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Treatment Policies & Programs for Mentally Ill Offenders: A Comparison of Kentucky and the Nation

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Abstract:
Approximately 10-15% of the nearly 6 million offenders in U.S. jails, prisons or on probation or parole, suffer from mental illness. Correctional systems are legally mandated to provide treatment, yet they are overwhelmed with the high costs associated with specialized staff training, the hiring of professional mental health providers, psychotropic medications and specialized housing. This article discusses the prevalence of the problem of the continually increasing numbers of offenders in need of mental health services. The article also presents the results of a national survey of the chief mental health administrators for the state correctional systems across the United States. The survey inquired about the areas of screening, assessment, classification, treatment services, suicide prevention, aftercare, and general perceptions of mental/behavioral health services administrators. Comparisons are made between the State of Kentucky and the rest of the nation. The results indicated that while there are many similarities across the states, there are some marked differences as well, particularly as they relate to suicide prevention and aftercare.

Treatment Policies and Programs for Mentally Ill Offenders: A Comparison of Kentucky and the Nation

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Research Topic: This survey is a comparative analysis of treatment policies and services of state-level departments of corrections targeting offenders with mental illnesses.

Research Issues: This survey research covers the areas of screening, assessment, classification, treatment services, suicide prevention, aftercare, and general perceptions of mental/behavioral health services administrators.

Major Findings: While many similarities exist across the states, there are some marked differences as well, particularly as they relate to suicide prevention and aftercare.

When popular culture portrays inmates, it usually depicts hardened men with calculating minds and predatory dispositions. In reality, our prisons are filled mostly with non-violent, property and drug offenders. Many of these prisoners are poor, uneducated, elderly, female, disabled, or physically or mentally ill; many are a combination of all of the above (Soderstrom, 2007). It is the mentally ill offenders who are the most vulnerable to self-harm and victimization by other inmates (Ruddell, 2006), and the most likely to fall

through the cracks of the treatment, habilitation, and rehabilitation components of the criminal justice system (Human Rights Watch, 2003).

The rate of mental illness among inmates is estimated to be two to three times higher than in the general population (Roskes & Feldman, 1999). There are several explanations for his phenomenon,[1] including the facts that:

- Deinstitutionalization of state mental hospitals has resulted in the mentally ill residing in communities rather than hospitals. Thus, there are increased opportunities for them to behave in ways that come to the attention of police officers. This behavior is often a manifestation of their illness.
- Mentally ill offenders of minor crimes are often subjected to inappropriate arrest and incarceration.
- More formal and rigid criteria are now in place for civil commitment to a state mental facility.

A special thank you is extended to Mr. Kevin Pangburn from the Kentucky DOC for allowing Kentucky=s responses to the survey to be individually presented.

[1] See (Soderstrom, 2007) for a more detailed discussion of prevalence rates.

- There is a lack of adequate support systems for mentally ill persons in the community.
- Released mentally ill offenders have difficulty gaining access to both community mental health treatments in general, as well as treatment that is appropriate to their specific needs. (Lamb & Bachrach, 2001, p. 1042)

Erik Roskes (1999) reports that most studies estimate that approximately 10-15% of the nearly 6 million offenders in U.S. jails, prisons, or on probation or parole are mentally ill. These estimated 600,000 to 900,000 individuals are not the relatively small group of mentally ill offenders who are adjudicated Not Guilty by Reason of Insanity under state and federal law (Roskes, 1999). Rather, they are the poorest, often homeless, socially and psychologically, educationally and vocationally, challenged individuals in our communities, who make society, in general, extremely uncomfortable.

The purposes of this study were: 1) To survey the current policies and practices regarding the treatment of mentally ill offenders in state departments of corrections across the United States; and 2) To survey the attitudes and perceptions of division directors for mental health treatment in state departments of corrections across the United States regarding those policies and practices. In a taped interview (conducted July, 2007) Kevin Pangburn, Director of the Division of Mental Health and Substance Abuse for the Kentucky Dept. of Corrections stated that he believes Kentucky is more progressive than other states with regards to treatment policies and programs for mentally ill offenders. Thus, the 3rd purpose of this study is to attempt to either confirm or contradict his claim.

Methodology

A survey was developed and sent to the list of division directors of mental/behavioral health programming who were identified based on policy and institutional data gathered from providing departments of corrections across the U.S. This survey both

assessed perceptions and attitudes of these administrators regarding their state=s policies and practices, as well as gathering related factual information.

The subjects for this research project were the 50 directors of the divisions of mental/behavioral health services for the departments of corrections for all 50 states in the Union. Identification of the subjects took place in two ways: 1) a search of the 2006 Directory for American Correctional Association; and 2) an internet search of each state=s Department of Corrections (DOC) website.

Data were collected through a mailed survey that was developed during the month of February, 2008. The original survey mailing, as well as follow-up mailings both two weeks and four weeks after the original mailing, followed up by multiple emails and phone calls, took place from March-May, 2008. Given the small population size (50 administrators), every effort was made to obtain a 100% response rate; however, we received a 50% response rate (25 administrators). This rate was considered acceptable for research purposes (Babbie, 2007), particularly since the respondents represented both

small and large correctional systems and were evenly spread across all regions of the United States.

Eighteen (72%) of the 25 survey respondents were male, seven (28%) were female. The average age of the respondents was 50.3 years (SD=7.59). Twenty-three (92%) of the respondents were White, while one (4%) respondent was Black, and one (4%) respondent did not indicate his race. Eighteen (72%) held doctorates, 6 (24%) had master=s degrees, while one (4%) had a bachelor=s degree. The respondents had served an average of 5.18 years (SD=4.74) in their current position, an average of 10.74 years (SD=7.81) in their own state DOC, and an average of 15.74 years (SD=9.45) in the field of corrections.

Responses to the surveys were submitted to a descriptive analysis, including frequencies and measures of central tendency and dispersion. Answers to open-ended questions were analyzed using content analysis. An assessment of the comparison

between Kentucky and the rest of the Nation was made as well. The analysis of the survey responses took place during the month of June, 2008.

Results

What follows are the results of a descriptive analysis of the survey responses. Included in each table are the data for the Kentucky DOC, which is highlighted because of its central importance to this study. Table 1 presents information regarding the percentages of state prison systems= inmates who have been diagnosed with a mental illness. It also includes some budgetary information. The percentages of the state prison populations who have been diagnosed with a mental illness encompass a wide range (8%-50%), but the average was 23.2% (SD = 10.6%). This average drops to 10.6% (SD=8.7%) for inmates diagnosed with a serious mental illness. Kentucky reported a much higher rate of mental illness in the prison population (30%), but a lower rate of inmates with a serious mental illness (1.8%), than the other 24 reporting states.

Table 1

Descriptive Information on Populations Served and Percent of DOC Budget Spent

Demographic	N	Mean	SD	Range	Kentucky Response
Percent of State Prison Population Diagnosed with a Mental Illness	25	23.2	10.6	8 - 50	30.0%
Percent of State Prison Population Diagnosed with a Serious Mental Illness	22	10.6	8.7	1 - 30.2	1.8%
Approximate Ratio of Psychiatrists to Inmates	19	1:1528		1:320 - 1:4000	1:2762
Approximate Ratio of Psychologists to Inmates	20	1:932		1:200 - 1:3000	1:531
Percent of State Prison Population on Psychiatric Medications	22	19.2	8.4	8 - 40	19.0%
Percent of Annual DOC Budget Spent on Mental Health Services	13	5.1	5.4	0.5 - 20	2.0%
Percent of Annual DOC Budget Spent on Psychiatric Medications	13	1.8	1.5	0.3 - 4	3.3%

The expense of treating such a large number of inmates for mental illness was substantial with respondents reporting that an average of 5.1% (SD=5.4%) of their annual

DOC budget was spent on providing mental health services, and another 1.8% (SD=1.5%) on providing psychiatric medications. This money was used to treat an average of 19.2% of the state prison populations. Kentucky reported spending 2.0% of its annual DOC budget to provide mental health services and 3.3% of its annual budget to provide psychiatric medications to slightly over 19% of its state prison population. It should be noted that there was wide variability in the budget figures reported, as is evident by the large ranges presented in Table 1.

Another area of wide variability occurred with respect to the ratios of psychiatrists and psychologists to inmates. The ratio of psychiatrists-to-inmates ranged from 1:320 to 1:4000, with an average of 1:1528 (see Table 1). The ratio of psychologists-to-inmates ranged from 1:200 to 1:3000, with an average of 1:932. Kentucky reported having a psychiatrist-to-inmate ratio of 1:2762, and a psychologist-to-inmate ratio of 1:531, with the latter ratio ranking much lower than the average ratio for the rest of the sample. It is obvious that such wide range of access to mental health professionals means that there is

a great deal of variability in the mental health services available across the state DOC systems.

Respondents were asked to report what types of services were included under the name of mental/behavioral health services in their state DOC. All 25 respondents indicated that they provide psychiatric/psycho-social rehabilitation, while 18 (72%) indicated that they also provide behavioral health services (not presented in tabular form). Sixteen (64%) DOC systems provide rehabilitation for developmental/cognitive disabilities, but only 14 (56%) provide sex offender treatment. Most disturbing is the fact that only 8 (32%) provide substance abuse treatment, even though co-morbidity of substance abuse and mental illness is a well documented, highly prevalent problem. Kentucky provides all of these services, indicating it is one of the more comprehensive state DOC mental health treatment programs in the United States.

Screening/Assessment/Classification

Survey respondents were asked a number of questions regarding their screening, assessment, and classification systems (not presented in tabular form). Most states (92%) use a standardized screening instrument for every incoming inmate (as does Kentucky DOC). Eighty percent of states, including Kentucky, use a DSM-IV-TR based form/process to diagnose inmates with mental illness. However, only 14 (56%) of reporting states have a mental/behavioral health classification for inmates with a mental illness (Kentucky DOC does not). Ten (40%) states use the Global Assessment Functioning (GAF) score, an axis of the DSM-IV-TR, when diagnosing inmates with a mental illness (Kentucky DOC does not). However, only one of these 10 states indicated that they have a cutoff score to diagnose a serious mental illness, which is 40 and below. Three states indicated that they base their diagnoses of mental illness on clinical interviews rather than any type of systematic screening and assessment process.

Respondents were asked which major diagnostic categories are included in their state=s DOC assessment of mental illness. All 25 states indicated that their assessment

processes evaluate mood, psychotic, and personality disorders, substance abuse and dependence, and suicidal history (not presented in tabular form). Most of these states (Kentucky DOC was an exception) also weigh mental retardation (23), trauma history (22), and sexual history (20), thus, the diagnostic categories included in the assessment process are very similar across state DOC systems.

Respondents were asked what types of information they include in their formal assessment of inmates for a mental illness (not presented in tabular form). All 25 states investigate the prior psychiatric histories of inmates, 24 states inquire about substance abuse history, and 24 states ask for a description of any presenting (or current) mental health problems. Twenty-two (88%) states consider an inmate=s medical history, 22 (88%) review an inmate=s criminal background during the assessment process, while 15 (60%) states utilize a case review or presentence investigation report during assessment. The Kentucky DOC uses all of the above-listed sources of information in their formal assessments except for the case review/pre-sentence investigation. Thus, there is a lot of

uniformity across the states with respect to the information included in their formal assessments for mental illness.

The assessment/evaluation process is crucial for inmates to be properly diagnosed with a mental illness and referred for treatment, which made the professional backgrounds of the persons conducting the formal assessment/evaluation of prime importance (not presented in tabular form). Only 18 (72%) states have psychiatrists performing the formal mental health assessment. More commonly, 22 (88%) states have psychologists perform the assessments. Eleven (44%) states have their counseling staff perform mental health evaluations, while eight (32%) states utilize nurses to conduct mental health assessments, and 3 (12%) states allow the case manager to perform the assessment. Finally, 7 (28%) states permit formal mental health assessments to be conducted by social workers and master=s level psychologists. Kentucky DOC only allows psychiatrists and psychologists to conduct formal mental health assessments, indicating an area where the Kentucky DOC surpasses other states.

The final set of questions respondents were asked, pertained to their state DOC screening, assessment, and classification systems asked administrators to rate the three components of evaluating mental illness on a 5-point likert rating scale ranging from very inadequate (1) to very adequate (5). The data (not presented in tabular form) indicated that respondents generally were pleased with their screening and assessment processes, as both systems received average ratings of 4.20 (SD=.866 and .577, respectively), interpreted as higher than adequate ratings. The average was slightly lower for their classification systems (M=3.86, SD=1.108), which indicated that administrators feel their systems do a good job of screening and assessing inmates for mental illness, but once mentally ill offenders are identified, there may not be a very good classification system in place to follow those offenders throughout the prison system. Kentucky DOC=s mental health administrator gave a rating of AAdequate@ (4) to each of its screening, assessment, and classification systems.

Treatment Services

Survey respondents were asked a number of questions regarding the treatment services provided by their state DOC system in order to identify which mental health professionals determine eligibility for treatment services for inmates diagnosed with a mental illness (not presented in tabular form). The largest proportion of responding states (88%) indicated that psychologists are used to make such determinations, followed by 80% of states who utilize psychiatrists. A majority (60%) of states allow counseling staff to make treatment services decisions. Possibly more problematic are the 6 states (24%) that allow nurses, and the 6 states (24%) that allow case managers, to make treatment services eligibility decisions. Kentucky DOC only allows psychiatrists and psychologists to make treatment service eligibility decisions.

Related to the questions about treatment eligibility decisions, is the question of the professional background of the person who develops the treatment plan. Large majorities of the responding states allow psychologists (88%), psychiatrists (72%), and counseling staff (72%) to develop inmate treatment plans (not presented in tabular form). However, 36%

of states allow the case manager to develop the treatment plan and another 32% utilize nurses for this. Kentucky DOC only allows psychiatrists and psychologists to develop treatment plans.

Respondents were asked to report the length of time until treatment needs are re-assessed. There was considerable variability across the states (not presented in tabular form). Exactly one-third of responding states reported that they re-assess treatment needs every 6 months, while another one-third reported that they do treatment needs re-assessments every 3 months. One state reported doing the re-assessments monthly (the positive end of the continuum), while another state (Kentucky) waits an entire year to do them (the negative end of the continuum). The most progressive states are the 5 (23.8%) that re-assess treatment needs on an individualized basis according to the particular mental health needs of the inmates.

Finally, mental health administrators were asked to identify the treatment services provided by their own state DOC system. As can be seen in Table 2, the vast majority of

systems provided crisis intervention/stabilization (100%), acute care for mental illness exacerbation (100%), individual therapy (96%; mostly for sex offender treatment), educational/psycho-educational therapy (96%), staff-lead group therapy (88%), pre-release/transitional services (88%), peer-lead drug/alcohol treatment (84%; mostly AA/NA), provisions for referral/admission to licensed community mental health facilities (84%), and peer-lead group therapy (80%). It was considerably less common for a state DOC to provide individual drug/alcohol treatment (64%).

Table 2

Treatment Services Provided by State DOC Systems (N=25)

Treatment Service	# of States Providing Service	% of States Providing Service	Kentucky Response
Crisis Intervention/Stabilization	25	100	Yes
Acute/Stabilization Care of Mental Illness Exacerbation	25	100	Yes
Individual/Specialized Therapy (e.g., Sex Offender Treatment)	24	96	Yes

Staff-Lead Group Therapy (e.g., RET, Psychodrama)	22	88	Yes
Peer-Lead Group Therapy (e.g., PPC, Therapeutic Community)	20	80	Yes
Individual Drug/Alcohol Treatment	16	64	No
Peer-Lead Drug/Alcohol Treatment (e.g., AA/NA)	21	84	Yes
Educational/Psycho-Educational Therapy	24	96	Yes
Recreational Therapy	19	76	Yes
Provisions for Referral/Admission to Licensed Community Mental Health Facilities	21	84	No
Pre-Release/Transitional Services	22	88	Yes
Other Services (Including Community Correctional Center, In-Patient/Residential Mental Health Centers within the System, Post-Release Clinical Consultation/Collaboration with Probation and Community Mental Health Providers, Telepsych Medicine, and Variety of Evidence-Based Practices such as Moral Reconation Therapy and Partners in Parenting)	7	28	YesB Telepsych Medicine

Kentucky provides all of the treatment services listed in Table 2 except individual drug/alcohol treatment and referral/admission to licensed community mental health facilities; it also offers telepsych medicine. Kentucky=s DOC combines mental health and substance abuse services into one jointly titled division suggesting that it recognizes the high co-morbidity of mental illness and substance abuse and treats them simultaneously and aggressively.

As was the case for screening/assessment/classification systems, respondents were asked to rate the adequacy of their state DOC system with respect to treatment services provided to inmates with mental illnesses (not presented in tabular form). The administrators were asked to make their ratings based on a 5-point likert scale measured as 1=Very Inadequate, 2=Inadequate, 3=Neutral, 4=Adequate, 5=Very Adequate. The average rating for the 25 states responding was 3.88 (SD=0.927), which indicates that the administrators were between Aneutral@ and Aadequate@ in their perceptions of the adequacy of their DOC in providing necessary treatment services.

Suicide Prevention

There is a high risk of suicide among inmates diagnosed with a mental illness. Table 3 presents the proportions of states utilizing various suicide prevention methods. All of the responding states use increased surveillance (100%), safety smocks/blankets (100%), and psychiatric medication (100%). A large majority of the states employ suicide screening (88%), additional staff contact (88%), specialized/designated housing (80%), strip cells (72%), safe cells (72%), and protective custody (68%). Less than half of responding states indicated that they use Aflags@ (40%), inmate companions/observers (24%), manualized counseling courses (16%), family involvement (16%), and other methods such as suicide prevention drills and tier walkers (12%).

Table 3

Methods the State DOC System Uses to Prevent Suicide (N=25)

Suicide Prevention Method	# Using Method	% Using Method	Kentucky Response
Surveillance (Suicide Watch)	25	100	Yes
Inmate Companions/Observers	6	24	Yes

Safety Smocks/Blankets	25	100	Yes
Strip Cells	18	72	Yes
Safe Cells	18	72	Yes
Protective Custody	17	68	Yes
Suicide Screening	22	88	Yes
AFlags@	10	40	No
Specialized or Designated Housing	20	80	Yes
Medication	25	100	Yes
Additional Staff Contact	22	88	Yes
Manualized Counseling Courses	4	16	Yes
Family Involvement	4	16	Yes
Other (Including Suicide Prevention Drills, Tier Walkers, Treatment Team that Develops Suicide Prevention Plan for each Inmate)	3	12	No

As a follow-up, respondents were asked to list any ways that they perceived their DOC system to be innovative or progressive with respect to methods used to prevent suicide and decompensation; the most typical response was the use of inmate companions/observers programs. The administrators also

were asked if there were any ways that they thought they could improve their efforts at preventing suicide and decompensation. The most typical responses were to start using inmate companions/observers, to designate alternate housing, and to implement constant staff training.

In the area of suicide prevention, Kentucky=s DOC is very comprehensive and cutting-edge in its approach. As can be seen in Table 3, the state uses almost all of the methods listed above including inmate companions/observers, and an inmate watcher system for actively suicidal inmates with a step-down program for support,. However, the division director for Kentucky=s DOC did suggest that making alternative housing available rather than isolating those in periods of crisis would further improve its suicide prevention program. Meanwhile, many of the other responding states indicated that they are hoping to implement a similar program in the near future.

Aftercare

It is crucial that inmates with mental illnesses receive aftercare once they have been released into the community. Eighty-four percent of responding states utilize some

kind of interagency referral process (see Table 4). However, only 24% of states provide both medication and counseling after release (average time provided = 30 days). Another 48% of responding states indicated that they provide medication only, upon an inmate=s release (average time provided = 38.6 days). That means that 28% of responding states do not provide any medication for inmates upon release, which is very troubling since decompensation is likely to occur once psychiatric medications have been stopped. One state indicated that it provides counseling only after an inmate=s release, and that only occurs while the inmate is either at the community correctional center or at the day reporting center. One state indicated that it did not offer any medication or aftercare services upon release.

Table 4

Aftercare Services Offered by State DOC Systems (N=25)

Aftercare Service	# Offering Service	% Offering Service	Kentucky Response
No Aftercare Services Offered	1	4	

Medication Only Offered After Release (Average Time Provided = 38.6 Days)	12	48	Medication Only for 30 Days
Counseling Only Offered After Release (Only while at Community Correctional Center and Day Reporting Center)	1	4	
Both Medication and Counseling Offered After Release (Average Time Provided = 30 Days)	6	24	
Interagency Referral Process Offered	21	84	Yes

A final aftercare question had to do with whether states have a civil commitment process in place for those qualified mentally ill inmates who are scheduled for release. Nineteen (76%) states indicated that they do have such a process in place. More troubling is the 24% of states that responded that they do not have such a system in place (not presented in tabular form).

Kentucky=s DOC fares quite well in the area of aftercare services. While Kentucky provides only medication for 30 days after release, it does utilize an interagency referral

process as well as case management for inmates identified as being severely mentally ill. It also has a civil commitment process for inmates scheduled for release who are in need of such a placement. When asked how he would like to see aftercare services improved in the Kentucky DOC, the division director responded that Kentucky is planning to measure outcomes of a pilot case management/trauma informed care program.

General Perceptions of Mental/Behavioral Health Services Administrators

Survey respondents were asked about their general perceptions of their own state DOC system (not presented in tabular form). Five statements were provided and respondents were asked to rate the statements on the following 5-point likert scale: 1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly Agree. In order of agreement, from high to low, the five statements were rated as follows: ATreating offenders with mental illness is one of the greatest challenges facing state DOC=s currently,@ received the highest average rating (4.65) and level of agreement. Next (average rating = 4.39) was the statement, AMy state=s DOC genuinely cares about providing effective

treatment for offenders with mental illness.@ Third (average rating = 4.04) was, AMy state DOC is progressive relative to other states regarding the treatment of offenders with mental illness.@ The next to lowest level (average rating = 4.00) was, AMy state DOC shares information with other states regarding the treatment of offenders with mental illness.@ Kentucky=s DOC administrator Aagreed@ with all of the above statements.

The lowest level of agreement (average rating = 3.04) was recorded for the statement, AMy state=s DOC receives adequate legislative support regarding the treatment of offenders with mental illness@ (not presented in tabular form). Kentucky=s DOC administrator was among those who Adisagreed@ with this statement. Thus, the administrators recognize the daunting challenge facing them in treating large proportions of their state prison population for mental illness, and feel their state DOC is committed to the challenge, but they see a need for more information-sharing across states and increased legislative support.

Finally, survey respondents were asked to list the three greatest strengths and the three greatest weaknesses of their own state DOC with respect to the treatment of offenders with mental illness. Tables 5 and 6 present the results of a content analysis of the responses.

As can be seen in Table 5, over one-third (36%) of responding states listed dedicated and competent staff as their greatest strength in treating inmates with mental illness. Twenty-eight percent of states credited good administrative (central office) support as a strength of their system. Also, having a continuum of care (24%), a good assessment/screening system (16%), re-entry services (16%), and a commitment to provide good clinical services (16%) made the top of the list as strengths of DOC systems in providing treatment to offenders with mental illnesses. As for three strengths of the Kentucky DOC, the division director listed recent legislative action, the fact that each prison offers mental health services often with more than one clinician, and having strong support from security and administrative staff.

Table 5

Mental/Behavioral Health Administrators= Responses to Question Asking Them to List the Three Greatest Strengths of their own State DOC with Respect to the Treatment of Offenders with Mental Illness (N=25)

Identified Strengths of DOC	# Listing Strength	% Listing Strength
Dedicated and Competent Staff (Including Security Staff)	9	36
Good Administrative (Central Office) Support	7	28
Continuum of Care/Services	6	24
Assessment/Screening System	4	16
Re-Entry Services	4	16
Commitment to Provide Good Clinical Services	4	16
Good Accountability System	3	12
Separate Mental Health Housing Options	3	12
Centralized Treatment Services	2	8
Good Record System	2	8
Other (Including Single Listings of: Low Suicide Rate, Good Provider-to-Inmate Ratio, Relatively Large Budget, Awareness of Need to Improve, Interagency Cooperation, Multi-disciplinary Treatment Approaches)	6	24

As presented in Table 6, having a lack of adequate staffing and resources was the key reported weakness (52%). The next most common shortcoming was having limited housing/bed space (28%), followed by a lack of post-release services (16%), a lack of continuity of care across institutions (8%), and a lack of standardized assessments (8%). The three weaknesses listed by the Kentucky DOC, were, the fact that not all facility staff in the state are as informed/supportive of mental health services as they need to be, that the division needs to do a better job partnering with the community, and that it needs to do a better job of measuring outcomes to get empirical support for what his division does.

Table 6

Mental/Behavioral Health Administrators= Responses to Question Asking Them to List the Three Greatest Weaknesses of their own State DOC with Respect to the Treatment of Offenders with Mental Illness (N=25)

Identified Weaknesses of DOC	# Listing Strength	% Listing Strength
Lack of Adequate Staffing/Resources	13	52
Limited Housing/Bed Space	7	28

Lack of Post-Release Services	4	16
Lack of Continuity of Care Across Institutions	2	8
Lack of Standardized Assessments	2	8
Other (Including Single Listings of: Absence of Organized Structure, Lack of Consistency in Staff on Mental Health Units, Community=s Unwillingness to Accept Axis II Referrals, Not all Facility Staff Informed/Supportive of Mental Health Services, Increased Suicide Rate, Poor Job of Partnering with Community, Private Prisons are of Poor Quality)	7	28

Conclusions and Discussion

It appears that, in general, the administrators recognize the challenge facing them in treating large proportions of their state prison population for mental illness, and they feel that their states= DOCs are committed to the task, but they see a need for more information-sharing across states and increased legislative support. According to these administrators, having a dedicated and competent staff, good administrative support, and a continuum of care across institutions are the three greatest strengths of their DOC systems

in treating inmates with mental illness. They listed a lack of adequate staffing and resources, limited housing/bed space, and a lack of post-release services as their three greatest weaknesses.

Some areas of concern that seem most pressing are: 1) Almost half of the responding states do not have a classification system for inmates with mental illness, making it more difficult to track, monitor, and protect them as they move throughout the system; 2) Over one-quarter of these states allow social workers and master=s level psychologists to conduct formal mental health assessments, increasing the likelihood that some offenders will fall through the cracks and not receive the treatment they need; 3) Many states wait too long before re-assessing inmates regarding their treatment needs; 4) Drug and alcohol treatment is provided on too limited of a basis given the high co-morbidity rate between mental illness and substance abuse; and 5) Not enough states take more progressive measures in preventing suicide such as using inmate

companions/observers, designating alternate housing, and implementing constant staff training.

Kentucky=s DOC appears to have an exemplary program in place for treating inmates with mental illness. It uses the most highly qualified mental health professionals to assess, diagnose, and treat offenders, and it offers a very comprehensive set of treatment services. It also has a very proactive suicide prevention program in place, as well as a fairly strong aftercare program. However, it could improve by re-assessing treatment needs more frequently.

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