Bureau of Clinical Services
Mental Health Division

Utah Department of Corrections,
Draper Utah

The Role of Mental Health in Prison

Introductions/Key Players

- Mike Hoglund Mental Health Director
- Roy Bickel Men's Outpatient Program Administrator
- Dan Boyden Olympus Program Administrator
- Marcie Remington Women's Program Administator
- Mica White PHD Supervising Psychologist

MEN'S OUTPATIENT SERVICES

Goal and Purpose of Presentation

- Overview of services
- Prison's and Jail's are the New Asylums
- 17-20% of prison population has a mental health diagonsis
- Specific challenges of providing services
- Staffing
- Transitional Services vs long term care

Men's Outpatient Housing Areas

Uinta

Wasatch

Oquirrhs

Lone Peak

Promontory

Statistics

	# of Inmates	# Admitted to OPMH	% on medication
♦ Uinta	757	300	39%
♦ Wasatch	886	231	26%
♦ Oquirrh	850	334	39%
♦ Lone Peak	240	50	20%
♦ Promontory	395	91	23%
♦ Total:	3,128	1,006	32%

Uinta 5:
Receiving and Orientation

- Enter prison.
- Nursing staff within 24 hours, usually the same shift.
- Intake screen
- Seen by mental health and assessed to determine appropriate mental health treatment:
  - 1). Referred to a psychiatrist for a medication evaluation.
  - 2). Referred to inpatient housing.
  - 3). No recommendation for treatment is neccesary.
  - 4). Admit to infirmary if considered to be suicidal or a threat/danger to themselves.
- P.A. within 72 hours

R&O Screening Form

- Depressive reactions, anxiety, stress
- Sleep disturbances
- Personality disorders
- Self harm
- Suicide attempt/suicide
- Psychosis
- Sex offense charges
- Drug related disorders
- ADHD
- PTSD

- Previous admits to state hospitals/psych wards.
- Previous/current prescription for medications.

Treatment

- The goal of treatment is the alleviation of mental health symptoms that significantly interfere with an inmate's ability to function.
- Sex Offender Treatment Program
- Con-Quest / Ex-cell
- B-North (Lower Functioning Housing)
- Outpatient Mental Health
  - Individual therapy, group therapy, crisis assessments, medication.
- Mental Health Inpatient Treatment Program

Wasatch Infirmary

- Psych side= 7 beds plus one ADA cell
- Medical side= 12 beds

Admit Reasons

- Response to a crisis call.
- The person has already begun any self harming behavior (i.e cutting, overdose, etc)

Wasatch Infirmary

Checks:

- Irregular intervals of Q15 (actively suicidal) or Q30 provided (observations) by custody & medical staff.

- Pipe II Electronic Monitoring System Device.
  - Allows for real time, electronic tracking of logs and is more accurate.
  - Tracks the person, time, activity and cell.
  - It is currently being used in the Wasatch Infirmary

Uinta 1 section 4

- Special housing section designed to manage difficult and problematic inmates with mental health issues.
- Daily checks from mental health staff.
- Q15 checks from custody staff.

Uinta 1 section 8

- Created May 2012
- 12 beds available

Need:

"Custody staff and mental health staff began to see a cycle emerge where less functional and emotionally unstable inmates would work themselves out of section 4 and then get tipped over by the harder and more controlling inmates from other sections". Matt Bradley, MFT

Uinta 1 section 8

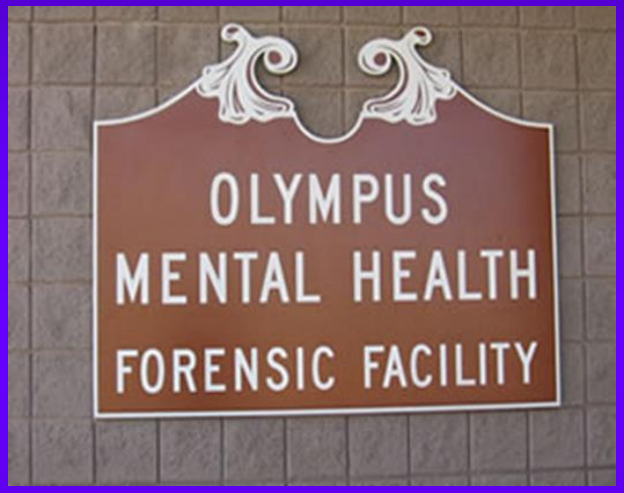
Solution:

- A meeting was held to discuss how best to mange and house these individuals. The meeting was attended by both selected custody staff and mental health staff and deputy wardens.
- Conclusion:
- Improved management of severely problematic inmates between Olympus and Uinta 1.
- Create a specialized housing section in Uinta 1 that would house selected inmates that are difficult to manage and emotionally unstable, without jeopardizing the safety and security of the prison.
- Increase opportunity for programming and treatment.
- Create a mental health library for Uinta 1.

Uinta 1 section 8

- Results:
- SWAT and A-Team call outs to Unita 1 have decreased by 80%
- Inmates inflicting self harm down by 90%
- Man hours and repairs to fire suppression equipment down by 95%
- Inmates in section 8 causing self harm or acting out: 2 in a 90 day period

OLYMPUS MENTAL HEALTH UNIT



Issues and challenges in providing inpatient mental health care to male offenders at the Utah State Prison.

Male Inpatient Facility
(Olympus)
160 Beds (medium & Maxium Security inmates)

2 Acute Medical Cell Beds
Single cell camera rooms 15 minute checks

A Section=12
Single cell, camera, officer in section,
15 minute checks

B/C Section = 94
Medium security 30/60 minute checks

D Section = 24
maximum security step down,30 minute checks

E Section= 36
medium security Dorm setting, officer present

REFERALS

- Screen and Staffed by Outpatient Mental Health
- Acute referrals from infirmary, Unita 5
- Administrative/Management referrals, high profile, prison adjustment issues
- Readmits from Unita 5 (want them to be classified before being admitted to Olympus)
- Clinical/Custody review of inmates i.e. PSI, treatment records and hx, Custodial hx to include housing, write-ups, safety issues, current symptoms and expected benefit
- MD order for admission to Olympus
- Coordination with referring housing area to accept inmate back once stabilized or often trade inmates in/out of Olympus.
- Referrals have to be carefully screened as there are many reasons outside of legitimate treatment why inmates want to come to Olympus.

OLYMPUS INMATE POPULATION

- 70% are chronically mentally ill, with schizophrenia, bipolar or depression
- 15% management/behavioral issues related to Axis II, requests for assessments and treatment recommendations
- 15% are medical, elderly, dialysis,
- Duel dx of mental health, substance abuse and sex offenders
- Atypical presentations/malingering/drug seeking

STAFFING AND PROGRAMNING

- Program Administrator (has caseload 18-24)
- 4 therapists (Caseloads of 30-35)
- 2 recreational therapists for Olympus/Timp
- Case manager life skill instructor/release planning
- Part time psychiatrist for Olympus (3 days per week, rounds 1 day per week infirmary and 1x a month at halfway house)
- 24/7 Nursing Services
- Weekly Medical Provider Visits
- Weekly therapy group and life skill classes
- Daily checks in A section and med cells
- Minimum of 2 individual therapy sessions per month
- Daily recreational activities with emphasis on exercise, diet, social skills, coping skills, budget planning, leisure planning
- Hygiene and self care issues

RELEASE PLANNING PROCESS AND CHALLENGES

- Early identification of inmate's release dates, Mental Status Reports and Coordination with Board of Pardons
- Close working relationship with caseworker, correctional specialist, therapists and Custody
- Parole, termination and expiration
- Coordination with community resources, Medicaid, social security, housing
- 30 day supply of medication
- Follow up services

Program Highlights

- Increase focus on Wellness
- Psycho-educational Classes
- NAMI
- Cooking Groups
- Tour and Inmate Panel for CIT Program

Program Highlights Cont.

- Substance Abuse
- Sex offender therapy for Mentally Ill
- Close coordination with Board of Pardons
- Garden Greenhouse Programs

MANAGEMENT ISSUES

- Close coordination with Custody and Medical Services to provide high level of care “The three headed dragon”
- Medication management, compliance, abuse and forced medication hearings
- Evaluation and long term management of personality disorders and management problems
- Costs of Care ie medications, older inmates, medical costs, staffing.

MANAGEMENT TOOLS

- Morning meetings, weekly treatment teams, mental health overrides, treatment plans
- Case Staffing
- State Hospital Consultation and reviews (2 Contracted beds at hospital)
- Collaboration with community resources and Specialists ie NAMI, Disability Law Center
- Forced medication hearings (criteria)

CONCLUSIONS

- Providing mental health care in a prison setting is one of the most challenging areas of mental health. We are the “New Aslyms” as more mentally ill enter the criminal justice system, more high profile cases of mentally ill committing crimes, and the need for transitional community services as most have little connections left with family. Need for medication compliance and structured living is the key to success.

Utah State Prison Women's Facility

Total Women Incarcerated in Prison = 540

Incarcerated Women in County Jails =

Total Women Admitted to:

Outpatient Mental Services = 226 or 41%

Total Women Admitted to:

Inpatient Mental Health Services =30 or 6%

Female Inpatient Mental Health

- 36 Total Beds

for both medium/maximum security IPMH female inmates

- 2 single cell camera cell rooms
- 3 Double Bunk camera cell rooms

Officer in section

15 minute checks

Gender in Prison makes a Difference.

The way women enter the criminal justice system is different, they way they experience criminal justice involvement is different, and what they need to lead law abiding, self-sufficient lives in the community is different!

Mental Health Issues

- **Depression**
- **Anxiety**
- **PTSD**
- **Personality Disorders**
- **Suicide Attempts**
- **Trauma**
- **Shame and Stigma**
- **Physical and Sexual Abuse**
- **Substance Abuse**
- **Relationship Issues**
  - fear of losing children
  - fear of losing a partner
  - needing partner's permission to obtain treatment

Treatment

- Psychiatric Provider Sessions
- Crisis Calls
- Individual Sessions
- Group Therapy

  - Grief Group
  - Mindfulness Groups
  - Adults Molested as Children
  - PTSD Trauma based groups
  - Domestic Violence
  - -Anxiety Buster Group
  - -Long timer Group
  - -Rape Recover y
  - -Eating Disorder

Trauma-Informed Services

•WRNA (Womens Risk Need Assessment)

More Trauma based groups being offered than ever before

An Innovative Approach to Treatment

Animals provided by
Intermountain Animal Therapy Association volunteers

- **Group Types**
  - Grief Group
  - Boundary Group
  - Social Skills

Suicide Prevention History

Clinical Services Bureau
2012

Historical Overview:

- **At USP from 1993 to 2001 they were 7 completed suicides. There were several years with no completed suicides (1994, 1997, 1998 and 2001).**
- **Then suicides began to increase , 4 in 2002 and 3 in 2003.**
- **From 2000 to the end of 2004 we had approximately 3.2 completed suicides per year.**

Continued:

- **January 2003:**

  CQI then requested an Independent Review of recent suicides and Lindsay Hayes, nationally known in the field of jail and prison suicide prevention, is suggested to analyze our situation and make changes in our suicide prevention process.

Continuation

- June 2003: Lindsay Hayes due for an On-Site audit rescheduled.
- August 2003: On Site visit by Mr. Hayes.
- August 28, 2003: First Suicide Prevention Committee meeting.
- September, 2003: Suicide Prevention Committee meets twice.
- October 1, 2003: Received report by Lindsay Hayes.

Completed Recommendations: Organizational "EXAMPLES"

*Both custody and clinical would attend meetings regarding suicide issues.

*Suicide training to be available for all USP staff with curriculum developed by CSB.

*UDC to initiate a written policy concerning suicide prevention, as would CSB, and establish a Suicide Prevention Committee to discuss issues relevant to suicide in prison i.e. isolation, restrictive mov't, etc.

Organizational (Cont.)

- All National Commission on Correctional Health Care standards concerning suicide are to be met. This to include nationally recognized categories of: Identification, Training, Communication, Housing, Levels of Supervision, Interventions and Administrative Review.

Report Recommendations: Procedural "Examples"

*An Intake Questionnaire would refer potential risky inmates for further in-depth mental health assessment.

* A 72 hr. Step Down for inmates after leaving Infirmary for f/u assessment.

* Treatment plans instituted upon discharge from Infirmary for suicidal pts.

to ensure continued mental health contact.

Procedural (Cont.)

* Selected cells in “special housing "evaluated for the removal of cell protrusions which could be potential hazards.

* Double bunks removed from Infirmary and mental health “special housing”.

*Physical visual checks implemented in selected “special housing” units. To be implemented with 15 minute or 30 minute checks with provider orders.

To Summarize

- CSB, along with active support from DIO, has initiated and implemented a complete program to stem as many potential completed suicides as possible.
- The number of completed suicides is now 1.6 per year, on average.

SUMMARY CONTINUED:

Procedures have been put in place to observe and/or "catch" those inmates verbalizing suicidal ideations. Special housing considerations were put in place for those mentally and non-mentally ill individuals who made frequent attempts, i.e. daily mental health checks, frequent visual checks, making cells safer with few objects from which to hang themselves.

CURRENT DISCUSSION POINTS

Safety on top tier of Women's mental health unit, new electronic suicide check recording, additional cameras in "special housing" areas.

Plus ongoing discussion on projecting suicides in the non-mentally ill and those vehemently denying suicidally.

Challenges

- Current Economic Crisis
- New Asylums –PBS Presentation
- Staff Burn-out due to large caseloads
- Security/Custody
- Legal issues
- Substance abuse

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A Prescription for Disaster: Cutbacks on Mental Health Programs Curb Access to Care

by Richard A. Sherer

In Virginia, a state agency charged with the protection and oversight of the disabled has filed a lawsuit charging that state-run mental hospitals are neglecting patients. In Florida, the North Broward Hospital District has stopped paying for psychotropic drugs for indigent patients. In Missouri, the state mental health department plans to shut down a treatment center and a psychiatric rehabilitation hospital to save money. In California, proposed cuts in the state's budget will force counties to shut down mental health facilities despite legal mandates to provide care.

From Maine to Oregon, from West Virginia to Texas, mental health services are being curtailed as bureaucrats and lawmakers try to stretch fewer dollars across an increasingly large, underserved population.

State tax revenues per capita declined 7.4% in fiscal 2002. In a Kaiser Commission on Medicaid and

wrote, "While the national recession was fairly mild, the falloff in state tax revenues was severe and led to daunting state budget shortfalls." They continued, "The big falloff in state tax revenue in 2002 means that it will take states some time to return to pre-2002 tax levels, and the recent modest growth in state tax revenues is far from sufficient to do that." Boyd is director of the Fiscal Studies Program at the Rockefeller Institute of Government, and Wachino is associate director of the Kaiser Commission on Medicaid and the Uninsured.

The immediate future does not look much better, according to Boyd and Wachino. "As the Rockefeller Institute recently observed, 'States will probably have to cut spending and/or raise taxes in order to balance the fiscal year 2005 budgets they will begin to consider in a few months.'" They added, "And unless the national economic picture, and especially employment, picks up significantly, states will have to face these condi-