Improving mental health for inmates

Using a variety of new strategies, psychologists in correctional settings are transforming care for people in prisons and jails

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Jamycheal Mitchell, 24, had not been taking his schizophrenia medication when he was arrested for stealing a bottle of Mountain Dew, a Snickers bar and a Zebra Cake from a 7-Eleven. After waiting more than a month in jail, he was found to be incompetent to stand trial due to mental illness and ordered to go to a state hospital for "competency restoration," a combination of psychiatric medication, mental health treatment and education about the legal process. But no beds were available, and Mitchell's condition deteriorated as weeks turned into months while he waited in jail. He refused to eat and take medication. Four months after his arrest, Mitchell was found dead in a cell covered in urine and feces. He had died of cardiac arrhythmia related to wasting syndrome, a disorder characterized by extreme weight loss.

Cases like this are so tragic because they are preventable, say psychologists who advocate for more effective mental health services in correctional facilities. The unfortunate truth is that despite improvements over the past 30 years, the correctional system continues to struggle to meet the vast needs of the increasing number of inmates with mental health conditions, says Thomas Fagan, PhD, professor emeritus at Nova Southeastern University in Florida and a former administrator for the Federal Bureau of Prisons.

About 37 percent of people in prison have a history of mental health problems, according to a 2017 report from the U.S. Department of Justice. More than 24 percent have been previously diagnosed with major depressive order, 17 percent with bipolar disorder, 13 percent with a personality disorder and 12 percent with post-traumatic stress disorder. The numbers are even higher for people in jail, where one-third have been previously diagnosed with major depressive disorder and almost one-quarter with bipolar disorder.

"We lock up people with mental health problems when we should really be treating these people in the community," says Fagan. "In the absence of that, prisons and jails become de facto treatment centers."

As a result, psychologists, psychiatrists and social workers have become essential mental health providers in correctional settings, and they can be a driving force for new programs in state and federal facilities, he says. Here is a look at some of the latest evidence-based approaches from psychologists.

New thinking patterns

Several psychologists are focused on keeping people with mental health problems out of correctional facilities. Among them is Robert Morgan, PhD, a psychology professor at Texas Tech University in Lubbock who is testing a new prison-based program that helps inmates learn to avoid behaviors that may lead to reincarceration after they are released. Morgan's program, Changing Lives and Changing Outcomes, seeks to address antisocial thinking and behavior patterns—which he calls "criminalness"—among inmates who have been diagnosed with mental illnesses. The program is novel because it diverges from the traditional belief that providing better mental health care alone will reduce the chances of criminal behavior patterns. Morgan contends that it's critical to combine mental health care and treatment for criminalness because inmates can learn not only how to cope with mental illness, but also practical life skills such as how to challenge antisocial

thought patterns and to develop healthy connections with others.

“We learned through a series of studies that people with mental illness in the justice system are there in part because they present with criminal risk in similar ways to those who are not mentally ill—they interpret interpersonal situations differently than noncriminals,” says Morgan. For example, this population is more likely to see someone bumping into them as asserting dominance rather than as an accident, Morgan explains.

Morgan’s ideas were born out of years of clinical work in prisons, where he witnessed the struggles people faced, especially those with mental illness. In federal and state prisons at both minimum and supermaximum levels of security, he saw that people with mental illness were at increased risk of victimization, psychiatric rehospitalization and criminal recidivism. They also had trouble adjusting to the institutional environment, and often their psychiatric symptoms worsened.

On the basis of that experience, Morgan wanted to help incarcerated people with mental illness stay out of prison once released; nearly 80 percent of all released prisoners are arrested again within six years, according to the U.S. Bureau of Justice Statistics. In a pilot study, he tested his model of addressing both psychiatric and criminogenic needs with 47 male inmates who were in prison or a residential facility. The six-month program included 155 hours of group and individual therapy sessions in which clinicians taught participants about healthy ways of dealing with anger and fear, how to interpret situations, medication adherence and other skills. He found that participants experienced decreased depression, anxiety, hostility, paranoid ideation, psychoticism and reactive criminal thinking (*Criminal Justice and Behavior*, Vol. 41, No. 7, 2014).

Morgan’s team then tried the program with a larger sample of 169 participants in residential facilities. This time, they wanted to determine how much of the program content the inmates retained. “This is important for improving community outcomes,” says Morgan. “Simply reducing distress during the course of treatment is a positive step, but that can be very temporary. We wanted to assess if participants were able to learn and retain the information to be applied in their everyday lives.”

The team found that most participants increased and retained their knowledge, but those who had lower scores on the quizzes after each module were more likely to drop out of the program (*Psychological Services*, in press). In these cases, clinicians may need to provide more sessions to reduce the risk of dropout. The next step,Morgan says, will be to investigate whether the program reduces recidivism rates.

The program has also been adapted for mentally ill inmates in solitary confinement who can’t participate in group sessions. Participants receive written material and worksheets, and clinicians provide brief feedback during mental health rounds. “The goal is to help them learn how to manage their mental illnesses and identify issues that put them at risk of continued segregation,” says Morgan, who is evaluating the program.

Influencing correctional policies

University of California, Santa Cruz psychologist Craig Haney, PhD, is exploring ways to reduce the number of people placed in isolation. Through interviews with hundreds of inmates in isolation, many of whom have mental illnesses, Haney has shown that people living in solitary confinement—defined as the absence of meaningful social contact and interaction with others—frequently experience depression, memory problems, difficulty concentrating, irritability and anger. Studies have also shown that stress-related reactions are common, including decreased appetite, heart palpitations and a sense of impending emotional breakdown, as well as sleeplessness, heightened levels of anxiety and paranoia. Over time, isolated inmates can also lose the ability to feel comfortable around people (*Annual Review of Criminology*, Vol. 1, 2018).

“Longing for the presence of other people and feeling that absence is painful, so these inmates

adjust by learning to cope in a world without other human beings," says Haney. "Once they are released, the presence of other people can create anxiety, so paradoxically many self-isolate."

Through his work as an expert witness in numerous court cases, Haney has advocated for reforms that would lead to more humane conditions, including increased mental health care and decreased use of solitary confinement. In 2017, his testimony in a federal case against the Alabama Department of Corrections helped to influence the court's decision to order the state to improve practices and conditions in its prisons. In Georgia, Haney was invited to inspect a prison where he discovered that inmates in solitary confinement were only allowed outside their cells for five hours a week, and some were in darkened cells for months. His report documenting the conditions helped inmates win a settlement in January that allows prisoners to spend four hours outside their cells each day, and to eventually have access to educational classes.

Haney recently turned his attention overseas to find innovative correctional models that could inspire prison reform in the United States. Through the U.S.-Norway Correctional Culture Exchange Program sponsored by the Criminal Justice & Health Consortium at the University of California, San Francisco, Haney regularly travels with a contingent of U.S. correctional officials to Norwegian prisons, where the prisoners' routines mimic normal daily life as much as possible. Inmates have more freedom of movement, can access rehabilitation programs and rarely experience solitary confinement.

"They also place a tremendous amount of emphasis on the interactions between correctional officers and prisoners," notes Haney. "The officers are more like social workers who get to know inmates rather than enforcing punishments." If a prisoner acts out, officers try to understand what led to the outburst and to address the problem or concern rather than punish the individual.

The results of this positive prison culture in Norway are clear: low turnover among staff and decreased recidivism because inmates are better prepared to re-integrate into society. Visiting prison officials from Alaska, Idaho, North Dakota, Oregon and Rhode Island were so impressed that they have started adopting the Norwegian philosophy in their own prisons by increasing the rehabilitation programming and training their staffs to relate differently to inmates, says Haney.

Introducing trauma-informed care

Like Haney, Dave Stephens, PsyD, believes that interactions between correctional staff and inmates significantly influence the mental health of prisoners, and he's improving conditions for inmates by teaching correctional employees about the brain's response to trauma. Through the National Institute of Corrections' training center in Colorado, Stephens has trained more than 100 jail and prison wardens, mental health professionals, caseworkers and nurses on how to communicate with inmates in ways that minimize the chances of retraumatizing individuals who have a history of trauma.

He helps staff understand that many inmates, especially those with mental illness, have histories of physical, sexual or emotional abuse that lead to distrust and a sense of worthlessness. Stephens explains how to halt this cycle by being respectful to inmates and by teaching them what to expect when they encounter new situations.

Correctional officers who conduct pat-down searches, for example, can explain beforehand what they will be doing to the inmate. "This can reduce anxiety and the risk of retraumatizing people who are expecting violation and abusive behavior," Stephens says. He also encourages facilities to provide inmates information at the time of booking about what they might experience psychologically once they are incarcerated and steps to take if they are having symptoms of anxiety, depression or other types of mental illness.

Stephens sometimes encounters resistance from staff who believe it is not their job to "make things easy for inmates," he says. "But with some explanation and discussion, staff become more open and

positive, especially because these strategies create a safer environment for both inmates and employees."

Alternatives to hospitalization

Forensic psychologist W. Neil Gowensmith, PhD, is taking another tack to improve care for mentally ill offenders: community-based treatment. Rather than relying on overcrowded state hospitals to provide competency restoration services for people with mental health problems who have been accused of misdemeanor offenses or nonviolent felonies, Gowensmith has been advocating for outpatient competency restoration. Through such programs, offenders receive these services from private contractors, outpatient treatment centers or community mental health systems.

To study the feasibility of using these programs in lieu of inpatient programs,Gowensmith, an assistant clinical professor of psychology at the University of Denver, collected data from 16 states that were using outpatient methods of restoring competency. He found that 70 percent of the participants in the outpatient programs achieved competency restoration, compared with roughly 80 percent in state hospitals. The duration of treatment was also comparable between the two settings (*Psychology, Public Policy, and Law*, Vol. 22, No. 3, 2016). "This early research shows that outpatient community restoration programs produce similar outcomes to inpatient programs at a fraction of the cost, and without compromising public safety."

In the study, Gowensmith also found that allowing people to have competency restored in the community did not pose a risk to the public, as measured by the number of negative incidents such as re-arrest or violence, which were very low. "Outpatient programs can also allow individuals to keep their housing and stay more connected to community support systems," he says.

Identifying suicide patterns

Psychologists are also working with correctional systems to develop better ways to identify inmates who may be at risk of suicide. In 2014, the Bureau of Justice Statistics reported that suicides accounted for 7 percent of state prison deaths. Reducing these numbers has become a high priority, says Sharen Barboza, PhD, vice president of mental health at MHM/Centurion, a company that provides health-care services to state correctional systems and large county jails.

To better understand who is at risk of suicide, Barboza and her colleagues conducted a study of 925 state prison and jail inmates, comparing those who had attempted with those who had completed suicide. The researchers found that those who had died by suicide tended to be male, older, more educated, married or separated/divorced, at the pretrial stage, committed for a violent crime, not on suicide precautions and not previously on close observation (*Suicide and Life-Threatening Behavior*, Vol. 48. No. 5, 2018).

Although Barboza was not surprised by those characteristics, she was concerned that those who had died by suicide had not previously been identified as at risk. "Inmates may not be inclined to share with staff that they are at risk of suicide because we respond by putting them alone in cells for close monitoring, which can be very isolating," Barboza says.

In an effort to change that, she is working with the National Commission on Correctional Health Care and the American Foundation for Suicide Prevention on a national initiative to improve assessment, training and interventions for inmates who may be at higher risk of suicide. The two organizations are partnering as part of an effort to reduce the nation's annual suicide rate for all people by 20 percent by 2025. So far Barboza has participated in three Suicide Prevention Summits, where she leads the assessment group that is working to develop better suicide-risk screening tools.

"We are seeing more completed suicides in both corrections and the general population nationally, and that is alarming," says Barboza. For her, each suicide is a reminder that finding ways to provide

better mental health care to more than 2 million incarcerated people in the United States has the potential to improve—and sometimes save—thousands of lives each year.

Further reading

Effectiveness of a Self-administered Intervention for Criminal Thinking: Taking a Chance on Change
Folk, J.B., et al., *Psychological Services*, 2016

Reducing the Use and Impact of Solitary Confinement in Corrections
Ahalt, C., et al., *International Journal of Prisoner Health*, 2017

Contingency Management Programs in Corrections: Another Panacea?
Gendreau, P., & Listwan, S.J., *Journal of Contemporary Criminal Justice*, 2018

Insane: America's Criminal Treatment of Mental Illness
Roth, A., *Basic Books*, 2018