

Mental Illness and Prisoners: Concerns for Communities and Healthcare Providers

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Abstract

The United States prison system is the largest in the world. Mental illness is disproportionately represented within this system where half of all incarcerated individuals have a mental illness, compared to 11% of the population. Four of 10 inmates released from prison recidivate and are re-incarcerated within three years. A social hypothesis suggests recidivism is the result of compounding social factors. Mentally ill individuals often find themselves in less than ideal circumstances of compounding social factors such as illicit substances and unemployment. Prison life may provide improved social situations and a rehabilitating environment, yet corrections often fall short of meeting acceptable standards of healthcare. This article provides a [brief overview of healthcare in the corrections](#) environment and discusses [factors that affect mental healthcare in prisons](#), such as characteristics of the prison population and social policy. The article also addresses factors impacting mentally ill persons who are incarcerated, including [access](#) and [barriers](#) to mental health treatment and [efforts to reduce recidivism](#).

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Inmate X is a 49-year-old Caucasian male who was first seen for mental health concerns at age 26 while incarcerated; he was diagnosed with schizoaffective disorder and antisocial personality disorder. Inmate X was born to working class parents and grew up with two younger brothers, a twin sister and an older sister. He was never married, but has a 15-year-old daughter.

Records indicate there is no family history of drug/alcohol abuse or mental illness. However, inmate X has an extensive substance abuse history beginning at the age of 11; he has admitted to abusing alcohol, marijuana, cocaine and hallucinogens. Inmate X graduated high school, worked several jobs, and also served briefly in the United States Navy until his less than honorable discharge. Inmate X's original offense was rape and burglary, but he sustained many additional probation violation charges for drug use, violation of restraining orders, and shoplifting. While incarcerated, inmate X picked up an additional charge for mailing threatening letters to the United States President. All of his time on these sentences has been served.

Since his incarceration, inmate X has been stabilized on Olanzapine, Fluphenazine Deconate, Cogentin and Clonazepam. Inmate X was transferred to an open mental health unit and has been a stellar resident indicated by job performance, medication compliance, group attendance and cooperation with other peers. Upon inmate X's risk panel assessment he was deemed to no longer be a risk to society and was released from prison. A short 5 months after release, inmate X reoffended while under the influence and was brought back into custody on violation of parole. Shortly thereafter, inmate X has again been stabilized on medications and according to his reviewing treatment team, inmate X appears to be upholding qualities deeming him appropriate for society.

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This case study presents one story that illustrates the fate of thousands of inmates. Prison inmates represent a very vulnerable population exposed to many stressors. These stressors can lead to outcomes such as substance use, suicide, and recidivism. This article will explore the issue of recidivism in corrections; discussion will include characteristics of corrections, reasons for recidivism, and the limitations presented to corrections in the treatment of mental health. The article will also describe current efforts to reduce recidivism and offer alternative, literature based strategies to reduce recidivism that are compliant with jail/prison protocols in the United States.

Facts about Imprisonment

The above inmate's story is one reflection of the inundated prison system. There are approximately 2.2 million pre-trial and 1.6 million post-trial inmates in county, state, and federal prisons; this equates to approximately 756 per 100,000 people incarcerated in the United States ([Carson & Golinelli, 2013](#); [Exworthy, Samele, Urquia & Forrester, 2012](#)). The United States has only 5% of the world's population, but 25% of the world's prisoners ([Liptak, 2008](#)). China, with a population four times the United States, has an average of 1.6 million prisoners ([Liptak, 2008](#)). Russia may be the only industrialized country that is close to the U.S. incarceration rate with an average of 627 per 100,000 ([Liptak, 2008](#)). The United Kingdom (U.K.) has an average of 152 per 100,000 people incarcerated, higher than other European countries that have an average of 120 ([Exworthy et al., 2012](#)). The U.S. prison system is thus the largest in the world.

In America, imprisonment was considered unusual in the beginning of the 18th century. Today the prison system is viewed as both a necessity to keep the public safe and as a mode of punishment for crimes. Imprisonment comes at an average cost per inmate of \$31,286 per year ([Henrichsen & Delaney, 2012](#)). Medical care alone accounts for an estimated 12% of prison budgets, second only to security costs, which include employee salaries, insurance, and retirement costs ([Stephan, 2004](#)). Cost concerns are a pressing issue as accommodating the expanding inmate population results in increased individual taxes to fund the necessary budget.

Recidivism and Mental Health Concerns

Recidivism, or repeat offenders, further strains the prison budget. Recidivism is defined as a repeated arrest or incarceration ([Baillargeon, Binswanger, Penn, Williams & Murray, 2009](#)). In a 15 state study, over 2/3 of released prisoners reoffended or were rearrested within 3 years; this equates to 4 out of every 10 people released from prison are re-incarcerated ([Bureau of Justice, 2013](#); [Stephan, 2004](#)). However, evidence shows the largest impact on prison budgets is from altering sentences and release policies, rather than altering per-inmate costs ([Stephan, 2004](#)). Operating a safe, humane, and well-programmed institution is not cheap and low per-inmate cost is not necessarily a priority ([Stephan, 2004](#)).

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Mental healthcare for this population is both expensive and crucial ([Stephan, 2004](#)). A 2006 Department of Justice study found more than half of all inmates have a mental health problem compared to 11% of the general population ([James & Glaze, 2006](#)). Mentally ill inmates are often inappropriately treated due to lack of knowledge about the rising mental health population ([FRONTLINE, 2005](#)). With recognition that prisons are not well equipped for the mentally ill, community programs have arisen to decrease sentencing of nonviolent offenders and the mentally ill. These community efforts have helped to educate the general public and debunk myths about mental illness.

Brief Overview of Healthcare in Corrections

Many people assert that the "right to health" is a fundamental human right, in which any person, regardless of legal status, is entitled to receive adequate healthcare. This right is the driving force behind establishing standards and protocols in the treatment of inmates ([Burns, 2011](#)). The World Health Organization (WHO) used this basic right to establish a guide detailing conditions that governments must generate to promote optimum health for their peoples, specifically stating that healthcare in prisons must be improved to better serve inmates. The integration of structured programs to serve populations endemic to corrections, such as persons with substance abuse issues and/or mental illness, is one bridge to provide quality healthcare ([Eytan et al., 2010](#)). The goal of these programs is for healthcare providers to ultimately contribute to the rehabilitation of inmates and thus reduce recidivism.

The U.S. prison system often falls short of meeting acceptable standards of care. Reasons may range from lack of resources to conflicts of interest between healthcare providers and security protocols ([Exworthy et al., 2012](#)). The U.K., considered more advanced in prison healthcare, strives to improve prison healthcare based on the concept of equivalence. Improvements in prison mental health care are driven by the idea that, whenever possible, healthcare should be equivalent to care available in the community. This concept of equivalence has underpinned efforts in the U.K. to improve prison healthcare ([Exworthy et al., 2012](#)).

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Both the U.S. and U.K. face limitations in prison settings. The supply of resources and treatment facilities is continuously challenged with the high demand and overcrowding of prison systems. Rates of mental illness and the lack of a clear legal framework for treating inmates with severe mental illness are other challenges to implementing the equivalence model. Identical services provided in the community may not be acceptable levels of care for the complexity of psychiatric cases present within the prison system. Healthcare providers are often

restricted by policies and security protocols that limit interventions they may prescribe. These limitations and restrictions suggest a great need for improvement in prison mental healthcare. The next section will explore several factors that affect mental healthcare in prison settings, such as characteristics of the prison population and the impact of politics.

Box. Brief Overview of Prison Nursing: One Nurse's Perspective

All inmate patients arrive at the prison in Receiving & Discharge (R & D). Here they are screened by several different disciplines including nursing (for a medical history and nursing intake), psychology, and a unit counselor. During this intake screening with the nurse, an inmate's medications are initially ordered. The nurse reviews the medications and receives a verbal/telephone physician order to continue any medication(s) for the inmate during the period of incarceration. The inmate will then receive that medication during the next designated pill line time, when oral medications are distributed. Most medications are continued; however, like other facilities, there are medications that require non-formulary requests. For these medications, an alternative medication may be prescribed as an equivalent or the medication will be continued through a pharmacy non-formulary request process. Following the initial intake, a patient designated to be on an inpatient unit must have a physical completed within 24 hours by a mid-level practitioner/provider (MLP). Inmate patients are also required to be seen by psychiatry services within 24 hours. Inpatient inmates, as well as inmates designated to a general population housing unit, must be followed up by a physician for a physical within 14 days.

A prison lifestyle includes a rigorous routine. There are predetermined times for meals as well as medications, including "insulin lines." Inmates prescribed insulin and other medications arrive at three separate, predetermined, designated times for pill line and insulin line to receive these medications. Medications are typically given on time. Exceptions to this may include: staff otherwise occupied handling medical emergencies; responding to body alarms for staff who need assistance during an altercation; or other institutional level emergencies. These exceptions typically cause a delay of less than 15 minutes.

Similar processes are in place for nursing treatments. There are designated times for procedures such as dressing changes and intravenous (IV) and other injections. Challenges are not typically a matter of lacking supplies, as one might imagine, but rather more about every day nursing supplies being locked up or a need for additional prudence when accounting for items (e.g., medications, supplies). All items (e.g., IV flush, epinephrine (EPI) pens) have to be counted and withdrawn from a medication dispensing machine. Other items that are locked and must be inventoried daily are: scissors required for a dressing changes, oxygen tanks, suture removal kits, catheter kits, and insulin pump supplies.

Factors Affecting Mental Healthcare in Prisons

Characteristics of the Prison Population

Rates of mental illness within prison systems across western countries are very high.

Rates of mental illness within prison systems across western countries are very high. A systematic review of 62 studies of mental health disorders within western countries found the following diagnoses among male prisoners: 3 to 7% psychotic disorder, 10% major depression, 47% antisocial personality disorder, and 65% personality disorder, including antisocial personality disorder (Fazel & Danesh, 2002). The same review yielded higher results for women. Among the female prisoners, diagnoses included: 4% psychotic disorder, 12% major depression, 21% antisocial personality disorder, and 42% personality/antisocial disorder (Fazel & Danesh, 2002). In addition to these diagnoses, a significant number had anxiety disorders, organic disorders, traumatic brain injuries (TBI), suicidal behaviors, distress associated with all forms of abuse, attention-deficit hyperactivity disorder (ADHD) and other developmental disorders, including mental retardation and Asperger's syndrome (Daniel, 2007).

Rates of mental illness in the U.S. alone are burdensome. The U.S. Department of Justice (USDOD) found that more than half of all inmates, or over than 1 million individuals, have a mental illness compared to 11% of the general population; and yet only 1 of 3 prison inmates and 1 of 6 jail inmates receive any form of mental health treatment (Daniel, 2007; James & Glaze, 2006). Thus 56% of state, 46% of federal, and 64% of jail prisoners have either a current or recent history of mental health problems (James & Glaze, 2006). The USDOD also studied the distribution of mental health problems and found that 43% of state prisoners and 54% of jail inmates reported symptoms that met criteria for mania; 23% of state and 30% of jail inmates reported symptoms of major depression; and 15% of state and 24% of jail inmates reported symptoms that met criteria for a psychotic disorder (James & Glaze, 2006).

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Furthermore, approximately 70% had a primary or comorbid substance abuse disorder (James & Glaze, 2006). The high amount of mental health disorders alone constitutes but one of the many limitations to appropriate healthcare presented in correctional settings.

Social Policy and Increased Incarceration Rates

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Many question why rates of mental illness are so high among incarcerated individuals. The answer is complex as several synergistic factors related to social policy have contributed to high rates of persons with mental illness behind bars. The first factor was the mass closing of public mental health hospitals in the 1960s. This national movement followed the availability of new antipsychotic medications, such as Olanzapine[®]. Movement leaders believed moving patients into a community-based setting was a humane alternative to overcrowded and understaffed institutions (Baillargeon et al., 2009). Unfortunately, resources fell short, coordination lacked, and promised clinics and halfway houses were not provided to care for released hospital patients (Baillargeon et al., 2009; FRONTLINE, 2005). Following this movement, health insurers restricted mental health coverage; private hospitals restricted enrollment of psychotic patients; and civil commitment laws became more restrictive (Baillargeon et al., 2009). As these

changes occurred, another policy change ensued that resulted in dramatic increases in rates of incarcerations of persons with mental illness(es). The 1980s "war on drugs" led to an increase in drug-related arrests and mandatory sentencing laws (Baillargeon et al., 2009). These arrests resulted in an increase in the proportion of inmates with psychiatric disorders and substance abuse problems (Baillargeon et al., 2009). Prison sentences and substance abuse remain significant contributing factors to the increased population of prisoners with mental health concerns.

Mentally Ill and Prison Sentences. Policy changes have increased the length of time served for mentally ill inmates. State prisoners who had a mental health problem served an average sentence of four months longer than those without a mental health problem (James & Glaze, 2006). In general, studies have found that individuals with a mental health problem serve an average sentence of 15 months longer than those without (Baillargeon et al., 2009; FRONTLINE, 2005). There was little variation noted in expected time served for jail inmates (approximately 55% with a mental health problem and 54% without one both expecting to serve 6 months or less) (James & Glaze, 2006).

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Individuals with a mental health problem tend to obtain conduct violations.

Often the reason individuals with mental illness serve longer sentences is related to the inability to follow the strict rules of prison life. Individuals with a mental health problem tend to obtain conduct violations. Statistics estimate that among state prisoners, 58% with a mental health problem (compared to 43% without) had been charged with rule violations (James & Glaze, 2006). Depending on the violation level, this may result in revoked privileges and changed security level and/or release date. For example, the resulting disciplinary record may lead to more difficulty achieving parole. Parole boards are also reluctant to release individuals with a mental health disorder back into the community due to inadequate community services available for them to obtain treatment (Rossman,

2001; FRONTLINE, 2005).

Mentally Ill and Substance Use. It is a common misperception that people with mental illness are dangerous. Two recent studies revealed illegal drugs as the primary contributor to violence, not mental illness (Dolan, Castle, & McGregor, 2012; Fazel, Gulati, Linsell, Geddes & Grann, 2009). The studies examined the potential link between mental illness and risk of violence and found violence risk was not significantly increased when compared to the general public. The studies also indicated that the risk of violence in persons with mental illness combined with substance use was not different than the risk of violence for individuals with a diagnosis of solely substance use.

There is a high rate of substance abuse among prisoners, but especially among those also diagnosed with mental illness. At the time of arrest, over a third of inmates who had a mental health diagnosis were under the influence of substances compared to a quarter of inmates without mental illness (James & Glaze, 2006). An assessment of nonviolent crimes found persons with schizophrenia or non-schizophrenia psychotic disorders had lower rates of driving under the influence, but higher rates of drug possession (Baillargeon et al., 2009). Dual diagnosis was common; 74% of prisoners who had a mental health problem met criteria for substance dependence or abuse, compared to 56% without a mental health problem (James & Glaze, 2006).

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An individual who has both an alcohol or drug problem and an emotional/psychiatric problem has a dual diagnosis (Mental Health America, 2013). Dual diagnoses are common, but this concept has not always been accepted. However, research has demonstrated that simultaneous treatment of

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mental illness and substance abuse supports better outcomes, which has furthered the acceptance of dual diagnoses. Approximately 50% of the mentally ill population also has a substance abuse problem ([National Alliance on Mental Illness, 2013a](#)). Additionally, 6 of 10 people with a substance use disorder also suffer from another mental illness ([National Institute on Drug Abuse, 2007](#)). Of those individuals who are incarcerated, the number increases to almost 70%, or nearly 3 of 4 persons ([Daniel, 2007](#); [Skeem, Manchak & Peterson, 2010](#)).

These statistics beg the question: why are individuals with mental illness more prone to substance abuse over those without a mental health problem? Self-medicating and social factors are viewed as common contributors to substance abuse amongst mentally ill individuals. Like their healthy counterparts, individuals with mental illness may begin to use drugs or alcohol for recreational use. Continued use has often been attributed to a misguided attempt to treat symptoms of their mental illness. In the short term, individuals may find they can reduce their level of anxiety or depression by self-medicating. Genetic vulnerabilities are hypothesized as a reason for continued use as well. Genetic factors predispose individuals to both mental disorders and addictions, or to having a greater risk of the second disorder once the first appears. ([National Alliance on Mental Illness, 2013a](#); [National Institute on Drug Abuse, 2007](#); [McKean & Ransford, 2004](#)).

Other factors contribute to substance abuse in this population. Mentally ill persons are often socially disenfranchised. Poverty situates them to live in neighborhoods endemic with illicit substances, unemployment, and other marginalized citizens. Research has also demonstrated that mentally ill individuals are more likely to have a history of victimization. Individuals who have difficulty developing social relationships, often as a consequence of mental illness, find themselves more easily accepted by groups whose social activities is based on drug use. Some believe that an identity based on drug addictions is more acceptable than one based on mental illness. ([National Alliance on Mental Illness, 2013a](#)). Together, social stresses and traumas and early exposure to drugs are common factors that can lead to addiction and mental illness ([James & Glaze, 2006](#); [National Alliance on Mental Illness, 2013a](#); [Skeem et al., 2010](#)).

Finally, some areas of the brain are affected by both drug abuse and mental disorders. For example, brain circuits linked to reward processing, as well as those implicated in the stress response, are affected by substance abuse and also abnormalities in specific mental disorders. With the commonality of dual diagnoses, it is naive to discount the evidence and fail to address both issues of substance use and mental illness when addressing mental health concerns and care for prisoners. ([National Institute on Drug Abuse, 2007](#)).

Mentally Ill Persons and Incarceration

A prison lifestyle is rigorous and routine with specific times for eating, sleeping, taking medications, standing for institutional counts, attending work, recreation or other structured programs and even moving from one place in the prison to the next. Prison rules are strict and inflexible and violation of rules is often addressed with segregation or revoked privileges. Most importantly, prison is a drug-free setting. Federal prisons have even banned tobacco products since 2004. Mental health treatment can help prisoners to make appropriate lifestyle adjustments, but is not available in every setting. Even when mental health treatment is in place, there are barriers for providers to consider.

Access to Mental Health Treatment

When necessary, psychiatric treatment is also mandated for those incarcerated. Many inmates with mental illness and access to treatment typically have psychiatric symptoms controlled and can function well while incarcerated. How can we best transition appropriately functioning inmates in the prison environment to continue stable behaviors upon release into the community, and thus decrease the chance of recidivism? Supporters of the legislation to close state hospitals urged funding for halfway houses and clinics. Those supporters, along with community mental health supporters, share the belief that offering the least restrictive environment to citizens is most beneficial. It seems prudent to suggest increased funding for public works, to ensure housing, employment, and structured community programs upon release for prisoners with mental illness to mirror the social circumstances found in prisons where inmates performed well. However, access to mental health services is not the case in all prison settings. The next section will discuss several barriers to mental health treatment for inmates.

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Barriers to Mental Health Treatment

Perhaps the most obvious hurdle to providing mental

The main duty of prisons is to keep society safe; therefore security of the institution is the primary concern. Perhaps the most obvious hurdle to providing mental health treatment is the mission of corrections: to maintain security within the institution, providing a safe environment for both staff and inmates ([Federal Bureau of Prisons, n.d. b](#)). For instance, a core value of the Federal Bureau of Prisons is correctional excellence. This means all employees, even healthcare

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providers, are correctional workers first ([Federal Bureau of Prisons, n.d. b](#)). It is unquestionable this is an appropriate value in a correctional setting as it is the most economical way of ensuring the security of institutions. However, healthcare providers within corrections also have their own mission of providing the best possible care to their patients. Balancing this dual mission is often a challenge for healthcare providers. Three important areas of consideration for healthcare providers are segregation, suicide, and drug abuse.

Segregation. Segregation is the housing of inmates in special units separate from the general population ([Federal Bureau of Prisons, n.d. a](#)). Within federal prisons there are two types of segregation, disciplinary and administrative. Disciplinary segregation is a form of separation from the general population for a specified period of time as a mode of punishment for violating rules. There is a specified hearing process directed by the Disciplinary Hearing Officer (DHO) to which each inmate charged with a violation is entitled. A Segregation Review Official (SRO) reviews these inmates every seven days and can release an inmate from disciplinary segregation if he or she finds segregation is no longer necessary or has fulfilled its purpose. ([Federal Bureau of Prisons, n.d. a](#)).

Administrative detention is a form of separation from general population used when the presence of an individual poses a serious threat to the security of the institution. This housing status includes inmates who, a) require protective custody, b) cannot be placed in general population because they are pending travel to another institution (holdovers), or c) those awaiting a hearing for a disciplinary violation. ([Federal Bureau of Prisons, n.d. a](#)).

Being confined to a single area for 23 hours a day for a prolonged period of time has proven to be psychologically harmful. Psychological effects can include anxiety, depression, anger, cognitive disturbances, perceptual disturbances, obsessive thoughts, paranoia, and psychosis ([Smith, 2006](#)). The nature and severity of the effects is dependent on the individual, length of stay, and conditions (e.g. access to natural light, books, radio). These effects are especially significant for individuals with mental illness. Individuals with mental illness often have an impaired ability to cope with stress as a result of their illness. The lack of social contact, unstructured days, and stress can exacerbate psychiatric symptoms or provoke recurrence ([Metzner & Fellner, 2010](#)). This may translate to bizarre, annoying, or dangerous behaviors.

Correctional workers generally respond to these behaviors as they would for other individuals who violate rules by issuing a conduct violation resulting in disciplinary segregation. Once the inmate is placed in segregation they can continue to receive conduct violations and be housed there indefinitely for continued misconduct, often as a result of psychiatric symptoms. This housing status of mentally ill inmates often proves challenging to mental health providers, who have an already burdensome caseload and, due to lack of time and resources, are unable to provide therapeutic interventions. Class action cases have ruled the segregation of mentally ill inmates to be cruel because of the psychological harm it can inflict. Yet, despite these rulings, in some prisons mentally ill inmates continue to be segregated. Segregation of mentally ill inmates is an ongoing issue and will continue to be a hurdle to mental health providers ([Metzner & Fellner, 2010](#)).

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Suicide. The World Health Organization ([WHO, 2007b](#)) estimates one suicide attempt occurs approximately every three seconds and one completed suicide occurs approximately every minute. The causes of suicide are multifaceted. One indisputable fact is that individuals are especially vulnerable when faced with a combination of stressors ([WHO, 2007b](#)). Not surprisingly, inmates are an especially vulnerable group who face stressors such as separation from family, legal battles, and dealing with a new culture and environment.

Within corrections, suicide profiles, based on research studies, are used to target high-risk individuals.

Suicide rates within corrections illuminate the harsh reality of prison life. Suicide is the third leading cause of death in U.S. prisons, exceeded only by natural causes and AIDS ([Daniel, 2007](#); [WHO, 2007b](#)). Pre-trial inmates have a suicide attempt rate of about 7.5 times greater, and sentenced inmates have a rate of almost six times greater, than the general suicide rate of males in the community ([WHO, 2007b](#)).

Within corrections, suicide profiles, based on research studies, are used to target high-risk individuals. Pre-trial inmates are generally male, young (20-25 years), unmarried, and arrested for minor, often substance related, crimes. This profiled group is at high risk during their first few hours of incarceration and near the time of a court hearing, especially when a guilty verdict and harsh sentencing is anticipated ([WHO, 2007b](#)). Another high profile group is sentenced individuals who are violent offenders, aged 30-35 who have served a good amount of time of their sentence (5 or more years); these suicides are often precipitated by a conflict, either within the prison, marital, or denial of parole. Extended length of incarceration presents a new set of stressors, such as victimization, loss of family support, fear of the unknown, embarrassment, and internal conflicts ([WHO, 2007b](#)). Accordingly, individuals with life sentences are particularly vulnerable to suicide attempt.

Inmates with mental illnesses are an especially vulnerable population as they have an impaired ability to cope with

stress, further heightening mounting stressors. Depressive disorders are the most often linked psychiatric illness to suicide, yet hopelessness is the most common psychological state preceding suicide (Daniel, 2006). Furthermore, anxiety heightens the risk factor of suicide as well as situational factors, such as segregation (Daniel, 2006). The accumulations of risk factors reiterate the increased risk of suicide amongst inmates with mental illness. Mounting stressors, such as those inevitable with incarceration, are inescapable for mental health providers in corrections. These stressors, coupled with subsequent worsening psychiatric illness, present a significant hurdle in correctional mental health treatment.

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Drug Abuse. An estimated 20% of people in the U.S. take prescription medications for nonmedical reasons (National Institute on Drug Abuse, 2013). This is considered prescription drug abuse, a growing problem in the United States. This increase is attributed to prescription drugs being easier to obtain and the medications being perceived as “safe” because a license professional prescribed it. Providers often have good intentions when prescribing medications, yet substance abuse and drug seeking is a harsh reality.

Given the high rates of substance abusers among the incarcerated population, misuse of prescription medications is a consideration amongst correctional providers. As in the community, medications may be used recreationally to achieve an altered mental state or high, instead of the intended therapeutic effect. A significant proportion of inmates seek prescribed medications for their psychotropic effect, rather than the intended use.

Misuse of anticholinergic agents (e.g. benzotropine, trihexyphenidal) is well documented in the literature. However, abuse of other psychotropic medications is a growing concern in corrections. Gabapentin (Neurontin®) is known to create an altered mental state or high from snorting the gabapentin powder. This is often preferred by inmates with a prior history of cocaine dependence due to the similar effects it creates. Quetiapine (Seroquel®) has become increasingly popular amongst incarcerated individuals. Quetiapine, referred to as “quell,” “susie Q,” or “baby heroin” is used in its powder form for its potent sedative and anxiolytic properties. Wellbutrin, nicknamed “welbys,” is used intranasally to achieve a “rush.” Other psychotropics such as Olanzapine (Zyprexa®) and tricyclic antidepressants (TCA) (amitriptyline, nortriptyline, desipramine) are abused for sedative properties, mind altering effects, or the potential to get a high. In addition to sedation, TCAs are lethal when hoarded and taken as an overdose. (Paggio, 2012).

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Psychotropic drugs that can create an altered mental state or high are valuable among a dense population of substance abusers. Even inmates who may actually need a medication may be tempted to barter, sell, or trade. Inmates may trade for commissary items, cash, or contraband items such as alcohol or illicit substances. Of greater concern, prescription drugs may be used as a currency to purchase services such as protection, assaults, and sexual favors (Burns, 2009).

Trading prescribed medications (and associated transactions and debts) could compromise patient security, staff security, and the overall security of the institution. Furthermore, it could worsen and inmate's mental and physical health (Royal College of General Practitioners, 2011). Abuse of some medications (e.g., quetiapine) has led to a non-formulary medication list. When a medication is considered non-formulary, it necessitates additional paperwork for providers to support its use. Providers may limit prescribing a medication that otherwise seems suitable in the community, based on the prison environment alone. Providers are presented with the challenge of finding alternative medications that closely equate the same results as non-formulary medications (Paggio, 2012).

The above issues are not an encompassing list of the difficulties presented to correctional mental health, but they do provide reasons to encourage action to provide funding to support the root of the problems. As a society, many want to offer the “right to health” to all citizens, regardless of legal status, to our citizens. In addition, appropriate treatment for mental health disorders within the prison system combined with a strong transition with appropriate supports, upon release may be able to impact the significant concern of recidivism. The Table summarizes common mental health treatments barriers encountered in prison settings and select nursing interventions

Providers may limit prescribing a medication that otherwise seems suitable in the community, based on the prison environment alone.

Table. Treatment Barriers and Potential Nursing Interventions

Mental Health Treatment Barriers in Prisons	Nursing Interventions
<p>Segregation</p> <p>Confined in a single living area for 23</p>	<ol style="list-style-type: none"> 1) Provide 1:1 social interaction 2) Encourage inmates to attend recreation 3) Provide routine structure to days

hours/day Psychological effects: Anxiety, depression, anger, cognitive disturbances, perceptual disturbances, obsessive thoughts, paranoia & psychosis	<ol style="list-style-type: none"> 4) Reorient daily/discuss current events 5) Offer structured recreation programs to encourage socialization and interaction; ie. Music therapy, psychology worksheets, activity worksheets, books, magazines, activities
Suicide People are especially vulnerable when faced with a combination of stressors	<ol style="list-style-type: none"> 1) Be vigilant of high risk suicide groups: <ul style="list-style-type: none"> • Pre-Trial inmates • Inmates with extended sentences; "lifers" • Sexual offender inmates • Mentally ill inmates • Inmates in locked units/single cells 2) Provide structure and activities to decrease stress, provide distraction and encourage hope
Drug Abuse Taking a prescription medication for nonmedical reasons	<ol style="list-style-type: none"> 1) Be aware of highly abused prescription medications: <ul style="list-style-type: none"> • Anticholinergics • Psychotropic medications 2) Complete appropriate "mouth checks" to ensure inmates are not "cheeking" or diverting the medications 3) Crush highly abused medications 4) Be cognizant of intoxication and withdrawal symptoms

Research and Recidivism

Four of 10 inmates released from prison are re-incarcerated within three years.

Four of 10 inmates released from prison are re-incarcerated within three years (Bureau of Justice, 2013; Stephan, 2004). Recidivism rates amongst general population inmates are well studied. Only a few studies have examined the association between psychiatric disorders and the risk of having a single repeat incarceration. State prisoners with a mental health problem (61%) were more likely than state prisoners without a mental health problem (56%) to have a current or past violent offense (James & Glaze, 2006). Among those who were repeat offenders, 47% were violent recidivists (compared to 39% without a mental problem) (James & Glaze, 2006). More recent statistics have indicated that 81% of mentally ill inmates currently in state prisons, 76% in federal prisons, and 79% in jails have prior convictions (FRONTLINE, 2013). There are several hypotheses related to recidivism.

Criminalization of Mental Illness

When the above statistics are considered in context, we see that individuals with mental illness are disproportionately represented in corrections and more likely to fail under correctional supervision (evidenced by rule violation records, longer sentences, and higher recidivism rates). These facts suggest that the mental health community has failed these individuals or that the perceived root of the problem is "criminalization" of mental illness. Criminalization of mental illness refers to the belief that if the mentally ill that are incarcerated had received the psychiatric services they needed, they would not be in trouble with the law (Skeem, Manchak & Peterson, 2010).

The perception of this criminalization as the sole problem has guided the corrections industry to the most logical solution: provide psychiatric treatment as a way of decreasing recidivism. In support of the criminalization hypothesis, one study of 113 jail arrestees with a dual diagnosis of a psychiatric disorder and substance abuse disorder concluded that approximately 8% of their study population had been arrested as a direct or indirect result of their psychiatric symptoms (Junginger, Claypoole, Laygo & Christiani, 2006). These results suggest that the criminalization hypothesis should not be completely discarded (Skeem et al., 2010). However, the hypothesis does not fully account for the link between mental illness and crime. The fact that the strongest predictors of violence and crime are the same for offenders with and without mental illness (substance use), and there being a common third variable of increased social risk factor leading to crime, suggests an alternate hypothesis. Additional study of these predictors may yield a more successful solution.

Social Hypothesis

The social hypothesis is related to lifestyle factors. Supporters of this hypothesis assert that people with mental illness engage in deviant behavior not because of a mental disorder, but because they are poor. Offenders with mental illness are more likely to live in disadvantaged neighborhoods (or are homeless); be under or unemployed; have a history of victimization; and/or abuse substances (James &

The social

Glaze, 2006). Poverty situates them socially to live in settings that are rife with illicit substances, unemployment, health burdens, and many similarly marginalized citizens (Skeem et al., 2010). Although each of these variables has been linked with criminal behavior, the extent to which they play a role in this behavior has not been established with research (Skeem et al., 2010).

hypothesis is related to lifestyle factors.

In support of this social hypothesis, as already mentioned previously, results showed that major predictors of recidivism were the same for mentally disordered and for non-disordered individuals. Yet, mentally ill prisoners had higher recidivism rates or were more likely to reoffend. The social hypothesis suggests this is because, statistically, these prisoners have more risk factors than their healthy counterparts. Further supporting the potential impact of lifestyle choices on recidivism was the finding that psychiatric symptoms have not demonstrated strong correlations with repeat arrests (Callahan & Silver, 1998; Monson, Gunnin, Fogel & Kyle, 2001; Phillips et al., 2005). The strongest predictors of recidivism were prior history, employment problems, and antisocial personality (Skeem et al., 2010). Moreover, studies found that illicit substance abuse was the strongest risk factor for violence; mental illness was not an indicator of violence.

Conclusion: Implications for Practice

Current Efforts to Reduce Recidivism

... the most common programs that have led to recidivism reduction have been substance abuse treatment, education, and employment services.

Although it is hard to compare, the most common programs that have led to recidivism reduction have been substance abuse treatment, education, and employment services. However, there are an abundance of programs in action.

The Bureau of Prisons philosophy is that preparation for release begins the first day of imprisonment. It is a responsibility of the Bureau to provide inmates with skills needed to lead crime-free lives after release. Structured programs such as education, vocational training, institutional jobs, substance abuse treatment, parenting, anger management, counseling, recreation, faith-based offerings, and other programs teach inmates essential skills necessary for successful community reintegration.

The goal of inmate programs is to assist in rehabilitating convicted felons into law-abiding citizens in order to decrease rising costs associated with recidivism. Research has demonstrated that these programs play a major role to improve public safety. Of note, inmates enrolled in the Bureau's Federal Prison Industries (FPI) program, where inmates are employed in factories and are compensated, has 1) significantly reduced recidivism in comparison to study control group members, 2) demonstrated that inmates are more likely to be employed during their first year after release, and 3) demonstrated that the inmates earn higher per average wages than counterparts not enrolled in the program. Inmates enrolled in education programs demonstrated a significant decline in recidivism rates. Those enrolled in the residential drug abuse treatment programs (RDAPs) (an intense half-day treatment program 5 days a week, for 9 months followed by enrollment and another inmate program for the remainder of the day) were significantly less likely to recidivate or relapse to drug use for at least three years as compared to similar non-participating inmates. These programs do not typically enroll a high population of mentally ill inmates. However, it is likely that these programs would be beneficial as research has demonstrated that reasons for recidivism were similar among general population and mentally ill inmates. (Federal Bureau of Prisons, 2011).

Other community efforts aim to reduce recidivism by diverting nonviolent mentally ill individuals away from correctional institutions and towards community based mental health services. There are two major types of diversion programs, prebooking and postbooking. Prebooking programs are based on formal liaisons between law enforcement and mental health personnel that are designed to resolve psychiatric emergencies without resorting to arrest. One example of prebooking is crisis intervention teams. These teams include specially trained officers who redirect individuals to treatment rather than through the justice system.

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Postbooking programs, on the other hand, aim to divert mentally ill offenders to community resources after they have been arrested. One promising postbooking program is the mental health court. The mental health court is utilized to transition nonviolent mentally ill individuals from prison to supervised treatment programs. Evidence reveals participation in a mental health court is correlated with longer periods without criminal recidivism (Baillaregeon et al., 2009).

Additional Implications for Mental Healthcare

To address mental health concerns for prisoners, health providers need to educate the public about mental illness in general, and in this population. National movements, such as the National Alliance on Mental Illness, that encourage mental health public awareness should also provide information pertinent to the inmate population and their challenges.

Parole officers should receive specified training about mental illness to support their efforts as a resource to avoid recidivism in released prisoners. Parole officers are often inundated with inmate caseloads beyond what they can handle. For inmates with mental health concerns, parole officers assume a role similar to that of a hospital case manager. These officers would likely benefit from smaller caseloads with time assist parolees to access appropriate services, such as day programs and home services.

National level emphasis on mental health concerns remains a necessity and should include specific directives that address the inmate population.

National level emphasis on mental health concerns remains a necessity and should include specific directives that address the inmate population. Community programs that provide housing and employment opportunities could supplement national initiatives. Healthcare providers can advocate for funding and emphasize the financial relief correctional facilities would likely gain by providing a stable environment to support inmate mental health needs and decrease costs associated with decreased recidivism.

Despite correctional challenges (segregation, suicide, drug abuse), inmates are provided housing, employment, psychiatric treatment, and a controlled environment inhibiting substance use while behind bars, thus eliminating social risk factors that may contribute to both the primary incarceration and recidivism. Healthcare providers can and should continue to educate the public to reduce the stigma of mental illness. Mental health concerns and high recidivism is a self-made public health crisis that can be transformed. Use of current evidence to support community level mental healthcare can lead to initiatives to avoid incarceration and decrease recidivism.

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References

Bailargeon, J., Binswanger, I.A., Penn, J.V., Williams, B.A., & Murray, O.J. (2009). Psychiatric disorder and repeat incarcerations: The revolving prison door. *American Journal of Psychiatry*, 166(1), 103-109.

Bureau of Justice. (2013). *Reentry trends in the U.S.* Retrieved from www.bjs.gov/content/reentry/recidivism.cfm

Burns, K. (2009). Commentary: The top ten reasons to limit prescription of controlled substances in prisons. *Journal of the American Academy of Psychiatry and the Law Online*, 37(1), 50-52.

Burns, K. (2011). Psychiatry behind bars: Practicing in jails and prisons. *Current Psychiatry*, 10(2), 15-20.

Callahan, L. & Silver, E. (1998). Revocation of conditional release: A comparison of individual program characteristics across four U.S. states. *International Journal of Law and Psychiatry*, 21, 177-186. DOI: 10.1016/S0160-2527(98)00011-9.

Carson, E. & Golinelli, D. (2013). Prisoners in 2012: Trends in Admissions and Releases, 1991-2012 (Rev. ed.). Bureau of Justice Statistics, December 2013, NCJ 243920. Retrieved from, www.bjs.gov/content/pub/pdf/p12tar9112.pdf

Daniel, A. (2006). Preventing suicide in prisons: A collaborative responsibility of administrative, custodial, and clinical staff. *Journal of American Academy of Psychiatry Law*, 34, 165-75.

Daniel, A. (2007). Care of the mentally ill in prisons: Challenges and solutions. *Journal of American Academy of Psychiatry Law*, 35, 406-10.

Dolan, M., Castle, D., & McGregor, K. (2012). Criminally violent victimization in schizophrenia spectrum disorders: The relationship to symptoms and substance abuse. *BMC Public Health*, 12, 445. doi:10.1186/1471-2458-12-445.

- Eytan, A., Haller, D.M., Wolff, H., Cerutti, B., Sebo, P., Bertrand, D., & Niveau, G. (2010). Psychiatric symptoms, psychological distress and somatic comorbidity among remand prisoners in Switzerland. *International Journal of Law and Psychiatry*, 34, 13-9. doi:10.1016/j.ijlp.2010.11.003
- Exworthy, T., Samele, C., Urquia, N., & Forrester, A. (2012). Asserting prisoners' right to health: Progressing beyond equivalence. *Psychiatric Services*, 63(3), 270-275.
- Fazel, S. & Danesh, J. (2002). Serious mental disorder in 23 000 prisoners: A systematic review of 62 surveys. *Lancet*, 359: 545-50.
- Fazel S., Gulati G., Linsell L., Geddes J.R., & Grann M. (2009). Schizophrenia and violence: Systematic review and meta-analysis. *PLoS Medicine*, 6(8): e1000120. doi:10.1371/journal.pmed.1000120
- Federal Bureau of Prisons. (n.d. a). *Guide to segregation in federal prisons*. Retrieved from www.washlaw.org/pdf/Guide_to_Segregation_in_Federal_Prisons.pdf
- Federal Bureau of Prisons. (2011). *About the Federal Bureau of Prisons*. Retrieved from www.bop.gov/news/PDFs/ipaabout.pdf
- Federal Bureau of Prisons. (n.d. b). *Agency pillars*. Retrieved from www.bop.gov/about/agency/agency_pillars.jsp
- FRONTLINE. (2005). *The new asylums*. Retrieved from www.pbs.org/wgbh/pages/frontline/shows/asylums/etc/faqs.html
- Henrichson, C. & Delaney, R. (2012). *The price of Prisons: What Incarceration Costs Taxpayers*. New York: Vera Institute of Justice, 2012.
- James, D. & Glaze, L. (2006). *Mental health problems of prison and jail inmates*. United States Department of Justice, September 2006, NCJ 213600. Retrieved from www.bjs.gov/content/pub/pdf/mhppji.pdf
- Junginger, J., Claypoole, K., Laygo, R., & Crisanti, A. (2006). Effects of serious mental illness and substance abuse on criminal offenders. *Psychiatric Services*, 57, 879-882.
- Liptak, A. (2008, April 23). Inmate count in U.S. dwarfs other nations' *The New York Times*. Retrieved from www.nytimes.com/2008/04/23/us/23prison.html?pagewanted=all
- McKean, L. & Ransford, C. (2004). *Current strategies for reducing recidivism*. Retrieved from www.impactresearch.org/documents/recidivismexecutivesummary.pdf
- Mental Health America. (2013). *Co-occurring disorders*. Retrieved from www.nmha.org/go/information/get-info/co-occurring-disorders/dual-diagnosis
- Metzner, J. & Fellner, J. (2010). Solitary confinement and mental illness in U.S. prisons: A challenge for medical ethics. *Journal of the American Academy of Psychiatry and the Law*, 38(1), 104-108.
- Monson, C., Gunnin, D., Fogel, M., & Kyle, L. (2001). Stopping the revolving door: Factors related to NGRI acquittees' maintenance of a conditional release. *Law and Human Behavior*, 25, 257-267. doi: 10.1023/A:1010745927735.
- National Alliance on Mental Illness (NAMI). (2013a). *Dual diagnosis: Substance abuse and mental illness*. Retrieved from www.nami.org/Template.cfm?Section=By_Illness&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=54&ContentID=23049
- National Alliance on Mental Illness (NAMI). (2013b). *The criminalization of people with mental illness*. Retrieved from www.nami.org/Content/ContentGroups/Policy/WhereWeStand/The_Criminalization_of_People_with_Mental_Illness_WHERE_WE_STAND.htm
- National Institute on Drug Abuse. (2007). *Comorbidity: Addition and other mental disorders*. Retrieved from www.drugabuse.gov/publications/topics-in-brief/comorbid-drug-abuse-mental-illness
- National Institute on Drug Abuse. (2013). *Prescription drug abuse*. Retrieved from www.nlm.nih.gov/medlineplus/prescriptiondrugabuse.html
- Paggio, D.D. (2012). Psychotropic medication abuse by inmates in correctional facilities. *Mental Health Clinician*, 7(8):13.
- Phillips, H., Gray, N., MacCulloch, S., Taylor, J., Moore, S., Huckle, P. & MacCulloch, M. (2005). Risk assessment in offenders with mental disorders: Relative efficacy of personal demographic, criminal history, and criminal variables. *Journal of Interpersonal Violence*, 20, 833-847. doi: 10.1177/088626050427898.
- Rossman, S. (2001). *Services integration: Strengthening offenders and families while promoting community health and safety*. Retrieved from <http://aspe.hhs.gov/hsp/prison2home02/rossman.htm>
- Royal College of General Practitioners. (2011). *Safer prescribing in prisons: Guidance for clinicians*. Retrieved from [www.emcdda.europa.eu/attachements.cfm/att_146300_EN_UK51_Safer_Prescribing_in_Prison%20\(2011\).pdf](http://www.emcdda.europa.eu/attachements.cfm/att_146300_EN_UK51_Safer_Prescribing_in_Prison%20(2011).pdf)
- Skeem, J., Manchak, S., & Peterson, J. (2010). Correctional policy for offenders with mental illness: Creating a new paradigm for recidivism reduction. *Law Human Behavior*, 35, 110-126. doi:10.1007/s10979-010-9223-7.
- Smith, P.S. (2006). The effects of solitary confinement on prison inmates: A brief history and review of the literature. *Criminal Justice*, 34, 441-568.

Stephen, J. (2004). State Prison Expenditures, 2001. Bureau of Justice Statistics, June 2004, NCJ 202949. Retrieved from, www.bjs.gov/content/pub/pdf/spe01.pdf

Torrey, E.F., Kennard, A.D., Enslinger, D., Lamb, R., & Pavle, J. (2010). *More mentally ill persons are in jails and prisons than hospitals: A survey of the states*. Retrieved from www.nami.org/Template.cfm?Section=CIT2&template=/ContentManagement/ContentDisplay.cfm&ContentID=101344

World Health Organization. (2007a). Health in prisons. Retrieved from www.euro.who.int/_data/assets/pdf_file/0009/99018/E90174.pdf

World Health Organization. (2007b). Preventing Suicide in Jails and Prisons. Retrieved from www.who.int/mental_health/prevention/suicide/resource_jails_prisons.pdf

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