such a designation are not given housing or program assignments that include special mental health care.

- Six (6) state DOC respondents cited the use of agency-developed systems in which assessment criteria place the inmate in one of several levels of mental health treatment need. For example, systems used in the Louisiana and Virginia DOCs place inmates into one of five mental health levels of care, and the Georgia and New Mexico DOCs identify six levels.

- Two (2) state DOCs use definitions established by other authorities. In Arizona, the definition is from the state Department of Health Services, and the Rhode Island DOC uses the state's statutory definition of chronic, serious mental illness.

Levels of service provided. As noted, in many DOCs the formal diagnosis or mental health classification of an inmate governs the level and intensity of service provided, the type of staff who provide services, and/or housing assignments. In some institutions, inmates with certain diagnoses are eligible for ongoing treatment and services, while others are not.

In some states, for example, a determination of mental illness or of certain categories of mental illness qualifies inmates for individual rather than group therapy, inpatient care programs, long-term mental health care, treatment planning or special management plans, mental health caseworker review, special due process requirements, special advocacy opportunities, assisted living in a highly structured setting, or care by a psychiatrist rather than a psychologist. All other inmates who do not meet specific definitions of mental illness have access to fewer services.

On the other hand, responses from 21 state DOCs and the BOP suggested more flexibility in service provision. In expressing one agency's philosophy, the Indiana DOC respondent observed, "The Department of Corrections tries to manage those with serious mental illness primarily as patients who are incarcerated and those with 'other mental health needs' as offenders who have additional needs. Essentially, all offenders have some mental health needs."

Management and Treatment of Mentally Ill Inmates

Agencies were asked to provide some detail on the ways they house and provide care for inmates identified as having a mental illness.

- All DOCs responding to this survey indicated that they use a psychopharmacological approach to treating mentally ill inmates.

- Inmates with non-acute mental illnesses typically receive less than 1 hour per week of counseling in

14 DOCs, 1 hour of counseling per week in 10 DOCs, and more than 1 hour of counseling per week in 4 DOCs. Respondents in 9 DOCs indicated that the amount of counseling provided varies depending on need. Several respondents noted that inmates housed in special needs units are an exception to these numbers, as they have access to additional therapeutic mental health services.

Assignment to separate housing. Survey respondents described diverse philosophies and management approaches for housing mentally ill inmates. Some DOCs attempt to mainstream mentally ill inmates to the extent possible, and others are more apt to manage these inmates separately from the general population.

Respondents identified several main criteria used to determine when mentally ill inmates are housed outside the general population (many respondents gave more than one answer):

- When the inmate is placed in a mental health treatment unit for inpatient care (22 state DOCs);
- When the inmate is in crisis or an acute state of mental illness (17 state DOCs);
- When the inmate can't function adequately or cope in the general population (16 state DOCs);
- When the inmate is severely impaired or is becoming more psychotic or decompensating, etc. (14 state DOCs); and
- When the inmate is considered dangerous, suicidal, or at risk of self-injury (11 state DOCs and the BOP).

Other criteria cited by fewer respondents include: when the inmate needs structure; when the GAF drops under 50; when the inmate needs help staying on medications; when the inmate becomes a management problem; when the inmate is unable to care for him- or herself; when the inmate is vulnerable; and when the inmate needs more observation. Respondents from two DOCs noted that mentally ill inmates may be placed in segregation if they become a threat or if they are sanctioned.

The approach in the Kansas DOC is to give points on the custody classification system to those with recurring psychoses, history of suicidal ideation, or current acute psychological disorders to classify higher-scoring inmates as maximum security, which allows for single cell status.

Types of separate housing used. The types of housing assignments available to mentally ill inmates differ with agency size, resources, and philosophy. Especially in agencies with larger inmate populations, a DOC can have two or three levels of security and treatment placements available for mentally ill inmates and makes assignments as appropriate to the inmate. Inmates also may be transferred to other state facilities.

A range of placement options emerged from agency responses. Because agencies were not asked specifically to describe their available placements, the numbers given below should be considered anecdotal.

- **Short-term separate housing for mentally ill inmates.** Mentally ill offenders are commonly placed in an infirmary or in other units removed from the general population when needed to respond to acute episodes. DOCs also use short-term placements to help staff monitor an offender's behavior, particularly after an incident such as a suicide attempt. The BOP "makes every effort to 'mainstream' inmates with mental illness in the general population"; mentally ill inmates are housed separately only if and when "their condition is such that the inmate is a threat to self or others." In four (4) state DOCs (in Maine, North Dakota, Rhode Island, and South Dakota) separate housing is available only for crisis care; the expectation is that mentally ill offenders will return to the general population once their behavior is stabilized. There are no special provisions for ongoing separate housing in these agencies.

- **Long-term, separate housing units for mentally ill inmates.** Most DOCs (in 33 states, the BOP, Puerto Rico, and Guam) noted the availability of a separate housing unit or units for mentally ill inmates in one or more their institutions. More than one type of long-term placement is available in several DOCs. Based on the terminology used by respondents, these units appear to function in different ways and with different security and treatment emphases. For example, 14 state DOCs described the use of "inpatient hospitals," "psychiatric hospitals," "secure psychiatric units," or "psychiatric infirmaries," and seven (7) states identified units for crisis or acute care. Three (3) states operate outpatient or day treatment units. Five (5) states provide "sheltered," "supportive," "partial care," or "assisted housing" for mentally ill inmates who need it. However, most agencies with dedicated mental health units (26 state DOCs and Puerto Rico) designate them as "special needs," "special housing," "treatment," or "severely mentally ill" units, or did not indicate a specific term for them.

- **Designated DOC institutions for offenders with mental illness.** Eight (8) state DOCs and the Correctional Service Canada noted the use of specialized facilities for housing mentally ill populations. Depending on the agency, these facilities may be used for all mentally ill inmates or only those whose mental illness is most severe. For example, mentally ill inmates in Nebraska can be managed in special mental health units in some facilities or may be placed in an inpatient mental health program at the Lincoln Correctional Center. The Maryland DOC operates an inpatient mental health unit at the Jessup facility, providing centralized mental health care for the DOC. Mississippi inmates diagnosed as psychotic are sent to the privately operated East Mississippi Correctional Facility. DOCs in Colorado, Iowa, New Mexico, North Carolina, and Texas also have designated mental health facilities. The Correctional Service Canada has a designated mental health facility in each of five regions.

- **Special facilities operated by other state entities.** DOCs in six (6) states and Guam noted the capability of sending mentally ill inmates to facilities run by other agencies. For example, the Colorado DOC makes emergency placements to the Colorado Mental Health Institution on the grounds of the state mental hospital. Mentally ill inmates in Delaware may be court-ordered to a forensic placement at the Delaware Psychiatric Center. Kansas inmates may be sent to the state hospital if their condition prevents adequate functioning and requires ongoing treatment. Nebraska inmates can be referred to non-correctional facilities. Inmates in the Maine and Wyoming DOCs may be sent to a forensic hospital or unit at the state hospital if they require more specialized treatment. Mentally ill inmates in Guam may be transported to the Department of Mental Health and Substance Abuse if court-ordered to treatment.

- **Reliance on outside agencies for treatment.** Outside providers assist with specialized clinical care for mentally ill inmates in three (3) state DOCs. The Alabama DOC contracts with a private provider. In Michigan, treatment for mentally ill inmates is provided by the Corrections Mental Health Program of the state's Department of Community Health, Bureau of Forensic Services; the DOC's Bureau of Health Care provides care for all other inmates. The California DOC contracts for long-term acute care with the Department of Mental Health.

Assistance for Inmates with Other Mental Health Needs

The NIC survey did not provide a definition of the "other mental health needs" that can exist in a prison inmate population. However, respondents described a broad range of mental health-related management and treatment needs present among inmates who are not considered mentally ill. Their responses also illustrate agencies' different approaches to providing services.

According to survey respondents, inmates with other health needs include: those with DSM-IV Axis II diagnoses (6 DOCs); those who are less seriously mentally ill than the "seriously" or "chronically" mentally ill population (11 DOCs); those who pose a risk to self or others, are self-abusive, or are self-mutilating (13 DOCs); those who are suicidal (6 DOCs), substance abusers (11 DOCs), or sex offenders (10 DOCs); and inmates who are mentally retarded, low functioning, or developmentally disabled (10 DOCs).

Fewer than 10 respondents identified offenders with other specific needs, such monitoring or adjustment of medications, counseling for anger management or social inadequacy, help in detaching from a gang, or low intellect or cognitive impairments. Others included those who need to discuss problems and "anyone with need."

All responding DOCs evidenced an awareness of the importance of responding to the needs of inmates who are suicidal. All agencies indicated that they provide either short-or long-term treatment programming for inmates with suicidal tendencies. Five DOCs (in Colorado, Kansas, Massachusetts, Michigan, and Ohio) referred to the availability of special housing units for suicidal or suicidal and self-abusing inmates.

Mental health services in prisons necessarily emphasize treatment for seriously or acutely mentally ill inmates. However, institutions typically make some counseling services available on a request basis to inmates with non-acute mental illness or other mental health needs. These services are often provided on a group basis. The Washington State respondent noted, "Care for inmates with other mental health needs is more episodic, more similar to community out-patient programs."

Housing for inmates with other mental health needs. With few exceptions, inmates who are not considered mentally ill but have other mental health needs are housed in the general population. Exceptions include when these inmates are in an inpatient or residential program (e.g., sex offender treatment, therapeutic communities, or addiction treatment, reported by 16 state DOCs and the BOP); when the inmate is dangerous, inclined to self-injury, or suicidal (21 DOCs); or when the inmate is not coping well or is dysfunctional in general population (9 DOCs).

Other circumstances were reported by fewer than nine DOCs: non-mentally ill inmates are housed outside the general population when they need structure, when they can't be managed by outpatient staff, when they are in transitional care units, or when they are considered predators or vulnerable to predation. Inmates who are receiving medications also may be housed together so all can be better kept in compliance. Three state DOCs reported that they provide short-term crisis housing when needed, often in an infirmary.

Six state DOCs (in Indiana, Kansas, Minnesota, Mississippi, Nebraska, and North Dakota) place inmates with other mental health needs, such as those with personality disorders, in segregation if their behavior warrants it. The Indiana respondent observed that this occurs only rarely. The Mississippi DOC, which has a separate corrections facility for mentally ill inmates, can place inmates housed in other facilities in segregation for behavior problems. When a Kansas inmate becomes self-abusive, he or she may be placed either in the infirmary or in segregation.

Counseling and Treatment for Specific Inmate Populations

Table 2, page 8, identifies the DOCs that provide counseling and mental health treatment programs designed to address the needs of specific inmate populations. Descriptions of these programs were not provided.

Totals for the categories addressed by the survey are as follows.

- Women inmates—DOCs in 37 states, the BOP, Guam, Puerto Rico, and the Correctional Service Canada;

Table 2. DOCs' Provision of Specialized Mental Health Care to Selected Populations

	Juveniles (Inmates Under Age 18)	Women	Elderly Inmates	Supermax/ Maximum Security Inmates	Ethnic/Racial Minorities	Sex Offenders (Dual Diagnosis)	Substance Abusers (Dual Diagnosis)
Alabama		✔	✔	✔	✔	✔	✔
laska	✔	✔			✔	✔	✔
Arizona	✔	✔		✔		✔	✔
Arkansas				✔		✔	✔
California	✔	✔	✔	✔	✔	✔	✔
Colorado	✔	✔					✔
Connecticut						✔	✔
Delaware		✔	✔	✔	✔	✔	✔
District of Columbia							
Florida							✔
Georgia		✔		✔			
Hawaii							
Idaho				✔			
Illinois	✔	✔	✔	✔		✔	✔
Indiana	✔	✔				✔	✔
Iowa							
Kansas		✔		✔			✔
Kentucky		✔	✔				
Louisiana						✔	✔
Maine				✔	✔	✔	✔
Maryland	✔	✔		✔		✔	✔
Massachusetts		✔				✔	✔
Michigan		✔				✔	✔
Minnesota	✔	✔	✔	✔	✔	✔	✔
Mississippi				✔	✔	✔	✔
Missouri						✔	
Montana	✔	✔		✔	✔	✔	✔
Nebraska	✔	✔		✔		✔	✔
Nevada							
New Hampshire		✔	✔	✔	✔	✔	✔
New Jersey		✔		✔		✔	
New Mexico		✔	✔	✔		✔	✔
New York		✔		✔			✔
North Carolina	✔	✔	✔	✔		✔	✔
North Dakota		✔		✔		✔	✔
Ohio				✔			
Oklahoma	✔	✔	✔	✔	✔	✔	✔
Oregon		✔	✔	✔			✔
Pennsylvania	✔	✔	✔	✔		✔	✔
Rhode Island		✔		✔		✔	
South Carolina	✔	✔		✔			
South Dakota		✔		✔		✔	✔
Tennessee	✔	✔	✔	✔		✔	✔
Texas	✔	✔	✔	✔		✔	✔
Utah	(No survey response)						
Vermont		✔				✔	✔
Virginia		✔	✔			✔	✔
Washington	✔	✔				✔	
West Virginia		✔	✔	✔		✔	✔
Wisconsin	✔	✔	✔	✔			✔
Wyoming	✔	✔	✔			✔	✔
U.S. BOP		✔	✔	✔	✔	✔	✔
Guam		✔			✔	✔	✔
Puerto Rico		✔		✔		✔	✔
Canada		✔				✔	✔

- Mentally ill persons dually diagnosed with substance abuse treatment needs—DOCs in 37 states, the BOP, Guam, Puerto Rico, and the Correctional Service Canada;
- Sex offenders dually diagnosed as mentally ill—DOCs in 35 states, the BOP, Guam, Puerto Rico, and the Correctional Service Canada;
- Maximum security or supermax inmates—DOCs in 32 states, the BOP, and Puerto Rico;
- Juveniles (inmates under age 18)—19 state DOCs;
- Elderly inmates, including but not limited to those with Alzheimer's/senile dementia—18 state DOCs and the BOP; and
- Ethnic, racial, or cultural minorities—DOCs in 10 states, the BOP, and Guam.

Staff Training on Mental Health Issues

Forty (40) DOCs require all custody/security staff to receive training on managing mentally ill inmates. Approximately 32 agencies also require training on managing inmates with other mental health needs. (The latter number is approximate because many agencies do not address these two groups separately but instead offer general training on mental health issues.)

- **Preservice training.** Thirty (30) DOCs provide custody/security staff preservice training on managing mentally ill inmates. Among these agencies, 10 DOCs provide 4 hours of preservice staff training. Thirteen (13) DOCs provide fewer than 4 hours of such training, and seven (7) provide more than 4 hours of such training.

  In 15 DOCs, custody/security staff preservice training addresses the management of inmates with other mental health needs.

  Respondents from 12 DOCs noted that these topics are covered in combined training on mental illness and other mental health issues.

- **Inservice training.** Twenty-two (22) DOCs provide inservice training on managing mentally ill inmates. Ten (10) of these agencies offer 1 to 3 hours of related training annually, six (6) others offer 3 to 4 hours, and seven (7) DOCs offer more than 4 hours of annual training.

  Nine (9) DOCs reported that they provide custody/security staff inservice training on the management of inmates with other mental health needs. In six (6) of these agencies, such training is provided in 4 hours or fewer. Seven (7) other DOCs noted that their inservice training covers both mental illness and other mental health issues in combination, with the training taking place in less than 4 hours in five (5) DOCs.

  DOC respondents in several states, such as Delaware, the District of Columbia, Louisiana, New Hampshire, New Jersey, New York, Ohio, and Oregon, noted that their agencies provide special training on mental health issues to officers in units that house inmates with mental illness. The Ohio DOC provides eight hours of preservice training on managing mentally ill inmates and inmates with other mental health issues and one hour of annual inservice training, and it also provides 24 hours of specialized mental health training for some staff. In New Hampshsire, officers assigned to the Security Psychiatric Unit attend four units of mental health worker training at the state psychiatric hospital.