Contemporary Issues in Jail Mental Health

Presented by

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Please note: This webinar does not offer Continuing Education credit.

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Contemporary Issues in Jail Mental Health

David Stephens, PsyD

At the University of the Rockies, Dr. Stephens developed an academic concentration in correctional/forensic psychology, which prepares students to work in corrections and to conduct forensic evaluations. He was the primary developer of NCCHC's executive curriculum on mental health services in jails for the National Institute of Corrections.
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Mental Health Services in Jails

• Best to think about a continuum and level of services

• Continuum and levels include consideration of facility size, budget, public health, risk management, recidivism reduction and inmate need
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Mental Health Services in Jails

Level 1: Suicide Prevention (most important)

• Applies to jails of any and all sizes
• Incorporates public health, risk management and inmate need considerations
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Mental Health Services in Jails

Level 2: Crisis Management (2nd most important)

- Not the same as suicide prevention
- Medications can be included here
- Incorporates public health, risk management, recidivism reduction and inmate need considerations
Mental Health Services in Jails

Level 3: Supportive Services (3rd most important)

- Includes responding to inmate and officer requests and referrals
- Not counseling or psychotherapy, but emotional, relational support
- Discharge planning can fall under this category
- Incorporates public health, risk management, recidivism reduction and inmate need
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Mental Health Services in Jails

*MUST have Levels 1-3 to meet constitutional AND accreditation standards*

• Regardless of facility size, some component of all of these needs to be present in order to meet constitutionally mandated elements of mental health services

• Don’t have to be elaborate services, but must have them

• To not provide them means not meeting basic inmate needs and introduces risk in the event of litigation
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Mental Health Services in Jails

Level 4: Treatment

- Includes diagnosis, a treatment plan and individual and/or group counseling or psychotherapy
- Counseling does not mean the “50-minute hour”
- Many options for providing counseling services
- Incorporates size and budget considerations (much more common for jails of 100+ ADP to provide actual counseling services as opposed to supportive services), public health, risk management, recidivism reduction and inmate need considerations
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Mental Health Services in Jails

Level 5: Special Services

• Includes “residential” or “inpatient” treatment units
• Includes “co-occurring disorders” (mental illness, substance abuse, criminality)
  – Co-occurring disorders faced by a majority of inmates
  – “Special services” only in the sense that there is not yet any requirement to provide them, but appropriate services very explicitly address COD issues
• Includes trauma
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Mental Health Services in Jails

Level 5: Special Services (cont.)

- Includes addressing more complex or complicated issues faced by inmates, such as:
  - Dementia (alcohol-induced or other)
  - Concussions
  - Autism-spectrum disorders

- Incorporates size and budget considerations (much more common for jails of 250+ ADP to provide special services as opposed to supportive and even treatment services); public health, risk management, recidivism reduction and inmate need considerations
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• QUESTION: Jail mental health is often different than community mental health in that we are told that to not refer to psychiatry or encourage mental health medications for low levels of depression, anxiety, or insomnia. Why does this difference exist?
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• QUESTION: How do jails handle the administration of involuntary psychotropic medications on a chronic basis?
  – What type of review committee/process is recommended?
  – How are hearings (including the incarcerated individual) structured?
  – How is the decision appealed?
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• QUESTION: There are many non-controlled medications that are regarded as drugs of abuse in the correctional setting. However, many are clinically indicated and sometimes the best choice. What are your thoughts on potential drugs of abuse in the correctional setting?
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Steven Helfand, PsyD, CCHP

Dr. Helfand has served in leadership roles for 20 years, including oversight of jail and juvenile mental health programs in New York City and the State of Connecticut, with responsibility for more than 300 staff members. He is a longtime instructor for the NCCHC seminar on Standards for Mental Health Services in Correctional Facilities.
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• QUESTION: How do you most effectively work with individuals with both mental health and behavioral issues that manifest in significant self-harm behaviors?
  – What do you see as best practices to prevent self-harm?
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• QUESTION: What are the most common or prominent signs and symptoms of malingering.
  – What are some less common or less prominent signs and symptoms?
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• QUESTION: In your opinion, what are current best practices for suicide prevention?
  – What about “false suicide statements”?
  – What is the role of suicide prevention step-down units?
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Nneka Jones Tapia, PsyD

As executive director of the Cook County Department of Corrections, Dr. Jones Tapia oversees one of the largest jails in the country, Cook County Jail, with more than 8,000 inmates, of whom approximately one-fourth have an identified mental illness. She is the first clinical psychologist to be appointed to such a role.
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• QUESTION: With limited space and resources at Cook County, what changes have been made with a mental health professional as executive director?

• Have there been measurable successes we can learn from?
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• QUESTION: How do you think providers remain motivated when they might feel the constant struggles of a revolving door of patients, noncompliance and perceived staffing shortages?
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• QUESTION: Upon discharge, what system is in place to ensure that patients with mental health disorders have the proper services for follow-up, and what system is in place to make sure follow-up occurs?
Where to go for help?
Where to go for help?
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Thank you!