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Exploring the Inadequacies of the Imprisoned Mentally Ill: Barriers to Sufficient Care

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Abstract

There is an epidemic of concern and little advancement regarding adequate medical management surrounding treatment of mental illness in densely populated prison system within the United States. Proper psychiatric care is hindered by an insufficient number of providers and resources, inadequacy in funding, poor compliance/ follow-up, failure to adequately treat, as well as a lack of patient insight and sought out treatment. Nearly half-million prisoners were housed in American prisons in 2012 (NAMI, 2015). The care delivered to the incarcerated is sub par and the resources provided are often inadequate to parallel their illness paradigm. Without more appropriate allocation of funding and institution of an improved mental health reform program, society is indirectly adding to the epidemic of reoffending and the breeding of chronic mental illness/instability in an already saturated prison system continues. We have established that at a minimum, 30% of the mentally ill encounter and occupy the criminal justice system and more than 20% suffer from severe psychosis. Also, each year, more than 2 million people with a serious mental illness are booked and retained into the prison system, and of those, only half are treated (Gilliberti, 2015). According to The Treatment Advocacy Center, 2010, mentally ill persons stay imprisoned longer, have a higher recidivism, increased risk of suicide, are more susceptible to abuse within the prison system, and are much more difficult to manage than prisoners devoid of such diagnoses. Insufficient funding and poorly allocated resources provided to the incarcerated mentally ill reveal ignorance in the ideology surrounding mental illness and its best practice. Medical adjuncts inclusive of pharmacological and psychotherapeutic services prove vital to mental health stability and overall wellness of incarcerated individuals. With the significant increase in prison populations, many facilities overcapacity, mental illness saturating prison systems, the economic burden on taxpayers, and subpar treatment resolve has led to many

areas of concern. One of which is inadequacies in the psychiatric treatment leading to worsening mental illness, increased prison violence, improper management of individuals with SMI, and reduced accountability. A search to obtain relevant material was conducted through the University of North Dakota Harley E. French Library of the Health Sciences using five databases, including PsychInfo, CINAHL, PubMed, Cochrane Library, and Clinical Key focusing on literature from 2006-2015. The search included data of imprisoned persons with mental health illness, prevalence, resources provided to the incarcerated and their transition struggles post-imprisonment. Barriers expected include lack of mental health knowledge, stigma, funding, and available resources. Findings were presented to fellow psychiatric mental health students as an Independent Study project. With supporting evidence, this writer will attempt to demonstrate that research indicates that with the implementation of improved mental health services to the incarcerated population, recidivism rates decrease and the chronically ill patients can be stabilized.

Exploring the Inadequacies of the Imprisoned Mentally Ill: Barriers to Sufficient Care

With awareness of effective mental health care services and interventions for the incarcerated mentally ill population, effective practice implementation may facilitate improved screening and assessment, psychopharmacology, suicide prevention services, and case management options for managing prison mental health services (Hills, Siegfried & Ickowitz, 2004). With the coordination and initiation of enhanced care, more patient-centered therapies, and increased knowledge of mental illness and its correlation to crime and recidivism, a direct link to policy change may be proposed to increase care and reduce recidivism. The financial burden placed on taxpayers to provide physician services, enhanced security and medication regimens was twice that of an imprisoned individual without mental illness, according to Shelton, 2015. It is estimated that 15% to 24% of prisoners who reside in U.S. prison systems have severe mental illness resulting in the need for mental health care. Nearly 25% of all persons incarcerated require some form of intensive care; such as medication administration and management, transportation to mental health visits, or further facilitation of group/individual psychotherapy adjuncts to function appropriately.

Purpose

The purpose of this project is to explore the challenges in providing mental health care to incarcerated individuals. Efforts made to bridge barriers could improve rates of re-offense, suicide, and provide a loftier transition back into the general public post-imprisonment. Also, to explore the potential barriers that may contribute to poor access or management of the incarcerated mentally ill; furthermore, how this has the potential to affect their treatment and potentiate a possible mental relapse negatively. Identifying the barriers will, not only, increase awareness and negotiation regarding policy changes that would target the initiation of change

and improve quality care to those imprisoned, cultivate community programs to increase pursuit of care, increase protective factors shown to decrease criminality, and furthermore, reduce the number of re-offense rate among the mentally ill. With 95% of all prisoners returning to the community, providing holistic mental health services to offenders in prison contributes to the community's health and safety (Wilkinson, 2000).

The difficulty in providing enhanced care within the prison systems has to do with funding and lack of it. The resources that could be provided to engage further and strengthen the probability of stabilization for these patients is nowhere near what it could be; without pharmacological and therapy adjuncts we are not only deprecating this population of adequate illness care but also, potentially worsening their mental health wellness.

The result of this research project will be presented to fellow psychiatric mental health nurse practitioner students to increase the knowledge surrounding healthcare treatment, or lack thereof; that is provided to the mentally ill incarcerated. With enhanced awareness, the adaptation of treatment regimens, management of inmate behavior & symptoms, and implementation of mental health treatment, there can be a positive influence among those incarcerated individuals. By recognizing mental illness upon prison entry, evaluating and treating them, and enhancing treatment with psychotherapy adjuncts; there may be a reduction in recidivism and relapse related to mental illness.

Significance

The astonishing increase in the number of imprisoned persons suffering from a mental health diagnosis is on the rise, and the already saturated criminal justice systems are inundated with re-offenders and prisoners new and existing to their facilities. The significance in recidivism among the mentally ill is unprecedented. According to the Bureau of Justice, 2013; four of every

ten inmates released from prison are re-incarcerated within three years. Furthermore, among those who were repeat offenders, 47% were violent recidivists compared to 39% without a mental problem (James & Glaze, 2006).

By examining the opposition between incarceration and treatment, we may be able to detect and dissect the variability in policy, harm reduction, stigma, treatment options, compliance, recidivism, and community outreach alternatives. By finding the key to quality prevention and its link to alternative treatment options for the mentally ill, we may be able to decrease criminality of these individuals and lower incidence of imprisonment; thereby decreasing economic strain and enhancing more optimal treatment options.

Shelton, 2015, expresses "prison is the new mental hospital." She explains that an "estimated 450,000 people with a recent history of mental illness are incarcerated in jails and prisons." She further illustrates how "criminalizing mental illness is costly, inhumane, and counterproductive." According to experts, the finances used to incarcerate these individuals could be better utilized assisting them to get mental health and additional community services to improve their mental health.

According to an article published by the United States Department of Justice & National Institute of Corrections, 2004, the substantial influx of individuals with mental illness into the prison system is likely due to the following factors: The closing or downsizing of state psychiatric hospitals; lack of an adequate range of community support programs for people with serious mental disorders and the chronic underfunding of public services; restrictive insurance and managed care policies that curtail access to more intensive services; poverty and transient lifestyles of many individuals with serious mental illness, which bring them into contact with the

police; and the likelihood that adults with a severe mental illness have a co-occurring substance abuse disorder, (Sundram, 1999).

Further exploration of community-based psychiatric facilities may significantly impact the mental health community by offering services to provide these individuals with provider services, medication therapy, psychotherapy adjuncts, counseling services, and housing opportunities. Socioeconomic status has important associations with disease-specific diagnoses and mortality in the general population and provides either protective or risk factors for an increase in crime, substance abuse, imprisonment, and psychiatric illness.

Theoretical Framework

In attempts to explain the occurrence of violent incidents within prisons, violence directed at correctional staff members, and violence directed from inmate to inmate, Jiang & Fisher-Giorlando, 2002), conducted research to examine the effectiveness of three models (deprivation, importation, and situational). As incarceration rates continue to rise to an unprecedented level, exploration of one's adjustment to confinement continues to be a topic of great interest. Examining the behavior of inmates reflects their adaptation and adjustment to imprisonment and this article survey several reasons why the monitoring of effective social control is crucial. First, misconduct among inmates reflects their adjustment to prison, and by measuring disciplinary infraction numbers, a direct correlation may be made. Second, from a safety standpoint, measuring the number of disciplinary infractions directly affects prison order and could pose a threat to the security of prisons, correctional staff, and other inmates (Goetting & Howsen, 1986; O' Donnell & Edgar, 1999; Patrick, 1998). Thirdly, numbers of disciplinary infractions are closely related to prison classification and are, furthermore, essential to adequately reclassify inmates within prisons. Fourth, from an economic perspective, discipline

within prisons is necessary and, on average, costs upwards of \$970 per infraction (at a medium-security prison), according to (Lovell & Jemelka, 1996). Lastly, noting the detrimental physical and emotional stress that a high number of disciplinary infractions can have for inmates, correctional staff, and their families.

The article, within *The Prison Journal*, titled 'Inmate Misconduct: A Test of the Deprivation, Importation, and Situational models' focused on three explanations of prison adjustment to dissect and further explain inmate misconduct. The deprivation model emphasizes the effects of deprivation and its relation to one's prison adjustment. The importation model focuses on the effects that pre-prison contributions have on one's prison adjustment. The situational model emphasizes the varying effects that situational factors have on one's prison adjustment. The other purpose, aside from explaining the behaviors and misconduct within a prison system, was to study the individual variables on inmate infractions. These models utilized three dependent variables to explain inmate misconduct: 1) Violent versus nonviolent misconduct, 2) misconduct among staff, and 3) misconduct among other inmates.

The first of three models, the deprivation model, has several characteristics that make it significant with regard to how prisoners adjust to their confinement. According to this model, prison is a whole institution completely cut off from the free world (Goffman, 1961) and how this confined environment encourages the process of prisonization through adaptation to the losses or "pains of imprisonment" (Sykes, 1958; Sykes & Messinger, 1960). The pains of imprisonment, according to Sykes, include deprivation of liberty, goods and services, heterosexual relationships, autonomy, and security and examines how adjustment variability among inmates forms an inmate subculture that opposes that of correctional administration. Some of the oppositions noted were negative attitudes, values, and self-concepts, which then lead

to aggression among prisoners, authority resistance, lateral inmate violence, and violation of other prison rules.

In contrast, the importation model focuses on the pre-prison influence of character and experience and debates that “inmates own distinctive traits and social backgrounds largely determine their behavior in prison” (Irwin, 1981; Irwin & Cressey, 1962). Also arguing that “not all inmates universally experience pains and deprivation of imprisonment” (Bonta & Gendreau, 1990; Bukstel & Kilmann, 1980) and that their adaptation ability is solely dependent on the individual’s ability to find a niche in prison. The importation model also discusses how “prison should be viewed as a ‘somewhat-less-than-total’ institution” (Farrington, 1992; Jacobs, 1976). Finally, it argues that “inmates are not a solitary group and are comprised of differing subgroups with different belief systems and norms” (Carroll, 1974; Irwin & Cressey, 1962; Jacobs, 1974, 1976, 1977; Paterline & Peterson, 1999; Toch & Adams, 1986; Wooldredge, 1991).

Finally, the situational model, suggests that the sources of origin and direction of an inmate's behavior come primarily from situational factors such as season of the year, location, the interplay between inmates & officers, and the surroundings in which these interactions occur. The situational model directly critiques the importation model for negating the important situational elements that are seen as critical. The model considers the ‘where, when, and with whom’ questions when formulating why a behavior occurred and provided the example of increased prisoner violence & rule infractions in summer versus winter months solely based on variations in temperature; regardless of their personal background or relative deprivation variability.

Definitions

Incarcerated- To imprison, confine, enclose or constrict closely

Segregation- The act or practice of segregating; setting apart or separation of people or things from others or the main body or group

Disciplinary segregation- The placement of an inmate in a segregated area as a form of separation from the general population for a specified period; for inmates who have committed serious violations of prison rules

Administrative detention- A form of separation from general population used when the presence of an individual poses a serious threat to the security of the institution

Suicide- The act of killing yourself on purpose, dying at your hand

Drug abuse- Improper or excessive use of any substance that makes a change in your body

Recidivism- Going back to a previous behavior, especially criminal behavior

Criminalization- The act of making something illegal, or making it against the law

Chronic psychiatric problem- Diagnosis of a significant behavioral or mental pattern that may cause suffering or poor ability to function in life; the impairment of a prolonged mental illness for an indefinite period

Institutionalize- To make institutional, to place or confine in an institution, especially one for the care of mental illness, alcoholism, etc.

Deinstitutionalize- To release (a person with mental or physical disabilities) from a hospital, asylum, home, or other institution with the intention of providing treatment, support, or rehabilitation primarily through community resources under the supervision of health care professionals or facilities.

Solitary Confinement- The confinement of a prisoner in a cell or other place in which he or she is completely isolated from others

Corrections- Anything built or serving to bar passage, as a railing, fence, or the like; anything that restrains or obstructs progress, access, etc

Barrier- Anything built or serving to bar passage, as a railing, fence, or the like; any natural bar or obstacle

Integration- The act or instance of combining into an integral whole; such as society

MDD (Major Depressive Disorder)- Also known simply as depression; a mental disorder characterized by at least two weeks of low mood that is present across most situations. Often accompanied by low self-esteem, loss of interest in usually enjoyable activities, low energy, and pain without an apparent cause

PTSD (Post Traumatic Stress Disorder)- A disorder that develops in some people who have experienced a shocking, scary, or dangerous event

OCD (Obsessive Compulsive Disorder)- A common, chronic, and long-lasting disorder in which a person has uncontrollable, reoccurring thoughts (obsessions) and behaviors (compulsions) that he or she feels the urge to repeat over and over

GAD (Generalized Anxiety Disorder)- A common, persistent, excessive fear or worry in situations that are not threatening.

Local Jail- A secure facility operated by a county or a city government that houses three main types of inmates: 1) people who have been arrested and are being held pending a plea agreement, trial, or sentencing, 2) people who have been convicted of a misdemeanor criminal offense and are serving a sentence of (typically) less than 1 year, and 3) people who have been sentenced to prison and are about to be transferred to another facility.

State Prison- A prison operated and maintained by a state that is utilized to confine and rehabilitate felons.

Minimum security – A prison in which prisoners are allowed more freedom than in most other prisons; not considered dangerous or likely to escape

Maximum security- Secure sanction within a state prison reserved for criminals who have committed a violent crime such as homicide; and watched closely

Federal Prison (Penitentiary) – A public institution in which offenders are confined for detention or punishment operated by the federal government; for reformation of convicted felons

Deinstitutionalize- To release (a person with mental or physical disabilities) from a hospital, asylum, home, or other institution with the intention of providing treatment, support, or rehabilitation primarily through community resources under the supervision of health-care professionals or facilities.

Serious Mental Illness (SMI)- Illness that include disorders that produce psychotic symptoms, such as schizophrenia and schizoaffective disorder, and severe forms of other disorders, such as major depression and bipolar disorder; often defined by its length of duration and the disability it produces.

Decarceration- Decreasing the number of persons in prisons and jails

ACT (Assertive Community Treatment)- A well- established and effective means of assisting people in their recovery with the goal to reduce their placement in the State Hospital, jail or contact with the police by 75%; reduce emergency room visits and psychological inpatient admissions by 75%; and to increase their housing stability by 75%.

FACT (Forensic Assertive Community Treatment)- A program that provides community-based treatment to adults who experience the most severe symptoms of mental illness and the greatest functional impairment in key areas of life.

CI (Confidence Interval)- A range of values so defined that there is a specified probability that the value of a parameter lies within it

OR (Odds Ratio)- A measure of association between exposure and an outcome. The OR represents the odds that an outcome will occur given a particular exposure, compared to the odds of the outcome occurring in the absence of that exposure

Transinstitutionalization- Refers to the movement of people with severe mental illness from large psychiatric hospitals to smaller group residences

MST-EA- Multisystemic Therapy for Emerging Adults

Literature Review

Characteristics of Serious Mental Illness, barriers to adequate care, and recidivism

An article published in the American Journal of Public Health titled Mental Health of Prisoners: Identifying Barriers to Mental Health Treatment and Medication Continuity, collected in 2004, assessed mental health screening and continuity of medication administration in a nationally representative sample of prisoners in the United States. Data was obtained from 18,185 detainees, and the data collection was provider per self-reporting. Inmates were aims from State and Federal correctional facilities and conducted per Stata version 13 as a survey logistic regression model.

The 2004 Survey of Inmates in State and Federal Correctional Facilities provided data necessary to study the intended sample population. A dual-stage stratified sampling design was utilized to select facilities randomly; inclusive of state and federal correctional centers. Inmates were systematically selected, although to represent both genders fairly, some nonrandom sampling was also conducted. The study was comprised of a total of 21 state and three federal prisons; from which a total of 243 male and 66 female prisons were ultimately selected. Using

both direct and in-person interviewing methods, a total of $s= 14,499$ state and $n= 3,686$ federal inmates were surveyed, and the response rate was 86.7% for the particular sample and 89.8% for the state sample. Inmates were selected using a computer-generated algorithm with a random starting point with exception to those serving sentences for drug-related offenses. These inmates were systematically chosen to ensure variability in crime type.

The measures utilized were uniform for all respondents. Each inmate who self-reported diagnosis of a mental health condition was asked "were you taking medications prescribed by a doctor for a mental or emotional problem at the time of [admission to current facility]? (TABLE 1: $n = 3718$) And "Have you taken medication for a mental or emotional problem since your admission to prison?" Those who answered yes to both were considered to have "treatment continuity, " and all others coded as "non-continuous." Also, all respondents were asked "[When you were admitted on your most recent admission date], did they ask you any questions about your health or medical history?", As well as, "Since your admission on [date of booking for current offense], have you had a medical examination?" and coded as so. Co-variables taken into data account were: receipt of other mental health services such as counseling (TABLE 1: $n= 4073$), time spent in prison (re-verified for reliability), and demographic information such as race, ethnicity, age, and gender (Reingle Gonzalez & Connell, 2014).

There were limitations noted within the study. The first limitation was prisoner self-reporting. The method of self-reporting a mental health condition may provide inaccuracies, and likely the prevalence of mental health conditions is higher than was self-identified. The second limitation noted was self-reported data, beyond the mental health condition, which may prove discrepancies in data collected. Finally, the data that was collected was from 2003-2004, which

may demonstrate data that is outdated; although it was identified that due to significant budget reductions, it was unlikely that screening and treatment had changed or improved since that time.

Despite these limitations, a large epidemiological survey of prisoners was studied, and among them, a significant variety of mental health conditions were measured, as well as, medication continuity and the degree of treatment provided. Regardless, "the convergence of medical and criminological data is a relatively rare occurrence. However, inmates who have lingering, untreated mental health conditions are likely to pose a major public health risk (e.g., recidivism) in the future (Gonzalez & Connell, 2014).

Results indicated that 26% of the state or federal prison inmates had been diagnosed with a mental health condition at some point during their lifetime, yet only 18% were taking medications for their condition upon admission to prison. Of the 18%, only half of those received medication while incarcerated. Of the psychiatric illnesses, schizophrenia had the highest rate of provided pharmacotherapy that compared with less severe disorders (e.g., depression). Adequate p values of $<.05$ and $p < .001$ were utilized in TABLE 1, similarly, p values of $< .05$; $p < .01$ and $p < .001$ were used in TABLES 2 and 3 with odds ratio; confidence interval (CI) of 95%. TABLE 1 results indicated that the amount of time spent incarcerated was lengthier for those housed in state prisons (5.33 years) than in federal (4.41 years). The surveyed sample was 93% male with a mean age of 36 years old and was primarily African American; a depression diagnosis showed most prevalent with mania, anxiety, and PTSD to follow. TABLE 2 reflects the analysis of health screenings and access to pharmacological treatment in prison; finding that inmates with schizophrenia were twice as likely to have medication continuity as compared to those with less overt conditions like depression. Race and age were positively associated with medication continuity and inversely were time served. Type of institution (state vs. federal) and gender

rendered no notable associations. TABLE 3 depicted a correlation between a medical screen and care seeking while incarcerated, finding that those who were screened had a strong correlation to seek medical treatment. Females, Caucasians, increase in age and time served also resulted in positive findings, whereas males & the Hispanic ethnicity showed the inverse.

In conclusion, a lack of adequate screening procedures attributed to the subpar to non-existent treatment provided to those with a psychiatric illness. Due to the inadequacies of treatment, the incidence of recidivism and potential to increase in health care costs are probable.

Another article published by American Journal of Public Health titled, The Health and Health Care of US Prisoners: Results of a Nationwide Survey conducted research to assess to availability and quality of health care provided to inmates with chronic medical conditions. Despite the constitutional right of all prisoners to receive care while incarcerated (under the Eight Amendment) of "cruel and unusual punishment," adequate care provided to inmates remains deficient (Wilper et al., 2009). Nearly 12 million inmates are released back into the community annually; large majorities of these individuals un-medicated and underserved. These inmates will likely return to prison due to continued treatment inadequacies, subsequently, increasing recidivism rates and worsening their health condition.

Data was collected and analyzed from the 2004 Surveys of Inmates in State and Federal Correctional Facilities (SISFCF) and the 2002 Survey of Inmates in Local Jails (SILJ). The US Census Bureau was responsible for conducting the survey; of volunteered inmates with confidentiality practices in place. Of 1585 state prisons, 301 were selected for participation accompanied by 39 federal and 417 local jail facilities. Chosen at random, 14,499 state-housed, 3686 federally-housed and 6982 jail housed inmates completed the survey. All inmates answered questions regarding diagnoses received or symptoms prior to incarceration as well as questions

regarding their health care while incarcerated. The self-reported mental health diagnosis inclusions (including prior diagnosis) were major depressive disorder, bipolar disorder, schizophrenia, posttraumatic stress disorder (PTSD), anxiety, panic disorders, personality disorders, or other mental conditions (Wilper et al., 2009). These inmates were asked about pharmacotherapy, counseling, or past psychiatric diagnoses in the year prior to admission, at entry, and during incarceration.

Comparison studies inclusive of access to medical examinations, access to pharmacotherapy, access to prescription medication, access to laboratory testing, adequacy of acute care, and receipt of mental health care were considered. Specific to psychiatric conditions mentioned, mental health inmates who reported prior care were further prompted to indicate if pharmacotherapy had ever been utilized, was used at the time of arrest, or since incarceration. Statistical analysis was examined using the interface SAS version 9.1 and SUDAAN version 9.0.3 to estimate variance in design variable with adjustments in sample weights to account for nonresponse and survey design.

A considerable portion of inmates were African American or Hispanic, younger than 35 years old, and male. Of the inmates that reported a mental health condition, (inclusion diagnosis criteria listed above), those that reported a prior psychiatric diagnosis included: 14.8% of the 19,117 federally-housed inmates, 25.5% of the 312,768 state-housed inmates, and 25% of the 157,634 jail housed inmates. Among the sample of inmates with a previous psychiatric diagnosis, a much smaller portion was taking medication for the condition at the time of arrest: 25.5% of federal, 29.6% of state, and 38.5% of jail inmates. Subsampled from those inmates who were diagnosed prior and treated with psychiatric medications in the past, only, 69.1% of federal, 68.6% state and 45.5% of jail inmates received similar medicinal/therapeutic parallels while

incarcerated. Astoundingly, the number of inmates who arrived taking pharmacological agents for a psychiatric diagnosis (including schizophrenia and bipolar disorder), were provided with supplemental medicinal treatment than they were at the time of intake.

With a prison population that has quadrupled in the past 25 years, it is reported that currently, 2.3 million US inmates rely on their correctional institution to receive health care. Of the prisoners with a persistent medical problem (including mental health diagnoses); 13.9% of federally-housed, 20.1% of state, and 68.4% of local jail inmates had not received a medical examination since incarceration admission. More than 1 in 5 inmates were taking some form of medication upon prison intake & among those: 26.3% of 7232 federally-housed, 28.9% of 80,971 state-house, and 41.8% of 58,991 locally- housed jail inmates had their current treatment regimen discontinued following incarceration (Wilper et al., 2009).

Some limitations noted were variability in duration of sentence, (prison versus jail), potentially distorting results, possibilities of inconsistencies or reliability due to inmate self-reporting, lack of global inclusivity that mental health patients had in a portion of the data collected & studied analysis (specifically in TABLE 2), and the variability in measurement of psychotropic medication to other pharmacotherapy used in prison. The reflection of increased psychiatric treatment and counseling services provided to inmates throughout their incarceration period, measured against the pre-arrest period, may reflect the substantial limitations in community access for individuals with a mental health condition.

Despite the noted inadequacies in." treatment of inmates with persistent/chronic conditions, Wilper et al., believe that there was sufficient evidence to support a presumption that correctional health care is far from adequate. Furthermore, the authors trust that vast improvements in inmate health care are possible; by increasing the availability of

addiction/mental health treatment provided to inmates and improvements in discharge planning/facilitation of societal reintegration (According to the American Journal of Public Health (2009).

A similar proposal for improved transition from correctional facilities to the community was proposed using the ACT (Assertive Community Treatment) model. The study design was to evaluate the impact on recidivism when pre-release planning and engagement in community mental health services were implemented; while taking into account the entirety of SMI and difficulty in therapy & treatment maintenance. The study included a total of 350 prisoners with a SMI and a variety of 4 prisons facilities ranging from minimum to maximum security. A group of 180 inmates with SMI who were released one-year prior to the implementation of the PMOC (Prison in-reach model of care) and were compared to 170 inmates with SMI one-year post implementation of the PMOC.

The PMOC model divides prison mental health care into five steps: 1) screening, 2) referral, 3) assessment, 4) treatment, and 5) release planning. The five step process was an enhancement from the prior 3 step model where additional evidence-based screening procedures were initiated (Evans et al., 2010). The study required collaboration with prisons at all five steps and employed ACT principles. Implementation of the pre-release planning required engagement with community mental health services (CMHS) and other social care agencies; which assisted with housing, support networks, and employment opportunities. The study incorporated inmates three months prior to release, six months post-release and staggered over a 7-month period. Its purpose was to show subsequent impact on engagement in CMHS services, post-release, and the impact on re-offense rates.

Results: The assertive PMOC was associated with enhanced engagement and pre-release community-based mental health care and a significantly greater number of post-release

community engagements after implementation. The p-value = 0.02 with $Z = 2.388$ (pre-release) and $Z = 1.82$ (post-release). Subsequently, when the ACT model was applied to inmates either pre or post release, the treatment was superior to 'usual treatment' devoid of such model implementation and showed beneficial to re-offense rates without any additional resources utilized (Dietrich et al., 2010). Additionally, a meta-analysis performed per Jones & Maynard (2013), placed released prisoners at a risk of suicide 7x higher than that of the general population (OR 6.75; 95% CI 6.08-7.52). In relation, inadequacies in post-incarceration care provided to schizophrenic patients, yielded a 3x higher risk of violent behavior (OR 3.68; 95% CI 2.44-5.55), per Keers et al., (2013). A higher incidence of both violence and suicide, alongside the researched values of recidivism for those with a SMI; demand further intervention.

After introduction of the PMOC, there was a significant improvement in the rate of released inmates utilizing CMHS; inclusive of at least one face-to-face contact post release. Pre-PMOC: 43/101, 43%; post-PMOC: 88/152, 58%; ($Z = -2.388$, $p = 0.02$).

Limitation of the study: This study was conducted in New Zealand where healthcare varies in relation to that of the laws upheld by the U.S. Constitution. Also, despite collaboration and principle adherence, there were limitations in after-hours functionality within the prison facilities.

All in all, this was significant to show that care must begin well in advance of release to ensure achievement of service engagement and mental state stability (Lurigio et al., 2004; Lurigio and Falloon, 2007). Before PMOC implementation, there had been no standardized or explicit principles of release in place and practice varied widely. With increased knowledge of the importance of providing mental health treatment within prison systems and, furthermore, care

post-release; the assistance in transitional management may assist to decrease recidivism and display vital to a reduction in already overcrowded correctional centers.

Data obtained from the U.S. Department of Justice & Bureau of Justice Statistics Special Report, reports an estimate of 50% of criminal offenders in jails and prisons in the United States have mental health problems, compared to 11% of the general population (James & Glaze, 2006). Through personal interviews conducted in State and Federal prisons between the years of 2002-2004, more than 50% of all prison and jail inmates had a mental illness; 705,600 in States prisons, 78,800 in Federal prisons, and 479,900 in local jails. An estimate of 50% of criminal offenders in jails and prisons in the United States have mental health problems, compared to 11% of the general population (James & Glaze, 2006).

Data based on inmate self-report in the Survey of Inmates in State and Federal Correctional Facilities, 2004 and the Survey of Inmates in Local Jails, 2002, exhibited the percentage of inmates with symptoms of major depressive disorder, mania, or psychosis. Those who showed symptoms of major depressive or manic symptoms as classified by, 1) persistent sad, 2) numb or empty mood, 3) loss of interest or pleasure in activities, 4) increased or decreased appetite, 5) insomnia or hypersomnia, 6) psychomotor agitation or retardation, 7) feelings of worthlessness or excessive guilt, 8) diminished ability to concentrate or think, 9) prior suicide attempt, 10) persistent anger or irritability, or 11) increase or decrease interest in sexual activities ranged from 23.7% to 39.6% of inmates dependent on the facility in which the inmate was incarcerated. To meet the criteria for MDD, inmates had to report a depressed mood (or) decreased interest or pleasure in activities, along with (4) additional symptoms of depression. To meet criteria for mania, inmates had to report (3) symptoms or a persistent angry mood during the 12-month period. Those with psychotic disorder symptoms of delusions or hallucinations

ranged from 7.8% to 17.5% of inmates. All symptoms taken into account were formulated within the past 12-month period or since admission. To meet criteria for a psychotic disorder, (1) symptom of delusion or hallucination need to be present (James & Glaze, 2006). Aside from sole mental illness, a range of 42% to 49% of inmates was found to have both a mental health problem with a substance dependence or abuse disorder to accompany. James and Glaze also note that a violent criminal record is more prevalent among those inmates who had a mental health problem; thereby increasing their time in segregation, lengthening their incarceration sentence, worsening their mental health condition, and increasing the rate of recidivism if released. An estimated 47% of state prisoners and 32% of local jail inmates who had a mental health problem were repeat and violent offenders compared to 22% of those devoid of a mental illness were violent recidivists.

Aside from longer prison sentences, increase in inter-prison violence leading to segregation, a poor mental health outcome, and subsequently, an increase in prison violence, only one-third of prisoners who had mental health problems received treatment since admission (James & Glaze, 2006). To no surprise, local jail inmates at 17%, state prisoners at 34%, and Federal prisoners at 24%, had received treatment. Due to federal policy, all inmates who resided in a federal facility are mandated to receive care, mental health or otherwise, whereas state facilities are not mandated by policy. Despite, a vast majority of or state-run prisons do provide healthcare to inmates; care that is inclusive of distributing psychotropic medications as well as providing therapy or counseling by trained mental health professionals. Only 22% of inmates residing in state prisons had received treatment for their mental health condition. In perspective, one may see that treating only 22% of those non-inmate individuals hospitalized for hypertension, diabetes, COPD, congestive heart failure, kidney disease, cancer, strokes, or

otherwise, has the high potential to lead to further complications and detriment, thus why would we only treat an estimated one-fifth of inmates with a formal mental health medical diagnosis or substance abuse related diagnosis?

These findings are noteworthy and demonstrate that those individuals with a psychiatric component are more apt to partake & indulge in criminal activity. In fact, according to James & Glaze, 2006, "among jail inmates who had a mental health problem, an estimated 23% had received treatment during the year before their arrest: 17% had used medication, 12% had received professional therapy, and 7% had stayed overnight in a hospital because of a mental health or emotional problem."

Another study evaluates the socioeconomic and cultural realities of many of the incarcerated mentally ill and attempts to focus on the variables and their relevance to incarceration & treatment and the socio-economic and culture surrounding them. The rates of mental disorders among inmates holds a valid relationship to mental health disorders and criminality. However, a clear divide evaluating the use of prisons as mental health facilities remains unclear. This proposal also seeks to demonstrate the wide array of mental health conditions ranging from less severe diagnoses (mild depression) to more serious (psychosis & delirium) and seeks to, not only, recognize but bridge the gap in treatment provided, as well as, recognizing the less debilitating mental illnesses and deliver therapeutic aids and treatment all the same.

The astounding correlation between mental illness and substance abuse is not one that comes as a surprise to many. The association between criminality and mental disorders varied it its regards to the amplitude of violence and was shown to be attributed to the amount & frequency of substance that was abused (Abdalla-Filho et al., 2010). French et al., also reported

that substance use disorders are common conditions among repeat criminal offenders. This correlates to an increase in recidivism rates and potentiates longer prison sentences and financial strain to taxpayers.

French et al. also reported a commonality in substance use and repeat criminal offenders. Upon conduction of one economic evaluation of a prerelease substance abuse treatment program for male offenders, they concluded that in comparison to a matched group of offender's half of which received treatment and half of which did not the economic benefit decreased from \$6209 to \$4307 over the one-year post-release period. Despite the secondary treatment aim, the study emphasizes the importance of an efficient intervention. (French & Fang, 2010).

Rothbard et al. also examined a jail program for inmates with co-occurring disorders and found that there was a significant reduction in recidivism for those who had a higher number of treatment sessions (Rothbard et al., 2009). Benos et al. report that treatment has, in fact, improved significantly over the years due to policymaker & legislative implementations to decrease recidivism; saying that with the use of cognitive behavioral therapy and the twelve-step program re-offense rates fell.

Unfortunately, despite improvements in policy and legislation there continues to be a profound reoccurrence of criminal offenses secondary to a mental illness, socioeconomic surroundings, drug & alcohol abuse, little opportunity, and a poor support system that lies at the forefront of recidivism. There is a strong stigma attached to those re-integrated into society post-incarceration for drug or alcohol abuse & criminal wrongdoing. The lack of job and housing opportunities plagues these individuals and is often viewed as difficult to overcome.

The continued existence of mental illness within the justice system is a reality that is irrefutable, devoid of reform implementation. With policy improvement and enhancement of

psychiatric treatment for offenders, there may be more favorable outcomes, evidenced by a decrease in substance abuse among the mentally ill; which proves to potentiate repetitive criminal activity and re-offense.

An additional article from the *International Journal of Criminology and Sociological Theory* titled 'Mental Health in Prison: A Trauma Perspective on Importation and Deprivation,' aimed to show that imprisonment increases the vulnerabilities of the mental health population and reinforces the probability of worsened mental health outcomes of those incarcerated individuals with a psychiatric component. Armour states that multiple studies report the prevalence of mental illness in prison far exceeds that of the general population and suggests that the pre-prison adversities subsequently contribute to mental illness. Several additional reports, based on deprivation models, that prison environment, may represent the origin of mental illness; further debating whether mental illness is rooted in an individual prior to incarceration or whether the trauma and factors of incarceration create mental illness. Studies report that trauma often precipitates the development of mental illness and that, perhaps, mental illness in prison is attributable to both importation and deprivation perspectives (Armour, 2012).

The Department of Health, 2009, also reported an increase in mental health vulnerability, furthermore, increasing the risk of suicide. Singleton et al., 1998, reported an astounding estimate of 90% of prisoners suffer from a mental health issue ranging from anxiety and depression to personality disorders and psychosis. There are barriers noted to accurate prevalence studies shown useful to quantify varying levels of mental illness of the imprison, such as little or no prior mental health training among those conducting the physical and psychological assessments as well as an inefficiency of staff to identify all mental health cases (Edgar & Rickford, 2009).

According to the World Prison Population, produced by Walmsley, the population of prisoners incarcerated worldwide is on the rise; with the highest prison population existing in in the United States. Whether imprisoned in the U.S. or elsewhere, the principle behind incarceration remains the same. The commonality that prison acts as an establishment used as a sanction of punishment for criminal acts "which aims to punish those who commit crime, protect the public from crime and criminals, thus serve as a deterrent to those contemplating committing crimes, and reform criminals into law abiding citizens, thus reducing re-offending" (Coyle, 2005). Coyle further explores the consequences of imprisonment, both intentional and unintentional by examining the social exclusion, increased drug abuse, increased inter-prison suicide rates, overall re-offense rates, deterioration in physical and mental health, and decay of one's cognitive skills, only further straining the system and rarely meeting expectations to reduce crime and improve mental health.

Aside from the consequences of imprisonment, that Coyle proposed, the significant financial burden to house and attempt the rehabilitation of prisoners is at an all-time high, with the average UK taxpayer, funding prisoners at an estimated 35,000 British Pound (equivalent to approximately \$44,107 US dollars) per prisoner, annually. Despite this, researchers and practitioners alike, continue to note that there is a continued failure to accomplish or achieve intended objectives; further yielding subpar outcome. This failure and increasing financial strain forces re-evaluation of prisoner mental health and the consequences imprisonment has on improving overall crime rates and mental illness concerns.

The Social Exclusion Unit, 2002, revisits the pre-prison prisoner adversities, concluding some specific social characteristics that contribute to those imprisoned, such as, poor reading, writing, and number skills, challenging childhood home environments, educational exclusion,

and living apart from biological parents. Most notably, the Social Exclusion Unit reported that 50% of all prisoners had not been evaluated by a practitioner prior to their imprisonment; showing a failure of individuals to engage in health services and help-seeking behaviors. Furthermore, McNeil, Binder and Robinson, 2005, concluded that "a substantial proportion of the prison population who were deemed to have a mental health issue were homeless prior to imprisonment." Additionally, the World Health Organization (WHO) factors in multiple variables that they conclude precipitate mental illness, although, note that many factors related to prison environment also contribute. The WHO highlighted pre-imprisonment adversities such as social exclusion, economic disadvantage, and trauma have the potential to precipitate psychiatric illness, while further noting that overcrowding, prison violence, segregation and confinement, poor health, substance abuse and access to drugs, and lack of privacy also plays a significant role. To further potentiate mental health decline, Durcan (2008) and Edgar and Rickford (2009), highlight that removal and relocation of prisoners with a serious mental illness into segregation units is standard prison protocol. Metzger & Fellner, 2010, also illustrate that extreme forms of solitary confinement and lack of socialization proves detrimental to these individuals; which begs the question: Are there better options for this variety of prisoners?

To reiterate the factors that researchers note as contributable to mental illness while imprisoned, Breslau et al. 1998, concluded that inter-prison violence is one of the highest contributors. The high level of inmate-on-inmate assaults combined with assaultive violence is one of the leading causes of mental health complaints among prisoners. A study that investigated the correlation between physical victimization and mental illness of the incarcerated concluded that those prisoners, who received treatment for a psychiatric illness such as anxiety, depression,

PTSD, bipolar disorders, and schizophrenia, were exposed to more inter-prison victimization than those who did not require treatment for such disturbances.

Aside from the traumas that occur in the confinement of prison, researchers continue to demonstrate the adversities and social components that factor into the mental health of individuals, pre-imprisonment. Considerations are made for the mental health stability of the individual resolve little conclusion as to whether the psychiatric illness is intrinsic prior to prison or whether prison produces mental illness.

Once an offender is imprisoned, the approach shifts from crime prevention to rehabilitation and recidivism prevention. An article by Huffman, 2014, titled 'The Therapeutic Relationship, Prison, and Responsivity, deduces that prisons and jails are now the largest 'treatment' facilities for the mentally ill. Metzner, 1999, echoes the significant populous of mentally ill that reside within the prison system, stating that 8%-19% have a significant psychiatric or functional disability, and an additional 15%-20% require some form of psychiatric intervention, while incarcerated.

On an encouraging note, Morgan, Rozycki, & Wilson, 2004, report that there is an increased interest by prison inmates to receive treatment and psychotherapy; which is superior to decades past. There has been significant emphasis on the importance of therapeutic alliance, which is cultivated by how, with whom, and why it operates in prison. Hentschel, 2005; Horvath & Simonds, 1991, report that a precondition of therapy success is a healthy therapeutic alliance and that there is a positive, measurable effect on an optimal treatment outcome. Hill & Knox, 2009, echo this by stating that "the therapeutic relationship is the most robust predictor of therapeutic outcome." If an active, professional, and constructive alliance could be formed

between staff & offender, as well as, an established compliance to treatment, one may predict optimal outcome and a reduction in recidivism.

According to Pew Center for the states, 2011, the average recidivism rate for prison offenders is about 40% -three years post release. These statistics had remained unchanged for an 8-year period from 1999-2007. By summer of 2000, one in every eight prisoners was receiving some form of counseling or mental health treatment; accounting for upwards of 150,000 inmates (Beck & Maruschak, 2001).

An article from the Journal of the American Academy of Psychiatry and the Law by Anasseril, 2007, discussed the challenges and possible solutions to the adequate care of the incarcerated mentally ill. With the echoed & extensively researched recidivism rates and prevalence of mental illness in US prisons, a solution to overcrowding and re-offending is critical. Anasseril searches for plausible solutions and, consequently recognizes the challenges that may follow these solutions.

It is not a secret that correctional institutions have now become the new rehabilitation establishment for the mentally ill; the trouble being the diversity and severity of mental illness that resides there and the inadequacies to appropriately manage their care. The United States has the highest rate of incarcerated adults among the developed countries, yet reveals rigidity in solution or issue resolve. Despite increasing attempts to deinstitutionalize US prisons, there continue to be significant barriers to offenders receiving adequate care within the community. The influx of individuals with psychiatric concerns inundates an already saturated community, with regards to mental illness/ instability. Clinicians, psychologists, as well as, ancillary staff such as case management and social workers are feeling the intensity of influx.

Deinstitutionalization, limited resources, subpar fund allocation, and lack of planning contributed to the saturation of communities and restricted ability to appropriately serve the mentally ill offenders. Subsequently, there were limitations and inadequacies in the care provided to or offered to these individuals; leading to recidivism or homelessness. Lamb & Weinberger, 2014, report up to one-third of homeless individuals possess a serious mental illness such as schizophrenia, bipolar disorder, or major depression. The significant amount of management and treatment that many of these persons require to function in society appropriately is concerning. Despite the care crisis, community-based limitations predominate and many are left untreated. These individuals have a high rate of re-offense or homelessness, which provokes similar obstacles to overcome. Aside from resource inadequacies, other barriers to obtaining adequate treatment are non-compliance, substance overuse & abuse, illness denial, and financial limitations. Then, with supporting knowledge, Lamb & Weinberger pose the question, “Will decarceration produce another crisis for many of those offenders with SMI who are being released?”

The practice to commit individuals, with a serious mental illness, to a psychiatric facility was unquestioned years ago; the vacancies and policy enforcement made admission easy and care accessible. Forward to the late 1950's and with advancements in pharmacological agents, community resources and implementation of federal programs, high institutionalization costs, and civil rights movements, institutions such as these were closing due to low census. There was a decreased need for beds and subsequent closing of facilities. Per Lamb & Weinberger, these individuals become acquainted with law enforcement and ultimately end up arrested and incarcerated where mental health care is sub-optimal and prisons are at capacity.

In the midst of over-capacity, the Justice Department proposed the redirecting of resources to addiction and mental health treatment and recommending, in some instances, early release. Another remedy of early release that was used to reduce overcrowding was to reward those offenders who chose to take part in a rehabilitation program during incarceration; ultimately showing a small decline in state and federal incarceration numbers. Additionally, in 2011, the Public Safety Realignment Act was passed, which assisted in the relocation of non-violent criminals to local jails versus state prisons & released offenders on probation status rather than parole. The U.S. Supreme Court ruled, in 2011, to reduce designed prison population in California by 137.5%, within a 2-year period, due to overcrowding that violated the constitutional rights of the mentally ill due to inadequacies in treatment. The two options provided were to build more prisons to lower inmate numbers and provide better care or release prisoners early and reduce congestion. Funding only allowed for the latter, and ultimately the 2011 Public Safety Act was established.

These remedies were great ideas to decrease overcrowding although still proved problematic. Local jails were becoming inundated with offenders and were over 100% capacity, those released on probation were reabsorbed into communities without any conditions, and the mentally ill were released without assigned treatment resources such as substance abuse, pharmacological follow-up, counseling or other therapy services to assist them. Without mandating those with SMI to receive treatment, compliance was poor and refusal to see a clinician or attend treatment mirrored similar challenges as seen prior.

Other challenges Lamb & Weinberger outlined were the ability of clinicians to absorb additional patients in an already saturated mental health system as well as the comfort level to treat these offenders. Psychiatric providers, whether NP or MD, were already flooded with

patients and the release of thousands more who required care would be tedious. Also, some clinicians were fearful of working with these offenders as some of them were convicted of violent crimes. All in all, the solution that was thought to serve as a problem-solving measure to enhance care to the SMI and reduce overcrowding only proved problematic elsewhere.

In conclusion, Lamb & Weinberger expressed the need for more community outpatient psychiatric services with the capability to treat and house the SMI for periods of varying length. They propose that the mental health system is adequately funded so the ability to retain and assume treatment of these individuals can be achieved. They believe that the mental health population needs structure and treatment to avoid the risk of recidivism and propose such structure in forms of supportive housing, outpatient treatment, increased number of inpatient beds, as well as ACT & FACT teams. The ultimate hope is that decarceration does not contribute to treatment inadequacies and place those with SMI at risk for re-offense; mirroring challenges seen in past years.

Aside from the alarmingly high rates of incarceration leading to overcrowding, substance abuse, mental illness, and recidivism flooding our federal, state, and local correctional centers, there are interventions in place to enhance the care & provide a transition to improved access within the community. A recent clinical trial was conducted in attempts to prove the effectiveness of a transitional treatment unit with a multisystem induced methodology. The MST-EA (Multisystem Therapy for Emerging Adults): a data analysis of conducted research in regards to those adults with serious mental illness (SMI) and the oppositions faced when transitioning from the justice system to a community setting. MST-EA is a subdivision of the already well-established basis of evidenced-based treatment, MST that ultimately focuses on increasing positive community and mental health functioning in EA's with criminal justice

involvement. Specific interventions to potentiate positive functioning, include enhancement in school, work, relationships, independent living while ensuring both treatment and management of mental illness and any co-occurring substance use disorder (Sheidow, McCart & Davis, 2016).

MST-EA is appropriate for those who are deemed safe to reside within a community & are approaching incarceration release. Intended for young adults (17-21 years) who are at the highest risk of re-offense; those diagnosed with an SMI (mood, anxiety, psychotic, or eating disorder); and those who had an arrest or prison release within the last 18 months. There were several criteria listed to substantiate the appropriateness of MST inclusion. Once in, treatment is provided by a multidisciplinary team monitored by professionals, including; 3-4 fulltime MST therapists (with a Master's degree), MST supervisor (with at least a Master's & 3 years of experience), and a psychiatrist or psychiatric nurse practitioner.

The study incorporated a total of 80 cases with diagnoses inclusive of dysthymia, MDD, bipolar disorder, panic disorder, agoraphobia, OCD, PTSD, GAD, schizophrenia, schizophreniform disorder, bulimia nervosa, among other psychotic disorders. The mean age of participants was 18; were 64% male/ 36% female; 31% Caucasian/ 30% African American / 35% Hispanic/ 1% Asian, and 69% with criminal justice involvement. Data included system reports, screening tools, client reports, social network, member reports, psychiatric evaluations, and therapist observations to conclude that 82% of clients had no new arrest during treatment & 76% demonstrated success in controlling symptoms of SMI (measured by psychiatric evaluations). There were no homeless participants at the time of study-end and 90% were living in the community (73% of which were actively enrolled in school or employed). There was a drastic improvement in communication skills, at 73% with a 58% decrease in substance use at discharge. Only 5 of 80 clients re-offended and were arrested throughout the course of treatment.

With astounding results from the MST-EA trial, (Sheidow et al., 2016), propose "a clinical trial with optimism that MST-EA will prove useful in reducing recidivism, improving young adult functioning, and effectively treating mental illness at a critical juncture in these EA's lives."

Methods

With the significant increase in prison populations, many facilities overcapacity, mental illness saturating prison systems, the economic burden on taxpayers, and subpar treatment resolve has led to many areas of concern. One of which is inadequacies in the psychiatric treatment leading to worsening mental illness, increased prison violence, improper management of individuals with SMI, and poor accountability. A search to obtain relevant material was conducted through the University of North Dakota Harley E. French Library of the Health Sciences using five databases, including PsychInfo, CINAHL, PubMed, Cochrane Library, and Clinical Key focusing on literature from 2006-2015. The search included data of imprisoned persons with mental health illness, prevalence, resources provided to the incarcerated and their transition struggles post-imprisonment. Barriers expected include lack of mental health knowledge, stigma, funding, and available resources. Findings will be presented to fellow psychiatric mental health students as an Independent Study project. With supporting evidence, this writer will attempt to demonstrate that research indicates that with the implementation of improved mental health services to the incarcerated population, recidivism rates decrease and the chronically ill patients can be stabilized.

All researched focused on academic journals with inclusion criteria containing those published between the years of 2006-2016, a population of adults aged 18 years and older, English-language sourced, and those incorporating the search terms "mental health + prison +

treatment”. PsychInfo initially yielded 191 results including four clinical case studies, 36 longitudinal studies, 63 interviews, and 185 qualitative and quantitative studies. When the search term “barriers” was added to the subject search, PsychInfo further yielded only 33 results. CINAHL yielded 31 results (all academic journals) and narrowed to 4 results when the term “recidivism” was added to the subject search. PubMed yielded 316 results and narrowed to 34 results when the term "recidivism" was added to the subject search; 3 of which were clinical trials. Cochrane Library yielded 31 results; 28 trials and three reviews. ClinicalKey articles were searched with criteria dated from 2011-2016 and yielded 987 results; 35 systematic reviews, 33 randomized control trials and nine systematic reviews.

To highlight the surge in the incarcerated mentally ill population, inadequacies of care provided to inmates, the increasing recidivism rates of those with a psychiatric diagnosis, variability in the access to community mental health treatment, and barriers to sufficient psychotropic and psychotherapeutic management within the prison systems, a poster presentation (refer to Appendix A) was presented to fellow psychiatric mental health nurse practitioner students and family nurse practitioner students attending the University of North Dakota College of Nursing and Professional Disciplines. By stressing the importance of mental health management/treatment provided to the incarcerated mentally ill populous accompanied by the importance of identifying the necessities of continued community access to psychiatric services once released, practitioners may be able to recognize the essential impact that care can have on their current and future state of mental health well-being.

Results

Studies included in this review of literature consisted of fifteen total analyses: one quantitative study, two meta-analyses, four retrospective cohort studies, one cross-sectional

analysis, three descriptive research studies, one standard of care analysis, two systematic reviews, and one randomized clinical trial. Of the retrospective cohort studies, one was longitudinal which focused on several variables and the causative effects of these when measured against the incarcerated mentally ill population. The quantitative study consisted of a dual-stage regressive analysis of stratified sample design to highlight barriers to mental health treatment within correctional facilities. The two meta-analysis studies compared pre-contributory factors and data analysis from inmate surveys on a voluntary interview basis. The systematic reviews focused on inmates who suffer from a SMI and the prevalence of suicide, violent related offenses, recidivism, substance abuse, and the social and environmental factors that may play a role in noted characteristics and statistics. The descriptive studies were selected to illustrate the methods of treatment within prison systems and the inadequacies noted in all facilities; local to federal.

Discussion

Although there have been improvements, certainly, there is progress to be made in regards to adequate standards of care provided to the incarcerated mentally ill. In response, care provided per APRN's pre-imprisonment, inter-imprisonment, and post-imprisonment require alignment and standardization to ensure best practice and wholesome care; physically, emotionally, and spiritually speaking. As evidenced throughout the literature review, the mentally ill are funneled in and out of correctional centers, primarily not to manage their illness or improve outcomes, but to keep the public safe from potential violence and crime partially stemming from mental illness, substance abuse & poor coping mechanisms. Arguing over socially confounding factors versus environmental factors that have contributed to mental illness may help to understand the individual better, however, does not change the treatment &

management offered or provided to them once incarcerated. The community structures in place are far from accessible to most persons with an SMI and the where with all of these individuals to seek care is a whole new barrier to overcome. The portion of individuals who are in need of psychiatric care either do not seek it due to illness instability, financial constraints, stigma related to mental illness, or lack of access to care within their communities. To provide adequate care to these individuals, there needs to be an enhancement of public knowledge, improved access, and funding available to potentiate a successful future. APRN's, as well as the public, need to suspend and personal biases associated with mental illness and repair the stigmas associated to serve this population better. The lack of providers is not only problematic within the psychiatric sub-specialty but within all specialties alike. With that being said, however, additional resources could be allocated to primary care focused on providing the mentally ill with additional supports and resources aimed to provide balance and stability.

Family and social supports provide a major source of security for these individuals and can largely impact their lives positively or negatively. Aside from support structure, cultural acceptances, and variances also play a role in overall health of the mentally ill and the practices within them. Many refrain from seeking care or utilizing pharmacological interventions or other adjuncts such as psychotherapy due to cultural limitations or stigmas associated with mental illness in regards to their specific practice rituals or regimen. APRN's can provide alternatives to idea expansion to align better with the cultural beliefs to enhance care sought and what treatment/management is acceptable within a specific culture.

Summary

Since the closing of mental health facilities beginning in the 1950's there has been a massive shift of mentally ill individuals from treatment facilities to correctional institutions. The

shift has also led to inadequacies in management and treatment of these individuals. The subpar management of the incarcerated mentally ill further illustrates increases in re-offending, inter-prison violence, conduct violations leading to segregation placement, suicide rates, and overall worsening of their mental well-being. The lack of uniform structure within correctional facilities and treatment provided while incarcerated and post-incarceration shows inconsistencies in access to care and variable outcomes once released back into the community. There have been studies conducted to illustrate the improvement in mental health stability if allied collaboration of services is offered or mandated to these individuals which show statistically less recidivism, substance abuse, violence, and suicide rates. Research continues to illustrate that with additional resources for management of mental illness in place that repeat offense and, therefore, taxpayer cost to detain these individuals will lower. In addition to lower annual expenditure, the enhanced support network will improve and provide stability for mental health clients that they may otherwise be lacking.

By exploring the treatment barriers, inter-prison policies and procedures in place from local to federal facilities alike, increased awareness and education can be modified to promote psychiatric well-being and long-term results. The alliance created by educating policy makers and fostering change through legislation may demonstrate great improvement in the care provided to these individuals and deduce long-term health achievements. The knowledge derived from this literature highlights the need for enhancement of mental health treatment and management throughout both the incarceration period and post-release. With this knowledge, a proposal for change through fund allocation, stigma reduction, treatment & support enhancements, and follow-up care has been indicated to reduce recidivism, violence, suicide rates, co-occurring substance abuse, and improve overall mental health.

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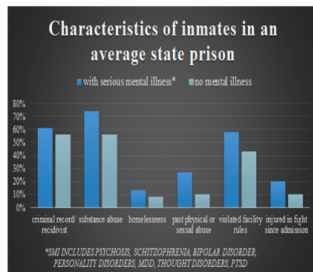
Appendix A

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Introduction

Despite the constitutional right of inmates to receive healthcare, only a fraction of those with a SMI receive treatment/management adequate to suit their illness. The suicide and recidivism rates among the mentally ill far surpass that of the general population. There are several barriers to adequate treatment & management of these individuals while incarcerated and post incarceration. Without implementation of improved care, their condition worsens and recidivism and suicide rates will continue to pose great public health concern.



Background

- More than 50% of the prison population suffers from a mental health issue (U.S. Department of Justice, 2006)
- Individuals with a SMI are at 7x the risk of suicide post imprisonment than the general public. (McKenna et al., (2014)
- Nearly 2/3 of individuals with a SMI recidivate within a 3-year period (Bureau of Justice, 2013; Stephan, 2004)
- American prisons housed 356,268 inmates with a SMI in 2012 and rates are on a steady increase (Treatment Advocacy Center)
- Psychiatric facility reduction & decarceration has led to mass incarceration as opposed to treatment; from 558,922 patients to 35,000 and falling (Swanson, 2015)
- The annual cost of an inmate with a SMI is \$30,000-\$50,000 compared to \$22,000 with individuals devoid of such illness (Treatment Advocacy Center)
- Access to treatment/management of mental illness post imprisonment is poorly accessible and inadequate
- The rate of serious mental illnesses among prisoners is three to five times the rate found in the community (National GAINS Center, 1997)

Matters of Concern

- The prison environment itself further potentiates the development of mental illness; also increasing the deterioration of established mental illness, inter-prison violence, depression, suicide, and substance abuse (Dye, 2010)
- Only 1 in 3 prison inmates and 1 in 6 jail inmates receive mental health treatment (James & Glaze, 2006).
- Cost to provide treatment to state-house inmates is \$150- \$250 million annually (Treatment Advocacy Center)
- Individuals with SMI tend to receive an increased number of conduct violations resulting in revoked privileges, transfer to solitary confinement, and difficulty achieving parole than that of the general prison population (James & Glaze, 2006).
- Those with SMI were inclusive of individuals with psychosis; specifically schizophrenia and bipolar spectrum disorders, personality disorders, and MDD.
- The research was proposed to examine and evaluate the healthcare and treatment provided to those incarcerated with diagnosis of a serious mental illness (SMI).

Policy/ Practice Recommendations

- Reduce stigmas surrounding mental illness paradigms in order to enhance treatment and optimize management.
- Instituting fund allocation for mandatory transitional treatment programs & participation post incarceration for optimal management
- Implement transitional programs to assist in community re-entry in hopes to maintain psychiatric stability, reduce recidivism, decrease suicide and substance abuse, and ultimately promote positive functioning.
- With implementation of post incarceration transitional programs, such as MST, only 5% of clients experienced recidivism and 90% were living independently, 73% were actively employed/enrolled in school, and 73% had improvement in communication skills (Sheidow & McCart, 2016).

