

# Managing Mental Health Treatment Units

Kathryn Cook and Wally Campbell  
2022



**NATIONAL COMMISSION  
ON CORRECTIONAL HEALTH CARE**

# Disclosure and Disclaimer

We do not have any relevant financial relationships with any commercial interests.

- This informational presentation was developed by independent experts. The information provided in this presentation is not the official position or recommendation of NCCHC but rather expert opinion. This information is not intended to be appropriate for every clinical situation nor does it replace clinical judgment.
- NCCHC does not endorse or recommend any products or services mentioned



NATIONAL COMMISSION  
ON CORRECTIONAL HEALTH CARE

# Learning Objectives

Learning Objective 1: Explain how to ensure compliance with NCCHC standard MH-G-02 Mental Health Programs and Residential Units

Learning Objective 2: Develop practical ideas to manage common treatment and management problems encountered in correctional mental health units

Learning Objective 3: Review current research on best practices in mental health unit operations



**NATIONAL COMMISSION  
ON CORRECTIONAL HEALTH CARE**

# SMI/SPMI – SAMHSA definition

**Any mental illness (AMI)** is defined as a mental, behavioral, or emotional disorder. AMI can vary in impact, ranging from no impairment to mild, moderate, and even severe impairment (e.g., individuals with serious mental illness as defined below).

**Serious mental illness (SMI)** is defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. The burden of mental illnesses is particularly concentrated among those who experience disability due to SMI.

- <https://www.nimh.nih.gov/health/statistics/mental-illness>



**NATIONAL COMMISSION  
ON CORRECTIONAL HEALTH CARE**

# Mental Health Units - nationally

- Specialized prison mental health treatment units are recognized as an important element of overall correctional mental health services
- However, standards for development and management of MHUs are not well disseminated or understood

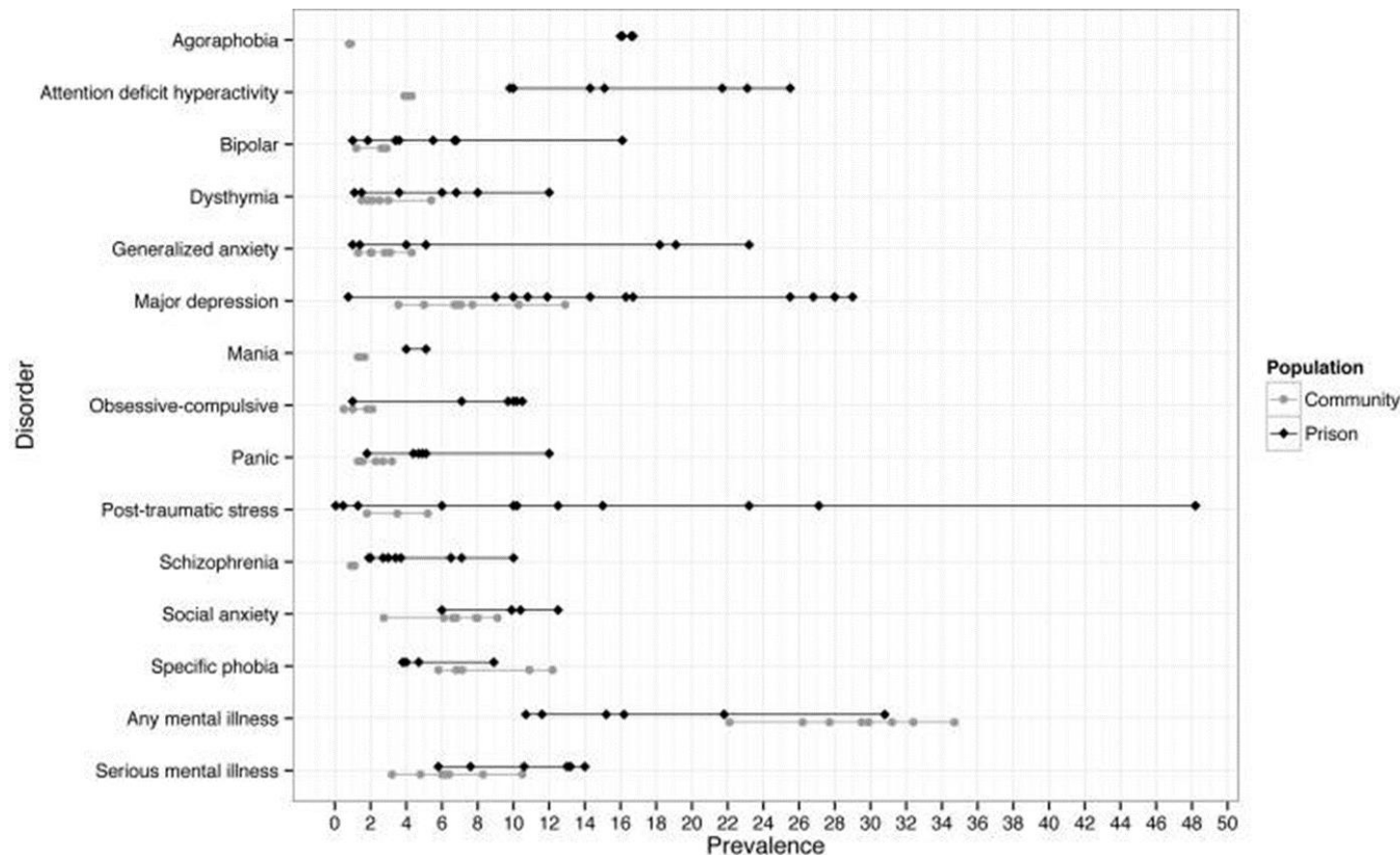
“Research has consistently shown that the prevalence of poor mental health among prisoners is considerably higher than that in the community. Mental health services in prisons cite several other vulnerabilities, such as substance misuse problems and poor physical health, and report high rates of self-harm behaviour.<sup>1</sup> In prisons, little is known about the underlying mechanisms for self-harm behaviour and research on this topic is crucial to understand more about how the problem can be addressed.”

Perry, 2020



**NATIONAL COMMISSION  
ON CORRECTIONAL HEALTH CARE**

# AMI: prison vs. community



“It is clear that community prevalence estimates tend to fall near or below the low end of the range of prison prevalence estimates, and that there is a generally a greater range in prison prevalence estimates than community estimates.”

- Prins et al., (2014)



**NATIONAL COMMISSION  
ON CORRECTIONAL HEALTH CARE**



# “OMI have criminogenic needs too”

“The results of this study are consistent with the notion that the relationship between mental illness and recidivism is largely indirect. If the goal is to reduce recidivism for OMIs, then antisocial features must be explicitly assessed, acknowledged, and targeted in correctional treatment efforts.”

- Skeem et al., 2013

*Raw Means and Differences of LS/CMI and HCR-20 Scores in Parolee Subsamples*

Measure	OMIs <i>M</i> ( <i>SD</i> )	Non-OMIs <i>M</i> ( <i>SD</i> )	Cohen's <i>d</i>	95% CI
<b>LS/CMI</b>				
Total	27.00 (5.66)	24.64 (5.93)	0.41	[−0.35, 1.17]
Criminal History	6.07 (1.05)	5.88 (1.39)	0.16	[−0.01, 0.32]
Education/Employment	6.10 (1.92)	5.44 (1.93)	0.34	[0.09, 0.60]
Family/Marital	2.59 (1.07)	2.12 (1.20)	0.42	[0.27, 0.57]
Leisure/Recreation	1.44 (0.75)	1.34 (0.81)	0.13	[0.03, 0.23]
Companions	3.41 (0.78)	3.36 (0.91)	0.06	[−0.05, 0.17]
Alcohol/Drug Problems	3.37 (2.12)	3.07 (2.10)	0.14	[−0.13, 0.42]
Procriminal Attitude Orientation	2.22 (1.26)	1.87 (1.34)	0.27	[0.10, 0.44]
Antisocial Patterns	2.46 (0.91)	1.80 (0.98)	0.70	[0.58, 0.83]
<b>HCR-20</b>				
Total unique	8.18 (2.27)	1.02 (2.06)	3.32	[3.03, 3.60]
Total general	26.61 (4.84)	23.81 (5.44)	0.55	[−0.13, 1.22]
Total combined	29.94 (4.85)	22.28 (5.45)	1.49	[0.82, 2.17]
Historical combined	16.36 (2.10)	13.22 (2.88)	1.25	[0.92, 1.58]
Clinical combined	6.93 (1.96)	4.06 (1.85)	1.51	[1.26, 1.76]
Risk combined	6.65 (2.03)	5.00 (1.72)	0.88	[0.63, 1.13]

*Note.* LS/CMI = Level of Service/Case Management Inventory; HCR-20 = Historical-Clinical-Risk Management-20; OMIs = parolees with mental illness, including early outpatient program parolees and community correctional case management parolees; non-OMIs = parolees without mental illness.



**NATIONAL COMMISSION  
ON CORRECTIONAL HEALTH CARE**

- Statistics from NIC re: inmates with mental illness
  - The US Department of Justice (DOJ) in 2006 found that “an estimated 10% of state prisoners . . . Reported symptoms that met criteria for a psychotic disorder.”
  - Reed & Lyne (2000) – Britain; 75% of inpatient inmates admitted to healthcare centers also have mental health problems





# Barriers to MH Treatment in Corrections

Significant numbers of inmates who reported mental health symptoms are not being treated, leading to higher rates of recidivism and increased healthcare costs

- a) Correctional healthcare staff “in short supply”
- b) “...the continuously declining correctional budget may limit treatment access to those with only the most serious mental health conditions.”

Gonzalez & McConnell, 2014



**NATIONAL COMMISSION  
ON CORRECTIONAL HEALTH CARE**

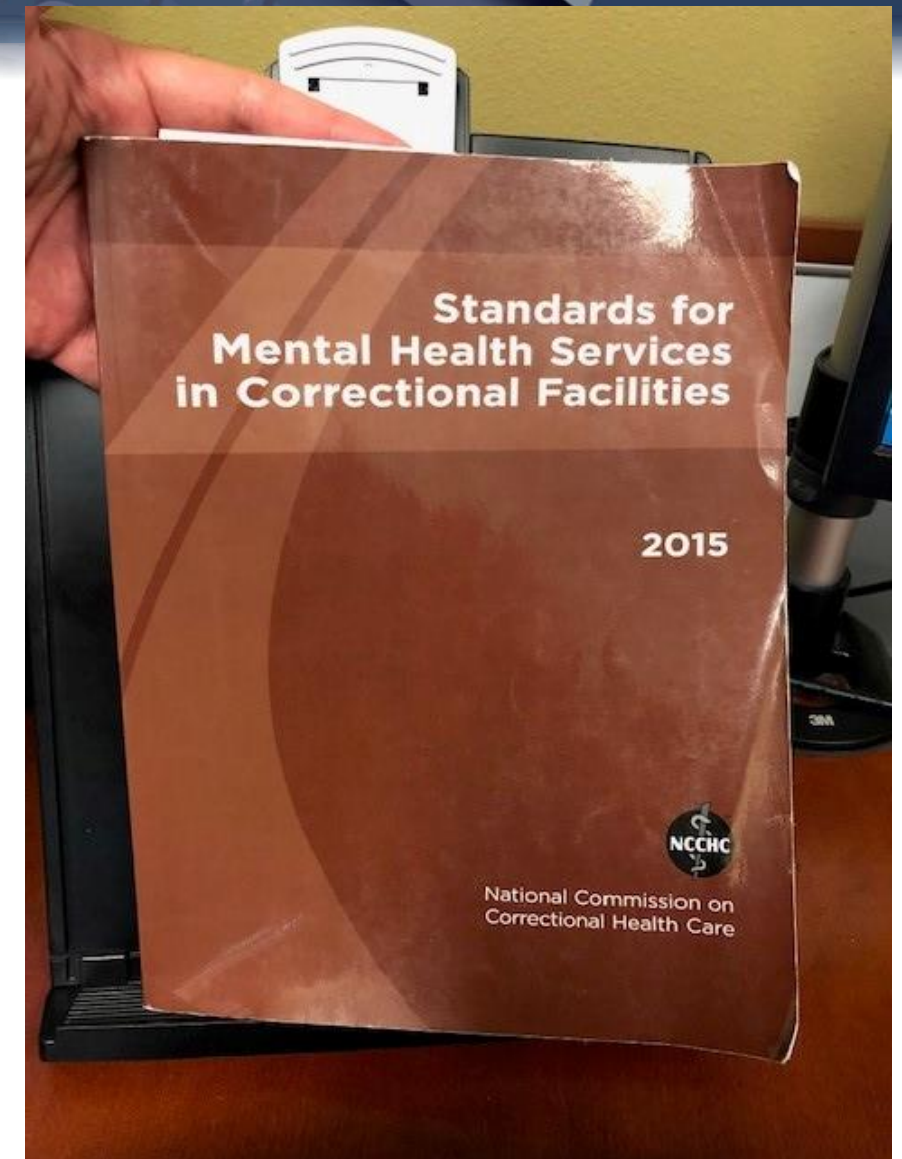
## Barriers, pt 2 (Gonzalez & McConnell, 2014)

- a) Experience of incarceration itself (crowded living quarters, limited supervision, solitary confinement, risk of victimization) exacerbates symptoms
- b) Logistical needs – need for special housing & specialized treatment equipment / staffing not always possible or available
- c) MH symptoms are dynamic, changing across locations with different triggers and with different staffing; more outward symptoms tend to be treated with pharmacotherapy when other internal symptoms (sadness about incarceration, lethargy, lack of motivation) are almost expected from a correctional population & “may not be cause for alarm among prison staff”



# NCCHC standard MH-G-02

- Mental Health Programs and Residential Units
- At a minimum:
  - Defined Goals
  - Mental health staff in sufficient numbers and kind in keeping with the program purposes
  - Individual treatment plans
  - Protocols for patient follow up at least every 60 days



**NATIONAL COMMISSION  
ON CORRECTIONAL HEALTH CARE**

# MH-G-02

- ACUTE units: “Safe and Therapeutic Environment”
  - Staffing should be sufficient to enable each resident to have daily contacts with QMHP
  - Psych meds should be available
  - Staffing plan should include # of patients, severity of illness, and staffing #
  - Patients should have increased monitoring, individual and group therapy, and psychosocial activities
  - Environment should be clean, safe, and adequate for their needs
  - Custody staff gets training on de-escalation and tx team participation



**NATIONAL COMMISSION  
ON CORRECTIONAL HEALTH CARE**

# MH-G-02

- Nonacute MH units
  - Patients should receive MH programming and supervision but less than acute
  - Weekly MH staff case conferences to review patient progress, coordinate services and propose modifications to treatment
  - Custody receives special training to be active contributors to the unit's therapeutic goals
  - Treatment goals should be documented and focused on reducing or stabilizing symptoms, attaining appropriate functioning, preventing relapse, and supporting patients in developing prosocial & effective coping skills



**NATIONAL COMMISSION  
ON CORRECTIONAL HEALTH CARE**

## II. Types of Disorders Requiring Specialized Units

- A. Low Functioning – autism spectrum disorders, intellectual or learning disabilities, traumatic brain injuries – risk of victimization, assistance with social skills
- B. Cognitive Decline – cognitive disorders, dementia – risk of victimization, need for assistance as mental & physical status declines





- Serious Mental Illness – major depressive disorders, bipolar disorders, schizophrenia & psychotic disorders – risk of victimization, inability to maintain treatment compliance (cycle of compliance), need for more intensive treatment services
- Co-Occurring Disorders – mental health & substance use disorders – risk of victimization & relapse, negative stereotypes from inmates & staff



## Some other standards to remember:

- Continuous Quality Improvement
  - (P-A-06)
- Review of suicide and “near misses”
  - (P-A-09)
- Training for security/correctional staff
  - (P-C-04)
- Staff safety (P-B-09)



**NATIONAL COMMISSION  
ON CORRECTIONAL HEALTH CARE**

# Criteria for Admission to Specialized Units

- A. Diagnosis of Mental Disorder – clinical evaluation, psychological testing
- B. Evidence of Inability to Function – more trips to confinement/SHU, disciplinary reports, verbal counseling by prison staff, documented concerns by staff, bizarre/aggressive behaviors



# Personality Disorders and MHU admissions

- Personality Disorders (especially Cluster B) poses special challenges to MHU admission decisions, especially:
  - Antisocial Personality Disorder
  - Borderline Personality Disorder
- Assessing functional impairment and treatment need:
  - *“Does one give precedence to a blow to the individual’s self-esteem (narcissism), or to a suspiciousness of the motives of others (paranoid traits), his or her substance abuse or the activation of PTSD symptoms in explaining his or her violent behaviour?” (Howard, 2015)*



# Staffing in Specialized Units

- A. Policies for those units (for healthcare & non-healthcare staff)
- B. Training for staff to work in those units
- C. Resources Available to manage treatment concerns, burnout, continued training, etc.
- D. Reed & Lyne (2000) – Britain; “...caring professionals who were trying under difficult circumstances to do their best to help their patients.”



# Treatment in Specialized Units

- A. Policies to dictate purpose of unit?
- B. Research-based services and promotion of coping skill development
- C. Schedule to allow all services to be implemented
- D. Treatment team meetings to discuss treatment progress, changes, possible discharge from units



**NATIONAL COMMISSION  
ON CORRECTIONAL HEALTH CARE**



# Specialized MHU challenges (1)

- A. Staffing Issues - shortages
- B. Funding & Budget Cuts
- C. MH Behaviors & Symptoms Disrupting the Unit
  - uses of force
  - contraband on the units
  - incidents in clinical services
  - conflict between patients / members of the treatment team



# Specialized MHU challenges (2)

D. Security Concerns / Needs – safety first

E. Lack of Transition – not appropriate resources to continue the level of treatment needed upon release from prison/jail

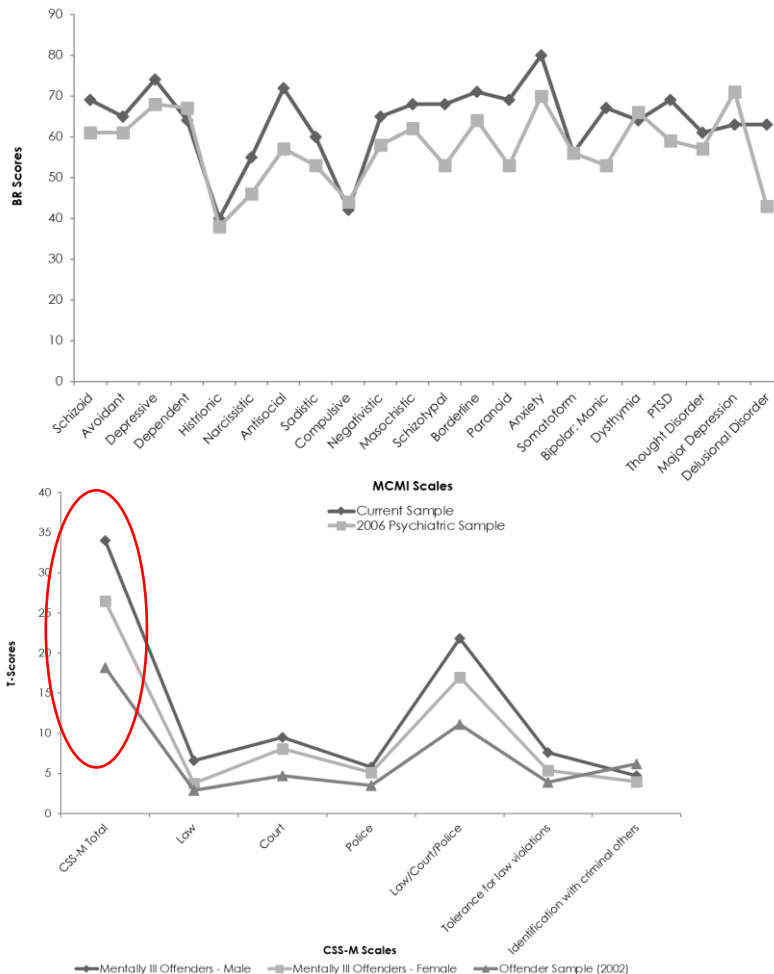
F. USA; lack of specialized housing & community resources prevented long-term success of specialized treatment programs

- Peters, LeVasseur, & Chandler (2004)



**NATIONAL COMMISSION  
ON CORRECTIONAL HEALTH CARE**

# Serious mental illness and criminal thinking - Morgan et al, 2010



- Serious mental illness and criminal risk factors are NOT mutually exclusive

“the results of this study indicated that mentally ill inmates presented with severe mental illness and psychiatric symptomatology comparable to that of non-inmate psychiatric populations as well as criminal thinking comparable to non-mentally ill inmates”

“The results of this study demonstrated that mentally disordered offenders in state correctional facilities are both mentally ill psychiatric patients and criminals. Thus, treatment providers must consider co-occurring issues of mental illness and criminality.”



**NATIONAL COMMISSION  
ON CORRECTIONAL HEALTH CARE**

# Criminal risk factors

- Andrews and Bonta (2016) – risk factors for criminal recidivism.
- Mental Health is NOT a predictive risk factor for criminal behavior
- Many MHU residents also have high criminal risk factors

## The Big Eight risk factors

History of antisocial behavior

Family/Marital Circumstances

Antisocial Personality Pattern

School/Work

Antisocial Cognition

Leisure/Recreation

Antisocial Associates

Substance Abuse



**NATIONAL COMMISSION  
ON CORRECTIONAL HEALTH CARE**

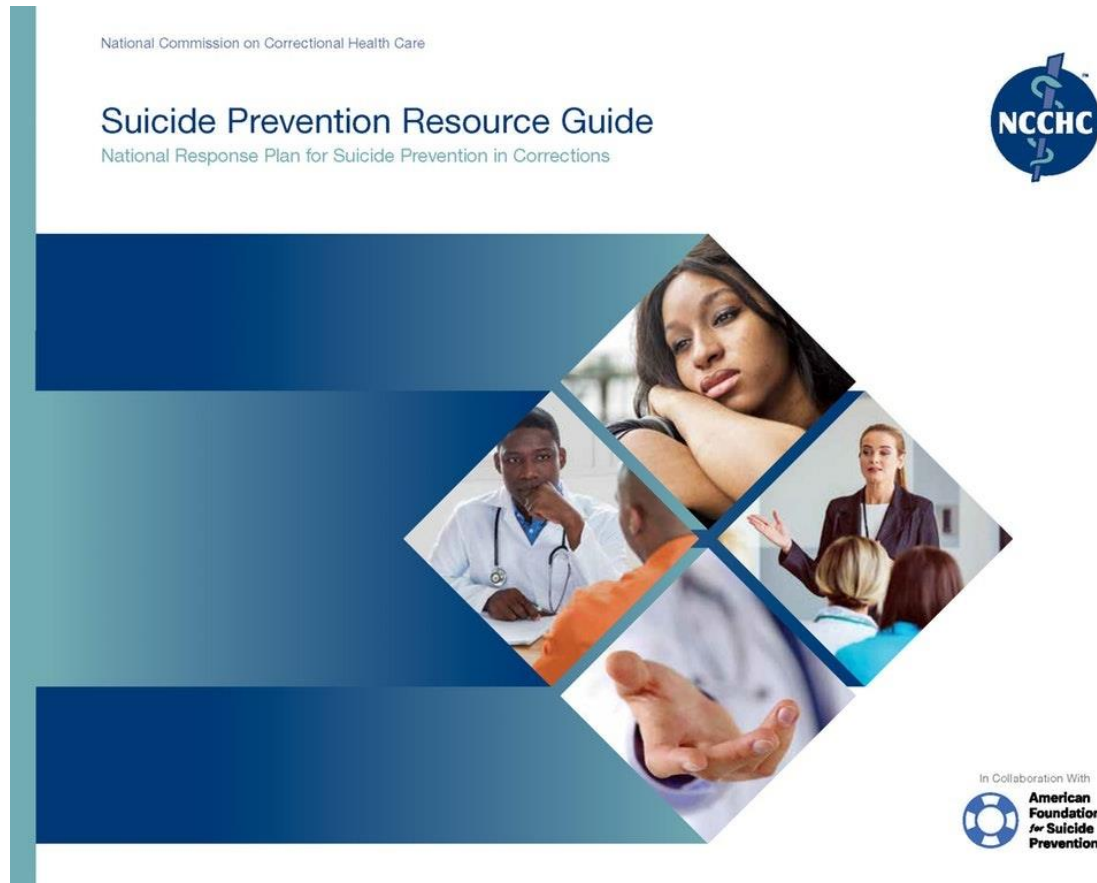
# MHU Suicide Prevention

1. Understand and implement NCCHC standards on suicide prevention
2. Understand suicide RISK FACTORS
3. Understand SUICIDE WARNING SIGNS
4. TRAIN non-clinical staff working in MHU's on suicide prevention
5. Ensure COMMUNICATION between clinical and security staff
6. Consider PEER MENTORING and SUPPORT programs



NATIONAL COMMISSION  
ON CORRECTIONAL HEALTH CARE

# NCCHC Suicide Prevention Resource Guide



A best practice guide to suicide prevention in corrections.

Not an accreditation standard, but a guide



**NATIONAL COMMISSION  
ON CORRECTIONAL HEALTH CARE**



# MHU management of NSSI

- “nonsuicidal self injury”
- Experience is that self harm is not uncommon with MHU residents
- “Self-harm was not associated with any specific psychosocial characteristics, but the predominant functions of NSSI in forensic psychiatric patients—**affect regulation, self-punishment, and distress signaling**—indicate that this group of vulnerable and exposed individuals may express their distress in a self-destructive manner.”



NATIONAL COMMISSION  
ON CORRECTIONAL HEALTH CARE

# Cognitive Impairment and Age-Related Decline

- Prisons face increasing numbers of cognitive impairment
- Multidisciplinary efforts between medical and mental health
- Traditional psychotherapeutic treatments tend to be ineffective
- Dementia care training important!



**NATIONAL COMMISSION  
ON CORRECTIONAL HEALTH CARE**

# Trauma informed care

- Prevalence of trauma
- Staff training
- MH interventions
- Interaction of trauma history and violent behavior

## 6 GUIDING PRINCIPLES TO A TRAUMA-INFORMED APPROACH

The CDC's [Office of Public Health Preparedness and Response \(OPHPR\)](#), in collaboration with SAMHSA's [National Center for Trauma-Informed Care \(NCTIC\)](#), developed and led a new training for OPHPR employees about the role of trauma-informed care during public health emergencies. The training aimed to increase responder awareness of the impact that trauma can have in the communities where they work. Participants learned SAMHSA'S six principles that guide a trauma-informed approach, including:



Adopting a trauma-informed approach is not accomplished through any single particular technique or checklist. It requires constant attention, caring awareness, sensitivity, and possibly a cultural change at an organizational level. On-going internal organizational assessment and quality improvement, as well as engagement with community stakeholders, will help to imbed this approach which can be augmented with organizational development and practice improvement. The training provided by [OPHPR](#) and [NCTIC](#) was the first step for CDC to view emergency preparedness and response through a trauma-informed lens.



**NATIONAL COMMISSION  
ON CORRECTIONAL HEALTH CARE**

# What Impact Do ACEs Have?

As the number of ACEs increases, so does the risk of negative health outcomes



Possible Risk Outcomes:

## BEHAVIOR



## PHYSICAL & MENTAL HEALTH



## Trauma and behavior

### It's not all about PTSD....

“I have come away from these experiences with the conviction that the best starting hypothesis in dealing with most killers is that they are ‘untreated traumatized children inhabiting and controlling the dangerous adolescents and adults that stand accused of murder.’ Approximately only 0.01% of Americans (1 in 1000) report an ACEs score of 8, 9, or 10. The scores reported by the last 10 killers I interviewed had an average score of 8.”

-Gabardino, 2016



**NATIONAL COMMISSION**  
ON CORRECTIONAL HEALTH CARE

# Adverse Childhood Events (ACEs)

## Individual and Family Risk Factors

- Families experiencing caregiving challenges related to children with special needs (for example, disabilities, mental health issues, chronic physical illnesses)
- Children and youth who don't feel close to their parents/caregivers and feel like they can't talk to them about their feelings
- Youth who start dating early or engaging in sexual activity early
- Children and youth with few or no friends or with friends who engage in aggressive or delinquent behavior
- Families with caregivers who have a limited understanding of children's needs or development
- Families with caregivers who were abused or neglected as children
- Families with young caregivers or single parents
- Families with low income
- Families with adults with low levels of education
- Families experiencing high levels of parenting stress or economic stress
- Families with caregivers who use spanking and other forms of corporal punishment for discipline
- Families with inconsistent discipline and/or low levels of parental monitoring and supervision
- Families that are isolated from and not connected to other people (extended family, friends, neighbors)
- Families with high conflict and negative communication styles
- Families with attitudes accepting of or justifying violence or aggression

CDC:

“ACEs are potentially traumatic experiences, such as neglect, experiencing or witnessing violence, and having a family member attempt or die by suicide, that occur in childhood (birth to 17) that can affect children for years and impact their life opportunities.”



**NATIONAL COMMISSION**  
ON CORRECTIONAL HEALTH CARE



# Adverse Childhood Events (ACEs)

## Community Risk Factors

- Communities with high rates of violence and crime
- Communities with high rates of poverty and limited educational and economic opportunities
- Communities with high unemployment rates
- Communities with easy access to drugs and alcohol
- Communities where neighbors don't know or look out for each other and there is low community involvement among residents
- Communities with few community activities for young people
- Communities with unstable housing and where residents move frequently
- Communities where families frequently experience food insecurity
- Communities with high levels of social and environmental disorder



**NATIONAL COMMISSION  
ON CORRECTIONAL HEALTH CARE**



# Clinical Supervision

- Many MHPs are not well trained in:
  - Working with an SMI population
  - Working in a correctional environment
  - Understanding criminal risk factors



**NATIONAL COMMISSION  
ON CORRECTIONAL HEALTH CARE**

# Closing / Discussion – Ongoing needs

- Continued Discussion for standards and implementation of Specialized Units
- More Out-of-the-Box Thinking to improve quality of clinical services provided
- Ongoing communication between all levels of management for problem-solving and sharing of creative ideas



**NATIONAL COMMISSION  
ON CORRECTIONAL HEALTH CARE**

# References

- Bonta, J., & Andrews, D.A. (2016). *The Psychology of Criminal Conduct* (6th ed.). Routledge. <https://doi.org/10.4324/9781315677187>
- Cohen, T R. Mujica, C A. Gardner, M E. Hwang, & Karmacharya, R (2020) Mental Health Units in Correctional Facilities in the United States. *Harvard Review of Psychiatry*: 7/8(28). doi: 10.1097/HRP.0000000000000267
- Garbarino, J. (2015). Listening to killers. In *Listening to Killers*. University of California Press.
- Howard, R. Personality disorders and violence: what is the link?. *border personal disord emot dysregul* 2, 12 (2015). <https://doi.org/10.1186/s40479-015-0033-x>
- Laporte, N., Ozolins, A., Westling, S., Westrin, Å., & Wallinius, M. (2021). Clinical characteristics and self-harm in forensic psychiatric patients. *Frontiers in psychiatry*, 1277.
- Morgan RD, Fisher WH, Duan N, Mandracchia JT, Murray D. (2010) Prevalence of criminal thinking among state prison inmates with serious mental illness. *Law and Human Behavior*. Aug;34(4):324-36. doi: 10.1007/s10979-009-9182-z
- Reingle Gonzalez, J.M., Connell, N.M. (2014) "Mental Health of Prisoners: Identifying Barriers to Mental Health Treatment and Medication Continuity", *American Journal of Public Health*. 104,12 (2014): 2328-33. doi:10.2105/AJPH.2014.302043.
- Peters RH, LeVasseur ME, Chandler RK. (2004) Correctional treatment for co-occurring disorders: results of a national survey. *Behavioral Sciences and the Law*. 22(4):563-84. doi: 10.1002/bsl.607.
- Perry, A. E. (2020). Self-harm in prisons: what do we know and how can we move forwards?. *The Lancet Psychiatry*, 7(8), 649-650.
- Prins, S. J. (2014). Prevalence of mental illnesses in US State prisons: a systematic review. *Psychiatric services*, 65(7), 862–872. <https://doi.org/10.1176/appi.ps.201300166>
- Skeem JL, Winter E, Kennealy PJ, Loudon JE, Tatar JR 2<sup>nd</sup> (2013) Offenders with mental illness have criminogenic needs, too: toward recidivism reduction. *Law and Human Behavior*. 38(3):212-24. doi: 10.1037/lhb0000054.



**NATIONAL COMMISSION**  
ON CORRECTIONAL HEALTH CARE