

Technical Assistance Report

McLean County Sheriff's Detention Facility

Jail Mental Health Design and Programming
“Options & Opportunities”

United States Department of Justice

National Institute of Corrections

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July 23-26, 2013

NIC Technical Assistance Request No. 13J1069

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U.S. Department of Justice
National Institute of Corrections

Washington, DC 20534

DISCLAIMER

RE: NIC Technical Assistance No. 13J1069

The Jails Division of the National Institute of Corrections funded this technical assistance activity. The Institute is a Federal agency established to provide assistance to strengthen state and local correctional agencies by creating more effective, humane, safe and just correctional services.

The resource persons who provided the onsite technical assistance did so through a cooperative agreement, at the request of the McLean County, Illinois Sheriff and through the coordination of the National Institute of Corrections. The direct onsite assistance and the subsequent report are intended to assist the agency in addressing issues outlined in the original request and in efforts to enhance the effectiveness of the agency.

The contents of this document reflect the views of Mr. Kenneth Ray and Mr. Mark Goldman, Technical Service Providers. The contents do not necessarily reflect the official views or policies of the National Institute of Corrections.

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Introduction

Nationwide, public officials struggle to balance budgets while providing necessary human and public safety services. Many states have slashed public mental health funding and closed state-operated mental health facilities. Resulting cuts to local mental health services further reduces access to care, increases and prolongs suffering, destabilizes family systems, unnecessarily overloads finite law enforcement resources, increases crime, overburdens already packed court dockets, and overcrowds jails that are ill designed to provide care and management for the mentally ill. The aggregate impact of reduced community mental health funding levels, combined with McLean County's obligation to ensure constitutionally adequate care of its growing mentally ill inmate population, presents very serious and time-sensitive challenges.

To its benefit, however, McLean County has made this issue a top priority; it clearly understands the value in preemptive and deliberative planning and has a proven record of accomplishment for solving serious problems that jeopardize quality of life for its community and precious tax dollars.

Purpose of this Technical Assistance

This Technical Assistance was provided upon request of McLean County, IL Sheriff Mike Emery in collaboration with McLean County government elected, administrative, criminal justice, and community officials and representatives. In his request letter, Sheriff Emery stated the following:

“...I seek technical assistance on planning, design, and programming a jail mental health unit. We would appreciate assistance on how to plan a unit, become familiar with evidence-based design concepts, and how to best open and activate this new type of jail operation...”

This work builds upon prior NIC assistance that identified options and opportunities to improve care of mentally ill inmates incarcerated at the McLean County Jail. Also, this work assimilates salient findings of the previous work in an effort to more closely focus attention toward jail capacity and design, and the extent to which the jail building and utilization adversely impacts McLean County's ability to provide constitutional and effective incarceration of mentally ill persons. Ultimately, this report intends to provide McLean County with options and opportunities for improving inmate care relative to the facility's ability to support that care through renovation and/or expansion. This report also intends to support McLean County's voiced desire to improve access to community-based care by mentally ill citizens.

The primary purpose of the assistance is to provide recommendations to McLean County officials for addressing physical limitations of the jail that, as discussed in the previous report, impair provision of adequate and constitutional care of its growing mentally ill inmate population. A second purpose, identified during this and the previous assessment, is to provide a few recommendations for improving access to care in the community.

Scope of Work and Activities

This technical assistance project includes activities performed prior to, during, and following the on-site visit. On-site work was performed July 23-26, 2013. Project activities included pre-visit preparation, on-site tours and meetings, post visit follow-up and report writing.

Pre-Visit Activities:

- Collect information and documents relevant to work scope.
- Review available jail floor plans and schematics.
- Review site plan.
- Review photos of the current housing units for inmates with mental illness.
- Review photos representative of intake/booking, in particular where the inmates with mental illness are held before being placed in permanent housing.
- Review prior studies and reports, if available, regarding the current physical plant such as reviews or assessments by the fire marshal, health agencies, and Illinois DOC.
- Update inmate data since January 2013 report on the number and characteristics of those inmates identified as mentally ill.

On Site Activities:

- Tour the McLean County Detention Facility with primary focus on current medical and mental health units and the proposed sites for the expansion.
- Have group interviews with corrections mental health staff, medical, custody staff, and inmates.
- Review the proposed programs and housing options for mentally ill inmates in McLean County.
- Conduct a workshop on the planning and design process with the core team for the expansion/renovation.
- Provide a workshop on how the design of a facility can support the needs of staff and the mentally ill inmate.
- Outline next steps with sheriff's office/county staff in meeting their objectives for building one or more new mental health units.

On Site Activity Agenda

The following itinerary provided a flexible structure to facilitate on-site activities.

Day	Time	Activities & Locations	McLean County Participants
Tues 7/23	8:30am	Introductory Meeting – Meet & Greet <ul style="list-style-type: none"> • Introductions of participants and consultants • Brief Overview of project and week • Comments from State and Local Officials 	<ul style="list-style-type: none"> • Chief Judge Beth Robb • States Attorney Jason Chamber • Public Defender Kim Campbell • Director of Court Services Lori McCormick • Superintendent Greg Allen and Staff • County Board Chairman Matt Sorensen • County Administrator Bill Wasson • State Senator Jason Barickman • State Representative Dan Brady • Sheriff Mike Emery • MCSO Staff
	8:50am	2013 Jail Use Study <ul style="list-style-type: none"> • Data Source • Methodology • Findings • Implications 	Dr. Frank Beck, ISU, Stevenson Center
	9:45am	Facility Tour	Sheriff Emery, Group
	10:15am	Envisioning A Mental Health Unit <ul style="list-style-type: none"> • Scenario Primer • Expectations • Performance Outcomes 	Mr. Ray, Mr. Goldman
	NOON	Lunch	
	1:30pm	Envisioning (cont.) <ul style="list-style-type: none"> • Developing Core Measures for MH Unit Performance Quality Assurance 	Ken and Mark, Group
	4:30pm	Debrief, Reset, Adjourn	Ken, Mark, Group

Wed. 7/24	8:30am	Review and Conclude Envisioning	Ken, Mark, Group
	9:30am	Observations within the existing Behavioral Health areas, Transition Team huddle and discussions, focus of discussion: current physical environment & how a different physical environment could better support supervision, manageability, provision of mental health services & care, & staff efficiency	
	10:15am	Continue discussions with integrated care team. Current delivery system, strengths and opportunities, review of Study data; implications and applications	Team, Ken, Mark
	Noon	Lunch	
	1:30pm	Interviews with Mentally Ill Inmates	Ken, Mark, Staff, Inmates
	2:30pm	Break for Media Op	Sheriff Emery, Mark & Ken
	4:00pm	Continue Interviews, facility tours, PRN	As Above
Thurs 7/25	8:30am	<p>Workshop on Planning & Design Process (modeled after NIC's Planning of New Institutions program, "PONI").</p> <ul style="list-style-type: none"> • While focusing on pre-design tasks, provide overview of the big picture, including Project Recognition (completed); Needs Assessment; Program Development; Project Definition & Implementation Plan; Design; Bidding; Transition; Construction; Occupancy; Post Occupancy • Develop matrix of tasks, participants, & timeframes 	Project and Transition Team, Ken & Mark
	Noon	Lunch	

Thurs 7/25 continued	1:30pm	Activities (following PONI): <ul style="list-style-type: none"> • Review & clarification of Needs: How the County can determine numbers of beds by type in new unit & elsewhere; • Develop Mission & Objectives of unit • Develop preliminary list of functions in unit • Discuss development of staffing plan 	Same as above
	4:30pm	Wrap-Up	Group
Fri 7/26	8:30am	Exit Meeting, roll-out, provisional recommendations, adjourn	All

It is important to note that on-site participation was exceptional involving many public officials, staff and members of the community, including:

Meeting Participants

**McLean County Project Meeting
July 23, 2013**

Matt Sorensen	County Board Chairman
Paul Segobiano	Property Committee Chairman
Keith Sommer	State Representative
Don Everhart	Circuit Clerk
Jack Moody	CFM, Director, Facilities Management
Jackie Mathias	Inmate Services
Melinda Fellner	Inmate Services
Liz Barnhart	Criminal Justice Project Manager
Mark Benson	Jail Counselor
Sheri Day	Jail Programs
Lori McCormick	Director, Court Services
Tristan N. Bullington	Public Defender
Hannah Eisner	Administration
Jamey Kessinger	Assistant Jail Superintendent
Diane Hughes	Jail Operations Supervisor
Gregory Allen,`	Jail Superintendent
Edith Brady-Lunny	The Pantagraph (PIO)
Will Scanlon	Trial Court Administrator
Rusty Thomas	Chief Deputy
Kim Behrens	Reporter/WMBD-31 TV
Beth Robb	Chief Judge

Jason Chamber	States Attorney
Kim Campbell	Public Defender
Jason Barickman	State Senator
Dan Brady	State Representative

**McLean County Project Meeting
July 25, 2013**

Jackie Mathias	Inmate Services
Michelle S. Butler	Assistant Director, Health Services
James Kessinger	Assistant Jail Superintendent
Diane Hughes	Jail Operations Supervisor
Gregory Allen	Superintendent
Will Scanlon	Court Administration
Mark Benson	Jail Counselor
Joan Hartman	Central Region Manager (Chestnut)
Alan Sender	Chief Operating Officer, Health Systems

**McLean County Project Meeting/Presentation
July 26, 2013**

Michael Donovan	Deputy Director, ACS
Kenneth Hall	NAMI
Cathy Jo Waltz	Superintendent, JDC
Lori McCormick	Director, Court Services
Robert Sutherland	CKCC (LWV); Jail Review Committee
Sharjeel Rizvi	Pretrial Coordinator
Chris Bailey	Deputy Director, Adult Probation
Gregory Allen	Superintendent
Diane Hughes	Jail Operations Supervisor
Jamey Kessinger	Assistant Jail Superintendent
Melinda Fellner	Inmate Services
Mark Benson	Jail Counselor
Sheri Day	Jail Programs
Jackie Mathias	Inmate Services
Chris Cashen	Jail Counselor
Sally Pyne	County Board Member; District 4
Don Cavallini	County Board Member; District 1
Carlo Robustelli	County Board Member; District 8
George Gordon	County Board Member; District 6
John D. McIntyre	Vice Chairman, County Board; District 5
Jon Sandage	Lt. McLean County Sheriff
Bill Wasson	County Administrator
Hannah Eisner	Assistant County Administrator
Susan Schafer	McLean County Board; District 9
William Caisley	County Board Member; District 4

Jack Moody	Director, Facilities Management
Paul Segobiano	McLean County Board; District 8
Beth Robb	Chief Judge
Victoria Harris	McLean County Board; District 7; Property Transportation Comm.
Laurie Wollrab	McLean County Board; District 6
Will Scanlon	Court Administration
Blair Wright	MHA McLean County intern
Laura Beavers	McLean County Health Department
Liz Barnhart	Criminal Justice Special Projects Manager
Dennis McGuire	Probation Deputy Director
Karen Major	Director, The Baby Fold
Jen Ho	Risk Manager, McLean County
Zach Dietmeier	WSBC – Radio
Edith Brady-Lunny	The Pantagraph
Pablo Eves	Civil Assistant State’s Attorney
Kim Campbell	McLean County P.D.
Mike Emery	McLean County Sheriff

The Problem: Incarceration of the Mentally Ill in Local Jails

Brief National Perspective

Current research indicates that, on any given day, approximately 64 percent of people booked into our Nation's 3200 local jails are diagnosed or have a diagnosable mental illness or problem. The high prevalence of mentally ill inmates can be traced to the deinstitutionalization of mental health programs throughout the country, draconian reductions in community mental health funding, and the closing of public mental health facilities resulting in an unprecedented incarceration of the mentally ill.

Many of these inmates also have other risk factors associated with a higher incidence of violent behavior (e.g., substance abuse, neurological impairment, poor impulse control) that is often exacerbated by psychotic symptoms. Because of their idiosyncratic and sometimes unpredictable behaviors, people with serious and pervasive mental illness may be at higher risk of victimization or harming others in correctional settings and often have their clinical conditions exacerbated by overcrowding, hostility, and loss of basic freedoms.

Providing timely and adequate jail conditions and treatment to inmates with mental illness not only helps the individual avoid disruptive and dangerous behaviors but may also reduce suffering and improve facility safety and security. Developing and maintaining effective jail-based treatment and case management services for inmates with mental illness is a constitutional obligation of local officials. The following provides concepts and direction for developing and maintaining jail-based mental health programs and service.

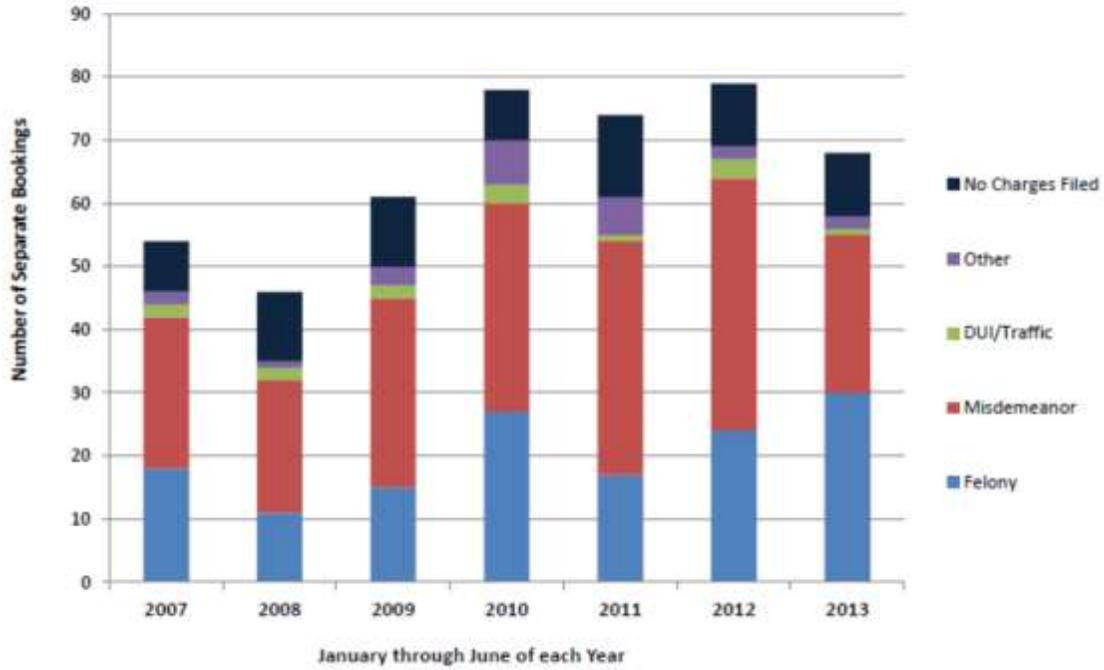
Growing Prevalence of Mental Illness in the McLean County Detention Facility

The previous Technical Assistance Report estimated reported prevalence of mental illness among inmates incarcerated at the McLean County Detention Center. These findings were further verified and described in a July 2013 study of jail data by Dr. Frank Beck, Stevenson Center, Illinois State University, Bloomington. This brief study was presented during this onsite visit to more than 40 public officials, criminal justice and corrections representatives, and community members.

This study analyzed jail inmate bookings from 2007 to 2013, producing the following salient findings that appear to follow national trends:

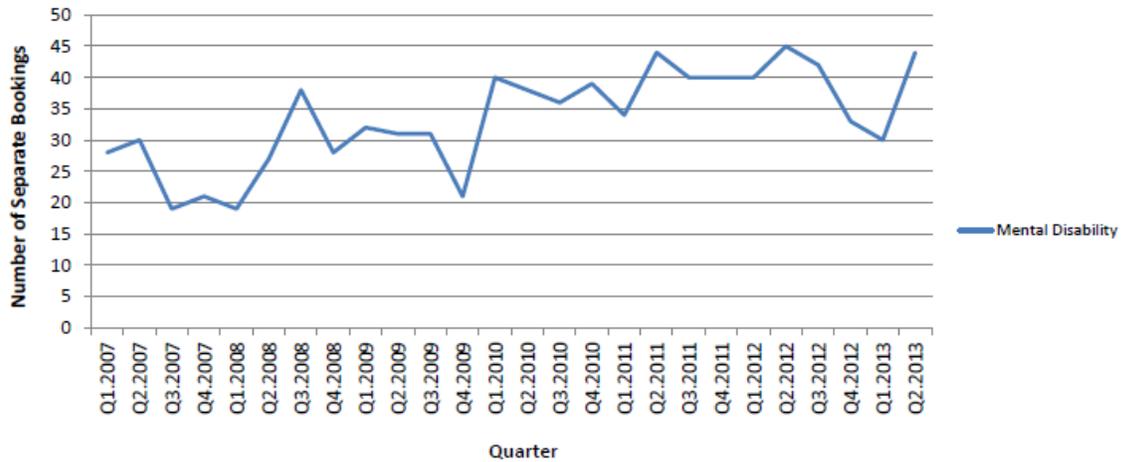
1. The number of bookings involving mentally ill persons has been increasing as shown in the following graphs and table. Note that this has been especially true for those charged with or convicted of felonies.

**Number of Bookings of the Mentally Ill and Disabled,
January through June, 2007-2013**



Number of Bookings of the Mentally Ill and Disabled, January through June, 2007-2013							
	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>2010</u>	<u>2011</u>	<u>2012</u>	<u>2013</u>
Felony	18	11	15	27	17	24	30
Misdemeanor	24	21	30	33	37	40	25
DUI/Traffic	2	2	2	3	1	3	1
Other	2	1	3	7	6	2	2
No Charges Filed	8	11	11	8	13	10	10
Total	54	46	61	78	74	79	68

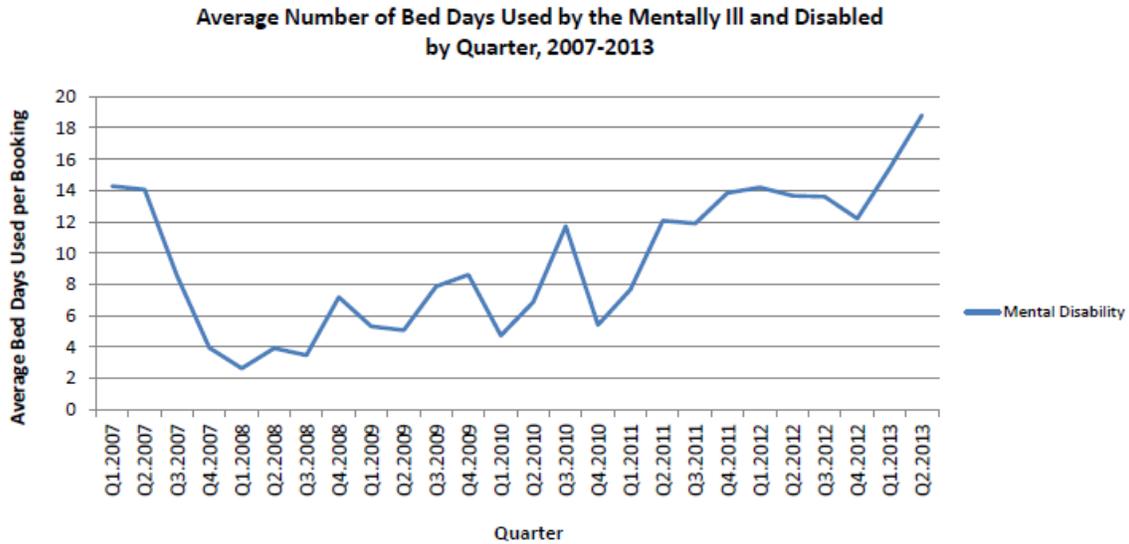
**Number of Bookings of the Mentally Ill and Disabled
by Quarter, 2007-2013**



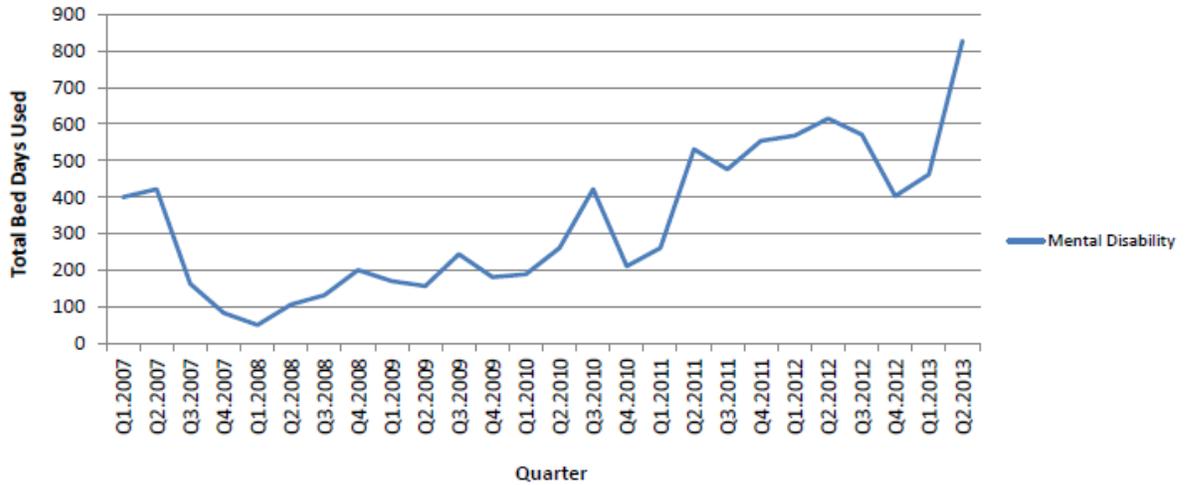
As shown above, aggregate bookings for bookings involving Mental Health Problem Risk and Mental Disability shows increases since January 2007. These data also show an increase in the charge severity for this population.

2. Average and total jail bed days are increasing for inmates with mental illness as shown in the next graphs and table:

Average Bed Days Used the Mentally Ill and Disabled, January through June, 2007-2013							
	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>2010</u>	<u>2011</u>	<u>2012</u>	<u>2013</u>
Felony	40	8	17	9	26	31	36
Misdemeanor	4	2	1	6	8	10	7
DUI/Traffic	1	2	4	3	7	1	1
Other	6	1	2	1	2	2	5
No Charges Filed	1	2	1	2	3	1	2



**Total Number of Bed Days Used by the Mentally Ill and Disabled
by Quarter, 2007-2013**



As shown above, average and total jail bed days involving Mental Health Problem Risk and Mental Disability show increases since January 2007. The report found that mentally ill inmates remained incarcerated 15 days more in 2013 than in 2008.

This study clearly evidences the basis for timely and strategic action by McLean County officials and the community. More people are being booked into the McLean County Detention Facility with more serious criminal charges and they are staying longer. Like a majority of jails in the United States, MCDF was not designed for nor is it adequately staffed to manage this growing inmate population effectively.

Adequate Jail-Based Management of Mentally Ill Inmates

Effective care and custody of mentally ill inmates involves the integration of three fundamental elements that include adequate and appropriate:

- 1) Jail-based management of mentally ill inmates
- 2) Jail physical environments and accommodations
- 3) Community mental health delivery systems

Effective care and custody of inmates with mental illness requires collaborative integration of all three elements listed above. Each element, individually, provides adequate conditions for constitutional care. Collaborative integration of these components maximizes the potential for best health care, criminal justice, and resource utilization outcomes. Therefore, all components must be evidence-based, fully functional, and strategically developed.

Management Overview

The course of mental illness, in general, is variable, with some people having exacerbations and remissions, some eventually recovering more or less completely, and others remaining chronically ill. The nature of the inmates current symptoms, comorbid conditions, associated functional impairments, and mental health history should be assessed when determining the severity of the specific person's illness, which will assist in determining the level of mental health treatment needed (e.g., outpatient, intermediate, crisis stabilization, inpatient) and in making appropriate housing recommendations.

Jail health care and custody staff should be diligent in monitoring an inmate's clinical and jail status in order to provide timely interventions. Additionally, mental health staff should provide all correctional staff with specific training so they can assist in the monitoring of inmates with mental illness, including suicide prevention, and can more effectively and humanely manage and interact with these individuals.

Program Treatment Goals

Treatment goals and ultimately a treatment plan should be developed in an integrated, multi-disciplinary fashion, which includes the active and ongoing participation of custody staff and leadership. The treatment programming attempts to address biological, interpersonal, social, environmental, and cultural factors affecting the inmate's adjustment to the jail environment. In developing treatment goals for mental illness, understanding the course of the illness is essential. Ordinarily, the course of mental illness can be divided into three broad phases: acute phase, a stabilization phase, and a stable phase. While somewhat arbitrary, these phases provide a structure for integrating treatment program approaches, which often involve different levels of mental health care and housing at different points.

During the acute phase, the goal of treatment is to eliminate or reduce acute symptoms and decrease functional impairment. Specific treatment goals are to prevent harm to self or others; control disturbed behavior; suppress or eliminate symptoms; reduce anxiety and unrealistic

fears; establish and maintain appropriate hygiene, grooming, and other adult daily living skills; develop a therapeutic alliance; and formulate short and long-term treatment plans throughout incarceration.

During the stabilization phase, the goals of treatment are to help the inmate effectively manage stress, provide a supportive environment and education about the illness to decrease the likelihood of relapse, promote psychosocial rehabilitation, foster the acquisition of relevant skills, and continue symptom management and prepare the inmate for reentry in to the community.

The goals of treatment programming during the stable phase are to maintain or improve the person's level of functioning, effectively treat symptoms associated with the onset of acute clinical exacerbations, and continue medication monitoring. Psychosocial rehabilitation, which includes helping people learn how to live with their condition, should continue as needed.

Assessment on Entry to the System

Standards and guidelines developed by the National Commission on Correctional Health Care (NCCHC) and a task force of the American Psychiatric Association recommend that all inmates be assessed during the intake screening process with follow-up mental health evaluation, if indicated, to identify and engage inmates requiring mental health treatment. In addition, both the NCCHC and APA guidelines recommend mental health screening procedures (which include mental health rounds) for all inmates who are placed in housing units that are segregated from the general inmate population (e.g., mental health units). This may include new admission housing in jails, reception center housing in prisons, or administrative segregation settings in both, which can include punitive/disciplinary cells or protective custody. While brief screening instruments are useful for screening purposes, the routine use of more extensive psychological testing is typically not warranted and should be reserved only for special clinical cases where it might be helpful in clarifying a confusing differential diagnosis.

It is important for a procedure to be developed and implemented that makes a reasonable attempt to obtain relevant past mental health records, especially inpatient psychiatric admission and discharge summaries for both diagnostic and treatment planning purposes.

Frequency of Follow-up Visits

In general, treatment during the acute phase involves daily contact between the inmate and treating clinician. Contacts with clinicians are often reduced in frequency during the stabilization phase. However, contact should be increased following significant changes such as housing transfers from one yard to another or to a different correctional institution, periods of stressful intervening events, and substantial changes in the inmate's treatment (e.g., medication changes). On average, clinical contacts during the stabilization phase will occur at least monthly, and often more frequently if psychosocial rehabilitation is more intensive or if an intervening event occurs that can cause relapse.

Inmates generally require less frequent clinical contact during the stable phase, although there are wide individual variations related to the person's clinical course, history, and changes within the correctional environment. For example, inmates usually require more frequent visits during prolonged lockdowns. More frequent contact will initially be required when significant changes in the person's life occur such as transfers to another prison or yard, being sentenced in court or a significant loss experienced by the inmate. In general, the frequency of visits with inmates during the stable phase should be at least once every 30 to 90 days depending on need.

Content of Follow-up Visits

Assessment

The specific content of follow-up visits is a function of the treatment plan and the nature of the clinical contact (e.g., medication management session, individual psychotherapy session, group therapy session, etc.). However, in each case, change from the last visit should be assessed and documented.

A mental status examination should be performed during each follow-up visit with specific questions being asked, as clinically appropriate (e.g., presence or absence of auditory hallucinations, presence of suicidal thinking, decompensation). If a person is receiving psychotropic medications, questions should be asked concerning relevant side effects, therapeutic effects, medication distribution issues, and whether or not they are taking the prescribed medications as ordered. In many correctional facilities, inmates with serious illnesses, including mental illness, are often housed together in mental health units or are concentrated in designated general population housing units. Under these circumstances, it is often important to solicit information from others knowledgeable about the inmate's functioning including such people as housing officers, program staff, or (in some cases) other inmates.

Due to the nature of many of these questions and the need for reasonable confidentiality, it is important for the clinician to meet with the inmate in a setting that is both safe and private, at least with regard to protecting patients from having other people overhear interviews. Obviously, exceptions to this principle may be necessary for safety reasons. For example, cell front contact, which may be an acceptable screening practice for inmates without significant mental health impairment in segregated housing units, may be inadequate when more significant mental health impairments are involved. At each follow-up visit, the clinician should assess and document in the appropriate record the level of control achieved.

Levels of Function

This section encourages the use of a level of function tool to bring as many patients as possible into good level of function, recognizing that many patients may only achieve a fair level of function even with all appropriate interventions. It is believed that greater standardization of information collection among clinical and custody staff can result in greater accountability for the professionals, and ultimately better care for the patients. This has

proven to be the case when using this approach with common chronic medical diseases and is believed that it may have the same impact on inmates with mental illness.

To effectively use this conceptual model, the clinician should apply the following rules:

1. Under any level of function, if all numbered parameters are not met, the level of function is assessed at the next lower level.
2. In determining whether a numbered parameter is met, it is not necessary that all examples described as part of the numbered parameter be present for the numbered parameter to be met.
3. To be reclassified as an improved level, (a higher level of function), the patient must meet all numbered parameters at the higher level.

Good Level of Function

1. Patient is a willing partner in the treatment plan. This can be judged by such attributes as: good medication compliance, attendance at all scheduled treatment sessions, understanding of disease process, and/or expresses support for the treatment process. The clinician uses his/her judgment to determine how many of these examples are necessary for the parameter to be met.
2. Patient does not require daily contacts with qualified mental health staff.
3. Patient can function appropriately and autonomously in the general inmate population. This can be judged by such examples as appropriate, non-bizarre behaviors and social contacts, self-reports of reductions in troublesome schizophrenic symptoms, regular attendance at/participation in available correctional programs, and/or participation in correctional work assignments with normal levels of staff supervision, maintenance of incident-free behavior, and/or positive staff reports regarding patient's adjustment. The clinician uses his/her judgment to determine how many of these examples are necessary for the parameter to be met.

Fair Level of Function

1. Patient functions marginally in general population with fairly regular crisis situations or functions satisfactorily in an intermediate care unit or special housing unit with its added staff supervision and program structure.
2. Patient requires daily contact by qualified mental health staff.
3. Patient reports a return of or an increase in symptoms.
4. Staff reports of patient behavior indicate deteriorating mental status. This can be judged by such examples as declining personal hygiene, increases in misconduct reports based on mental condition, increases in observable bizarre or deviant behaviors and/or complaints from other inmates about inmate's behaviors. The clinician uses his/her judgment to determine how many of these examples are necessary for the parameter to be met.
5. Patient does not fully cooperate with treatment process. This can be judged by such examples as: a general lack of understanding regarding the illness process, a general distrust or resistance to the treatment process, intermittent compliance with medication

regimen, missed treatment sessions. The clinician uses his/her judgment to determine how many of these examples are necessary for the parameter to be met.

Poor Level of Function:

1. Patient displays active symptoms of illness. This can be judged by such examples as: deterioration in personal hygiene, hallucinations and/or delusions, social withdrawal, alienation, and or other interpersonal problems, immobile, vegetative state or agitated, aggressive state, bizarre, inappropriate behavior and/or suicidal and/or homicidal thoughts, gestures, or actions. The clinician uses his/her judgment to determine how many of these examples are necessary for the parameter to be met.
2. Patient is unable to function in the general population, an intermediate care unit or special housing unit due to severity of symptoms and their disruptive effect on the orderly running of the unit.
3. When use of restraints and/or seclusion is sometimes required to manage symptoms. Patient is totally noncompliant with medication regimen and treatment process/recommendations and/or patient threatens or victimizes other inmates, or is threatened or victimized by other inmates as a function of symptoms of mental illness.

Use of the Assessment to Guide Treatment Efforts

Each clinical contact should generally result in reassessment of the current treatment plan, which should include a careful evaluation of the inmate's clinical status. If the inmate's clinical condition has either worsened or not improved as expected, the treatment plan needs to be revised as appropriate. Treatment plan revisions will often include changes in diagnosis, changes in the general therapeutic modalities being used, and changes in the frequency and nature of clinical contacts, changes in work and/or housing assignments, and, at times, an increased level of mental health care. The clinician may decide to observe for a period without changing the treatment if the clinical reasoning is documented.

Continuity of Care

For continuity of care to be effectively implemented across the facility and community agencies, support from management/administrative staff both within and across agencies is essential. Without this support, systemic obstacles are often difficult to overcome.

Continuity of care is clinically very important for establishing and maintaining a therapeutic alliance, for conducting ongoing assessment and monitoring, for maintaining treatment successes, and for reducing recidivism. Frequent changes of clinicians interrupt continuity of care and interfere with treatment efficacy. When clinicians are inconsistent, inappropriate changes in diagnosis and medications are common, and psychosocial therapy and monitoring tend to be superficial.

Frequent re-incarceration can also interfere with continuity of care where lack of community mental health services is inadequate or non-existent. This discontinuity can be reduced by

both written (which should include timely transfer of medical records) and oral contact between the appropriate mental health staff at each care delivery component. Policies and procedures that establish a communication process between custody and mental health staffs, relevant to transfers of people in the mental health caseload, and community providers will help to facilitate such a process.

Problems with continuity of care are common when the level of mental health care is changed. This problem can be minimized by both oral and written communication between the inmate's various primary and mental health providers.

Continuity of care also includes planning discharge to the community. Active involvement and collaboration between mental health staff and case management/classification staff is essential for mental health staff to be able to identify an inmate's actual discharge date in a timely fashion. Inmates who are well adapted to the correctional setting often experience increased stress as their release-date approaches. Jail health care clinicians and custody staff should monitor this period closely and adjust the treatment plan accordingly.

Discharge planning requires that a process be in place for establishment of linkages with primary care and mental health services in the community, social services, and housing. Policies and procedures should include guidelines for effective discharge planning within specified time frames, as well as the provision of medications on discharge and the establishment of an appointment with an aftercare provider in the community. The collaboration between mental health staff, community social services, duly involved criminal justice/court staff is also a vital component in helping the soon-to-be discharged person obtain necessary housing and available entitlements. Newer electronic technologies (e.g., telehealth, barcoded charts, electronic records, etc.) may prove helpful in creating smoother linkages between correctional and community mental health treatment providers.

Treatment Strategies

As in the non-incarcerated community, inmates with mental illness benefit from a variety of treatments, including medications, individual and group interventions. Pharmacologic treatments are generally an essential component of the treatment and are often necessary to facilitate participation in helpful psychosocial interventions. In general, symptoms of mental illness are more responsive to psychotropic medications when counseling and social support services accompany treatment.

Noncompliance with treatment, during incarceration or post-release, especially with psychotropic medications, is a common difficulty. Managing this problem includes assessing the reasons the person is not taking medication, evaluating any delusions about the medications, treating side effects, etc. In some instances, court intervention may be required to require medication compliance.

Psychosocial interventions are essential in treating mental illness in correctional settings. The correctional environment includes severe environmental stressors such as overcrowding, high stress levels, poor housing conditions, and frequent prolonged stays in lockdown units.

Adapting to these stressors is especially difficult for many individuals with mental illness, especially psychotic and bipolar illnesses. Lockdown is especially troublesome, as it prevents mentally ill inmates from using social interaction to correct their faulty reality testing and practice pro-social behaviors. Many psychosocial interventions are most effectively provided in a group setting that occurs out of an inmate's cell and in a safe treatment setting that allows for appropriate confidentiality and privacy. This is especially true in jail reception centers, which tend to be more regimented and whose housing units are more routinely locked down, as compared to most other correctional settings. Treatment of co-occurring substance use disorders is also an important component of the rehabilitation program, since remission of substance abuse improves prognosis of many mental illness.

Housing considerations have profound impact in the correctional setting. Inmates with serious mental illnesses, particularly when associated with significant paranoia, mania, or other psychotic symptoms disturbing to other inmates, should be carefully evaluated prior to placement in double-celled (two-person) housing as well as dormitory housing for the potential impact of such placement on their illness. Treatment in the least restrictive setting consistent with the inmate's custody classification should occur. The least restrictive setting for some inmates with mental illness in a jail setting will require an intermediate and adequate level of mental health care throughout their incarceration. Many other inmates with mental illness will be able to live in the general population within a correctional setting for much of their incarceration, if adequate mental health providers are available and an appropriate treatment plan is developed and implemented.

Inmates with mental illness should generally not be placed in a 22-24 hours/day lockdown for behaviors that directly result from severe mental illness, absent imminent risk of harm to self or others, because such an intervention is not likely to reduce the risk of the clinically relevant behaviors in question, and often exacerbates the person's underlying psychiatric condition due, in part, to lack of access to important treatment modalities and the increased stress associated with these environments. When it is necessary for an inmate with acute symptoms to be housed in such a setting, the institution is not relieved of its duty to provide treatment, despite the difficulty in bringing treatment to segregation settings. For this reason, it is seldom appropriate to house such inmates in disciplinary or administrative segregation units.

Safety of the correctional environment is a primary goal of correctional administrators and custody officers and should also be for correctional mental health providers. Individuals with mental illnesses constitute special circumstances, which should result in security aspects for correctional safety applied to the treatment environment and/or an appropriate treatment regimen applied to the lockdown environment. This may include inmates with mental illness in lockdown status having more out-of-cell time and clinical contacts than would be ordinarily expected in a lockdown setting, or may include more custodial interventions and control in a treatment setting than would ordinarily be expected in such a setting. This may result in designation of specialized mental health lockdown cells or units and/or individually managed treatment and custodial planning.

Mental illness is a condition that is associated with many symptoms that can cause significant functional impairments. Treatment of most inmates involves a multidisciplinary approach to

reduce the frequency and severity of episodes and to decrease associated morbidity and mortality. Such treatment is frequently lifelong and is facilitated by maintenance of a therapeutic alliance between the inmate and clinical staff and custody staff. Involvement by community volunteers and organizations can provide care and support during incarceration and following reentry into the community.

An important treatment strategy is to provide education to both the inmate and custody staff about the need for a long-term treatment approach. Mental health clinicians should advocate with policymakers and administrators for needed resources, which will enable the provision of adequate mental health treatment to inmates with serious mental illness.

Because many mentally ill inmates have comorbid medical and mental health conditions, jail-based integrated care management is strongly recommended. This care management approach often includes a physician or nurse practitioner, psychiatrist, mental health clinicians, infection/chronic care nurses, custody staff, and a layman advocate. This model is often successful in coordinating a treatment approach that involves staff from general and mental health care, custody (including classification staff), and other professional personnel (e.g., teachers), and the community. This case management function will help to minimize people "falling through the cracks" within a correctional system. This treatment team should meet on a regular basis with the frequency determined by the inmate's clinical condition and level of mental health care required. Additionally, proactive efforts for identifying, treating, and monitoring incarcerated people with mental illness will result in a decreased morbidity and mortality associated with this serious illness.

Environmental Controls

Correctional settings vary significantly in terms of inherent stress depending on many different variables that include the size of the jail or prison, level of security (e.g., minimum or supermax), nature of the housing unit (e.g., dormitory, double-celled, lockdown unit), and the nature of the physical plant (e.g., built in the late 1800s or in the late 1990s).

Inmates with mental illnesses do much better clinically in correctional environments that attempt to minimize stressors and provide a more positive and supportive treatment approach. The mental health staff should provide consultation and training to custody staff pertinent to behavioral principles that include the importance of positive reinforcement for desired behaviors. A more therapeutic milieu can be established in an intermediate level of care setting over time as a result of mental health and correctional staff developing good working relationships with each other.

Due to limited resources, mental health and correctional staff generally need to be very creative in identifying positive reinforcements that are actually available to people with serious mental illness in a correctional setting. Within an intermediate level of care setting, access to television sets, increased yard time, first housing unit to be served dinner, etc. are simple but frequently effective positive reinforcements for specific desired behaviors. So-called token economies, when appropriately managed, may have an important place in long-term care. Scheduled large-group meetings with all inmates and staff often add structure

and stability to the inmates lives as well as an opportunity to address common stressors. Some systems use a therapeutic community or inmate government model in addition to other variants.

Inmates in mental health units should have at least as much out-of-cell time as general population housing inmates, and equivalent yard (outside) time. This requires collaboration between clinical and custody staff, particularly to support therapeutic interventions on the units, while maintaining as much of a normalized activity schedule as possible to reduce the stigma of being on a mental health unit. Out-of-cell time, including recreational time, religious services, and visitation are extremely important to inmates; and if these are compromised by treatment activities, treatment refusal rates may be unnecessarily high. For an effective treatment program to exist within a correctional setting, there may be an additional requirement for consistent custody support on the units as well as in the yards, and may in fact include the necessity for a separate or segregated yard for people with serious mental illness and/or higher custodial presence to assure these people are not victimized by other incarcerated people.

Stigma associated with mental illnesses continues to be problematic, especially in a correctional environment. Training and supervision of correctional staff relevant to people with mental illness will be an initial step in reducing such stigma.

Correctional Barriers

The most common correctional barriers to providing adequate treatment to inmates with mental illness include the following:

1. Failure of top administrative staff to recognize and endorse treatment as an essential part of the agency's overall mission.
2. Inadequate numbers of mental health staff (both clinical and clerical staff) that is frequently related to rural settings of many correctional facilities or non-competitive salaries.
3. Limited understanding of mental illness by correctional officials resulting in obstacles to the provision of mental health care.
4. Poor or inadequate training of correctional staff.
5. Inadequate numbers of other health-care staff (e.g., nurses, pharmacists, etc.), which results in significant medication distribution difficulties.
6. Inadequate number of correctional officers for escort purposes, which results in inmates with serious mental illnesses not having reasonable access to needed mental health treatment.
7. Inadequate physical plant resources (e.g., lack of office space and programming space for activity and group therapies as well as individual treatment.
8. Inadequate numbers of inpatient psychiatric beds, crisis stabilization beds, and/or intermediate level of care units.

9. Overcrowded housing units, older facilities with inadequate climate control mechanisms etc.).
10. Lockdowns that result in access problems.
11. Lack of an adequate computerized management information system, which results in untimely responses to referrals, poor follow-up to missed appointments, other scheduling problems, and an inefficient quality improvement process.
12. Fiscal issues exacerbated by the cost of the newer psychotropic medications and increased funding constraints.

Simple Quality Improvement Monitors

The following quality improvement monitors are suggested, but are not intended to be a complete list to ensure a successful treatment program for inmates with mental illness in a correctional setting. It is not intended that every program be required to measure all of the following annually:

1. Policies and procedures have been implemented that result in timely identification of inmates with mental illness. These procedures will include receiving screening, intake assessments, comprehensive mental health evaluations, a referral process, and mental health rounds in lockdown units.
2. Indicators should include the percentage of the correctional facility population that has been diagnosed as having a serious mental illness, with the diagnostic categories being specified on a percentage basis, and the time frames required for completion of the various screening and evaluation processes.
3. Continuity of care is provided as characterized by medications being delivered on a regular basis, timely medication renewals, and inmates on the mental health caseload not frequently having changes in their assigned mental health clinicians.
4. Appointments with mental health clinicians should be monitored relevant to timeliness, frequency and missed appointments.
5. The number of mental health caseload inmates that are noncompliant with prescribed psychotropic medications should be monitored. Additionally, whether timely inmate referrals to the psychiatrist are initiated relevant to such inmates and, if so, whether a timely and clinically appropriate intervention subsequently occurs should also be assessed.
6. The percent of inmates on atypical or mood stabilizing medications, whose medications expired without reorder or whose medications were reordered but without psychiatric evaluation.
7. Treatment plans are appropriate to the inmate's clinical condition as well as to policies and procedures. Documentation is present in the healthcare record that confirms the treatment plan is being implemented.
8. Number of inmates referred to a more intensive level of mental health care on a monthly basis, and the percentage of those referred who are accepted to the higher

level of care. Other relevant indicators include the time frame between referral and actual transfer and percentage of inmates admitted to a crisis stabilization unit or psychiatric hospital that have had three or more such admissions during six consecutive months.

9. Number of inmates whose diagnoses have changed from a schizophrenic disorder to either malingering or a personality disorder and vice versa. An analysis should be performed relevant to the documentation and basis for making such a change
10. Number of rule violations (by severity) among inmates with mental illness on a monthly basis. An analysis should be performed relevant to whether mental health input was obtained concerning inmates with mental illness who received rule violation reports and, what impact, if any, these mental health assessments had on the disciplinary process. Another analysis should assess whether there was any relationship between these rule infractions and the person's mental illness(es).
11. Average number of hours per week of out-of-cell, structured therapeutic activity offered to inmates in intermediate levels of mental health care, and average number of hours actually used per inmate per week.
12. Number of mentally ill inmates currently housed in segregation units as compared to the total number of inmates in these units. An additional analysis should determine the nature of the mental health programming, if any, available to these inmates.
13. The number of inmates referred from lockdown units to crisis beds or hospital care as acute emergencies per month.
14. Number of inmates who are receiving psychotropic medications on an involuntary basis.
15. Number of mentally ill inmates who are restrained for any reason on a monthly basis. The duration of restraints and documentation relevant to clinical indications should also be assessed.
16. Use of force incidents involving inmates with serious mental illnesses should be reviewed to determine whether the person had been receiving appropriate mental health treatment and whether appropriate interventions occurred prior to any non-emergency use of force.
17. All suicides and suicide attempts should be reviewed with a focus on issues relevant to identification, monitoring, and treatment.
18. Assaults involving mentally ill persons should be reviewed with a focus on issues relevant to medication, monitoring, and treatment.
19. Appropriate laboratory testing for mood stabilizing medications is ordered, results available to clinicians and appropriate intervention performed when clinically indicated.
20. Percentage of mental health caseload inmates who receive prescribed psychotropic medications immediately prior to discharge from the correctional system, and whether an adequate supply of such medications upon discharge is given.
21. Percentage of patients in each level of function at the end of each quarter.

22. Study of patients on each class of psychotropics and their weight change over 6 months.
23. Study of patients to be released for documented follow-up appointments in the community.

Findings, Options & Recommendations

McLean County officials should refer to the previous Jail Mental Health Assessment “Options and Opportunities” for more complete description of findings, recommendations, and options for this element. In general, conditions have changed very little since that assessment, and that report provides a solid foundation for improving jail-based management of mentally ill offenders when assimilated with discussion provided in this section above. Nonetheless, it is important to note that the NIC consultants found that the McLean County administrators and staff continue to provide above average levels of services and programming to its mentally ill inmate population.

Adequate Jail Physical Environments and Accommodations

Limitations of the Existing Jail Building Regarding Accommodating Mentally Ill Inmates

There are five major issues with the McLean County Detention Center regarding housing mentally ill inmates:

1. No designated housing unit for mentally ill inmates.
2. Mentally ill inmates are primarily housed in the Booking area, which is not designed for the mentally ill, has far too little space for the mentally ill, and results in mixing several populations who should be separated from each other.
3. With the number of inmates often close to or over design capacity, inmates cannot always be housed based on their particular sets of security requirements and behaviors.
4. The design of the housing units in the original part of the jail is not appropriate for mentally ill inmates, partially because these units are not conducive to continuous monitoring by staff, and also because of their ambience.
5. The layout and ambience of the newer housing units are much more appropriate for mentally ill inmates, but the capacity of these units is too large for McLean's mentally ill population.

Booking Area, which is the primary place that mentally ill inmates are currently housed, sometimes sleeping on the floor due to limited capacity.



Typical cell in older part of Jail, not suitable for mentally ill inmates due to bars (suicide risk) and layout not conducive to continuous observation.



Ambience of newer housing units is much more appropriate for mentally ill inmates, but each of these units' capacities is 54, too many for Mental Health housing units.



Exploration of Initial Option for Creating a Mental Health Unit within the McLean County Detention Center

Prior to this National Institute of Corrections Technical Assistance, the McLean County's Sheriff Department and Detention Center were considering closing in the original outdoor recreation area to create a mental health unit. Ken Ray and Mark Goldman explored the feasibility and potential benefits and challenges with this concept.

Outdoor Recreation Yard – Potential Place for Mental Health Unit



The Recreation Yard was considered for the Mental Health Unit for numerous reasons, including:

- In recent years the Yard has been rarely used.
- The older part of the Detention Center also has an indoor Recreation Area, so inmates would still have access to recreation.

- It was thought to be relatively inexpensive to complete.
- It could be relatively inexpensive to staff (requiring few additional staff).
- It would not only provide critically needed mental health beds, but it would increase total capacity, slightly reducing overcrowding.

The TA providers first looked at the likelihood of the building’s structure being able to support the additional weight of a one level or two level Mental Health Unit. They reviewed the building’s plans with Facilities staff, including staff who worked with the architect during design of the main part of the Detention Center in 1976 and the addition in 1990. They were told that the architect designed the Detention Center so that it could take additional floors.

Next, again with Facilities staff, they looked at the space under the floor to see if there would be adequate space to run plumbing lines, as the Unit’s cells would each contain a toilet and sink, and the Unit would need to have multiple showers.

Access panels were opened up and Facilities staff and one of the TA providers studied the space between what would be the floor of the Mental Health Unit and the ceiling of the spaces below (Booking, Vehicular Sallyport).

Cavity between the floor of the Recreation Yard and ceilings below.



It appears that there is adequate space for all the plumbing lines that would be needed. However, if this option moves forward, this should be verified by structural and plumbing engineers.

Much of the floor would need to be opened in order to install plumbing lines to each toilet/sink in each cell, and to each shower.

Surrounding the Recreation Yard are several program rooms – including Indoor Recreation and a Library/Multipurpose Room – and several housing units, all of which have windows and receive natural light from the Recreation Yard. Closing in the Recreation Yard would eliminate this natural light, which as noted elsewhere would have negative impacts on staff and inmates that occupy these spaces.

Housing Unit adjoining Recreaton Yard

Library/Multipurpose Room



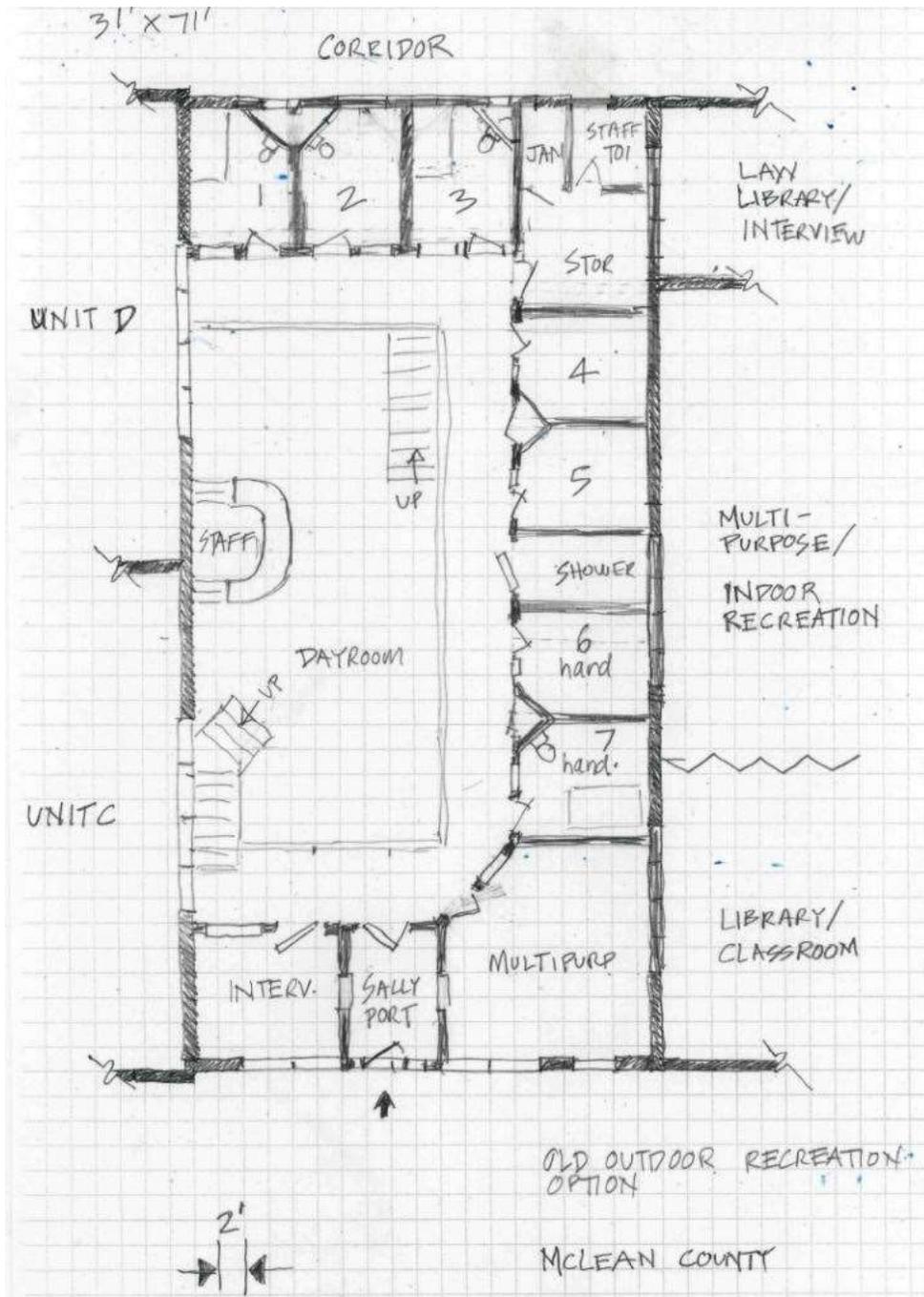
Next, to test whether the Recreation Yard would have adequate space for the Mental Health Unit, the TA Providers and McLean County representatives developed a list of spaces that would be needed within the Mental Health Unit. These spaces and the number of each consisted of:

Type of Space	Number of these Spaces Needed
Single Occupancy Cells with Toilets / Sinks	At least 16, more if feasible
Dayroom	1
Staff Workstation (within Dayroom)	1
Showers	1 for every 8 inmates
Interview/Counseling Room	1
Group Room / Multipurpose Room	1
Janitors' Closet	1
Storage Closet	1
Staff Restroom	1
Sally port Entry	1

After the Space List was developed, measurements were taken of the Recreation Yard and an initial conceptual plan was developed (next page).

This exercise demonstrated that the size of the Recreation Yard would be adequate for a seven-cell single level unit, or a 14 to 18 cell two level (including mezzanine) unit. To come closer to meeting capacity needs for the mentally ill, the two level/mezzanine option was greatly preferred over the single level option.

To increase the capacity of the Mental Health unit even more, it would be feasible to open up and combine one or both of the adjoining housing units C and/or D with the new Unit. Unfortunately, combining the existing unit or units with the new Mental Health unit would result in decreasing the number of general population beds. Further, the existing cells are not suitable for mentally ill inmates due to the presence of bars and the configuration, so the existing unit or units would need to be gutted and totally rebuilt.



How Jail Design Impacts Behaviors of Mentally Ill Inmates

During one meeting with a diverse group of McLean County Detention Center administrators, managers, counselors and others, the TA provider Goldman presented a summary of research that the project team may wish to consider when moving forward on the detailed planning and design of the new mental health care units.

Note that the research is drawn from studies in jails (which unfortunately are few) and in mental and medical health care facilities, and from interviews with national experts. Here is a summary of the findings.

Views of Nature. In a recent study by long time jail environment and behavior researchers Jay Farbstein, Melissa Farling and Rich Wener, findings showed that views of nature help reduce stress levels of inmates and staff. Hence, it is likely that views of nature also reduce tension and the likelihood of aggressive behavior and destruction of property. Lower stress is also likely to result in improved physical and mental health, a reduced need for sick leave, and perhaps less staff turnover.¹

While views of “real” nature are considered best, the Farbstein et al study showed that where windows with views are not possible, as was the case in the place of the study, that murals of nature also have a very positive impact on reducing stress.



Capacity of Housing Units. Evidence from both the literature and anecdotal sources is very slim on optimal inmate/patient numbers. The Environment and Behavior literature offers the most information on unit sizes, but focuses mainly on Alzheimer’s patients and those in some form of assisted living.

For the mentally impaired populations not in correctional settings, the most therapeutic environments tend to be smaller, with eight to ten residents in non-institutional, home-like settings that have private rooms. Such settings seem to offer the most normative environments which facilitate healing. The implication from this is that “smaller is better” for patients in correctional mental health units.

For the mentally impaired who only need minimal assistance in daily living, the numbers can be somewhat larger – but the type of housing recommended for these populations is still less institutional. Numbers of up to approximately 26 residents in units, each with their own dayrooms and close proximity to program areas is supported by the research.

¹ Developing the Evidence for Evidence-Based Design: The Impact of Simulated Nature Views on Stress in a Correctional Setting.” Jay Farbstein, Melissa Farling, and Richard Wener,

In short, mental health care research indicates that “smaller is better.” Recognizing that it is also vital for mental health units to be continuously staffed, the units need to be large enough so that jurisdictions can afford to provide staff 24/7. For example, it is better to have a 20-bed unit with continuous direct supervision than to have two 10-bed units that are staffed using indirect supervision, with staff in the units intermittently.²

Another major advantage of smaller units is that populations who should not mix (e.g., male/female, 16-18 year olds/19+ year olds, violent/vulnerable) can more readily be kept apart from others.

Capacity of Cells. McLean County realizes the many benefits of single cells compared with multiple-occupancy cells and dormitories for all inmates. Environment and Behavior research supports single cells, especially for mentally ill inmates. Reasons include:

- Reduces inmates’ levels of stress and anxiety, which facilitates healing.
- Facilitates manageability by staff.
- Reduces unwanted noise, facilitating better sleep.
- Reduces unwanted light, also facilitating better sleep.
- Promotes accountability should there be any damage.
- Minimizes risk of physical, verbal, and sexual assaults.
- Better enables some personalization of space (e.g., how items on shelves are arranged), which promotes self-esteem and well-being.
- Results in better physical health too (e.g., less likelihood of infections from others).

Observation. Some Mentally ill inmates, especially those likely to harm themselves, require continuous observation, with staff having direct views 24/7. Here is an example from another state that requires staff to sit a few feet away from suicidal inmates 24 hours per day, seven days per week. This is obviously extremely staff intensive, with a staff: inmate ratio of five staff to every one or two inmates.



² Research Impacting the Design of Secure Facilities in California Intended to Support Patients’ Physical & Mental Health, For the California Prison Receivership, 2008, Mark Goldman & Dita Peatross.

Healing Environments. The types of settings that appear to be most successful in supporting good mental and physical health are³:

- Enriched – with color, art, music, views of nature, opportunities for positive stimulation, etc.
- Normative – allowing patients to maintain as complete a behavioral repertoire as before incarceration.
- Supportive – designed so as not to diminish the scope and range of behavioral repertoires; i.e., cueing, way-finding, recognizable.
- Familiar and meaningful -- so as to offer the fullest possible support to inmate/patient's strengths with opportunities for information, choice, and activity within a recognizable (even though secure) environment.
- Soft, normative finishes and living quarters are appropriate and often not abused by the mentally ill. These environments can be less expensive to build than highly secure, institutional settings and they can work. They can also provide cues to patients as to the expected normative behavior.
- Meeting, congregating and multi-purpose spaces are important for socialization and treatment-oriented activities.
- Access to outside spaces and fresh air is beneficial to mental and physical health.
- Indoor air quality is very important for the functioning and health of residents and staff.
- Natural and full spectrum lighting improves health outcomes, lowers stress and depression, can shorten length of stay, and helps retain staff. Daylight and soft, non-direct, non-institutional lighting is preferable.
- Inmates/patients' mental health can benefit from the inmates having choices throughout the day and some control within their living quarters (turning lights on/off, moving a chair).
- Quieter environments lessen stress in residents and staff.

Environments that Support Staff. Secure Mental and Physical Health environments not only have an enormous impact on patients, but also on staff, who spend substantial portions of their lives in these environments. A review of the literature in this area finds that many of the same features that impact patient behavior and lessen stress can also improve staff morale and lessen stress in staff. In addition to other factors, limiting noise-related stressors and providing ample natural light and views to the outside when feasible can help to keep staff stress levels to a minimum. It is also important to provide staff with places to rest and “recharge.”⁴

³ Research Impacting the Design of Secure Facilities in California Intended to Support Patients' Physical & Mental Health, For the California Prison Receivership, 2008, Mark Goldman & Dita Peatross.

Other characteristics of the physical environment that appear to support staff well-being and job performance include:

- Small unit sizes. These facilitate good access, visibility and observation, and communications between staff and patients.
- Conveniently located storage and support spaces to reduce staff walking and stress.
- Decentralized staff stations that are close to patient areas.
- Well organized units that limit the amount of time that staff are required to spend searching for supplies and materials.

Ultimately, effective management and treatment requires that staff in correctional health care settings circulate throughout housing areas frequently and interact with and observe patients.

With concern over being able to attract and retain good, trained medical and mental health professionals and custody and security personnel, providing quality work environments for staff that will positively impact performance and contribute to the therapy and rehabilitation of patients should be a high priority.

Findings, Options & Recommendations on Accommodations for the Mentally Ill within the Jail

With extensive input from and discussion with the leaders of the Sheriff’s Office and Jail, counselors, Facilities managers, and elected and appointed officials, the NIC TA providers developed and began the evaluation of options for providing one or more Mental Health Units in addition to the original concept, that of closing in the Recreation Yard. Three primary building options evolved, each with two or three sub-options, as follows:

Building Option		Sub-Option	Summary Description	Number of Beds Gained or Lost	
Unit Option				MH Beds	GP Beds
1	Renovate Older Recreation Yard	A	Closes in entire Recreation Yard; Tiered; negatively impacts surrounding spaces and eliminates outdoor Rec for many.	16-18	0
		B	Same as A plus incorporates one or both of adjacent Units C &/or D gutted and remodeled; Tiered; negatively impacts surrounding spaces and eliminates outdoor Rec for many.	18-30	-12
2	Renovate West Pod	A	Vertical Split (wall), double bunks some GP's in order to not reduce GP capacity; would need to add showers & renovate areas for programs, support and circulation.	18-27	0
		B	Horizontal Split (Floor/Ceiling), double bunks some GP's in order to not reduce GP capacity; would need to add showers & renovate areas for programs, support and circulation.	Approx. 27	0
3	Vertical Expansion Above 1990's Pods	A	One Level; designed specifically for MH population with program and support spaces.	30-50	0
		B	Two Level (Mezzanine); designed specifically for MH population with program and support spaces.	50-90	0
		C	Two Single Levels (one on top of the other); designed specifically for MH population with program and support spaces.	60-100	0

Next the team began the evaluation and comparison of the seven building options. Criteria were developed along with a 1 to 10 scoring system, as follows:

0 = lowest score, totally fails this criteria

3 = relatively low score, does poorly with this criteria

5 = middle score, partially meets this criteria

8 = relatively good score, mostly achieves objectives/meets most needs

10 = top score, fully achieves objectives/meets needs

Preliminary Evaluation of Options for Accommodating Mentally Ill Inmates

Building Option		Time Period this Option should Meet MH Bed Needs			Works for:		Could Foster Safety & Security	Access / Delivery of Services		Provides Outside Recreation for All	Avoids Double Bunking	No Negative Impacts on Spaces Surrounding Outdoor Rec Yard	Minimal Negative Operational Impacts	Total for Each Option		
		Unit Option	Sub-Option	Short-Term: up to 3 years	Mid-Term: 4 to 8 years	Long-Term: 9 to 20 years		Males	Females					MH Services	Medical Services	Points
1	Renovate Older Recreation Yard	A	10	3	0	10	0	8	9	3	0	10	0	2	55	46%
		B	10	7	0	10	0	9	9	3	0	10	0	2	60	50%
2	Renovate West Pod	A	10	7	0	10	0	7	8	5	10	4	10	1	72	60%
		B	10	7	0	10	0	7	8	3	10	4	10	1	70	58%
3	Vertical Expansion Above 1990's Pods	A	10	10	4	10	8	10	10	9	10	10	10	9	110	92%
		B	10	10	9	10	10	10	10	9	10	10	10	9	117	98%
		C	10	10	10	10	10	10	10	9	10	10	10	8	117	98%
Maximum Score			10	10	10	10	10	10	10	10	10	10	10	10	120	

Clearly the three options that build male and female mental health housing units and support and program space above, the 1990's Pods are far superior to the renovation options. Of these three options, the ones that provide the most mental health beds, 3B and 3C are best for the long term.

Next Planning Tasks

The NIC TA providers recommend that before McLean County moves forward to secure funding and hiring an architect that the best performing options be detailed further and scrutinized. Tasks should include:

- Projecting bed needs by classification category, including mentally ill males and mentally ill females, for the next 20 years in 5-year increments;
- Further studying the projected mental health bed needs by subcategories, which may include those who are dangerous to themselves and others and need to be watched continuously in smaller housing units, and those more suitable to be in environments similar to the existing Pods. This will help define the number and capacity of each of the mental health units;
- Determining what types of spaces, and how many of each, would be needed for the mental health units;
- Determining what other areas should be included in the addition, such as the primary physical health clinic, and an infirmary;
- Confirmation by design architects and structural engineers that the Pods could sustain the weight of a two-level (two single levels or mezzanine units) expansion.

Adequate Community Mental Health Delivery Systems

Recent cuts in state and federal spending for community mental health services have dramatically affected the quality of life and criminal justice systems in local communities nationwide. In some states, publically funded mental health facilities have closed permanently and/or access to outpatient treatment has been reduced to the point where many people have lost access to vitally needed services. As a result, many people suffering from mental illness are incarcerated for the first time and many others are re-incarcerated following stable community living. Many local jails, by default, have become the local community mental health facility. Local criminal justice systems, budgets, law enforcement, and jails have become the primary safety net for people suffering from mental illness. This further exacerbates community barriers causing mentally ill stigma by the added title “criminal” to these already “left-out” community members.

Research over the past 20 years has consistently shown the benefits that an adequate local community mental health delivery system can have on criminal justice. Lower incarceration and lower recidivism rates are two salient outcomes found in the literature.

An adequate local community mental health system is fundamental to the effective and sustainable treatment of inmates with mental illness. An adequate system is considered effective if services are 1) timely, 2) accessible, 3) and provide an array of evidence-based therapeutic services involving medication, counseling (individual and group), social-rehabilitation and housing, and crisis intervention response capabilities. Additionally, an effective local community mental health delivery system must have adequate facilities to provide short and long-term residential care appropriately designed, staffed, and located to maximize access to care outcomes. Communities operating collaborative integrated systems that involve the three components previously discussed are showing very promising results and at a lower cost overall. Even greater positive outcomes are being found in delivery systems that provide housing and employment opportunities. However, the most effective outcomes are not necessarily determined by the types and kinds of services provided, but by the degree and extent to which local community leaders and agency heads share a common vision, regularly exchange relevant information and data, and actively work together to eliminate political and egocentric barriers from planning and decision making. The most effective local mental health delivery systems do not operate from protected independent silos but from a protected value system of collaboration, shared knowledge and resources, and mutual respect.

This assessment, combined with findings from the previous assessment, found a very strong desire among McLean County officials and community members to create such a local community mental health delivery system. Interviews with elected and appointed government officials, community members, and citizens clearly evidenced a very strong consensus for timely, strategic, and significant change in the current system. More specifically, McLean County participants stated their intentions to change the current community mental health system to ensure that it:

1. Is adequately funded based on a comprehensive assessment of community needs;

2. Functions based on collaborative, integrated, and inter-dependent values;
3. Fully maximizes most appropriate use of existing resources utilizing performance-based requirements; and
4. Provides an adequate array of services to ameliorate suffering of its mentally ill community members while minimizing their criminal justice involvement and incarceration.

Findings, Options & Recommendations

The McLean County community mental health delivery system is currently unable to support the desired performance outcomes voiced during this and the previous assessment for the following reasons:

- Inadequate funding levels.
- Absence of a functional mobile mental health crisis response program.
- Absence of long and short-term residential treatment beds.
- Absence of crisis stabilization beds.
- Lack of unified coordination among and between mental health agencies.
- Lack of unified coordination with local criminal justice and law enforcement.
- Disengagement by local mental health leaders.
- Absence of performance measures for allocating mental health resources.
- Lack of a comprehensive strategic planning process or planning document that involves criminal justice, law enforcement, and community agencies and that encompasses community-wide needs .

The current local community mental health delivery system is ineffective in significantly reducing suffering of its citizens or in reducing mentally ill involvement in the criminal justice system. It is clearly unable to provide timely or adequate levels of services to meet the needs of the community without significant changes and determine commitment among government officials and community leaders.

Recommended Next Steps

The NIC Technical Assistance Providers recommend that McLean County take the following next steps regarding appropriate and adequate accommodations for mentally ill inmates:

1. Define the Project Team and Planning Committee. The Team and Committee should include staff and administrators that represent custody/security, mental health, medical, and facilities/maintenance. Some members of the Planning Committee should also become the Transition Team.
2. Appoint a McLean County project manager for the renovation/expansion project.

3. Conduct a needs assessment and develop a plan.
4. Engage a corrections/mental health consultant/planner to take the lead with the needs assessment and plan. First define the scope of work and develop, if needed, a request for proposals.
5. Clarify the Problem Statement; develop a mission statement, operational objectives, and design objectives for the mental health units.
6. Further detail profiles of mentally ill inmates – for each sub-category of mentally ill offender that will be accommodated in the new unit(s), study their characteristics that will help define sub-categories that should be in separate housing units (e.g., perhaps that who need constant observation), group sizes, treatment services and programs.
7. Project bed needs by mentally ill sub-category (e.g., mentally ill females who need protective custody; less acute and lower risk males) – in 5 year increments over the next 15 to 20 years.
8. Study other correctional mental health and psychiatric facilities. Confirm/learn “best practices” and “what works” both operationally and pertaining to design; confirm/learn what not to do; determine what is appropriate and inappropriate for the new mental health units. In addition to structured tours with agendas and questionnaires, also review relevant studies and reports.
9. Develop an Operational and Architectural Program. Once the numbers of beds and the number and sizes of the various mental health housing units are determined, then the planning consultant can lead the way in developing an operational and architectural program. This detailed document should specify functions, activities, staffing, numbers of spaces by type, sizes of spaces, space descriptions, and adjacency/flow requirements.
10. Hire an architect/engineer. Develop criteria. Develop a Request for Proposals. Review proposals. Check references. Score proposals. Develop short-list. Interview short-listed firms, and review their fee proposals. Hire best architecture/engineering team.
11. Ensure that the Planning Team and Transition Team works closely and continuously with the architect/engineer (as they hopefully do with the planning consultant), always ensuring that the design is following the mission and objectives; is in concert with the inmate profile and projections, and follows the operational and architectural program.
12. Transition Team develops Staffing Plan, Job Descriptions, Policies and Procedures, and Post Orders – building from existing ones.
13. Transition Team, Sheriff’s Office, and Personnel recruit and hire staff.
14. Sheriff’s Office and mental and physical health care provider’s train (and cross-train) staff.
15. Architect/engineer develops at least two Conceptual Design Options.
16. Planning Team and Decision-Makers review the Conceptual Designs and select elements of each one for the architect into incorporate in Schematic Design.

17. Architect/engineer develops Schematic Design for review and approval.
18. Transition Team selects and orders furniture and equipment for the new units and new support and program areas.
19. Architect/engineer produces Design Development documents, again with reviews and approvals.
20. Architect/engineer develops Construction Documents, including Working Drawings and detailed Specifications.
21. Renovation/additions begin.

Strategic Planning Recommendations

Effective response to improving custody and care of mentally ill persons involved in the criminal justice system requires a strategic, integrated, and collaborative process that produces evidence-based solutions and plans. The process must be inclusive and comprehensive, which is McLean County's standard operating procedure for resolving important issues and problems. Government and community leaders must engage a process, not only to determine additional jail capacity and programming, but also one that expands community capacity for care and housing of its mentally ill citizenry. Recommendations/options are provided to assist McLean County trigger such a process.

Obtain consensus for 1) the need to expand jail and community capacity for care and housing of mentally ill inmates and non-offender populations in the community.

1. Task the Local Criminal Justice Coordinating Council with overseeing a process to create a community mental health action task force.
2. Task the Task Force with developing a comprehensive strategic plan for moving forward. This plan must be evidence-based, collaborative, and integrated in focus and design.
3. Conduct a comprehensive inventory of current levels of services in the community, need for those services, quantify and qualify needs and gaps.
4. The above planning process should assess the following three specific structural options for expanding jail and community capacity:
 - A. Build appropriately designed additional capacity at the jail for mentally ill inmates
 - B. Build crisis and residential community capacity for residential and crisis care that has beds of criminal justice purposes
 - C. Build both additional jail capacity and community capacity and use collaborative agreements for diversion, step-down, and reentry use of community facility.

Officials should engage a qualified correctional expert with combined experience in the areas of correctional design and planning, mental health, law enforcement, and community mental health and planning as needed. Each of the above options have merit in meeting criminal

justice and community needs but only will do it in the most efficient manner considering construction and operating costs. Additionally, McLean County officials should reach out to a local or national community mental health agency having an solid resume for effective and efficient community mental health delivery systems, and who is not just “willing”, but passionate about contributing to the process.

At first glance, and based on over 70 years combined experience of these consultants, it is believed that the most cost effective, practical, inclusive, and sustainable option proposed above is Option C.

Option A, build appropriately designed additional capacity at the jail for mentally ill inmates has the following limitations:

It does not address community needs, is a “status quo” response, and has no impact on reducing the growth in the mentally ill inmate population. However, it may be possible to secure additional building space below the jail area (Coroner space), build and staff a community mental health crisis stabilization facility. However, again, capacity would be limited, combined construction would be very expensive, and staffing a crisis center would further decentralize mental health professionals for non-crisis community based care.

Option B, build crisis and residential community capacity for residential and crisis care with correctional beds for low risk mentally ill inmates.

This option begins to address community mental health and jail needs but requires considerable investment in designing and constructing secured jail beds in the community. This would be redundant to the existing jail and increase jail operating costs more than would in Option A because jail staff would be required at both facilities to manage the mentally ill inmate population.

Option C, build both additional jail capacity and community capacity and use collaborative agreements for diversion, step-down, and reentry use of community facility.

This option is likely to present the most feasible option. It addresses both community and jail needs while supporting the highly successful initiatives of the Local Criminal Justice Coordinating Counsel. Additionally, this option does not incur additional liability in terms of operating two jails, both housing mentally ill inmates (high and low risk). This option should also maximize utilization of jail staff and reduce the number of jail staff required to managing this population within well-designed expanded jail capacity. Conceptually speaking, Option C is likely to produce the most effective outcomes overall for these reasons:

- A. Increases community collaboration in planning and operations
- B. Operating costs incurred by the McLean County are likely less than Options A or B
- C. Eliminates liability associated with operating two jails for mentally ill inmates
- D. Creates needed community crisis beds and improved services to the mentally ill
 - Crisis beds can be used as a jail diversion to prevent incarceration of certain offenses and persons
 - Crisis beds can be used as a step-down from jail by court order or criminal justice system agreement requiring no incarceration component

- Crisis beds can be used to support development of a jail Reentry program to prepare inmates with mentally illness for linkage and return to the community
- E. Provide the LCJCC additional options for expanding and sustaining jail alternatives programs and strategies

A final recommendation is for McLean County officials to conduct an inmate population assessment, as part of the comprehensive strategic planning process. Identify all inmate populations that are eligible for existing jail alternatives, with or without expanded program resources, and those inmates who would be eligible for other evidence-based programs currently supported by the literature and used successfully in other jurisdiction. This is essential to ensure that construction costs (options A-C) are based on capacity needed.

Conclusion

McLean County remains determined and committed to improve the care and custody of mentally inmates. The jail must expand operationally and structurally to meet this commitment, and appropriately house this special inmate population according to constitutional standards. Officials are clearly cognizant of their obligation to provide for the mentally ill in the community and understand the proven connection between lack of services and housing at the community level and growth in the inmate population. To its credit, McLean County is determined to join a very small consortium of communities in the United States determined to take action to meet both of these very important and demanding social needs.

In closing, Mr. Ray and Mr. Goldman wish to again thank Sheriff Mike Emery, his entire staff, local officials, and community members for their unquestionably support of this project and the mentally ill in the community. Additionally, we want to thank Fran Zandi and the National Institute of Corrections for approving this TA project.