Cover Page and Inside Cover: The Test, HM Prison Greenock, oil on canvas, 2019

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Advancing Corrections Journal. ISSN 2517-9233
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As this Edition of Advancing Corrections is released, the world will likely still be suffering from an unparalleled ‘collective’ mental health crisis. Other than the deniers among us who choose to remain blissfully uninformed or misinformed, the spread of an invisible virus has slammed most of us into a state of acute and uncomfortable mental distress – fear, anxiety, depression, isolation, loneliness and even paranoia and panic. Millions of us have had to endure (or perhaps are still enduring) home confinement, separation from family and friends, boredom, restlessness, and gnawing uncertainty. We can ‘feel’ what it is doing to us. But, of course, there are millions of people we confine involuntarily for much lengthier periods of time and who are now facing similar anxieties but with even much less control over their lives. We often fail to ‘feel’ what confinement is doing to these millions of other individuals. Compound the effect of confinement with the psychic vulnerabilities of mental illness, and it becomes almost impossible to conceive what it might ‘feel’ like for these individuals. Correctional services all over the world are working feverishly to mitigate the effects of Covid-19 and the dedication of staff members in-the-line of fire is deserving of our utmost respect. But when this crisis is over, the management and treatment of the mentally ill in our prisons, jails, and community centers will continue as one of the most persistent, complicated and resource-taxing issues facing correctional services worldwide.

It is interesting to speculate that perhaps one silver lining from this emotional pandemic that we are going through is that it may arouse a bit more empathy and compassion for the mentally ill and mentally unwell who we incarcerate in growing numbers. Yet correctional services can’t rely on this possible silver lining. The challenge will remain for years to come and this Edition of Advancing Corrections will hopefully inspire some further refinement and innovation in practice in how we Manage and Treat the Mentally Ill and Mentally Unwell in Corrections.

The articles we feature in the Edition are again international in scope – from the US, Canada, Scotland, Singapore, New Zealand and Australia. The Edition begins with my own attempt to give a broad overview of ‘best practice’ strategies for dealing with the mentally ill. This is intended as ‘managing the mentally ill 101’ for correctional practitioners – nothing strikingly new; only a collection and summary of good, research-informed policies and practices; I hope it is helpful. In the rest of our Featured Articles section, we include a very well-executed empirical analysis on the role of ‘mental health factors’ in predicting success/failure on parole (Rely et al.); an interesting qualitative study of the experiences of older schizophrenics who are being transitioned back to the community (Hubbard et al.); a methodical, quantitative analysis of the mental health needs of a cohort of prisoners in New Zealand (Wilson et al.); a qualitative look at how incarceration in England & Wales has affected the mental well-being of Irish prisoners; and a rather unique study of how prison design features can affect an incarcerated person’s access to mental health services (St. John).
In our Views and Reviews section, we are pleased to publish an article from the Office of the Correctional Investigator in Canada (Zinger et al.). The paper offers a particular perspective in arguing that “Even in a generally well-resourced correctional agency like the CSC, and despite the correctional reforms implemented to date, there remain challenges in complying with international standards, and the fundamental principles of humane care and custody.”

In our section on Practice Innovation in Corrections, we feature two excellent examples of truly integrated practice innovation – one that looks at the importance of master planning and architectural design for responding to the complex physical and mental health needs of vulnerable prisoners (Grant), and another that discusses the development of an innovative Psychiatric Housing Unit within the Singapore Prison Service (Zain et al.).

In focusing on the management and treatment of the mentally ill, this Edition of Advancing Corrections certainly does not pretend to offer an exhaustive analysis of all the complicated and interconnected challenges for correctional services. Hopefully, however, it will give some guidance to move a step further forward.

I will end with my usual thanks to the reviewers on my Editorial Board for this and other Editions of Advancing Corrections. I continue to be impressed with the selfless support they provide to help us keep our corrections community evidence-informed.

Please forward your feedback, either regarding this Edition or any other matter pertaining to our Advancing Corrections vision. Stay safe and stay sane!

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AN OVERVIEW OF BEST PRACTICE STRATEGIES FOR MANAGING AND TREATING THE MENTALLY ILL IN CORRECTIONS

Frank J. Porporino, Ph.D

Abstract

This paper outlines some possible practical responses to the challenge of managing the mentally ill in corrections. Part I helps us contextualize the issue, especially as it pertains to the origins and prevalence of the problem of the mentally ill in corrections. Part II then attempts to sketch out some current best practice examples of: (a) appropriate and encompassing evidence-informed policies and strategies for dealing with the mentally ill and other special needs offenders; (b) programmatic alternatives, before imprisonment as diversionary measures, during incarceration and after release into the community, (c) systematized approaches for assessing needs, monitoring behavior and evaluating impact of interventions; and finally, (d) training and skills development of staff members both to sensitize them to the unique needs and characteristics of these offenders and equip them to respond more professionally.

Editor, ICPA Advancing Corrections Journal; President, International Association for Correctional and Forensic Psychology and Senior Partner T3 Associates Inc. E-mail contact at fporporino@rogers.com. This paper is a significant revision and update of a lecture given in May 2014 to participants of the 157th International Training Course of the United Nations Asia and Far East Institute (UNAFEI).
Introduction
The management and treatment of the mentally ill has evolved into one of the most significant challenges facing correctional services worldwide. The problem tends to remain relatively hidden in many developing correctional jurisdictions where formal identification of the mentally ill may not be occurring routinely (PRI 2019). But the struggle to service offenders who are mentally ill or seriously mentally unwell is not just characteristic of under-developed or under-resourced correctional services. It is a reality for some of the finest correctional systems in the world. Every day all over the world incidents involving the mentally ill play out in our prisons and correctional facilities, with some escalating into human tragedies that reverberate throughout the system, receive unprecedented media attention and galvanize community reaction to what can be seen as the apparent ‘inhumanity’ of incarceration for the mentally ill.  

It is now common in correctional discourse to refer to prisons and jails as the ‘new asylums’ (Roth 2018). Despite all of our continued attempts to humanize correctional environments, prisons remain primarily as ‘schools of crime’ for young, tough men who can find their place in the ‘schoolyard hierarchy’ and are somehow able to endure the pains of imprisonment and cope with their circumstances. But our prisons and community centres are also filled with a significant proportion of both men and women who are severely mentally unwell, often also having to contend with the mental distress of early trauma, addictions, stigmatization and social exclusion. For those individuals who are a little different and don’t fit in, those who are mentally ill, the intellectually disabled, the vulnerable and the emotionally disturbed, then our correctional response often becomes their nightmare.

Correctional staff can sometimes use (or more accurately abuse) the miss-fits in our correctional environments as fodder for their entertainment. I remember one of my own incidents of indoctrination into the prison culture as a young psychologist. I was called upon to visit the segregation cells to intervene with an offender who had apparently threatened to slash his writs with a razor. As I approached his cell and caught the foul smell (he had smeared his body and cell walls with his feces), I noticed that two officers at the other end of the unit were having quite a laugh at my expense. The mentally ill in prisons can become the butt of jokes. But much more often, these miss-fits in our prisons irritate and annoy, and quite routinely frustrate and anger, both correctional staff and their fellow offenders. In the absence of clear policy, early and sensitive assessment of needs and ongoing monitoring, appropriate staff training, and the availability of a range of programmatic alternatives, correctional practice will tend to resort to adoption of traditional punitive measures. It is not unusual to see systems remove basic privileges and overuse segregation as a means of managing the challenging behaviors of the mentally ill and other special needs offenders.  

The changing demographics and characteristics of offender populations, with a much higher incidence of a variety of mental disturbance, cognitive deficits, addictions, proneness to violence, poor education

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1 As an example, a number of years ago the Ashley Smith story received unprecedented media attention and significantly raised community awareness about the treatment of offenders with mental health problems in Canada. Both an official inquest and Canada’s Correctional Investigator declared that this was a preventable death and the Correctional Service of Canada has since taken significant steps in elaborating its Mental Health Strategy across the system, both in prisons and for aftercare after release. See http://en.wikipedia.org/wiki/Ashley_Smith_inquest

and chronic unemployment, and both community and familial alienation, are posing serious challenges to modern corrections. It can be overwhelming to attempt to outline all of the issues that deserve more determined and focused attention. But rather than simply cataloguing the problems, this paper will focus on outlining some possible practical solutions or responses. Part I will give an overview to help us understand and contextualize the issue, especially as it pertains to the origins and prevalence of the problem of the mentally ill for correctional services. Part II will then attempt to sketch out some current best practice examples of:

1. Appropriate and encompassing evidence-informed policies and strategies for dealing with the mentally ill and other special needs offenders;
2. Programmatic alternatives, before imprisonment as diversionary measures, during incarceration and after release into the community, aimed to both support these offenders and reduce the likelihood of further exacerbating their mental or physical distress, effectively managing their conditions and minimizing harm to themselves or others;
3. Systematized approaches for assessing needs, monitoring behavior and evaluating impact of interventions; and finally,
4. Training and skills development of staff members both to sensitize them to the unique needs and characteristics of these offenders and equip them to respond more professionally.

PART I: Historical Context, Prevalence, and the Mental Illness-Offending Relationship

De-institutionalization of the Mentally Ill

The ‘deinstitutionalization’ movement began in America in the mid 1950s. Deinstitutionalization refers to the policy of moving severely mentally ill people out of large institutions, ideally in order to reintegrate them back into communities with appropriate psychiatric aftercare. Although undoubtedly fueled in large measure as a rather straightforward cost-effective practice for reducing public expenditures, there were other well-meaning aspects to the movement. After the Second World War, psychology and psychodynamic psychiatry emerged in importance with their emphasis on the influence of life experiences and social factors. Similarly, advances in pharmacology led to the widespread introduction of chlorpromazine, commonly known as Thorazine, arguably one of the most well-known psychotropic medications and the first significantly effective antipsychotic medication. These breakthroughs, together with the introduction of other social and psychological therapies held out the promise of a more normal existence outside institutions for persons with mental illnesses. It was believed this could prevent chronicity and the dependency effects of institutionalization (Grob 1991, 2005). A Mental Health Commission under President Jimmy Carter in 1978 summarized the new, progressive approach as having:

“...the objective of maintaining the greatest degree of freedom, self-determination, autonomy, dignity, and integrity of body, mind, and spirit for the individual while he or she participates in treatment or receives services.” (p.44)

The deinstitutionalization movement began to spread quickly worldwide. Other than prohibition, the magnitude of deinstitutionalization of the severely mentally ill perhaps qualifies as one of the largest social experiments in American history. In 1955, census estimates indicate there were 558,239
severely mentally ill patients in the nation's public psychiatric hospitals. By 1994, this number had been reduced to 71,619, a decrease in institutionalization of the mentally ill of 87% at a time when the nation’s total population increased by close to 60% (from 164 million to 260 million) (Torrey 1997).

Unfortunately, though perhaps quite expectedly, the promised approach of ‘community-based’ care and treatment for persons with serious mental illnesses was never created. It is generally acknowledged that the deinstitutionalization movement led to a quite decentralized and uncoordinated mental health system that was not providing integrated and comprehensive services to those with the greatest needs, namely, persons with severe and persistent mental illnesses.

In the years following the beginning of the de-institutionalization movement, despite it’s well intentioned aims, some serious unintended consequences emerged, and for many mentally ill persons, unemployment, poverty, homelessness and community rejection and stereotyping, simply compounded their suffering and added to their loss of dignity. Another major consequence that is now generally accepted and deplored is that our prisons and jails have become the ‘new asylums’ for the mentally ill, ill-equipped surrogate mental hospitals where there is no other apparent alternative to manage their behavior. Referred to as the phenomenon of ‘criminalization of the mentally ill’, it has become perhaps one of the most prevalent and intractable challenges facing correctional services worldwide.

**From Prisons to Asylums and Back to Prisons**

It is interesting to note that the situation we are facing today, with so many mentally ill individuals locked up in our prisons and jails, often without receiving appropriate treatment and under conditions that exacerbate their illness, is exactly the situation we faced in the early 1800s, before the advent of modern psychiatry and before the invention of the psychiatric institution, or mental health hospital.

From the mid-1800s, early reformers who visited prisons and jails in America were aghast with the conditions in these institutions of punishment. Dorethea Dix, for example, one of the most prominent of these early reformers, reported the following to the legislature in the State of Massachusetts:

“I come to present the strong claims of suffering humanity. I come to place before the Legislature of Massachusetts the condition of the miserable, the desolate, and the outcast. I come as the advocate of helpless, forgotten, insane and idiotic men and women ... of beings wretched in our prisons ... I proceed, Gentleman, briefly to call your attention to the state of Insane Persons confined within this Commonwealth, in cages, closets, cellars, stalls, pens: Chained, naked, beaten with rods, and lashed into obedience!” (taken from Torrey, 1997)

In the 1800s the mentally ill were being picked off the streets and confined in prisons and jails in large numbers for minor and nuisance offences like theft or disorderly conduct. In an interesting precursor of later history, it was just as it is today. But curiously, and in considerable contrast to today, the situation of the confined mentally ill in the 1800s spurred government officials into concerted action. The abhorrent conditions that were documented by a number of early reformers served as at least one impetus for a wave of construction of what were, for the time, more modern, sanitary and humane ‘insane asylums’. The reform efforts of the day were remarkably successful in advocating
for the confined mentally ill. Gradually though quite steadily, mentally ill individuals were moved out of prisons and jails and placed in public psychiatric hospitals. By 1880, there were 75 public psychiatric hospitals in the United States for the total population of 50 million people. A census of ‘insane persons’ was carried out that year which was perhaps one of the most comprehensive ever carried out. It included letters to all physicians asking them to enumerate all ‘insane persons’ in their communities, a question about ‘insanity’ on the census form that went to every household, and a canvassing of all hospitals, jails, and public almshouses. A total of 91,959 ‘insane persons’ were identified, of which 41,083 (44.7%) were living at home, and 40,942 (44.5%) were in hospitals and asylums for the insane. The remainder (9,302) was in public housing of one kind or another and only 397 (or a small 0.7%) were in jails (Torrey 1997).

The Scope of the Problem Today

“Deinstitutionalization doesn’t work. We just switched places. Instead of being in hospitals the people are in jail. The whole system is topsy-turvy and the last person served is the mentally ill person.” Jail official, Ohio

There is no doubt that the number of mentally ill in American prisons and jails today is dramatically higher than the rather small .7% documented in the 1880 census. Estimating the scope of the problem in a statistically precise fashion is difficult to do, however, both because of the issue of diagnostic unreliability and definitional inconsistency from study to study (Cohen & Eastman 2000). Sometimes researchers restrict the definition of mental disorder only to major psychotic and manic-depressive or serious depressive illness. At other times, studies include developmental disabilities (IQ below 70), low functioning (IQ above 70 with limited adaptive abilities), brain injury (organic or acquired), fetal alcohol effects/syndrome, other less serious disorders (e.g., anxiety, post-traumatic stress), and quite often, serious substance abuse disorder. Of course, when the latter is included, the prevalence rates rise significantly.

Researchers have also tried to highlight the problem by focusing on different points in the criminal justice process, or by looking at the issue from different perspectives. For example, we can look simply at prevalence rates within jail or prison populations, to capture the scope of the problem as an end result, or we can look at the issue in terms of the experience of the mentally ill individual and ask the question of what the likelihood of incarceration might be for that individual over the course of their life. In one study, for example, a telephone survey was carried out of 1,401 randomly selected members of the National Alliance for the Mentally Ill, an American advocacy and support group composed mostly of family members of persons with schizophrenia and manic-depressive illness. It was found that 40% of the mentally ill in this group had been arrested and incarcerated at some time in their lives (Steinwachs et al. 1992).

But regardless of definitional issues or where we look to get a sense of the problem, it is indisputably recognized that the mentally ill routinely ‘slip through the cracks’ in health and social support systems and are at considerably higher risk for contact with the criminal justice system. This occurs at every point in the process; disproportionate numbers of mentally ill come into contact with the police, are arrested, end up in police cells or on remand, appear in court, and are convicted and imprisoned (Ogloff 2004).
Headlines began to appear routinely in the early 1990s to highlight the extent of the problem. For example, in New York, the estimated population of 10,000 mentally ill inmates in the state’s prisons was noted as surpassing that of the state’s psychiatric hospitals. In Seattle it was remarked that ‘quite unintentionally, the jail has become King County’s largest institution for the mentally ill.’ And the Los Angeles County Jail, where approximately 3,300 of the 21,000 inmates require mental health services on a daily basis, was referred to as the ‘the largest mental institution in the country.’ The headlines continue today and it has been noted recently that ‘America’s three largest psychiatric facilities are jails’ – in New York, Los Angeles and Chicago.

A comprehensive survey by the Treatment Advocacy Centre in 2004-05 estimated that there were close to three times more mentally ill confined in prisons and jails in America than in psychiatric hospitals (Torrey et al. 2010). In 2014, another survey adjusted the estimate to ten times the number of individuals with serious mental illness in state prisons and county jails compared to the nation’s remaining mental hospitals (Torrey et al. 2014). It was highlighted as well that in 44 states in America, the largest institution housing people with severe psychiatric illness was now a prison or jail and not a mental hospital. Figure 1 below displays the historical increase in concentration of the mentally ill in prisons and jails in America in graphic manner. The numbers are clearly staggering but the confinement experiences for the mentally ill offender are even more distressing. For example, mentally ill offenders remain in prison longer, are overrepresented in solitary confinement and are much more likely to commit suicide (Treatment Advocacy Centre 2016).

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Admittedly, the criminalization of the mentally ill may not be as dramatic in other nations, but it is nonetheless widely recognized as significant (Salize & Dreßing 2005; Knight & Stephens 2009). Mullen, Holmquist, and Ogloff (2003) conducted an extensive review of existing Australian epidemiological data to arrive at a reliable composite prevalence estimate. They concluded “that the prevalence of major mental illness among male prisoners is significantly greater than in the general population in the community” (p. 2). They noted that 13.5% (1 out of 7) of male prisoners, and 20% (1 out of 5) of female prisoners, had reported having prior psychiatric admissions, figures that are clearly much higher than the general population. Reviewing results from 49 worldwide studies of mental illness among incarcerated individuals (19,011 prisoners) compared to the general population, Fazel and Danesh (2002) reported overall prevalence rates of 4 times higher for psychotic illnesses and 2 to 3 times higher for major depression. An interview-based prevalence study in one of the largest prisons in South Africa reported that 55.4% of prisoners had an Axis 1 disorder, where close to one-quarter (23.3%) of prisoners could be diagnosed with current serious psychotic, bipolar, depressive and anxiety disorders. The majority of prisoners diagnosed as having an Axis 1 disorder in the study were neither previously diagnosed nor treated in prison (Naidoo 2012). In Finland, a recent prevalence study concluded that there has been a 10-fold rise in the number of prisoners with psychotic disorders in the past decade (Juriloo et al. 2017). A recent comprehensive meta-analytic study looking at findings on the prevalence of mental illness in incarcerated populations in 13 low- and middle-income countries found prevalence rates of psychosis that were on average 16 times higher among prisoners as compared to the general population, major depression six times higher, and alcohol abuse disorders double that of the general population (Baranyi et al. 2019).

One quite large scale and well-conducted survey by the Correctional Service of Canada (1990), using an acknowledged reliable interview schedule (the D.I.S.), involved a random sampling of more than 2000 male offenders sentenced federally across Canada. Results showed a lifetime prevalence of 10.4% for psychotic disorders, 29.8% for depressive disorders, and 55% for anxiety disorders. Co-occurring antisocial personality, drug, and alcohol problems were present in close to 40% of federal prisoners. More recent Canadian research (Boe et al. 2003) looked at the changing profile of the federal inmate population over the years 1997-2002. Over just a few years there was a significant increase in the number of male offenders who were admitted with a past mental health diagnosis (10% to 15%), a current diagnosis (7% to 10%), or being prescribed medication (9% to 16%). The rates were considerably higher for female offenders, although not showing the same level of increase over the years (for past diagnosis from 20% to 23%, for current diagnoses from 13% to 16%, and for the percent for which medication was prescribed from 32% to 34%). This steady increase in prevalence rates for newly admitted offenders has continued to be documented more recently (Beaudette & Stewart 2016; Brown et al. 2018).

Some consistent findings worth noting are the higher prevalence of mental illness for both female offenders and prisoners held in remand (Archambault et al. 2010). The Fazel and Danesh (2002) review, for example, found higher rates of depression among females, a finding that has been confirmed in a number of other studies (Brinded et al. 2001; Brown et al. 2018). Prins (1995) reviewed numerous studies and concluded that one third of the population of British prisoners required psychiatric treatment, and that this number was considerably higher among those on remand. Similarly, in a New Zealand study (Brinded et al 2001), it was found that male remand offenders had higher rates than the male sentenced offenders for all categories of mental disorder that were studied. Parsons, Walker,
and Grubin (2001) investigated mental illness among 382 female remand prisoners in the UK. They found that a very high 59% had at least one current disorder (excluding substance use disorders), including 11% with psychotic disorders.

In the US in 2006, the federal Bureau of Justice Statistics (BJS) reported on the findings of perhaps the single largest survey ever conducted of mental health problems among state, federal and local jail prison populations throughout the US. Some of the major findings are shown in Table 1.

Table 1
Recent History and Symptoms of Mental Health Problem Among US Prisoners*

<table>
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<tbody>
<tr>
<td>Recent history of mental health problems(^a)</td>
<td>56.2%</td>
<td>44.8%</td>
<td>64.2%</td>
<td></td>
</tr>
<tr>
<td>Symptoms of mental health disorder(^b)</td>
<td>49.2%</td>
<td>39.8%</td>
<td>60.5%</td>
<td></td>
</tr>
<tr>
<td>Major Depressive Disorder</td>
<td>23.5%</td>
<td>16.0%</td>
<td>29.7%</td>
<td>29.8%</td>
</tr>
<tr>
<td>Psychotic Disorder</td>
<td>15.4%</td>
<td>10.2%</td>
<td>23.9%</td>
<td>10.4%</td>
</tr>
</tbody>
</table>

\(^a\) In the year before arrest or since admission.

\(^b\) In the 12 months prior to the interview.


Interestingly, the BJS survey differentiated between recent histories of mental health problems versus actual symptoms of various mental disorders. With both types of definition, the findings showed quite substantial prevalence rates.\(^7\) The figures of prevalence for major depression (16 to 30%) and psychotic disorders (10 to 24%) were in the same range as was found in the Corrections Canada survey. This BJS survey also confirmed the trends noted in other research of higher rates of mental health disturbance among remand versus sentenced prisoners, and higher rates among females versus males (for example, within State prisons, 73% of females reporting mental health problems versus 55% for males). Moreover, the typical pattern of high co-occurring substance abuse was also highlighted. Over 50% of prisoners with mental health problems were found to have a co-occurring substance abuse disorder, a prevalence that was much higher than what was identified among prisoners without mental health problems. As a rather unique aspect of this survey, the backgrounds of mentally ill offenders were also examined. Quite strikingly, it was found that compared to the non-mentally ill, the mentally ill population demonstrated both much higher rates of homelessness prior to incarceration, and much more early experience of physical or sexual abuse.

\(^7\) A recent history of mental health problems included a clinical diagnosis or treatment by a mental health professional. Symptoms of a mental disorder were based on criteria specified in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV).
In a more recent *National Inmate Survey* by BJS that examined self-reported experiences of recent serious psychological distress, it was found once again that more jail inmates (26%) than prisoners (14%) met the threshold for serious psychological distress (SPD) in the past 30 days. Similarly, a higher percentage of females in prison (20%) or jail (32%) than males in prison (14%) or jail (26%) met the threshold for SPD in the past 30 days (Bronson & Berzofsky 2017). Generally, prisoners and jail inmates were three to five times more likely to meet the threshold for SPD as compared to adults in the general U.S. population.

In summarizing an answer to the question of how many people with mental illnesses are in jails and prisons on any given day, it is clear that numerous studies of prevalence rates have been carried out over the years that vary in definition of mental illness and the kinds of populations that are sampled. However, it is generally agreed that in the extreme, if mental illness is defined to include only schizophrenia, manic-depressive illness, and severe depression, then 40% or more of all jail and prison inmates appear to meet these diagnostic criteria, a figure in the range of at least *four times* that found in the general population. Similarly, it seems that prisoners and jail inmates report prevalence of serious psychological distress in the range of *three to five times* that in the general population. The figures are higher for females than for males and tend to be higher for offenders held on remand versus sentenced. Finally, if we add substance abuse disorder to the mix, then more than half of these offenders also have co-occurring substance abuse disorders.

**Mental Illness and Offending: A Complex Relationship**

To what extent mental illness is predictive of offending is still very much debated. We know, for example, that individuals suffering from psychotic illness are at higher risk for violent offending than the general population. This is exacerbated when there is co-occurring substance abuse and/or evidence of certain kinds of delusions (Mullen 1997; 2001; Robert et al. 2014; Wallace et al. 2004). However, when we look at offenders with or without mental illness, then research has shown consistently that offenders with mental illness are actually at lower risk of re-offending (e.g., Porporino & Motiuk 1995; Quinsey et al. 1998).

In a major Canadian meta-analytic review of 64 studies examining the relationship between mental illness and offending (Bonta et al. 1998), the authors concluded that: “the major predictors of recidivism were the same for mentally disordered offenders as for non-disordered offenders” (p. 123). Particular criminal history factors (e.g., juvenile delinquency) were predictive of offending for both groups. Moreover, some of the best ‘dynamic’ predictors (i.e., criminogenic needs) for both general and violent recidivism were quite similar for both mentally ill and non-mentally ill offenders (e.g., poor living arrangements, antisocial personality, substance abuse, relationship instability and employment.

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8 An estimated 11% of the U.S. population age 18 or older met criteria for these mental health disorders, based on data in the National Epidemiologic Survey on Alcohol and Related Conditions, 2001-2002 (NESARC), U.S. Department of Health and Human Services, National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism, Bethesda, Maryland.

9 Examples are persecutory delusions or delusions that ‘command violence’ against others and/or that provoke fear.
problems). Other research confirms these findings (Skeem et al. 2014) as does research described in this Edition of *Advancing Corrections* (Rely, Houser & Nelson 2020).

It has been suggested that for some mentally ill offenders (sometimes referred to as being both ‘bad’ and ‘mad’), there are perhaps two separate trajectories or pathways operating simultaneously. The criminal trajectory begins in early adolescence with the emergence of disruptive and delinquent behavior, and then the mental illness trajectory follows in the early to late 20s as the genetic predisposition towards psychotic illness flares up in psychotic episodes (Wallace et al. 2004). This obviously argues for the treatment of both aspects of risk for mentally ill offenders – managing their illness as well as addressing the more usual risk factors for offending (e.g., substance abuse; unemployment; criminal attitudes).

In managing mentally ill offenders so as to avoid further contact with the criminal justice system, it is also clear that particular dynamic risk factors should be considered (Rely et al. 2020). For example, it has been demonstrated that maintaining psychiatric treatment after release can substantially reduce violent recidivism among offenders with schizophrenia (Robert et al., 2014). One of the most popular risk assessment tools used with mentally disordered offenders (The HCR-20 by Webster et al. 1997) describes five situational factors which should be addressed to avoid re-offending: *a lack of feasible plans, exposure to destabilizers, lack of personal support, non-compliance with remediation attempts, and stress*. These contextual factors that can put mentally ill offenders at higher risk for re-offending are clearly crucial for the design of correctional services for the mentally ill that are preventive and protective in nature (as will be discussed later in the paper).

However, preventing the reoffending of the mentally ill is not the only concern that should preoccupy correctional services. At the front end, there is a major issue to contend with in terms of diverting the mentally ill from contact with the criminal justice system in the first instance.

In contrast to the typical media portrayal of mentally ill serial killers committing heinous crimes, the reality is that most mentally ill individuals never commit crime, or at least never commit any serious crime. What we know quite clearly is that most severely mentally ill people we imprison are there because they have been charged with a variety of rather minor offences. One American study (Valdiserri et al. 1986), for example, reported that compared with the non-mentally ill, mentally ill jail inmates were “four times more likely to have been incarcerated for less serious charges such as disorderly conduct and threats.” They were also 3 times more likely to have been charged with disorderly conduct, 5 times more likely to have been charged with trespassing, and 10 times more likely to have been charged with harassment. Another American study tracked a sample of seriously mentally ill individuals discharged from a psychiatric hospital in Ohio (Belcher, 1988). After six months, 32% had been arrested and imprisoned, typically for exhibiting bizarre behavior such as walking in the community without clothes and talking to themselves. They mostly failed to take their prescribed medications and frequently abused alcohol or drugs. Significantly, all of these former patients also became homeless during the 6-month follow-up period. The most common charges brought

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Within the predominant ‘rehabilitation theory’ in the field, commonly referred to as the Risk-Need-Responsivity paradigm (RNR) (Andrews & Bonta 2003), an important distinction is made between ‘static’ risk factors that are unchangeable (e.g., background and criminal history factors), and ‘dynamic’ risk factors often referred to as criminogenic needs. These latter dynamic factors can be altered and should be the focus of our correctional services and intervention attempts.
against the mentally ill who end up in jail are lewd and lascivious behavior (such as urinating on a street corner), defrauding a store owner (eating a meal, then not paying for it), disorderly conduct, panhandling, criminal damage to property, loitering or petty theft. These are clearly offences that are mostly expressive of mental illness rather than indicators of any intractable criminality.

We can conclude that though there is some relationship between mental illness and offending, it is neither straightforward nor inevitable. How we typically manage the mentally ill offender also seems to strengthen the relationship rather than weaken it. From what we know about which mentally ill individuals we imprison and why, the risk factors for offending among the mentally ill, and the treatment and support needs of these individuals, it is clear that a broader, integrated criminal justice and social service response is called for. The remainder of this paper will outline what this could like in the ideal.

PART II: Responding to the Challenge of Mentally Ill Offenders in Corrections

Challenges and Concerns for Correctional Services

For the most part, jails and prisons all over the world are inadequately equipped or resourced to deal with the mentally ill offender.

- Assessment is typically the result of informal observation of unusual behavior rather than the application of diagnostic tools for early detection of symptomology or mental health background.
- Staff members are poorly trained to deal with these offenders, especially line prison officers who have to contend daily with the pressures and difficulties of managing these individuals.
- Psychiatric care is difficult to access, both because forensically trained psychiatrists are few and far between\textsuperscript{11}, and the few that are available would rather work within psychiatric hospitals (where they are typically in charge) rather than correctional settings (where they typically are not).
- Specialized mental health correctional facilities, where there can be an appropriate balance of correctional supervision and professional mental health intervention, are the exception.
- And programs designed and developed specifically to intervene with mentally ill offenders are rare; with those that have been evaluated for effectiveness being even rarer.

The National Sheriffs Association in the US, responsible for oversight in the administration of jails across the country, succinctly outlined some of the key challenges as follows (Torrey et al. 2010).

Mentally ill offenders:
- Are ‘frequent flyers’ to highlight the fact that they are regular and repeat offenders, often being arrested and imprisoned dozens of times.

\textsuperscript{11} Forensics is not a popular specialization within psychiatry and the few forensic psychiatrists who are trained tend to work in forensic psychiatric settings where they focus mostly on assessing individuals for the courts for competence to stand trial. There are variations across jurisdictions around the world, but most acknowledge some variant of a ‘not guilty by reason of insanity’ plea which then leads to indefinite civil commitment rather than sentencing and imprisonment in a correctional institution.
• Cost more to manage.
• Tend to remain in jail or prisons longer than the non-mentally ill, often because they find it difficult to understand and follow jail and prison rules and are charged much more frequently for infractions.
• Are often major management problems and end up in administrative segregation in large numbers.
• Are at much higher risk for committing suicide.
• Are more often abused, both by fellow inmates and staff.

Of course, some correctional jurisdictions have few if any resources at all for managing the mentally ill (Agomoh 2013). But even some fairly advanced correctional agencies point to the limitations in programs and services available for these offenders. Illustrative of this are the findings from a 2004 survey by the Province of British Columbia in Canada of the service and program needs for mentally ill offenders (Ogloff et al. 2004b). The survey included all Canadian Provinces and Territories, as well as specific international jurisdictions that were similar in population and culture to British Columbia (i.e., New Zealand, Scotland, Victoria (Australia), and Maryland, USA). Some of the findings are shown in Table 2 below, listed in order of how frequently each concern was mentioned.

Table 2: Most Urgent MDO Service/Program Needs
(Adapted from Ogloff et al. (2004)

- The need for increased resources for mentally disordered offenders
- Increased community services for offenders
- Programs for needs of developmentally/cognitively challenged offenders
- Diversion programs, such as mental health courts and drug courts
- Programs/services for individuals suffering from Fetal Alcohol Effects/Fetal Alcohol Syndrome
- Additional services for young offenders with mental disorders
- Better collaboration between service providers and criminal justice personnel
- Better assessment/diagnostic service to place people in appropriate programs and housing
- Increased funding for research and dissemination of information
- Need to change public perception of mentally disordered offenders and reduce the stigma of being an MDO
- Need for better case management
- Coordinating services for dually diagnosed individuals (mental illness and substance abuse) placed in the community
- Requirement for high-quality mental health care in prison
Additional resources were seen as especially critical in order to improve the necessary ‘continuum of care’ for the mentally ill. This included both more and easier access to secure forensic psychiatric beds to treat acutely disordered offenders, more programs for individuals with co-occurring mental health and substance abuse, sustainable funding for diversion initiatives, and funding to ensure aftercare upon return to the community. The enhancement of community-based services was seen as particularly urgent, especially community-based residential support and programs to support social reintegration of offenders into the community. This of course is consistent with findings that suggest that re-entry programs for mentally ill offenders need to emphasize both basic sustainable economic and material support for these individuals as well as their specific treatment needs (Wilson 2013). Though conducted almost 20 years ago (Ogloff et al. 2004b), it is unlikely that the situation would be described as much improved with any repeat of this kind of survey today.

Clearly, even well-developed correctional jurisdictions are able to identify a range of service gaps. But what is encouraging is that a number of correctional jurisdictions around the world are now working collaboratively to close the service gaps and manage the mentally ill offender in the least restrictive and most humane way possible. Common to many of these ‘best practice’ examples is the establishment of formal links between law enforcement, the judiciary, forensic and correctional services and other non-governmental and governmental services and agencies responsible for community mental health, social services, employment, housing and family services … etc. It is this focus on the development of an integrated and collaborative service delivery model that creates correctional policies and strategies for managing the mentally ill offender that are ultimately effective (Osher et al. 2012).

The next section outlines a number of these integrated criminal justice and social service responses that have been developed and refined in recent years.

Innovative Policy and Strategic Direction for Dealing with Mentally Ill Offenders

What focus and underlying principles should underpin an effective, well integrated approach for dealing with the issue of the mentally ill in corrections?

The American National Sheriffs Association (2010) highlighted a few broad areas as practical and sensible options:

- Greater use of ‘Mental Health Courts’ where offenders are essentially given a choice between either following a treatment plan in the community (including the taking of medication) or going to jail (Lamb & Wienberger 2008; Moore & Hiday 2006).
- A greater emphasis on assisted outpatient treatment (AOT) for the mentally ill released from hospitals, jails, or prisons, where there is a court ordered requirement to continue taking medication as a condition for living in the community. A number of studies have demonstrated that even this rather straightforward change in practice can substantially reduce the likelihood of re-arrest, alcohol or drug abuse, as well as homelessness, risk of suicide, and episodes of violent behavior among individuals with serious mental illnesses (Phelan et al. 2010; Swartz et al. 2009).
- Change in government funding systems so that departments of mental health pay the local
corrections departments for the treatment costs of all seriously mentally ill inmates.

- A reform of mental health treatment laws so that treatment interventions can be made based on 'need for treatment' criteria rather than dangerousness. Typically, it is the dangerousness standard that necessitates law enforcement involvement. But mentally ill individuals should be able to access treatment before they become dangerous or commit a crime, and not after.

A good example of a significant broad-based change in policy direction is the comprehensive Mental Health Strategy adopted by Corrections Canada, developed in collaboration with the Mental Health Commission of Canada and the various provincial/territorial correctional jurisdictions across the country (Correctional Service of Canada 2009). The strategy appropriately highlights the fact that:

"Individuals with mental health problems and/or mental illnesses often have previous points of contact with multiple systems, including provincial/territorial and federal correctional jurisdictions, health care institutions, and social services. All systems have a shared mandate to provide an integrated approach of active client engagement, stability, successful community integration, and overall harm reduction in ways that are sensitive to diverse individual and group needs. Integrated efforts with the “common client” will result in fewer justice system contacts and increase public safety.” (p. 7)

As guiding principles, the strategy accepts that:

- Individuals with mental health problems and/or mental illnesses should be provided access to services irrespective of race, national or ethnic origin, color, religion, age, sex, sexual orientation, marital status, family status and disability (Canadian Human Rights Act, 1977, c.33, s.11);
- Mental health services should be client-centered, holistic, culturally sensitive, gender-appropriate, comprehensive, and sustainable;
- Mental health care should be consistent with community standards;
- The role and needs of families in promoting well-being and providing care should be recognized and supported;
- Prevention, de-escalation of behaviors associated with mental health problems and/or mental illnesses, interventions, and other mental health activities/services are critical to minimizing and managing the manifestations of mental health symptoms and promoting optimal mental well-being;
- Promotion of mental health recovery is a grounding philosophy underpinning the continuum of care;
- Meaningful use of time, including participation in programming for individuals with mental health problems and/or mental illnesses, is critical to their becoming contributing and productive members of the community;
- In addition to their involvement in correctional systems, individuals with mental health problems and/or mental illnesses experience a compounded stigma that creates barriers in their ability to obtain services, and also influences the types of treatment and supports received, reintegration into the community and their general recovery; and finally,
- Mechanisms should be established to ensure ongoing evaluation of the effectiveness of mental health services throughout the continuum of care.
Beginning in 2007, Corrections Canada enhanced resources significantly in two major ways. An Institutional Mental Health Initiative (IMHI) focused on enhancement of institution-based services. This included:

- Development of a computerized Mental Health Intake Screening System for early identification of offenders who could be experiencing significant psychological distress at intake. Follow-through assessments then try to develop a more precise picture of an offender’s mental health needs, which is in turn incorporated into the offender’s overall correctional plan (Stewart & Wilton 2011);
- Primary Multi-Disciplinary Mental Health Care teams in institutions who would work to provide offenders with access to comprehensive mental health care, and focus as well on mental health promotion, mental illness prevention, and early intervention, treatment and support (e.g., suicide prevention);
- Design of a mental-health training package delivered to all correctional staff to increase staff awareness of mental health issues and enhance their skills in working with these offenders;
- Development of intermediate care units for male offenders with mental health issues in institutions;
- An attempt to ensure consistency in standards of care at each of the five Corrections Canada accredited Regional Treatment Center facilities.

Approximately 125 new positions were created to fulfill the staffing complement for the IMHI including nurses, psychologists, social workers, and behavioral counselors.

A Community Mental Health Initiative (CMHI) was also introduced to ensure effective discharge planning for the mentally ill and appropriate, supportive community supervision. Approximately 50 new positions were created across Canada as a part of this CMHI, including:

- Clinical Social Workers (Discharge Planners) to assist in planning the institutional release of offenders with mental health disorders and building a plan for support in the community;
- Community Mental Health Specialists to work directly with offenders at selected parole sites, participate in multidisciplinary teams, provide training for front-line staff and develop partnerships with local agencies;
- Coordinators to manage the initiative in each region, and to help new staff work with existing community-based services to enhance mental health support for offenders in the community.

The CMHI provides targeted funding to local agencies and organizations, for example, for personal support workers for some offenders and to address the unique needs of mentally ill Aboriginal and women offenders.

A key aspect of the Corrections Canada strategy was to engage provincial/territorial jurisdictions as partners in the care of the mentally ill offender, especially in terms of diversion from the justice system in the first instance and reintegration support post-release. In Canada, federal offenders are excluded from the Canada Health Act and are not covered by Health Canada or provincial health care systems. Concerted efforts were therefore necessary (and continue to be necessary) to encourage provincial mental health services across the country to create effective pathways of care for the
mentally ill offender. Signs of coordinated action are appearing. For example, as part of a broader provincial ‘mental health plan’, the Province of Alberta has focused on creating a comprehensive diversion framework for mentally ill offenders (Alberta Health Service 2001). In British Columbia, where large numbers of people with mental illness and addictions live on the streets of Vancouver’s Downtown East Side, the province has developed several coordinated initiatives including: Vancouver’s Drug Treatment Court, an alternative therapeutic approach to treating drug addiction that has been found to be particularly effective for women and indigenous people; and an Intensive Supervision Unit that coordinates case management for high-needs clients who go back and forth between the justice system and community mental health services.

In a country as large and diverse as Canada, it is admittedly difficult to develop integrated and coordinated services that can stem the flow of the mentally ill into the justice system. Some critique suggests that service delivery for the mentally ill in Canada, in some ways, continues to fall short of accepted international human rights standards of care (see Zinger, 2020 in this Edition of Advancing Corrections). The Canadian Mental Health Strategy clearly needs to be refined, adjusted, coordinated and appropriately funded over time for greater impact but it at least sets out the kind of multifaceted approach that is required for meaningful change to occur.

Another impressive, comprehensive and well-integrated Policy Framework for dealing with the mentally ill within criminal justice was developed by the State of Victoria in Australia (Thomas 2010). Victoria has established the Victorian Institute of Forensic Mental Health, also known as Forensicare, governed by a council that reports to the Minister of Health and includes representatives from the Attorney General, Corrections Victoria, and the Minister of Health. An outgrowth of this government sector collaboration has been the development of a well-recognized and multi-faceted forensic mental health service that includes court liaison workers (nurses and psychologists) in magistrate courts to assist in diverting mentally ill offenders, formal intake assessments of all offenders entering jails, a range of psychiatric services in prisons and jails, an acute assessment unit for mentally disordered offenders in the state remand jail, a secure forensic hospital, a range of community-based forensic mental health services, and close coordination with regional and local mental health services.

The document ‘Diversion and support of offenders with a mental illness: Guidelines for best practice’ (Thomas 2010) is required reading for any correctional jurisdiction wishing to embark on a similar course. Not only is there a thoughtful presentation of some key principles for managing this issue at the systemic level, in partnerships with other stakeholders, but the evidence-base in support of these principles is reviewed, how policy and program development should proceed is outlined, including for special groups such as female offenders, young offenders and offenders from culturally diverse backgrounds, and finally, a set of ‘best practice’ examples, both from Australia and internationally, is outlined and discussed (see Table 3).

The Victoria Justice strategic framework takes as its point of departure the fact that there is a logical sequence of interventions that should take place in order to reduce the chance that people with a mental illness will penetrate deeper into the criminal justice system. This concept is nicely captured in the Sequential Intercept Model developed by Munetz and Griffen (2006) (see Figure 2). It describes a series of possible interception points that are critical for a truly integrated response for managing the
mentally ill within the criminal justice system.

A final well integrated jurisdictional strategy that deserves mention is Belgium. After many years of criticism and litigation regarding human rights violations in the treatment of the mentally ill offender, the government of Belgium enacted a new ‘internment law’ in 2016 which codified in legislation the ‘right to care’ for the mentally ill (Seynnaeve & Beeuwsaert 2017). In a fast paced collaborative initiative with Public Health and other public and private sector partners, the Belgium Prison Service embarked on a determined phased development of new services for the mentally ill, including community-based alternatives to divert the lower-risk mentally ill, a number of well-staffed specialised prison units, greater use of existing external mental health resources, and perhaps most ambitiously, developing two state-of-the-art forensic psychiatric hospitals for more effective management of the mentally ill in a ‘secure but humane setting’. The reduction in numbers of mentally ill in Belgium prisons tells the story of success; from 1,088 in 2014 to 491 in 2019.

**Programmatic Interventions and Services for Dealing with the Mentally Ill Offender**

Mentally ill offenders are both ‘mentally ill’ and prone to ‘criminal offending’ at some level of severity. Often the offending is of a minor nature, fueled and exacerbated by the symptoms of mental illness.

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12 An FPC (Forensic Psychiatric Centre) opened in Gent in 2014 with capacity of 264 and another in Antwerpen in 2017 with capacity of 182.
Table 3
Victoria Justice Framework for Managing the Mentally Ill Within Criminal Justice

PRINCIPLES THAT UNDERPIN BEST-PRACTICE DIVERSION AND SUPPORT FOR MENTALLY ILL OFFENDERS

Collaboration, communication and coordination are essential
Complex programs involving multiple stakeholders should seek to deliver a ‘single system’ experience wherever possible, requiring program goals and activities to be coordinated, process duplication to be minimized, and timely and appropriate information sharing.

Community safety is not compromised
Research indicates that well-designed diversion and support programs do not increase risk to the community. Addressing mental health and related problems that are linked to offending is more likely to reduce recidivism than usual criminal justice sanctions.

Accountability for criminal behavior is retained
Mental illness may sometimes reduce moral culpability but not legal responsibility. Participation in diversion from mainstream criminal justice processes is commonly linked to alternatives to imprisonment that meet community expectations for accountability. The rights and interests of victims must be acknowledged.

Human and legal rights are protected
Diversion and support programs should seek to enhance and support the exercise of the human rights of people with mental illness. They should also ensure that legal rights are not infringed by the diversion and support process.

Consumer and family or carer participation ensures policy and service development are better targeted, more effective and sustainable
People with mental illness (consumers) and family and friends who care for them (carers) provide vital insights into policy and program design that cannot be provided by other stakeholders.

Mental illness and associated issues are identified, assessed and treated as early as possible
Screening and assessment should seek to identify mental illness and associated problems (especially substance use) as early as possible. Early identification, assessment and treatment increases prospects for recovery and prevention of escalating problem behaviors.

Programs deliver culturally safe, holistic services tailored to individuals
Mental illness is experienced differently by different people, and is often associated with many complex and interacting problems. Programs should be needs-based, and provide or broker well-coordinated, integrated and culturally safe services. This often means working with individuals within the context of their family and community.

Quality and integrity of health interventions are maintained
The quality of services and supports provided to people through diversion programs should be equivalent to services available in the general community. Health interventions should be provided and managed by health services and retain a focus on achieving health and wellbeing related outcomes for individuals and families.

A recovery orientation is essential
Recovery is a personal process of changing one’s attitudes, values, feelings, goals, skills and roles. It involves the development of new meaning and purpose and a satisfying, hopeful and contributing life beyond the effects of mental illness. The model is consistent with the “good lives” model of offender rehabilitation.

Programs balance fidelity to the evidence base with environmental constraints and innovation
The evidence for diversion and support programs is growing, but incomplete. Fidelity to the existing evidence base should be balanced by the desirability of local flexibility, innovation and evaluation. Resource limitations, including workforce, infrastructure, funding and other constraints also necessitate innovation. ²

But clearly as well, serious violence is also possible. Many mental illnesses are chronic or relapsing conditions where acute phases or relapses may trigger offending behavior. What is clear is that regardless of level of risk for offending, treatment for the mentally ill offender should balance both a focus on the ‘mental illness’ and on the ‘criminal propensity’. Criminal justice and mental health outcomes can be significantly affected if there is a judicious and mutually supportive convergence of interventions and services that can address both dynamic criminological risk factors as well as appropriate management of the mental illness. One recent meta-analytic review of 26 program evaluations that met criteria of methodological soundness concluded that interventions with offenders with mental illness can effectively reduce symptoms of distress, improve the offender’s ability to cope with their problems, improve behavioral markers such as institutional adjustment and behavioral functioning and produce significant reductions in both psychiatric and criminal recidivism (Morgan et al. 2012).

Of course, the ‘how’ and the ‘when’ programs should deliver needed services is critical, as is the emphasis on a number of other key factors such as co-occurring substance abuse disorders, a history of trauma (especially with female offenders), the severity of the psychopathology and whether there are multiple forms of mental impairment, physical health problems (chronic illness or disability), and various practical issues like housing or accommodation problems and employment.

One particular consideration for program design merits special emphasis, namely gender (Derkzen et al. 2012; Leschied 2011). It is now commonly accepted that gender-responsive strategies are needed to deal with female offenders (Blanchette 2000), and this clearly applies as well to management of mentally ill female offenders, where some specific approaches such as Dialectic Behavior Therapy have been shown to lead to significantly improved outcomes (Blanchette et al. 2011; Linehan et al. 2007). Important to remember in allocating treatment resources for dealing with women with mental health issues in criminal justice are some of the following points highlighted recently by the World Health Organization (2008):

- Gender is a critical determinant of mental health and mental illness;
- Gender influences the rates of depression and anxiety (e.g., unipolar depression, predicted to be the second leading cause of global disability burden by 2020, is twice as common in women);
- Gender specific risk for common mental disorders that disproportionally affect women include gender-based violence, socioeconomic disadvantage, low income and income inequality, and low or subordinate social status;
- Lifetime prevalence rates of violence against women range from 16% to 50%);
- High prevalence of sexualized violence to which women are exposed and the correspondingly high rate of Post-Traumatic Stress Disorder (PTSD) following the violence renders such women the single largest group affected by this disorder.

Gender and other characteristics of the individual should obviously drive the specifics of the intervention approach that is adopted, but more generally, creating correctional services and environments that are responsive to the needs of the mentally ill requires adherence to some minimum standards of practice (Livingston 2009). These should include:

- Providing a comprehensive and balanced continuum of services;
Article 1: An Overview of Best Practice Strategies for Managing and Treating the Mentally Ill in Corrections

- Integrating services within and between systems;
- Matching services to individual need;
- Responding to population diversity; and
- Using evidence to make system-wide improvements.

With regards to specific treatment of mental illness that can support reintegration, the treatment of choice in the mental health field for mentally disordered individuals is commonly referred to as ‘psychosocial rehabilitation’ (Corrigan et al. 2007). The ultimate goal of this multi-faceted approach is to enable mentally ill individuals, as much as possible, to live independently by compensating for, or eliminating, functional deficits. The focus is on a range of social and educational services and supportive community interventions (e.g., intensive case management, supportive housing, social and vocational rehabilitation, substance abuse treatment, family support services ...etc.). Deployed in an interconnected fashion, a number of particular treatment strategies have shown effectiveness and are widely considered evidence-based (Mueser et al. 2003).

- Collaborative psychopharmacology—where individuals are included in the medication decision-making formula;
- Family psycho-education—where family members are educated about the effects of mental illness, and assisted in maintaining positive interpersonal relations and creating a supportive ‘familial’ environment;
- Supported employment—to help the individual gain competitive employment and assistance regarding skill development and employment maintenance for job security;
- Illness management and recovery—so that the individual assumes responsibility for their recovery, managing their illness, and seeking assistance as needed to obtain personally meaningful and satisfying life goals;
- Integrated dual disorders treatment—where service providers target issues of mental illness and substance abuse simultaneously in an integrated fashion rather than treating these issues as separate disorders.

Adapting the concept of Psychosocial Rehabilitation and Assertive Community Treatment (ACT) to forensic populations has been shown to improve a host of indicators such as future psychiatric hospitalizations, quality of life and symptom severity (MacKain & Mueser 2009). However, some evidence suggests that that ACT has been generally less successful in reducing re-offending or rates of arrest and incarceration, possibly in part because of the limited emphasis on criminological risk factors (Morrisey et al. 2007). It has been noted (Hodgins et al. 2007) that in order to reduce re-offending, community-based programs should:

- Be highly structured, intense and make use of multiple problem-specific interventions;
- Encourage clinicians to go beyond their clinical focus and accept an active role in preventing offending and guiding program participants through their personalized program;
- Allow for rapid hospitalization when necessary; and
- Employ court orders for some patients to support compliance.

Project Link in New York is a good example of an ACT-based approach with a simultaneous structured emphasis on criminological risk factors. Project Link is a multi-site consortium of five community
agencies that provide a mobile treatment team to service people with mental illness and past convictions, people diverted from current charges or transitioning out of prison. Within an ACT outreach model of comprehensive wrap-around services, the program incorporates a supervised residential program for people with mental health and substance use problems. Evaluations have demonstrated significant reductions in arrests, days in jail, hospitalizations and average hospital days. A follow up of clients enrolled in the first year in Project Link found a reduction in both the average number of days in jail (from 104 to 45) and hospital (114 to 8) and the average cost of care per individual fell from US$74,500 one year prior to enrolment to US$14,500 one year after enrolment. The program’s success has been attributed more particularly to a combination of effective service coordination and culturally sensitive service delivery (Weisman et al. 2004).

Many similar ACT-based programs have been developed throughout America (see http://www.nami.org) as well as in the UK (Fiander et al. 2003), Europe (Burns et al. 2001), Canada (Wilson et al. 1995), Australia and elsewhere (Ogloff et al. 2004b).

Although not as broad in scope as the psychosocial rehabilitation approach adopted by Project Link and other similar programs, a number of innovative, curriculum-based interventions for use with people with mental illness also deserve mention.

The first is the Illness Management Recovery (IMR) program, a standardized, curriculum-based intervention that has been translated into ten languages and is supported by considerable evaluative research (McGuire et al. 2014). The program can be delivered in a variety of settings (e.g., community mental health center, correctional facility) by trained behavioral health practitioners in either one-to-one or group format in 40–50 weekly or twice weekly sessions over a period of 6–12 months (Gingerich & Mueser 2011). Essentially, the program adopts motivational, educational, and cognitive-behavioral techniques to help individuals set personal goals and learn more effective strategies for dealing with their own psychiatric disorder. The curriculum is organized so that specific information and skills related to illness management are taught in a set of modules that includes: Recovery Strategies; Basic Facts About Mental Illness; The Stress-Vulnerability Model; Building Social Support; Using Medication Effectively; Drug and Alcohol Use; Reducing Relapses; Coping with Stress; Coping with Persistent Symptoms; Getting Your Needs Met in the Behavioral Health System; and Healthy Lifestyles.

A number of randomized controlled studies, conducted in the U.S., Sweden, and Israel, have shown that IMR improves illness management outcomes significantly more than traditional services (McGuire et al. 2014). IMR has been implemented extensively in America and elsewhere with individuals involved

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13 The ACT approach that originated in America is of course heavily driven and managed by mental health professionals. In contrast to this, many European jurisdictions focus much more deliberately on lay community involvement and support for reintegration of the mentally ill. A world-renowned example is the oldest continuous community mental health program in the Western world in Gheel, Belgium, a small town of 35,000 located in the province of Antwerp. Gheel is internationally known for the century’s old tradition of foster family care for the mentally ill associated with the legend of St. Dymphna, the patron saint of the mentally ill. Gheel and other similar initiatives in Belgium and elsewhere in Europe promote the concept of ‘community recovery’ where communities should strive to live with rather than fear the realities of mental illness. Hundreds of mentally ill individuals live their daily lives in Gheel without any stigmatization of any kind, and with broad based community acceptance and ongoing support.
in the criminal justice system. In order to make the program more accessible for persons with both intellectual disability and a psychiatric disorder, an adapted version that appropriately condenses and simplifies the curriculum has also been developed, the *Happy and Healthy Life Class* (Gingerich et al. 2009).

The second curriculum-based intervention worth noting is an adaptation of the *Reasoning & Rehabilitation Program* (R&R), one of the earliest (Porporino et al. 1991) and perhaps most well researched and widely applied correctional interventions adopting cognitive-behavioral principles to teach offenders a variety of new skills for ‘thinking and behaving’ more pro-socially. Evaluations with heterogeneous groups of offenders in different countries have shown that R&R can reduce risk of re-offending by up to more than 20% (Antonowicz 2005; Tong & Farrington 2006).

R&R has been adapted more recently to be more particularly responsive to the needs of mentally ill offenders (*R&R2 MHP*, Young & Ross 2007). At only 16 sessions (rather than the original 38), the program has been modified so as to maintain engagement with individuals who commonly present with cognitive deficits (e.g., in attention and memory). It also incorporates guided individual mentoring between group sessions to consolidate the material introduced in the group and transfer acquired skills into daily activities. A recent multi-site controlled trial of the program with a sample of 121 adult males drawn from 10 forensic mental health sites in the UK showed significant improvement across a number of measures from baseline to post-treatment (Reese-Jones et al. 2012). Close to 80% of group participants completed the program and in contrast to controls, there were significant treatment effects on self-reported measures of violent attitudes, rational problem solving and anger cognitions. Importantly, improvements were endorsed by informant ratings of social and psychological functioning within the establishments.

**Table 4**

**Interventions with Potential to Improve Health and Recidivism**

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<th>Evidence based practice</th>
<th>Potential to achieve*</th>
<th>Data to support*</th>
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* The possible number of positive icons ranges from 1 to 6, with higher numbers indicating a higher degree of potential impact and available data.

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14 Among the skills the program tries to teach are to problem solve and consider the consequences of their actions, think more critically and avoid biased or unfounded assumptions, assess the impact of their behavior on others, make better decisions, and learn more socially skilled ways of interacting with others.
Particular ‘programmatic’ interventions can make a significant difference in the lives of the mentally ill and life outcomes can be affected quite substantially. However, it may be the broader context of meaningful support that can make the most difference. As a summary, the findings from a recent comprehensive review are instructive. The review identified at least six evidence-based practices for their potential in reducing both risk of re-offending and improving mental health outcomes for mentally ill offenders (Osher & Steadman 2007). These are outlined in Table 4.

What we can conclude is that based on the treatment evidence we have to date, we can be quite effective in dealing with mentally ill offenders when we attend to both mental health needs and what are commonly referred to as ‘criminogenic’ needs. For example, integrating drug and alcohol treatment with mental health services (and thereby targeting an important ‘criminogenic’ need) is generally considered not only best practice but also essential practice (Clearly et al. 2008). The emphasis should be on early intervention, as well as relapse prevention and support, and should adopt an approach that promotes engagement but also challenges drug taking and its link with offending behavior. Unstable accommodation and/or homelessness and lack of access to the labor force for stable employment are several other key ‘criminogenic’ factors that significantly increase risk of offending, including among mentally ill offenders (Mullen & Ogloff 2009).

Quite interesting to note as well, however, is that the emphasis on the recovery model and illness self-management within the mental health field, strongly agrees with another emerging rehabilitation theory within criminal justice --- the “Good Lives” model of offender rehabilitation, which suggests that we can best reduce recidivism by equipping individuals with “the tools to lead more fulfilling lives” (Ward & Brown 2004).

Another comprehensive overview of treatment alternatives with mentally ill offenders makes the point that many of the strategies that have been applied to date have been borrowed from use with other populations (Knabb et al. 2011). Of the ten treatment options found in the literature, it was concluded that only five have been empirically validated with mentally ill populations (i.e., behavior therapy, cognitive behavioral therapy, dialectical behavior therapy, assertive community treatment, and therapeutic communities). Others may be of some value as adjunctive therapies but evidence has not been accumulated (e.g., music therapy, art therapy, analytical therapy, attachment theory). In dealing with mentally ill offenders there are a variety of clinical problems that can emerge quite regularly (e.g., including aggression, criminal tendencies, institutional management, poor life skills, substance abuse, social isolation, and psychotic and mood symptoms) (Rice & Harris 1997). Future...
treatment integration efforts should combine the strengths of existing interventions, address the plethora of clinical concerns presented by mentally ill offenders, and more reliably measure efficacy with well-designed randomized controlled trials.

Assessment Issues in Managing Mentally Ill Offenders

Treatment planning and effective delivery of services hinges on proper assessment. You can’t treat what you don’t identify and you can’t monitor how well your treatment might be doing without some clear indicators of outcome. As we have already seen, in dealing with mentally ill offenders, there is the prerequisite to assess both risk for offending, so as to address some of the criminogenic factors that can reduce that risk, as well as to screen for mental health needs and/or diagnosis of actual disorder.

Over the last several decades, a number of state-of-the-art assessment tools have been developed to assess the risk/needs of offenders. Andrews and Bonta (2003) have popularized reference to what has been coined as the central eight ‘risk factors’ for offending. These include four considered as high in predictive ability (history of antisocial behavior, antisocial personality pattern, antisocial cognition, antisocial associates) and another four considered as moderate (family, school, leisure/recreation, substance abuse). Other than the history factor which follows the old adage that past behavior predicts future behavior, the remaining set of risk factors are seen as ‘changeable’ in some fashion; that is, programs and services can do something to minimize their influence on possible future offending. Although with some different emphasis on one or other of these eight factors, most risk/needs assessment tools that have been developed and validated over the years include some detailed analysis of one or more of these eight dimensions.17

References for some of the most popular risk/needs assessment tools in the field of criminal justice are shown in Table 5, including the Level of Service/CM Inventory (LS/CMI), the Violence Risk Appraisal Guide (VRAG), and the Structured Assessment of Violence Risk in Youth (SAVRY).

An effective risk and needs assessment tool should sample a number of factors that research shows are predictive of criminal behavior, assesses dynamic factors that can be used to guide treatment decisions, and demonstrate satisfactory reliability and validity across a number of independent studies (e.g., Bonta 2002). Importantly, there should always be some attempt to locally validate both the relevance and accuracy of selected tools since information can lead to inaccurate classification of all or part of the local population. Subsequent treatment decisions based on those classifications could actually be quite misdirected. This has been referred to as the ‘validation dilemma’ where many jurisdictions simply adopt tools but are unable to speak to the accuracy of the assessment and classification schemes they use with their local populations (Byrne & Pattavina 2006).

When we turn to the other key aspect of assessment for mentally ill offenders, the obvious goal is to identify, for the purposes of treatment, the nature and extent of any mental health issues and/or any possible ‘diagnosable’ disorder. The most reliable sources of information for this come from structured interview schedules in the hands of a competent clinician. A good example is the Diagnostic

17 For example, the well-respected Psychopathy Checklist (PCL, Hare 2003) mostly emphasizes a set of personality traits that have been related to antisocial personality disorder (e.g., narcissism, callousness, manipulativeness).
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Table 5
References to Standard Risk/Needs Assessment Instruments

Level of Service Inventory Revised (LSI-R)

Risk Assessment for Sex Offender Recidivism (RRASOR)

Violence Risk Appraisal Guide (VRAG)


HCR-20; Assessing Risk for Violence

PCL-R; Hare Psychopathy Checklist

Structured Assessment of Violence Risk in Youth (SAVRY)

Youth Level of Service/Case Management Inventory (YLS/CMI)

*interview Schedule* which has been used extensively in epidemiological studies of the prevalence of mental illness (Robins et al. 1981). However, on practical grounds, reliance on these interview-based measures can be unrealistic. It has been noted that “budgets could never afford enough psychiatrists or psychologists to meet the demand [for correctional mental health assessment]” (Grisso, 2006, p.5). The design of tools for use by non-mental health professionals has consequently been a major concern in the field. We know that measures are needed as well for screening early in the correctional process, preferably in the first few days in custody, and “self-report measures offer a better alternative to lengthy clinical interviews given the large number of prisoners” (Krespi-Boothby, et al. 2010, p. 93).
A number of brief, reliable and relevant tools to screen for offender mental health have been developed. Several of these are briefly summarized below.

**Brief Jail Mental Health Screen (BJMHS):** This rather brief assessment form (which takes an average of 2.5 minutes to administer) is considered a practical and efficient screening tool that correctional officers can give detainees on intake screening (Steadman et al. 2005).

**Jail Screening Assessment Tool (JSAT):** The JSAT is a brief, semi-structured interview developed in Canada to identify mental health problems and risk for suicide, self-harm, violence, and victimization among new admissions to jails and pretrial facilities (Nicholls et al. 2005).

**Offender Assessment System (OASys):** As part of a more comprehensive assessment protocol for assessing the risk/needs of offenders (OASys), the Home Office in the UK has included some mental health screening indicators that provide a preliminary analysis of mental health risk, which can then be examined further with other tools (Fitzgibbon & Green 2006).

**General Health Questionnaire (GHQ):** Twelve items from the GHQ formed this self-report inventory developed to assess for clinically significant emotional distress with offenders. The instrument has been shown able to detect risk for self-harm and suicide and/or mental health problems requiring long-term care (Krespi-Boothby et al. 2010).

**Computerized Mental Health Screening:** Developed by Corrections Canada as a 30 to 40-minute computer-assisted assessment of mental health indicators adopted from the Brief Symptom Inventory of mental health along with a depression, hopelessness and suicide scale, developed within Corrections Canada. The information is collated into a report that goes to the offender’s confidential medical file and if the score exceeds a certain threshold, there is an automatic referral to a psychologist for a more thorough assessment (Correctional Service of Canada 2008; Stewart et al. 2011).

It is worth noting that specialized assessment tools may also be required for assessment of mental health issues in female offenders, for example, in order to focus on trauma and trauma-related disorders like PTSD (Weathers et al. 1994).

Before concluding this section, there is one particular mental health assessment tool that merits some brief description both because of its rather innovative approach and the extensive validation studies that have been conducted to support its use. The *Massachusetts Youth Screening Instrument-Version 2* (MAYSI-2) (Grasso & Barnum 2006) was designed specifically as a self-report 15-minute screening (triage) tool to be administered, often by nonclinical personnel, to all youth at the time of intake (within 1-3 hours after admission) in juvenile probation offices, juvenile pre-trial detention centers, and juvenile justice corrections and residential facilities. Its primary purpose is to identify symptoms (represented by thoughts, feelings and behaviors) that are found in many psychiatric diagnostic conditions of youth, but as well in adults. In a set of seven key areas (see Table 6), the tool provides information for whether individuals might require an immediate mental health response (e.g., suicide precautions, need for further evaluation, referral for clinical consultation). Importantly, through the use of specific cut-off scores, the tool also differentiates whether the individual is in the
‘caution range’ of clinical significance for symptoms, or in the ‘warning range’ of very high level of disturbance.

Released 12 years ago, the MAYSI-2 is now registered for use in over 2,000 sites in 47 states in America, including statewide use in all intake probation, detention and/or corrections facilities in 44 American states. Researchers have also translated the MAYSI-2 into 13 languages.

Table 6
Scales in the MAYSI-2

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Scale Name</th>
<th>Number Of Items</th>
<th>Brief Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADU</td>
<td>Alcohol/Drug Use</td>
<td>8</td>
<td>Frequency and pervasiveness of use of substances</td>
</tr>
<tr>
<td>AI</td>
<td>Angry-Irritable</td>
<td>9</td>
<td>Feelings of preoccupying anger and vengefulness, irritability and “touchiness”</td>
</tr>
<tr>
<td>DA</td>
<td>Depressed-Anxious</td>
<td>9</td>
<td>Depressed and/or anxious feelings</td>
</tr>
<tr>
<td>SC</td>
<td>Somatic Complaints</td>
<td>6</td>
<td>Bodily aches and pains often related to depressed or anxious feelings</td>
</tr>
<tr>
<td>SI</td>
<td>Suicide Ideation</td>
<td>5</td>
<td>Thoughts and intentions about self-harm, feelings of hopelessness</td>
</tr>
<tr>
<td>TD</td>
<td>Thought Disturbance</td>
<td>5</td>
<td>Altered perceptions of reality, things not seeming “real”</td>
</tr>
<tr>
<td>TE</td>
<td>Traumatic Experiences</td>
<td>5</td>
<td>Self-reported exposure to events that have potential traumatizing effects</td>
</tr>
</tbody>
</table>

In both the fields of criminal justice and mental health, the design of assessment tools to determine the risk and needs of individuals has proliferated in the last several decades. But assessment processes should aim to collect more than initial baseline information. Methods are needed as well to track individual progress and response to our interventions, both to determine program effectiveness and to plan further interventions to address emerging and outstanding needs. This is where structured Case Management procedures come into play where there should be vigilant and continuous monitoring of a whole variety of life indicators. For managing mentally ill individuals, this should include at a minimum the monitoring of a whole range of criminal justice, mental health and broader health/social indicators.

Important to capture as well are early signs of disruptive behavior (e.g., whether the person is difficult to manage; if they are verbally aggressive or attention seeking) and any deterioration in social and psychological functioning (e.g., insight into behavior, feelings of guilt, social interactions with others). It goes without saying that issues that are caught early are easier to manage and less likely to exacerbate. The very successful Assertive Case Management model for managing the mentally ill is based on this fundamental assumption (Ziguras & Stewart 2000).
Article 1: An Overview of Best Practice Strategies for Managing and Treating the Mentally Ill in Corrections

Training and Development of Staff in Managing Mentally Ill Offenders

In both community and institutional settings, staff training is key to affect a more appropriate response to the challenges presented by mentally ill offenders. The first point of contact with an individual who is displaying bizarre or disruptive behavior because of mental health reasons is often not a professional mental health worker. In the community, it is typically law enforcement officers, and in prisons or jails it is prison officers. In both types of settings, training of these front-line staff needs to focus: first, on recognizing the various behavioral manifestations of mental illnesses; second, on how to manage and de-escalate as necessary, and finally, on how to appropriately respond to incidents, including to ensure that timely access to professional, clinical intervention will occur.

Considerable success has been shown in various community programs where specialized training of law enforcement officers encourages diversion of the mentally ill towards mental health care rather than further criminal justice involvement. One excellent example is the New South Wales Police Mental Health Intervention Team (MHIT) model in Australia (Laing et al. 2009) based on the Crisis Intervention Team approach that emerged in America in Memphis, Tennessee (Steadman et al. 2000). The MHIT program involves four-days of intensive training for police officers on how to work with mentally ill or disordered people in a sensitive, safe and efficient manner. Training gives participants an understanding of mental health legislation applying in NSW and provides them with an array of communication strategies they can employ, as well as risk assessment, de-escalation and crisis intervention techniques. The overall aims of the program are to reduce the risk of injury to both police and mentally ill individuals, improve collaboration with agencies in the response to, and management of, mental health crisis incidents, and finally, increase the likelihood and reduce the time taken by police in the handover of individuals to the mental health care system. It has been demonstrated that these kinds of training approaches to alter police response can lead to significant reductions in arrest rates for mental health crisis incidents; to as low as 2% (Steadman et al. 2000).

Within institutional correctional settings, there should be by the very nature of incarceration, a greater likelihood of close observation and supervision of the mentally ill. Unfortunately, the prison officer ‘culture’ in these settings is often unsupportive of intervention with the mentally ill, other than for punitive reactions to misbehavior (Kropp et al. 1989; Rotter et al. 2005). The control of these individuals consequently becomes more ‘punitive control’ rather than ‘caring control’. It is axiomatic in prison settings that the more active and involved correctional staff are with a program, and the more input they are encouraged and allowed to have on the development of policies and programs, the more successfully the program will be implemented. When the advantages of providing professional intervention and programming for the mentally ill are couched in terms of the benefits for line staff (i.e., less stressful day-to-day interactions), prison officers will be much more likely to get on board. Interestingly, even relatively brief exposure to appropriate training seems able to alter prison officer behavior quite dramatically. For example, in one study it was found that a ten-hour mental health training program developed by the National Alliance on Mental Illness (NAMI-Indiana) for correctional officers on a prison (‘supermax’) special housing unit significantly reduced the frequency of ‘use of force’ with mentally ill prisoners (Parker 2009).

Strong arguments have been made to include correctional officers as essential and fully participating members of multidisciplinary treatment teams for offenders with mental illness, rather than simply
relegating them to the role of ‘turn key guards’ (Applebaum et al. 2001). Dvoskin & Spiers (2004) quite accurately describe the culture of the community inside prison walls and argue that correctional officers can play a vital role in the provision of specialized mental health services to offenders, for example, by learning to talk with offenders in a therapeutic manner, informing the mental health consultation process with their observations, and observing medication effects and side effects.

A number of jurisdictions have developed standardized training curricula to educate prison officers on the basics of mental illness and strategies for improved management of these individuals. Some excellent examples include the Correctional Service of Canada and their recent development of a two-day mental health awareness-training package tailored to the specific needs of various frontline groups including case management staff, institutional health care nurses, and correctional officers. Another is the State of Colorado’s Mental Health Training Course for Law Enforcement and Corrections Officers (Sherman 2001). In Europe, the European Union ‘Erasmus’ funding initiative has recently supported a quite significant AWARE project (Cross-sectoral awareness building on mental health needs in the criminal justice system and on release), with multiple related objectives to create improved services for the mentally ill offender, and including an array of training curricula for staff (see http://www.aware-project.org). Also deserving of mention is the very interesting Mental Health First Aid movement, beginning in Australia in 2003 and which has since spread internationally to 25 countries. The organization certifies trainers in delivery of a standardized mental health ‘awareness and support’ curriculum that has been delivered extensively to law enforcement staff but increasingly as well to correctional staff all over the world. 18

There is certainly no magic bullet curriculum that can make law enforcement or correctional staff members do what they should do (and can do if properly informed) in dealing with the mentally ill offender. Undoubtedly, if there is a key ingredient to success, it is to allow these line staff to become core members of a multidisciplinary team, not to remain peripheral to it. Some of the basic tenets of the Assertive Case Management model are a good way to conclude what this should involve:

- A clear focus on those individuals who require the most help from the service delivery system;
- An explicit mission to promote the mentally ill offender’s rehabilitation and recovery;
- A ‘total team approach’ where all of the staff work with mentally ill clients, under the supervision of a qualified mental health professional who serves as the team’s leader;
- An interdisciplinary assessment and service planning process that typically should involve a psychiatrist or psychologist and one or more nurses, social workers, substance abuse specialists, vocational rehabilitation specialists, occupational therapists, and where possible certified peer specialists (individuals who have had personal, successful experience with the recovery process);
- A willingness on the part of the team to take ultimate professional responsibility for the mentally ill individual’s well-being in all areas of institutional or community functioning, including most especially the “nitty-gritty” aspects of everyday life;
- A conscious effort to help people avoid crisis situations in the first place or, if that proves impossible, to intervene at any time of the day or night to keep crises from turning into unnecessary incidents; and

A commitment to work with people on a time-unlimited basis, as long as they continue to demonstrate the need for this unusually intensive and integrated form of professional help.

Conclusion

The effective management of mentally ill offenders raises a host of interconnected and complicated issues. It stretches the expertise of corrections to its limits and exposes the reality that the criminal justice system often does not really function as a ‘system’, much less connect very well with other social service and health care systems. A focused and integrated strategy is needed to divert mentally ill offenders away from the experience of imprisonment as much as possible, lessen the harm of the experience for those who must be incarcerated, and ensure there is adequate after-care post-release to prevent reoffending. *Primum non nocere* (first do no harm) should be a motto for correctional services worldwide and not just the Hippocratic oath of the medical profession. Many offenders enter prisons with pre-existing mental health issues that are then exacerbated. For others, imprisonment itself serves as the catalyst for igniting mental disorder. Though it is not just a correctional problem, but a community and broader social problem, corrections should aspire to do more in managing these special needs offenders with determined and innovative evidence-informed approaches.

LIST OF REFERENCES


Advancing Corrections Journal: Edition #9-2020


About the Author

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THE ROLE OF MENTAL HEALTH RISK FACTORS IN PREDICTING PAROLEE PERFORMANCE IN THE COMMUNITY: AN EMPIRICAL EXAMINATION IN A LARGE US JURISDICTION

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Abstract

Correctional facilities hold a disproportioned percentage of society's mentally ill. Research also shows that incarcerated individuals afflicted with mental health disorders are more likely to be charged with prison infractions and to serve longer periods of incarceration. Despite deeply rooted stereotypes, the research is mixed, however, on whether mental illness is a risk factor for criminal behavior. Yet, individuals with mental health problems tend to fare worse in criminal justice risk assessments. This study specifically addresses the role that mental health risk factors used in correctional assessment instruments play in explaining prisoner performance upon release in the community.

The research draws on rich empirical data on a large sample of persons released from prisons in Pennsylvania, United States, followed for a period of two and a half years to record two main recidivism outcomes: re-arrest for any crime and re-arrest for violent crime. The main data were provided by the Department of Corrections and the Parole Board. The analyses tested for both direct and indirect effects of mental health factors on parolee performance upon release. These factors were derived from the risk instruments employed by the correctional agencies providing the data. Other risk factors usually considered in the prediction of recidivism literature (e.g., prior criminal history) were used for control purposes. Among the eleven mental health factors tested, only a couple significantly predicted the reoccurrence of arrest, but only in the presence of other predictors of re-arrest, which fully mediated the impact of the mental health factors.

In sum, the study results provide support for the indirect effects hypothesis regarding the nature of the association between mental health conditions and crime involvement. The study also provides insights regarding the empirical validity and utility of the risk assessment tools used in corrections. Thus, the study holds significant theory, policy, and research relevance. The discussion focuses on immediate policy implications, most relevant for both institutional and community corrections.

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Introduction

Television and movies sensationalize the mentally ill as dangerous and violent, informing attitudes and reinforcing stereotypes (Parrot & Parrot, 2015). Stigmatization is not limited to the general public, however, and has been shown to be prevalent among healthcare and correctional professionals (Lavoie, Connolly, & Roesch, 2006; O’Reilly, et al., 2019; Waugh, Lethem, Sherring, & Henderson, 2017). Despite the stigmatizing stereotype that mental illness and criminal risk/violence are inextricably linked, research is mixed on the independent contribution of mental illness on criminal behavior and violence, with several scholars suggesting that the relationship is largely indirect (Harvard Medical School, 2011; Rueve & Welton, 2008; Skeem, Winter, Kennealy, Louden, & Tatar, 2014).

It is against this backdrop that we examine the role that mental health risk factors used in correctional assessment instruments play in explaining parolee recidivism over a period of two and a half years, using a large representative sample of persons released from prisons in Pennsylvania, United States. Specifically, we test for both direct and indirect effects of mental health factors on parolee performance upon release. These factors are derived from the risk instruments employed by the correctional agencies providing the data, the Pennsylvania Board of Probation and Parole (PBPP) and the state’s Department of Corrections (DOC). Other risk factors usually considered in the prediction of recidivism literature (e.g., prior criminal history) are used for control purposes and tested for their possible role in facilitating an indirect effect (i.e., thus, acting in a mediating role) for mental health factors. We begin by reviewing the overrepresentation of mentally ill persons in the correctional system, followed by a discussion of the association between mental illness and violence and mental illness and recidivism.

The Mentally Ill in Correctional Facilities

The mentally ill are overrepresented in correctional institutions around the world. In the United States, for example (where this research was conducted), 37% of prisoners report a mental health disorder and an additional 14% experience serious psychological distress; these numbers are even higher among the populations of local institutions (Bronson & Berzofsky, 2017) and are likely conservative estimates due to limitations in measurement. Moreover, the mentally ill typically serve longer periods of incarceration compared with their non-mentally ill counterparts (James & Glaze, 2006). They are also more likely to have multiple criminogenic risks including higher rates of physical and sexual abuse, as well as dependency on alcohol and drugs (James & Glaze, 2006). Despite the vast and immediate needs of the mentally ill, few will receive treatment during their incarceration (James & Glaze, 2006; Human Rights Watch, 2003).

While incarcerated, adjustment to the institution can prove difficult for the mentally ill due to “undeveloped or underdeveloped” coping mechanisms (Spencer & Fallon, 2012) and impaired cognitive function that are core features for some disorders (e.g., schizophrenia, bipolar, depression) (Calipari, 2018). In a large US national survey, correctional administrators reported the severely mentally ill to be one of the most difficult populations to manage in the institution; more difficult than gang members (Ruddell, Decker, & Egley, 2006). It is not surprising then to find that mentally ill are also more likely to be charged with institutional misconduct (i.e. violation of a formal rule or regulation while in the custody of the Department of Corrections) (Houser, Belenko, & Brennen, 2012; Steiner, Butler, & Ellison, 2014; Steiner & Wooldredge, 2009) and to be disproportionately placed in segregation (Cohen & Gerbasi, 2005); a factor associated with future recidivism (Houser, McCord &
Nicholson, 2018). However, for many mentally ill, their infractions are associated with symptomatic manifestations of their disorders (e.g., self-injurious behavior), rather clinical in nature (Adams, 1986) and therefore not intentional misbehavior.

Given the sheer volume of mentally ill persons in correctional facilities and the challenges that they pose for the criminal justice personnel, the role of mental illness on crime and recidivism has garnered considerable scholarly attention. Yet, research examining the independent contribution of mental health status on recidivism remains limited (Ostermann & Matejkowski, 2014).

The Relationship between Mental Health Disorders and Violence
Despite media sensationalism depicting the mentally ill as inherently violent, studies suggest only modest support for a link between mental illness and violence (Harvard Medical School, 2001; Van Dorn, Volavka, & Johnson, 2012; Walsh & Fahy, 2002). Indeed, research has consistently demonstrated that the majority of the mentally ill will not commit an act of violence and that most acts of violence are not committed by the mentally ill (see Slate, Buffington-Vollum, & Johnson, 2013, for a review). Mental health studies are often limited in their ability to reliably demonstrate a direct relationship between disorders and violence (Rueve & Welton, 2008) with some research questioning the role of mental health conditions as independent contributors to violent behavior (Elbogen & Johnson, 2009; Harvard Medical School, 2011; Mulvey, 1994; Rueve & Welton, 2008; Skeem, et al, 2014; Steadman, & Cocozza, 1974; Volavka, 1999).

Taylor (2004) suggests that “while significant associations between disorder and violence may be direct, the relationship may be mediated by other intervening factors” (p. S33). Findings from the MacArthur Violence Risk Assessment Study showed that violent offending among patients with a major mental disorder increased from 17.9% to 31.1% when a substance use disorder was present. In a similar finding, Van Dorn et al. (2012), using data from the US National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), found that while there was a modest association between serious mental illness and violence, the relationship was stronger when there was a co-occurring substance use disorder. Identifying the independent contribution of mental illness on crime and violence is critical if we are to successfully address their treatment needs and provide appropriate community care planning, particularly as we consider the large number of mentally ill offenders released in communities each year.

The Relationship between Mental Illness and Recidivism
The mentally ill face substantially greater challenges on release including higher rates of homelessness, unemployment, victimization (James & Glaze, 2006; Roman & Travis, 2004), and limited access to community-based treatment (Slate et al., 2013), increasing their likelihood of failure on reentry. It is for these reasons that some scholars suggest that the mentally ill cycle in and out of the criminal justice system (Bailleargeon, Hoge, & Penn, 2010; Carroll & Lurigio, 1984; Slate et al., 2013). Ostermann & Matejkowski (2014) found that although mental health status increased the likelihood of recidivism, mentally ill offenders supervised on release had higher rates of success, underscoring the importance of providing needed services to this population.

In the United States, the Bureau of Justice Statistics estimates that 25% of mentally ill state prisoners have three or more incarcerations (James & Glaze, 2006). Findings from the Los Angeles County Jail
show 90% of their mentally ill population to be repeat offenders, with 31% having been incarcerated ten or more times (Mentally Ill Policy Org, n.d.). Using a large sample of inmates, Baillargeon et al. (2009), too, found that inmates with major psychiatric disorders were at a substantially greater risk of multiple reincarcerations, with the greatest risk among inmates with bipolar disorders. Drawing from a sample of female parolees, Houser and McCord (2018) also found women with a mental health disorder to be more likely to return to prison than women with no disorders and to do so on average 471 days sooner. Similarly, Mallik-Kane and Visher (2008) found that while the mentally ill had overall higher rates of rearrest, women with mental health disorders were more likely than their male counterparts to be rearrested and reincarcerated.

It is therefore unsurprising that "most policy recommendations for this population reflect an implicit assumption that mental illness is the direct cause of criminal justice involvement" (Skeem, Winter, Kennealy, Louden & Tatar II, 2014, p. 212). This assumption is questionable, however, in light of studies showing "untreated mental illness to be, at best, a weak predictor of recidivism" (see Skeem, et al., 2014, p. 212). For example, Phillips et al. (2005) found that mental health diagnosis was not predictive of general or violent reoffending when controlling for other predictors of recidivism. Although individuals with personality disorders reoffended at higher rates, their diagnosis was not significant in predicting reconviction when other significant variables were also considered. The authors suggested that studies finding relationships between antisocial personality disorder and reoffending without controlling for prior criminality are "bound to be confounded" (p. 845). Similarly, Monson, Gunnin, Fogel and Kyle (2001) found that mental health diagnoses were not predictive of conditional release revocations among a sample of patients released from a state mental hospital. Their findings underscored, among other factors, prior criminal history as a robust predictor of unsuccessful release.

Skeem et al. (2014) suggest that while there is empirical support of a direct association between psychiatric symptoms and a "small but important minority of offenses" (p. 222), the relationship between mental health and criminal behavior is largely indirect. Using a matched sample of parolees with and without mental illness, Skeem et al. (2014) found that although mentally ill offenders were equally likely to be rearrested as non-mentally ill, they were more likely to be reincarcerated. Additional findings showed that in conjunction with factors unique to their mental health status, mentally ill offenders had more general risk factors for recidivism, and that it was these factors that were significant in predicting recidivism and not those unique to mental disorders.

The findings by Skeem et al (2014) are reflective of those reported earlier by Bonta, Law, and Hanson’s (1998) meta-analysis, concluding that the major predictors of recidivism were the same for mentally ill offenders as for non-mentally ill offenders. Further, they found criminal history variables to be the strongest predictors of recidivism similar to those of other studies (e.g., Monson et al., 2011; Phillips et al., 2005). Bonta et al. (1998) argued that risk assessment of the mentally ill would be improved with greater emphasis on social psychological factors and less on psychopathology. Phillips et al. (2005) further suggested that risk assessment of offenders with mental disorders can be predicted using the same criminogenic variables that are predictive in non-mentally ill offenders.

Although there is a growing body of research suggesting that the revolving door of prison for many mentally ill is not uniquely attributable to their clinical condition, further research is needed. Baillargeon, Hoge, and Penn’s (2010) review suggesting that few studies have examined the
relationship between mental illness and risk of criminal recidivism and that several of these studies are methodologically limited (e.g., small sample size, follow-up time) still stands today.

The current study examines the relationship between inmate mental health status and recidivism with a rigorous design that avoids the limitations affecting some of the previous research. Thus, the study relies on a large representative sample of more than 1100 parolees from Pennsylvania, United States, and a rich data set that allows controls for a variety of other factors, including criminal histories and demographics. Importantly, the study also employs a multitude of mental health factors, deriving from multiple sources, which should increase the validity of the study. Similarly, the analyses predict both outcomes of interest to correctional staff and policymakers when it comes to the mentally ill, that is, recidivism for any type of crime and recidivism for violent crime. Additionally, the study relies on a longitudinal design with an enough follow-up period length to capture the outcomes of interest, i.e., two years and a half. Lastly, but not the least, the study tests for both direct and indirect effects (i.e., mediated by other factors), thus attempting to provide insights into the primary question of concern identified in the extant literature, regarding the nature of the association between mental health conditions and crime involvement and whether such relationship is only an indirect one. The next section provides more details on the study methods.

**Study Methods**

*Research Setting, Data Sources, and Sample*

The study draws on data from a comprehensive review of the correctional processes in Pennsylvania, United States, conducted during 2008-2010 (Goldkamp, Vîlcica, Harris, & Weiland, 2010; Vîlcica, 2016). Pennsylvania is a large jurisdiction that relies on discretionary parole (i.e. conditional release) as the main means for releases from prison. The sample was randomly drawn and consisted of 1,139 parolees who gained release from correctional institutions across the state during January-October 2006. Their performance was tracked over a two-and-a-half-year follow-up period to record recidivism outcomes. The two main data sources were the Pennsylvania Board or Probation and Parole (PBPP) and Department of Corrections (DOC). The PBPP provided decision-related data, including information from parolees’ interview files, risk assessment information, and the supervision level assigned to the parolees upon release. The DOC data included information on the sentence from which the parolees gained release and controlling offense, classification data, as well as institutional record data (misconduct and programming). Both the PBPP and DOC datasets included information relevant for assessing mental health status in their risk assessment data (see below). Lastly, information on the follow-up outcomes (records on new arrests) was obtained from the Administrative Office of Pennsylvania Courts (AOPC).

The demographics of the sample indicate that he vast majority of the parolees were male (92 percent), the majority non-White (59 percent), and the mean age 36 years. Additionally, the average amount of time served before release hearing was 48 months (4 years); 43 percent of the parolees were assigned high-level supervision, 26 percent were released under medium-level supervision, with the reminder assigned low supervision levels. (The demographic characteristics of the sample are summarized in Table 1 in the Appendix).

*Study Variables*

*Outcome Measures*. The analyses focused on two outcomes: any reoffending for any type of crime,
and any reoffending for serious crimes against the person (i.e. violent offenses).\(^1\) Both were measured as rearrest during the two-and-a-half year follow-up period.

**Mental Health Status Factors.** We derived mental health status information from three specific sources. Two of them are based on the two risk tools in use by the two correctional institutions: The Level of Service Inventory-Revised (LSI-R) (Andrews & Bonta, 1995), in use by PBPP, and the Post-Conviction Risk Assessment (PCRA) (U.S. Courts, n.d.), in use by DOC. The LSI-R is one of the most widely employed risk-needs assessment instruments in corrections in the US and elsewhere, available on the commercial market. PBPP uses it both in its determination of release decisions, and to establish levels and conditions of supervision. The risk tool in use at study time by the DOC for classification purposes, the PCRA instrument, is too a risk-needs actuarial tool, also employed in many jurisdictions in the United States. Both of these risk tools build on a large number of dynamic and fixed risk attributes. For this study, five specific items from LSI-R, comprising the “Emotional and Personal” sub-scale and tapping emotional wellbeing, were deemed particularly relevant because they convey information relevant to mental health status. These include: whether emotional issues create moderate interference in one’s life (Question # 46); whether emotional issues create severe interference or indicate active psychosis (Question #47); whether the inmate had undergone mental health treatment in the past (Question #48); whether the inmate was undergoing mental health treatment currently (at assessment time) (Question #49); and lastly, whether or not there is an indication of a psychological assessment (Question #50). We tested them individually as well as grouped together.

The PCRA, too, contains several domains. We included here five items complementing information gained from LSI-R. These are: indication of anger management problems (PCRA Risk #10); indication of history of impulsivity (PCRA Risk #16); indication of personality disorder (PCRA Risk #18); indication of suicide attempts (PCRA Risk #22); and lastly, indication of history of non-compliance to treatment and medication (PCRA Risk #24). Again, we tested each of these separately and in block. Lastly, the third source of information on parolees’ mental health derives from their parole hearing interview, which among others noted whether the candidates reported a history of mental health problems. (To distinguish this measure from the others, we designated this as the "self-reported" measure in our analyses.)

**Control Factors.** In efforts to identify any unique influence that mental health risk factors identified prior to release might have on subsequent reoffending, we first identified other predictors of reoffending to use for control purposes. Informed by prior research, this pool of factors included demographic characteristics (gender, race, age), characteristics of the offense controlling the sentence (e.g., offense type, offense gravity scores, whether co-offenders were involved), and prior criminal record information (e.g., prior convictions and incarcerations, probation and/or parole revocations, arrest before age 16). All these in the past have been empirically shown to be predictive of recidivism post-incarceration—and some to facilitate the influence of mental health conditions. In addition, because of their most immediate recency, we also included institutional behavior and programming factors (e.g., misconduct charges and verdicts, program enrollment, housing classification), as well as the length of time served. Lastly, we used the release method (directly in the

\(^1\) The following crimes were included as serious crimes against the person: murder, manslaughter, arson, kidnapping, robbery, rape and other sexual assaults, aggravated assault, as well as attempts of each.
community, or to a Community Corrections Center) and the supervision level assigned (high, medium, and low) to control for time at risk. In using supervision levels as controls, the point was to consider the presumptive intensity of monitoring involved by the different levels of supervision imposed. Detailed measures of dosage or units of supervision, or services actually delivered, were not available; thus, we settled instead for the level of supervision that was assigned. All in all, the analyses used a host of potential other predictors, in efforts to isolate the unique influence of the mental health factors on subsequent reoffending. (Table 2 in the Appendix presents the descriptives for all study variables.)

Analysis Plan
For both outcomes, any rearrest and violent crime rearrest, we staged the analyses to capture both direct and indirect effects. The ultimate aim was to determine whether mental health indicators predicted the outcomes net of the effects of other factors that might explain them. Additionally, this staging allowed us to determine the extent to which the addition of the mental health factors improved the prediction of any rearrest and violent crime rearrest. In sum, for each outcome we run a series of statistical models. The first model included control factors but not mental health factors. This is our baseline model. The next three models estimated the outcomes by including separately each of the three categories of mental health factors described above, grouped based on their source (self-reported, LSI-R items, and PCRA items, respectively). Lastly, the final models combined all mental health indicators and added them to the other predictors of the outcomes (baseline models).

Results
During the two-and-a-half-year follow-up period, 36% of the parolees were rearrested for any kind of offense and 9% were rearrested for violent offenses. Table 3 in the Appendix includes the results for the prediction of rearrest for any crime and Table 4 presents the estimates for rearrest for violent crimes.

Prediction of Rearrest for Any Crime
Our baseline model, for comparison purposes, included factors independent of mental illness such as demographic characteristics, characteristics of the offense, and prior criminal record information. Several factors emerged as robust predictors of rearrest for any crime. We briefly list their influence below:

- Prior parole/probation revocation: parolees with parole and/or probation revocation in their record were twice as likely to be rearrested compared with their counterparts with no prior community supervision failure.
- Arrest before age 16: having the first arrest before the age of 16 increased chances of rearrest

2 Thus, we examined first relationships at the bivariate level, and next, the multivariate level. Given the dichotomous nature of the outcomes, we relied on logistic regression modeling, specifically the techniques recommended by Hosmer and Lemeshow (2002). Initially, variables were screened for their relationship with the outcomes through bivariate analyses at a relaxed significance test (p<.25). Those variables that passed this initial screening stage were further employed at the multivariate stage, after being screened for multicollinearity as well. In a final stage, the focus was on identifying the best fitting model, that is, the most parsimonious model that provided a good fit to the data. At this stage, dropping of variables was based on examining the significance of the difference between the goodness of fit tests (-2LogLikelihood) of the models with and without the variable being dropped. All correlations among variables included in the models presented were well below the .7 acceptable threshold (correlation matrix available upon request).
by almost 50%.

- Program enrollment during prison stay: parolees who enrolled in any program during their incarceration were 60% less likely to be rearrested compared to those not participating in such programs.
- Length of time served: each additional month served decreased the likelihood of rearrest by approximately one percent.
- Institutional behavior: having a misconduct charge involving threats against persons increased the chances of rearrest by 66%, and having a record of any adjudicated misconduct increased the probability of rearrest by 55%.
- Attributes of the controlling offense: having a property offense as the conviction controlling the sentence from which the parolees were released increased the probability of their rearrest by 55% percent; similar results emerged for having a robbery offense; in contrast, having a co-offender involved in the instant offense reduced the probability of rearrest (weak effect, however).
- Demographics: age had a very strong effect, with each year increment in age decreasing the likelihood of rearrest by three percent; White parolees, in contrast with the non-White individuals in the sample, were about 33% less likely to be rearrested; gender was not significant.
- Time-at-risk factors: the method of releases, i.e., whether the parolees were released straight to parole supervision or to a transitional facility first, did not make a difference; however, the supervision levels carried significant weight: when contrasted with parolees assigned to the minimum level of supervision, those parolees assigned to maximum supervision were the most likely to be rearrested, followed by the parolees assigned to medium supervision.

In sum, consistent with prior research on prediction of recidivism, our baseline analyses suggest that the predictors with the greatest influence include prior criminal history attributes, factors related to the most recent incarceration, the parolee’s age, and the level of supervision assigned.

**Effects of Mental Health Factors.** Our next set of models tested for the impact of mental health factors on rearrest for any crime, the primary focus of our analyses. At the onset, we have to note that when looked at on their own, none of mental health factors we tested were significantly correlated with the occurrence of subsequent arrest for any crime, suggesting a lack of direct effects. Subsequently, we tested each set of mental health factors in block (self-reported, LSI-R items together, and PCRA items together, respectively). At this stage again, neither the self-reported measure nor the LSI-R measures were significantly associated with the likelihood of rearrest. In the PCRA model, two measures show a weak effect: the indicator of personality disorder, associated with an increase in rearrest, and the indicator of non-compliance with treatment medication, associated with a decrease in rearrest.

With all this being done, an interesting picture emerges when all mental health factors are combined with the previously identified predictors of rearrest (baseline model) to estimate the influence of the mental health factors in the presence of these other predictors of rearrest. In this combined model (Model 5 in Table 4, Appendix), two particular mental health factors contribute significantly to the prediction of rearrest. These include:

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3 For space economy, we did not tabulate the bivariate results, which are available upon request.
• The indication of current mental health treatment (at assessment time), an LSI-R item previously not significant, which now increases the chances of rearrest by 50%; and
• Among the PCRA factors, the influence of non-compliance with treatment becomes significantly stronger, associated with about a 70% decrease in the likelihood of rearrest.

Importantly, comparing these results with our baseline model (without mental health factors) we note that the addition of the mental health factors did not alter in any meaningful way the impact of any of the previously identified predictors of rearrest. This, coupled with the non-significance of the independent direct relationships between mental health factors and rearrest, indicates that their impact is entirely brought out (i.e., mediated) by the combination of all other predictors of rearrest—most of which include criminal history and controlling offense characteristics.4

**Prediction of Rearrest for Violent Crime**

Similar to our analyses for rearrest for any crime, we began the analyses of rearrest for violent crime by examining predictors independent of mental health factors, and then we examined contribution of the latter (all models are presented in Table 4 in the Appendix). The baseline model, identified for comparison/control purposes, showed the following:

• Controlling offense: having a robbery offense for the controlling conviction sentence increased the chances of rearrest for a serious personal offense by two and half times.

• The DOC grouping of offense gravity scores (OGS) was also strongly associated with the likelihood of subsequent arrest for violent crimes: compared to parolees with instant offenses rated as OGS low category, parolees with instant offenses rated in the OGS high category and medium categories had significantly higher probability of being arrested for a violent crime (six times, and three times as high, respectively).

• Institutional behavior: having a misconduct charge involving illegal possession of drugs and contraband and having a misconduct charge involving threats against persons both increased parolees’ chances of being rearrested for violent crimes over parolees with no such misconducts in their most recent prison stay.

• Program enrollment and related factors: participation in any institutional programming while incarcerated and having DOC housing reports with “above average” ratings both reduced the chances for being rearrested for violent crimes by half.

• Length of time served: any additional month in prison decreased the chance of rearrest by 1%.

• Criminal history indicators: whether the parolee had an early arrest (before the age of 16) contributed strongly to the prediction of rearrest for violent crimes, with these parolees being 80% more likely to be rearrested.

• Demographics: age did not predict violent crime rearrest, nor did gender; race was a significant predictor, with White parolees being half as likely to be rearrested than non-White parolees.

• Time-at-risk factors: the only measure raising to significance was the maximum supervision indicator, with parolees placed under this supervision level being more than twice as likely to be rearrested (when compared to parolees under minimum supervision).

In sum, a slightly different picture emerges for the predictors of violent crime rearrest when

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4 Comparing the model fit statistics, the relative increase in the percentage of variance explained (about 4%) is also notable. Although this goodness-of-fit measure has limitations (see Hosmer and Lemeshow, 2002), it can be useful when comparing analyses and predictive models based on the same sample.
contrasted to the “any rearrest” outcome. More specifically, the attributes with the strongest influence were those related to the characteristics of the controlling offense rather than prior criminal history or demographics (recall that parolee’s age was a very strong predictor for any rearrest). This being said, the factors related to the most recent prison stay (institutional behavior and programming, and length of time served) as well as the supervision level had similar effects for both outcomes.

Effects of Mental Health Factors. As we did with the “any rearrest” models when introducing our mental health factors, we began by examining the direct relationships—and again, slightly different results emerged at this stage when contrasting the findings with those for the any rearrest prediction. Although neither the self-reported measure nor the LSI-R measures were significantly associated with the likelihood of rearrest for a violent crime, two PCRA items showed significant associations at this stage: the indicator of history of impulsivity and the indicator of personality disorders. Specifically:

- 12% of the individuals with a history of impulsivity were rearrested, compared with 8% of those parolees without such a record; and
- 14% of parolees with indication of personality disorder were rearrested, compared with 8% of parolees without such indicator.

When moving to the next stage of analyses, however, estimating the violent crime rearrest outcome by using the mental health factors grouped based on their source, none of the mental health factors seemed to predict the outcome—similar to our efforts predicting rearrest for any crime. Lastly, and in contrast with the corresponding analyses for any rearrest, the lack of significant effects, for the most part, persisted when we also estimated the full model, combining all mental health factors with the previously identified predictors of violent crime rearrest. Here, with one possible exception, we were mostly unable to detect the kind of indirect effects we uncovered in the analyses of rearrest for any crime. Additionally, the presence of the control factors explained away the two correlations found earlier between violent crime rearrest and the indicators of impulsivity and personality disorder, respectively. The one exception is the effect of the self-reported mental health status, which in the presence of all other predictors becomes comparatively stronger, with parolees who had reported mental health problems being almost twice as likely to be rearrested for a serious personal crime than parolees not reporting mental health problems. However, the significance of the effect was very weak, not reaching statistical significance.

Discussion
To start with, we should note that the rearrest rates in this sample of Pennsylvania parolees, 36% for any crime and 9% for violent crimes, are comparatively low rates of reoffending, relative to US national estimates (Mears & Cochran, 2015)—especially considering that the study used rearrest as the measure of recidivism, a conservative measure compared to reincarceration. In particular, the violent crime rearrest figure supports a fact already shown in the literature (Alper & Durose, 2018; Berk, 2017), that reoffending for violent offenses occurs much less frequently than other types of reoffending, despite what the public may believe and their over-emphasis in the media.

When looked at all results combined, the most important takeaway finding from this study is that none of the mental health factors tested here had any direct role in predicting future recidivism. This finding is all the more outstanding considering that the study tested for a multitude of factors, tapping into a variety of mental health dimensions, ranging from overall status to treatment-related
indicators and to specific conditions or symptoms. The study did identify indirect effects for a couple of mental health factors tested, facilitated fully by other factors, including overall criminal history and most recent institutional stay. Thus, our study adds external validity to the growing body of research reviewed above on the relationship between mental health conditions and violence and recidivism. The study supports the conclusion reached by others (Bonta et al., 1998; Honegger & Honegger, 2019; Mason et al., 2001; Phillips, 2005; Skeem et al., 2014), that efforts to assess the influence of mental health conditions on crime involvement need to take into account the other criminogenic risks of the mentally ill individuals; and that their over-representation among the criminal justice population is an indirect effect of their mental health problems and not a direct consequence of their unique risk as mentally ill afflicted individuals.

Another important contribution of this study stems from its dual focus on overall recidivism and violent crime reoffending, both of concerns to practitioners and policymakers alike. The results here support the notion that efforts to explain and predict violent crime separately are warranted (see, for other recent efforts, Berk, 2017; Shepherd, Campbell, & Ogloff, 2018), as our analyses were able to identify different sets of predictors for each outcome. Moreover, the influence of mental health factors varied across the two outcomes: we found indirect effects mostly for the overall measure of recidivism, and the one significant correlation found with the violent crime outcome disappeared once we accounted for other factors in our statistical models. Admittedly, some of these differences might be an analysis artifact, due to differences in the occurrence rates for the two outcomes. That is, it could be that regarding the violent crime rearrest analyses, we were unable to detect the indirect effects we found for the overall crime rearrest merely because of the lower base rate of the outcome (9% v. 36%), and not because such relationship was not manifest in the sample. (In other words, it was statistically easier to detect the effects we found for the overall measure of rearrest, because those individuals rearrested for any crime represented a larger proportion of the sample.)

Narrowing in on those significant relationships uncovered in this study regarding the any rearrest outcome, they themselves are interesting, given their different directionality. Thus, the indication of current mental health treatment (at LSI-R assessment time) increased the chances of rearrest, while the indication of non-compliance with medication-based treatment (at PCRA assessment time) decreased those chances. At face value, these results seem to contradict conventional expectations: ideally (assuming the treatment works), the treatment should reduce the likelihood of future crime involvement; and non-compliance with treatment should increase that same likelihood. In trying to reconcile these two results with this expectation, and between themselves, the one explanation that comes to mind relates to the recency and nature of the treatment itself. This conclusion would be supported also by the fact that the indicator of past mental health treatment, also tested, was not significantly related to the chances of rearrest, reinforcing the notion that there must be something about the treatments themselves and their timeline that can explain the observed differences. This is very plausible, considering the timing of the measurement of these indicators: all these indicators of mental health were noted at the assessment time by the correctional staff conducting the assessments. The LSI-R assessment, conducted by the Parole Board, was done close to the release time; the PCRA assessment was conducted instead at the front-end, by the Department of Corrections, for classification purposes. Thus, the indication of “current” treatment in the LSI-R refers to the treatment provided in the correctional facility during the prison stay from which the parolee is gaining release, while the indication of “past” treatment refers to any type of community-based
treatment (including self-initiated) that the parolee had received before his/her incarceration. The PCRA items, on the other hand, take note of mental health issues occurring early in the prison stay, focusing on detection of active symptomatology with the purpose of managing special supervision needs.

It is quite conceivable then that the individuals identified early in their prison stay during their PCRA/DOC assessment as "non-compliant" with medication might have later become compliant, particularly knowing that such compliance would increase their chances of gaining earlier release from prison via parole. In turn, their compliance might have increased treatment effectiveness, which carried over post-release (Andrews, Zinger, Hoge, Bonta, 1990; French & Gendreau, 2006; McGuire, 2002), and thus could explain their lower likelihood of rearrest. Conversely, for the individuals under any type of mental health treatment at LSI-R/parole eligibility assessment time (close to release), it is conceivable that their mental health issues continued to persist following their release (and during the study follow-up period). They very likely experienced a break in their treatment protocol as they had to transition from their institution-based treatment to community-based treatment, which is often reserved for the more seriously mentally ill offenders, with overt symptomatology (Lurigio, 2001). If their needs for treatment persisted and were not adequately met following their release (Slate et al., 2013), all this could have negatively affected their readjustment and behavior while under community supervision on parole. In sum, a combination of factors might explain the differences in the effects we found in this study for the different mental health indicators tested, related to the timing and nature of the treatment provided to the parolees in the study sample.

Besides the significant factors discussed above, two other mental health factors are worth mentioning for their potential influence on the likelihood of crime reinvolvement: the indicator of personality disorder, which increased the chances of rearrest for any crime, and the self-reported history of mental health problems, which too increased the chances of rearrest for violent crime. Although their influence did not reach conventionally significant levels, they nonetheless point to the need for further exploration in future studies. More generally, given the differences in effects found for the various mental health factors we tested here, the current study underscores the continuing need for future research focusing on examining the relationship between mental health status and crime involvement to delve into various and specific dimensions and conditions of mental health. In line with previous recommendations, such future efforts should also attempt to use measures of mental health status independent of criminal involvement (or, absent that, control for prior criminal history) (see Phillips et al, 2005, p. 845, noting the "circular nature" of the definition of antisocial personality disorder, specifically that a diagnosis is largely dependent on a significant history of previous offenses).

Implications and Conclusions
With all this being said, we should not lose sight of the main finding of the study: that all effects found here were indirect, fully mediated by the presence of the other predictors of rearrest, that is, criminogenic risk factors that equally affect the non-mentally ill parolees. The implication of this finding is critical: for crime prevention purposes, the focus among practitioners should be on identifying general risk factors that equally affect mentally and non-mentally ill individuals. Thus, we join others who in the past called for placing greater emphasis on mentally ill's general criminogenic risk factors rather than their clinical manifestations in assessing criminal involvement risk (Bonta et al., 1998; Phillips et al., 2005; Monson et al., 2001; Skeem et al., 2014). More specifically,
risk assessment tools aimed at classifying individuals based on their risk of reoffending should not include mental health indicators, which run the risk of continuing to stigmatize a population of offenders already subjected to “dangerousness” stereotyping due to their mental health afflictions. Although parole boards and corrections departments’ reliance on evidence-based risk assessments is commendable, the inclusion of mental health factors may discriminate against the mentally ill, whose afflictions already confounds their criminogenic risks (Phillips et al., 2005). For example, persons suffering from borderline personality disorders tend to suffer a myriad of other symptoms such as those found on criminal justice risk assessment tools (e.g., substance abuse; poor employment history) (National Institute of Mental Health, n.d.).

The mentally ill also have more difficulty adjusting to the prison environment and consequently tend to be charged with more institutional misconduct than their non-mentally ill counterparts (Adams, 1986; Houser & Welsh, 2014; Houser, et al., 2012; James & Glaze, 2006). In this study, too, we found institutional misconduct indicators to be robust predictors of post-release reoffending, which again exacerbates the outlook for the mentally ill offenders. As Houser & Belenko (2015) argued, punitive responses to the seriously mentally ill only serve to set them up for future failure. Lastly, for many mentally ill, their disorders are exacerbated by the co-occurrence of a substance use disorder, necessitating integrated treatment programming to address the disorders simultaneously, which most often is not available (Houser & Welsh, 2014; Houser, et al., 2012; James & Glaze, 2006; Wexler, 2003).

To be clear, our call for excluding mental health factors from risk instruments should not be taken as a recommendation that the specific needs of mentally ill offenders be ignored. To the contrary, knowing that mental health issues may confound the criminogenic risks of the mentally ill, greater attention and resources should be allocated to screening and assessment specifically for mental health—for the purposes of identifying and meeting the specific needs of this burgeoning correctional population. It is worth repeating here that even in this study the mental health factors we employed in our predictive analyses derive from risk tools focused on predicting reoffending. As such, the overall assessments, including the mental health components, were conducted by non-clinical correctional staff. As others have advocated (Spencer & Fallon, 2012), better trained staff, starting at assessment stage, and more mental health specific programs, under the purview of clinical staff, can lead to improvement in treatment success and perhaps reduce both institutional misconduct and future reoffending.

Study limitations and future research. The study drew on a rich dataset and a large sample, and employed rigorous analytic techniques, including its longitudinal design. It also employed multiple measures for the mental health status as the primary predictor, and a host of control variables. All of this offers great confidence in the reliability and validity of the study’s results. This being noted, we also note that the study is not without its limitations. In particular, the use of rearrest as a measure of reoffending suffers the limitations normally associated with reliance on official records. Here, rearrest was measured by using state court system data from the Administrative Office of the Pennsylvania Courts (AOPC) to include any criminal charge reaching the courts stage during the follow-up period. This court-based definition of reoffending or re-contact with the justice system does not include arrests never reaching the first judicial stage and includes arrests that in some cases may later have been dismissed. Ideally, future investigations into the role of mental health factors
in crime involvement move away from official measures of crime—especially given the fact that the mentally ill are more likely to be caught up in the criminal justice system due to their stereotyping as more dangerous. For the current study, which followed the tradition of many before it using official records, among available choices of data that could have served as a measure of reoffending by parolees, this choice, of rearrest, was not only the most feasible and reliable, it was also the most conservative.

Similarly, although the study employed several distinct measures capturing various dimensions of mental health—all of which increase reliability and validity of measurement—the fact remains that these are not based on clinical assessments of mental health status. They are indirectly inferred from a restricted set of items contained in risk instruments administered by non-clinicians; thus they are rather proxy measures that we used to determine mental health status. In the absence of clinical assessments, which we have called for above, these accessible measures are nonetheless allowing the research to move the field forward.

In terms of controls we employed, our study included a variety of potentially relevant individual level factors, such as, demographics, prior criminal history, institutional record, and time-at-risk measures, thus addressing many limitations affecting prior research. However, further research should also explore and attempt to account for community level conditions, particularly those tapping into the level, type, and availability of resources. Research has shown that recidivism rates vary by neighborhood structural factors, in particular neighborhood disadvantage (e.g., Sampson, 2011; Peterson & Krivo, 2010); and furthermore, that the role of mental health factors in predicting violence and recidivism may disappear once neighborhood conditions are accounted for (Houser, Saum, & Hiller, 2019; Silver, 2000). Conceivably, parolees returning to communities benefiting from more resources, especially mental health programs, would fare better during their supervision and beyond (see Seto, Charette, Nicholls, & Crocker, 2018).

**LIST OF REFERENCES**


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5 The use of rearrest as a measure of recidivism, and lack of neighborhood/community-level controls, may also explain the race effects found in this study, as research has documented that the disproportionate representation of minorities in the criminal justice system is to a certain extent due to their being disproportionately targeted by law enforcement agents or strategies (Beckett, Nyrop, Pfingst, 2006; Fagan, Braga, Brunson, & Pattavina, 2016; Rios, 2011; Golub, Johnson, & Dunlap, 2007) and that the relationship usually disappears once community level factors are accounted for (Sampson, 2011; Silver, 2000; Peterson & Krivo, 2010).


Article 2: The Role of Mental Health Risk Factors in Predicting Parolee Performance in the Community: An Empirical Examination in a Large US Jurisdiction


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## Table 1: Sample (N=1139)

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\(^a\) Counts do not add up to 1139 because of missing data on 1% of cases.
Table 2: Descriptive Statistics for Study Variables in Logistic Regression Models

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Abbreviations: OR = Odds Ratios; SE=standard error. *** p ≤ .001; ** p ≤ .01; * p ≤ .05; * p ≤ .10.
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Abbreviations: OR = Odds Ratios; SE=standard error. *** p≤.001; ** p≤.01; * p≤.05; ^ p≤.10.
### Table 4: Logistic Regression Models Predicting Rearrest for Violent Offense: Control Variables, and Self-Reported, LSI-R, & PCRA Mental Health Models

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Abbreviations: OR = Odds Ratios; SE=standard error. *** p<.001; ** p<.01; * p<.05; * p<.10.
### Table 4: (Continued)

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Model 4</th>
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<th>Model 5</th>
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<tr>
<td></td>
<td>B (SE)</td>
<td>OR</td>
<td>B (SE)</td>
<td>OR</td>
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<tr>
<td>Gender</td>
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<td>1.18 (.77)</td>
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<tr>
<td>Race</td>
<td>---</td>
<td>---</td>
<td>-.66 (.28)</td>
<td>.52*</td>
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<tr>
<td>Age</td>
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<td>-.01 (.01)</td>
<td>.99</td>
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<tr>
<td>Controlling offense – Robbery</td>
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<td>.88 (.31)</td>
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<td>Offense gravity score (OGS) – Medium</td>
<td>---</td>
<td>---</td>
<td>1.09 (.62)</td>
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<tr>
<td>Offense gravity score (OGS) – High</td>
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<td>---</td>
<td>1.85 (.72)</td>
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<tr>
<td>Arrested before age 16</td>
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<td>---</td>
<td>.58 (.24)</td>
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<tr>
<td>Misconduct charge – Illegal possession</td>
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<td>.68 (.27)</td>
<td>1.97*</td>
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<tr>
<td>Misconduct charge – Threat/extortion/blackmail</td>
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<td>---</td>
<td>.81 (.30)</td>
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<tr>
<td>Any program enrollment</td>
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<td>-.78 (.24)</td>
<td>.46***</td>
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<tr>
<td>Housing performance at reclassification</td>
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<td>---</td>
<td>-.81 (.40)</td>
<td>.44*</td>
</tr>
<tr>
<td>Time served (in months)</td>
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<td>---</td>
<td>-.008 (.003)</td>
<td>.99*</td>
</tr>
<tr>
<td>Parole supervision level – Medium</td>
<td>---</td>
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<td>.59 (.37)</td>
<td>1.81</td>
</tr>
<tr>
<td>Parole supervision level – High/enhanced/special</td>
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<td>2.24*</td>
</tr>
<tr>
<td>Release to Community Correction Center</td>
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<td>.35 (.24)</td>
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<tr>
<td>Self-reported mental health problems</td>
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<td>.66 (.35)</td>
<td>1.94*</td>
</tr>
<tr>
<td>LSI-R – Moderate interference</td>
<td>---</td>
<td>---</td>
<td>.20 (.33)</td>
<td>1.22</td>
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<tr>
<td>LSI-R – Severe interference, psychosis</td>
<td>---</td>
<td>---</td>
<td>-1.24 (1.11)</td>
<td>.29</td>
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<tr>
<td>LSI-R – Past mental health treatment</td>
<td>---</td>
<td>---</td>
<td>-.06 (.28)</td>
<td>.94</td>
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<tr>
<td>LSI-R – Present mental health treatment</td>
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<td>.15 (.31)</td>
<td>1.16</td>
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<tr>
<td>LSI-R – Psych assessment indicated</td>
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<td>---</td>
<td>-.27 (.28)</td>
<td>.76</td>
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<tr>
<td>PCRA – Anger management</td>
<td>.09 (.31)</td>
<td>1.10</td>
<td>-.16 (.34)</td>
<td>.86</td>
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<td>PCRA – Impulsivity</td>
<td>.34 (.26)</td>
<td>1.40</td>
<td>.08 (.30)</td>
<td>1.08</td>
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<tr>
<td>PCRA – Personality disorder</td>
<td>.39 (.34)</td>
<td>1.48</td>
<td>.45 (.38)</td>
<td>1.56</td>
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<tr>
<td>PCRA – Suicide attempts</td>
<td>.27 (.43)</td>
<td>1.31</td>
<td>.01 (.50)</td>
<td>1.01</td>
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<td>PCRA – Non-compliant with meds</td>
<td>-.81 (.79)</td>
<td>.45</td>
<td>-.78 (.85)</td>
<td>.46</td>
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<tr>
<td>Constant</td>
<td>-2.50 (.14)</td>
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<td>4.60 (1.14)</td>
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<table>
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<tr>
<th>N</th>
<th>1139</th>
<th>1120</th>
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<tbody>
<tr>
<td>Pseudo (Nagelkerke) R²</td>
<td>.01</td>
<td>.20</td>
</tr>
<tr>
<td>-2 Log Likelihood</td>
<td>679.43</td>
<td>573.03</td>
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</table>

Abbreviations: OR = Odds Ratios; SE=standard error. *** p<.001; ** p<.01; * p<.05; ^ p<.10
COMMUNITY TRANSITION FROM THE CRIMINAL JUSTICE SYSTEM FOR OLDER ADULTS WITH SCHIZOPHRENIA – A PILOT STUDY

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University of California, San Francisco, Department of Physiological Nursing

Abstract

Older adults with schizophrenia who are involved in the criminal justice system have unique circumstances around community re-entry. The purpose of this paper is to describe the impact of programs and services addressing symptom management and transition to community integration for people with schizophrenia that have a history of criminal justice involvement in the United States and are currently successfully living in the community. An exploratory secondary analysis of semi-structured individual interviews was conducted with 7 older adults (mean age 59, sd= 2.9, range 56-65) with schizophrenia. Qualitative data were collected and analyzed with content analysis. Seven participants discussed involvement with the criminal justice system and emphasized the importance of ongoing access to medications and therapy to help maintain symptom management. Housing, case management, and social services were indicated as promoting community integration. A recurrent theme was the need for continuity of services and engagement in supportive programs as a means to successful community re-entry and avoiding additional contact with the criminal justice system. Our results suggest that time unlimited access to medications and therapy, in addition to programs providing housing, case management, and social support have a positive impact on successful community re-entry for older adults with schizophrenia. Programs that provide time unlimited, integrated services to meet the specific needs of this vulnerable population may increase successful transition to re-entry, ameliorate recidivism, and benefit the community at large.

Key words: criminal justice, serious mental illness, transition, forensic re-entry, mental health policy
Background and Objectives

The number of people 55 or older with schizophrenia in America is projected to double, reaching 11 million by 2025, representing 25% of all people with schizophrenia (Cohen, et al., 2008). People with schizophrenia are overrepresented in the criminal justice system. A 2011-2012 United States Department of Justice, Bureau of Justice Statistics special report on indicators of mental health problems reported by prison and jail inmates found that 14.5% of prison and 26.4% of jail inmates were currently in psychological distress. To that point, 36.9% of prison and 44.3% of jail inmates had a history of a mental health problems. Respectively 8.7% of prison and 11.7% of jail inmates had a history of schizophrenia or other psychotic disorder (Bronson and Berzofsky, 2017). People with serious mental illness (SMI) have a 150% greater relative annual risk of going to jail than being admitted to a hospital for psychiatric care (Morrissey, Meyer and Cuddeback, 2007). In the U.S., state prison incarceration of people 55 and older has also increased at a rate faster than that of younger adults (Carson and Sabol, 2016). For example, from 2003 to 2013, there was a decline of 69% in the number of incarcerated individuals age 39 or younger, while incarcerated individuals age 55 or older accounted for most of the growth in the prison population.

The course of psychiatric illness for older adults with schizophrenia varies: some achieve symptom remission or become experts at managing symptoms, many struggle daily to manage symptoms, and others fluctuate between statuses (Cohen et al., 2018). Positive symptoms (e.g., hallucinations, delusions) may decrease in later life yet the negative symptoms (e.g., apathy, anhedonia) tend to persist. Depression is common (44-75%) for middle-aged and older adults with schizophrenia (Cohen et al., 2018). The symptom experience is further impacted by incarceration.

Older adults with schizophrenia tend to experience significant disabilities and comorbidities that interfere with daily function (e.g., chronic obstructive pulmonary disorder) (Chafetz et al., 2006; Viertio et al., 2009; Cohen, Meesters and Zhao, 2015). The cost to care exceeds that of other common medical and psychiatric disorders (e.g., dementia) (Bartels et al., 2003). Age adjusted mortality rates for people with schizophrenia are two times that of the general population and they often die 10-25 years earlier than someone without SMI (Parks et al., 2006).

Medications are used to manage symptoms such as delusions, hallucinations, and paranoia. Social skills training programs are helpful as adjunct treatment of symptoms (e.g., apathy, anhedonia, depression), and life skills training and socialization can help with depression and isolation (Kurtz and Mueser, 2008). Supported employment programs and cognitive training are also known to be effective (Twamley et al., 2009; Bell et al., 2014). Case management strategies include the improvement of the patients’ social and cognitive skills in conjunction with physical health enforcing strategies (Bartels and Pratt, 2009; Cohen, Meesters and Zhao, 2015).

In the U.S., there is no national standard for the provision of treatment and services for community re-entry after incarceration for older adults with schizophrenia. Schizophrenia and aging can compound difficulties of reintegration, such as finding adequate housing and healthcare. In addition to the stigma of prior involvement with the criminal justice system, older adults with schizophrenia experience unique forms of self-stigma, public stigma, and institutional stigma, negatively impacting community integration (U.S. Department of Health and Human Services, 2005). Currently, there are inadequate transitional programs and services, during incarceration and post-release, for this population.
(Baillargeon, Hoge and Penn, 2010). Mental health policies in the U.S. affecting transitional treatment vary by counties and states. For example, in California, under Proposition 63 (a mental health policy), about 1.8 billion dollars are allocated annually to county and state mental health programs. Analysis of Proposition 63 suggests that it has helped lower recidivism rates among Californians with mental health problems and could serve as one example of a policy for other states or countries to follow (Scheffler et al., 2010).

The purpose of this paper is to describe the impact of programs and services addressing symptom management and transition to community integration for older people with schizophrenia that have a history of criminal justice involvement and are currently successfully living in the community.

Research Design and Methods

Materials: In the original, parent study, conducted during 2007-2009, participants self-referred or were referred to the principal investigator by staff at the mental health facility they attended. Participants self-selected a pseudonym to be used throughout the interview. Inclusion criteria required that participants be at least 55 or older, have a diagnosis of schizophrenia or schizoaffective disorder, and pass a capacity to consent test based on comprehension of the consent form. Potential participants were excluded if they did not understand study procedures and purposes determined by failing a capacity to consent form.

Twenty-eight older adults (mean age 61, s.d. = 6, range 55-76) were enrolled from 3 locations: a transitional residential and day treatment center for older adults with SMI, a locked residential facility for adults with SMI, and an intensive case management program. Data collection consisted of interviews and participant observation. The interviews were conducted with a semi-structured interview guide that was malleable to the responses and emerging themes encountered. Some of the interview questions included; 1. Tell me what being healthy means to you; 2. Tell me about your health; 3. In what living situation have you felt the most and least healthy? Interviews lasted approximately 30 to 90 minutes. Ongoing participant observation was completed during the interview and visits to the sites.

In the parent study, data collection and analysis were conducted using a grounded theory approach of constant comparison analysis as initially described by Glaser and Strauss (1967). The base approach to grounded theory was further informed by Charmaz (2006). Field notes, memos, and interview transcriptions were entered into Atlas.Ti software to assist with data organization. The researcher transcribed interviews verbatim and then checked transcriptions with audio recordings. Interviews and field notes were initially coded by the researcher.

Grounded theory provided the methodological basis for the parent study and guided data collection and analyses of the parent study. Symbolic interactionism provides the theoretical framework of grounded theory methodology, supporting the approach that individuals’ understandings occur within the context of relationships and situations (Blumer, 1969). Human subjects’ approval was obtained from the sponsoring university’s Institutional Review Board (IRB). Confidentiality and anonymity were maintained according to IRB guidelines.
Article 3: Community Transition from the Criminal Justice System for Older Adults with Schizophrenia – a Pilot Study

**Design:** Qualitative content analysis is a strategy for the analysis of qualitative studies (Sandelowski, 2000). Content analysis was chosen as the approach for this secondary analysis because of the limited data in the sample that focuses on criminal justice which limited our ability with theory development. In addition, content analysis allowed the research team to extract categories from the data that can be further explored in future work.

**Analysis:** For this exploratory secondary analysis, we limited our content analysis to the interviews from the parent study that included narratives about criminal justice involvement and re-entry after incarceration from the jail or prison setting. We utilized a type of focused coding that allowed us to hone in on narratives around criminal justice involvement, re-entry, jail, and or prison. Through this type of focused analysis, the researcher moves “across interviews and observations and compares people’s experiences, actions and interpretations” (Charmaz, 2006) allowing the researcher to condense the data. From our focused analyses, the concepts that emerged were community integration, case management, symptom management, and social services. The PI for the parent study led the analyses for the secondary analysis conducted for this report.

**Results**

**Participants:** Seven participants (mean age 59, sd= 2.9, range 56-65) described narratives about criminal justice involvement. Analysis of the narratives revealed the categories of symptom management and community integration as playing critical roles in the re-entry process.

**Symptom Management:** Participants emphasized the importance of ongoing access to therapy and the right medications for their unique symptoms to help maintain symptom management. Earl was a participant that struggled for years to find an effective medication and finally a treatment that worked when he was incarcerated:

> I tried Haldol, Prozac, Prolixin, cogentin — I tried every kind of medication you could think of. And the Abilify, I’m taking — it seems — it has no side effects. It seems to work the best for hearing voices.

It may not be necessary for a patient to have insight into their illness, as long as they know the importance of adhering to their medication. One participant, Freud, described how he was prescribed a medication by a provider at a clinic that he trusted. Although he did not necessarily agree with his diagnosis, he talked about how he takes his medication daily, both while he was in jail and out in the community, in order to stay safe. Participants also described how medications, in conjunction with seeing a therapist, helps them engage as a part of society by doing everyday activities like going for a walk, a bike ride, or taking public transit. Participants described the importance of finding a therapist that could meet their needs and preferences. For example, Zach said:

> When I first came here (case management program), I asked him can I have a gay case manager. I feel better when I’m with a gay person. Then I can feel more freely and talk and stuff like that. See, when I’m with you, I can’t really be free and talk, because I don’t know how you’re going to react.
Finding the right combination of medications and therapist could take a while, but once established, participants found it easier to manage their daily lives and integrate into the community.

Participants also described how symptoms, especially the negative symptoms and cognitive disorganization, make some tasks, like completing forms, difficult. These forms include benefits applications required to receive services, such as Medicare (healthcare) and housing.

Suzie: Yeah, because I need a therapist for many reasons because I get turned down for housing because of my criminal history. Well, in order to offset that, I need some letters from a therapist, from a psychiatrist, and from my case manager to take to City Hall in the Mayor’s Office on housing, or whatever it is, and turn that over...you know? Appeal it. So I need some of those doctors’ help.

Community Integration: Housing (including assistance finding housing), case management, and social services were indicated as promoting community integration. John described how case management and a community organization helped him navigate housing issues and criminal justice interactions.

John: I ended up in jail, and I got help by a group called "Homeless---", something to do with the sheriff’s department...One of their programs, and I happened to know the lady there from years before, and she got me a place...and see, I was homeless...I had to go to court, and make court dates, so I had to stay inside the city. I couldn’t go out where I was used to staying when I was homeless, which was out at the beach and stuff. She said I want you to go over here to the homeless outreach team... And they provided me a place to live. It’s not too bad. I don’t mind...I know it’s not the greatest place in the world, you know, but for me right now. I don’t mind it at all... I like that... I’m pretty much left alone and nobody bothers me, and I don’t bother other people.

Participants frequently described how case managers are often instrumental in helping clients with housing and social support. Malcom describes the role of his case manager:

Malcom: so I learned that if I’m going to have an issue or a problem, I’ll try to have it all home, or have it here with (case manager) in the center where I’m safe... you know, don’t get out of hand with it. Don’t you know, if you’ve got a problem, you need to talk with somebody.

Participants talked about difficulties adjusting to living on their own after the cycle of going from hospital or incarceration to home and back. These perspectives help us understand why some older adults in prison seem unmotivated about participating in programming and parole. Independent living difficulties included learning how to cook, managing medications, and scheduling appointments. For example, Joe, who had spent most of his life living in a locked facility, talked about feeling content to stay in the locked facility. Joe described his lack of training to live independently as well as little confidence in his ability to transition:

I can’t work. I don’t know how to work...I don’t know how to get by in the world. I can’t support myself. I can’t look after myself
A recurrent theme was the need for continuity of services and engagement in supportive programs as a means to successful community re-entry and avoiding additional contact with the criminal justice system. Programs providing structure and services, such as symptom management, smoking cessation, meals, opportunities to socialize, etc. are important.

Zack: I just started feeling suicidal, and just started feeling like I wanted to hit somebody, but I didn’t. You know, I controlled it. I told somebody... the best thing to do I think. Well, I don’t want to hit nobody, because if I hit somebody... I’ll go to prison, because I’ve been to prison 3 times already. And if I go to prison, and hit somebody and get a felony, they’ll throw away the key - 24 to life. And I don’t want to go back to prison for 24 to life, you know. So I’ve been out of trouble for – since 1999... doing real good... I don’t want to go to prison, because prison is like – it reminds me of right now of living in a dorm (homeless shelter). You know, all the men together, and it just – I don’t have no privacy, no nothing. I couldn’t live – I can’t live there with a lot of people. You know, it makes me schizophrenic and all this stuff.

Referring to her interactions with her case manager, doctors, and therapist, Suzie expressed the importance of being engaged in one’s own care:

Of course, they try, but still, the bottom line is that I would like to be included. I would like somebody to ask me what I need, instead of telling me what I need.

A client-centered approach is more likely to engage clients.

Discussion
Our results from this exploratory secondary analysis suggest that time unlimited access to medications and therapy may have a positive impact on symptom management for older adults with schizophrenia. Future work should further explore the concept of community integration for this vulnerable population utilizing grounded theory methodology. The development of theoretical frameworks to guide the re-entry process for older adults with schizophrenia would be useful for researchers, clinicians, and public policy makers. Access to programs providing housing, case management, and social support positively impact community integration. Time unlimited, integrated services meeting the specific needs of older adults with schizophrenia may increase re-entry success, ameliorate recidivism, and benefit the community at large.

The importance of symptom management in successful community integration is supported in previous studies. For example, a meta-analysis showed a significant negative relationship between symptoms and quality of life, and that symptoms were more disabling for those living in the community than for inpatients (Eack and Newhill, 2007). As people age, positive symptoms may decrease and negative symptoms that can be difficult to treat may increase and go unrecognized (Cohen, Meesters and Zhao, 2015). Additionally, people with schizophrenia may experience cognitive decline at an earlier threshold than those without SMI (Cohen et al., 2018). Thus, older adults with schizophrenia should have symptoms as well as cognition assessed. Existing tools, such as the Brief Psychiatric Inventory (Morlan and Tan, 1998) and the Montreal Cognitive Assessment (Nasreddine et al., 2005) can be used to efficiently screen for psychiatric symptoms and cognitive impairment, respectively. Assessments should be done prior to and upon release from incarceration and once an
individual has transitioned to the community. Assessments may be a first step to decrease barriers to transition, such as disabling psychiatric symptoms and impaired cognition. Screening and treating symptoms and cognitive deficits could help maximize one’s ability to conceptually organize and navigate the requirements of daily life (Jeste et al., 2003).

Medication adherence and side effects should be addressed and stabilized while incarcerated. Upon release, individuals should have an adequate supply of medication and linkage with case management and psychiatric care. Unfortunately, this scenario is frequently not the case (Binswanger et al., 2011). Having medical coverage in place prior to release, can help ensure coverage immediately upon release and sustained access to medications. In the U.S., State Medicaid eligibility policies for individuals moving out of incarceration vary, yet research shows that coverage immediately upon release can improve access to care (McKee et al., 2015).

Creating a Wellness Recovery Action Plan (WRAP®), an evidence-based, peer-led, behavioral health self-management intervention can help with symptom management (Cook et al., 2012). WRAP® was developed in 1997 by individuals to help manage their own mental health issues. Through peer-led education and modeling, participants learn coping strategies with individualized wellness tools, as well as how to recognize symptoms and triggers, enabling capacity building for disease management and crisis aversion (Copeland, 2002).

In a randomized controlled trial including more than 500 adults with SMI, WRAP® was significantly more effective than usual care for reducing psychiatric symptoms, improving participants’ hopefulness, and enhancing their quality of life (Cook et al., 2012). WRAP® could be initiated prior to release and revisited once participants are living in the community. Additionally, WRAP® could be entered into electronic medical record (EMR) systems, allowing clinicians and counselors access. In another study, consumers of WRAP® showed significant positive changes of: awareness in early signs of decompensation, awareness of symptom triggers, having a crisis plan in place, a plan for dealing with symptoms, and having a social support system (Cook et al., 2010). Some states, counties and correctional facilities have already incorporated the use of WRAP® with programs for those involved or previously involved in the criminal justice system (Advocates for Human Potential, no date). More evaluation should be done on existing implementation of WRAP®, to inform and encourage dissemination and adoption of peer led planning.

Psychiatric advance directives (PADs) are documents giving people the opportunity to state their treatment preferences for future psychiatric care and designating surrogate decision makers in the event that they are incapable of making informed choices (Zelle, Kemp, & Boonie, 2015). PADs are an inherent component of WRAP® or they can be done independently. Srebnik et al. (2005) found that for community mental health outpatients (n=106), 95% of facilitated PADs were clinically useful (Srebnik et al., 2005). The directives were feasible, useful, and consistent with practice standards. A study among public mental health consumers in 5 cities (n=1,011) found that while a small proportion of users had a PAD in place (range between cities was 3.90-12.87%), a large proportion (between cities 66.34-77.45%) would like to have a PAD (Swanson et al., 2006). For those unwilling or unable to complete a WRAP®, having a PAD in place upon release could enhance resilience in managing mental health and symptoms.
In the U.S., the Affordable Care Act (ACA) Medicaid expansion made it possible for individuals to connect with Medicaid during incarceration. However, there is variability among state policies regarding Medicaid eligibility and coverage for incarcerated people (McKee et al., 2015). For example, there is variability among states regarding whether connection to Medicaid managed care services (such as behavioral health) are required upon release (McKee et al., 2015). Consistent policies across states to ensure contiguous Medicaid eligibility is an appropriate step toward improved health status as well as state cost savings (McKee et al., 2015).

Assertive community treatment (ACT) and intensive case management (ICM) models are beneficial in reducing time spent in the hospital and increasing housing stability (Mueser et al., 2010). These models are of critical importance for people with schizophrenia re-entering the community as they have increased risk of suicide, recidivism, and hospitalization (Kim, Becker-Cohen, & Serakos, 2015). Transitional Case Management (TCM) involves a multidisciplinary team providing individualized assessment and comprehensive support services, thus providing the spectrum of support required for community integration. Considering our findings, we suggest that TCM is an appropriate model to meet the specific needs of older adults with schizophrenia who are re-entering the community. TCM has been shown to be effective in reducing rates of arrests for people with mental illness (Chintakrindi et al., 2013).

Policies supporting mental health case management implementation could create a standard for older adults with schizophrenia to connect with continuous, comprehensive, and coherent services while incarcerated, during transition, and once living in the community. In 2004, California passed Proposition 63, the Mental Health Services Act (MHSA). Prop 63 is funded by an additional 1% personal income tax for those earning in excess of 1 million dollars. One purpose of MHSA is to expand the types of successful mental health service programs, in particular targeting underserved populations. The community and services support component have helped counties in California provide access to ACT programs. After implementation in Los Angeles county, people with SMI showed lower rates of recidivism and those who were engaged in case management programs experienced a 50% reduction in days spent in jail (Scheffler, et al., 2010).

Study Limitations: It is worth noting that those with more social capital and networks outside the mental health community may not integrate into their community in the same way. Also, in this paper we discuss re-entry from both jails and prisons in California. However, there are distinct differences in length of sentences and regulating bodies, local and county government versus state and federal control, respectively. These differences can impact how programs and services are provided and funded. For example, it may be more difficult to successfully manage symptoms before release from a short jail sentence. Findings in this pilot study were limited by sample size and future investigation with a larger number of participants could support findings and elaborate on theoretical development.

Finally, we were limited in our secondary analyses by examining interviews conducted for the parent study aims. Although, the aims of the parent study were not to understand re-entry from jail or prison, participants spontaneously described these narratives. Future work should more fully examine the topic of re-entry from criminal justice settings from the perspective of older adults with schizophrenia.
Implications

Older adults with schizophrenia involved in the criminal justice system have specific needs for transition and re-entry into the community. For successful community re-entry the following are necessary:

- Assess symptom relief prior to leaving prison or jail and ensure access to medications prior to, upon release, and frequently re-assess once in the community. Psychiatric care and transitional case management are key.
- Work on community integration prior to, upon release, and frequently re-check in the community. This includes, but is not limited to, housing, help with benefits applications, and support.
- Address health needs prior to, upon release, and frequently re-check once in the community.

Symptom management and community integration are two overlapping elements in the larger scope of successful transition to community re-entry. For example, access to case management prior to release and when in the community can be instrumental in helping people maintain stable housing and support as well to develop WRAP®s and / or PADS and sustain access to medications and treatment to ameliorate symptoms. Decreased recidivism is beneficial to not only those with direct involvement in the criminal justice system but to the quality of life for everyone in the community at large.

Acknowledgments:
This work was supported by the Betty Irene Moore Foundation. The content is solely the responsibility of the authors and does not necessarily represent the opinions or policies of the Betty Irene Moore Foundation. Preliminary results were presented to the California Board of Parole Hearings on December 18, 2017.

Funding:
This work was supported by the Betty Irene Moore Foundation. The content is solely the responsibility of the authors and does not necessarily represent the opinions or policies of the Betty Irene Moore Foundation.

Declaration of Conflicting Interests:
No disclosures to report.

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Bartels S., et al. (2003) ‘Medicare and Medicaid costs for schizophrenia patients by age cohort compared with depression, dementia, and medically ill patients’, American Journal of Geriatric...


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MENTAL HEALTH IN A REPRESENTATIVE COHORT OF PRISONERS IN NEW
ZEALAND CORRECTIONS - ANALYSIS OF SEVERITY OF NEED AND ETHNICITY
DIFFERENCES

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Abstract

The focus of this article is research carried out into the mental health needs for those imprisoned at three prison sites in the New Zealand Corrections, Central Region. The picture of mental health needs from mild to serious was created to inform the services for New Zealand’s only within the wire dedicated 100 bed mental health facility, currently under construction. The review of mental health needs for the 2,000 men placed into these prison settings covered a 12 month period. It included those placed into special prison management (SM) units due to acute mental health or behavioural difficulties (At Risk, Management, and Directed Segregation units). Second, all the psychotropic medication prescribed across the participating prisons was analysed. Due to the over representation of the Indigenous people of New Zealand (52% of prison compared to 14% community), the analysis looked at Māori SM placement and prescribed medication. Key findings from the descriptive analysis were that those placed in special management units for mental health issues were younger; of moderate to high risk of reimprisonment, had repeated placement in these units; and the majority were Māori rather than other ethnicities. In terms of sentence status, the majority were placed in prison for violence but 50% were on remand rather than sentenced. An analysis of psychotropic medication distribution identified a group (n = 390) who were older, majority sentenced, and on lower security management due to compliant behaviour. Most were on antidepressant medication (77%), followed by antipsychotic (39%), stimulant (5.6%), and antianxiety (3.6%). Some differences based on ethnicity were found with higher use of antipsychotic medication for Māori after taking the higher number in prison in this region into account. The service implications of the different mental health needs for this prison population in relation to the proposed new service are discussed.

Keywords: Corrections; Mental Health; Wellness; At Risk; Prison; Māori; Indigenous; Ethnicity; Psychotropic Medication; Psychosis; Depression; Anxiety; Behavior Management

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Introduction
It is clear that people in correctional facilities around the world present with a far higher prevalence of mental health disorders than the general population, with a significant number of individuals requiring intervention. In their systematic review of the international literature, Fazel and Danesh (2002) stated that people in prison were several times more likely to have a diagnosis of depression and/or psychosis, and in an English prison study were ten times more likely to have a personality disorder (Bui, Ullrich, & Coid, 2016). It was also reported that in Western countries, one in seven people in prison care have major depression, or a psychotic illness, a rate which has changed little over the last 30 years (Fazel & Danesh, 2002; Fazel, Hayes, Bartellas, Clerici, & Trestman, 2016).

Additionally, reviews acknowledge that suicide and self-harm are more common within prison populations with relative risk for suicide being 5 to 6 times higher in men and women respectively compared to the general population (Fazel et al., 2016). In their review of 62 studies (12 countries, 22,790 prisoners, 81% men, 26% violent offenders) Fazel and Danesh (2002) reported the following prevalence rates; 3.7% of men and 4% of women had a psychotic illness, 42% of participants had personality disorders and 12% had major depression (the rate of major depression was slightly higher in sentenced individuals than people on remand). It is therefore not surprising, although disappointing, that in some countries such as the USA there are more individuals with severe mental health needs in prison than psychiatric hospitals. Additionally, although the level of need for people in prison care is disproportionately high, there is considerable evidence for significant delays in diagnosis and treatment due to the overwhelming demand for such services (Fazel & Danesh, 2002).

International evidence
The United States of America has the highest incarceration rate in the world, and correctional services in the United States are often considered the largest provider of mental health services for the country (Gonzalez & Connell, 2014). The disproportionate representation of mental health conditions in correctional settings far outpaces clinical resources, contributing to delays in receiving diagnoses and treatment. For example a prison study completed in the state of Iowa with 8,574 individuals found that 48% had been diagnosed with a mental health condition (Al-Rousan, Rubenstein, Sieleni, Deol, & Wallace, 2017). In addition, 99% of these diagnoses were first made during incarceration which while a positive in identifying needs, reflects either a lack of resource or access in the community. Other research has found that at least half of male and up to three quarters of female prisoners reported symptoms of mental health conditions in the year prior to imprisonment, compared to 9% or fewer in the general population (Gonzalez & Connell, 2014). This is further supported by Lynch et al., (2014) who found that 43% of women in a multisite study involving 491 women in urban and rural jails in four geographic regions of the United States met lifetime criteria for a serious mental illness. With 32% meeting the 12 month criteria and 26% of women in this study with co-occurring mental health conditions such as Post Traumatic Stress Disorder (PTSD) and Substance Use Disorder (SUD), revealing the complexity of the treatment needs of these individuals.

Similar findings have been cited in Canada. A 2015 study looking at 1,100 men sentenced to prison in Canada found that over 70% met the criteria for at least one mental health disorder (Beaudette, Power, & Stewart, 2015). There were high rates of alcohol and substance use disorders and antisocial personality disorder found in prisoners that were higher than those observed in the Canadian public (approx. 5-20% higher across the five Canadian regions).
European studies into the prevalence of mental health disorders in prisoners identified current psychiatric disorders within 58.7-84.4% of participants, compared with 8.7% of randomised community comparison groups (Maccio et al., 2015; Vicins et al., 2011). Presentations of psychotic disorders were identified in 10-20% of participants and personality disorders in 20.7 - 51.9% (Hassan Rahman, King, Senior., & Shaw, 2012; Maccio et al., 2015; Piselli et al., 2015; Vicens et al., 2011). In the United Kingdom (U.K), Tyler, Miles, Karadag, and Rogers (2010) reported that nearly half of their sample population across 13 prisons screened positive for two or more types of mental health diagnoses. Similarly studies conducted in Italian prisons found that around 21%-36.6% of participants had two or more co-morbid mental disorders (Maccio et al., 2015; Piselli et al., 2015). Unfortunately, although incarceration presents an opportunity to detect mental health needs and provide treatment, Hassan and colleagues (2012) found that across five English jails 23% of participants who received a diagnosis received no intervention and just half of participants with co-occurring disorders received an intervention from substance misuse services.

**Australia.** As is commonly found in prison populations, individuals in prison in Australia have disproportionately high levels of mental health conditions compared to the community, and high levels of comorbid mental health and substance use disorders (The Australian Institute of Health and Welfare, 2018). Butler and colleagues (2011) found that in a sample of 1,478 individuals in prison, of which 1,208 were male, 42.7% had a mental health condition and 55.3% had a substance use disorder. The prevalence of a co-occurring Substance Use Disorder and mental health condition was 29% in the last 12 months. It was found that women had higher rates of mental health conditions and substance used disorders than men highlighting the multiple and complex needs of those in prison.

These findings are supported by a health survey of a random sample of individuals from all 30 correctional centres in New South Wales (Indig et al., 2010). This survey found that rates of anxiety disorder, affective disorder, substance use disorder and personality disorder were substantially higher than in the community. Again, it was found that these rates are higher in women than men. For 17% of men and 4% of women, prison was their first encounter with a health care provider. This demonstrates the opportunity for high quality mental health services delivered in prison to reach an underserved population.

**New Zealand/Aotearoa.** The pattern of higher mental health need among those in New Zealand prisons is similar to other jurisdictions with many of those subject to sentences of imprisonment for criminal behaviour also struggling with mental health issues. While direct comparisons are difficult due to differences across jurisdictions in regards of sentencing and other defining characteristics, most studies find 50-80% of prisoners with one or more mental health issues and in New Zealand the upper end of this range has been found. The high prevalence of people in prison with mental illness and addiction means New Zealand Corrections (Ara Poutama Aotearoa) manages more people with mental illness than any other single institution in New Zealand (Indig, Gear, & Wilhelm, 2016). To put this in perspective as of February 2020, the total prison population in Aotearoa was 10,080 with

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1. *Aotearoa, is the Māori name for New Zealand. It translates as the land of the 'long white cloud' or variations on this theme.
2. *Ara Poutama Aotearoa is the official Māori name for the New Zealand Department of Corrections. Māori are the Indigenous people of New Zealand. The name translates as a pathway, or progression, towards excellence and improvement and reflects the journey towards self-improvement and rehabilitation.*
6,177 sentenced and 3,903 on remand. In terms of gender, 699 were recorded as female (Department Of Corrections, 2020). In comparison, the last New Zealand annual report on mental health service in 2017 reported 5,284 people were subject to either compulsory mental health assessment or treatment during that year (Office of the Director of Mental Health & Addiction Services Annual Report 2017).

The issue of high levels of mental health need among those placed in New Zealand prisons is not new with research from 20 years ago reporting up to 70% of those within facilities having substance abuse issues with a large proportion also with mental health issues (Department Of Corrections, 1999). However, while efforts were made to increase access to appropriate Alcohol and Other Drug (AOD) programmes, and to ensure forensic mental health services were available for the most unwell, the more recent study by Indig and colleagues (2016) found an even higher prevalence of mental health and substance abuse issues in comparison to the 2006 New Zealand Mental Health Survey (Oakley Browne, Wells & Scott, 2006). Indig and colleagues (2016) found participants in their study had a 12 month rate for anxiety of 22.5% compared to 15% for the general population, mood disorders this was 24% versus 8%, substance abuse 47% versus 3.5%, with 46% of those imprisoned seeking mental health treatment in the year before imprisonment compared with 39% of the general public.

In terms of key statistics, Indig et al. (2016) reported nearly 91% of individuals in prison had a lifetime diagnosis of mental health or AOD disorder, with 62% receiving this in the past 12 months. Females in New Zealand Corrections care in prisons had a 75% diagnosis rate in the last 12 months compared to 61% for males. Thus, in terms of comparison to the general 2006 population, those placed in prison care were three times more likely to have a 12 month diagnosis of mental disorder (62% compared to 21%) compared to people in the community.

It is widely acknowledged that New Zealand faces significant and long-standing disparities in health outcomes for Māori compared to the remaining New Zealand population (Nuku, 2013). The over representation of Māori in prisons has been consistent at around 50-52% over the last three decades, a time period in which they have comprised 14-15% of the overall New Zealand population (Corrections New Zealand, 2019). With this in mind, it is essential that disparities be recognised and investigated in order to improve health equality in New Zealand, especially for Māori being managed by Corrections.

One area where much international research has focused is on ethnicity disparities in the prescription of psychotropic medication; drugs which affect a person’s mental state and mind. International studies investigating these medicines often document conflicting results. When researching prescribing patterns and treatment outcomes for inpatients suffering from schizophrenia, Douzenis et al. (2011) found in a Greek study that ethnic minority patients from mainly Eastern European ethnic groups were less likely to receive Selective Serotonin Reuptake Inhibitors (SSRIs). However, no significant ethnic disparities in the use of antipsychotic medication were found by Puyat et al. (2013) who conducted a systematic review and meta-analysis of racial and ethnic disparities. This review included 12 studies, seven of which were US, with African Americans, non-African Americans and Latinos, Asians, “White”

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3 Māori are the Indigenous people in New Zealand with their own distinctive culture whose language, mythology, crafts and performing arts that has evolved independently from other eastern Polynesian cultures. In the 2013 census, 14.9 % of the New Zealand population identified as being part of the Māori ethnic group.
and Black British”, and Māori and Pacific Islanders (one New Zealand study) samples.

In New Zealand, a study by Metcalfe, Laking and Arnold (2013) using the National New Zealand database of prescription medicine for the financial year 2006/07 found that Māori were less likely to access medicines than non-Māori. This finding is supported by Barczyk, Rucklidge, Eggleston and Mulder (2019) who reported that Māori were prescribed medication at a lower rate than the general population, and are less likely to be prescribed antidepressants than European and Asian populations. However, an investigation by Wilkinson and Mulder (2018) into antidepressant prescribing trends in New Zealand adults from 2008-2015 using a national database from the Ministry of Health found Māori men aged 24-44 were being prescribed antipsychotic medication at a rate higher than any other male population in New Zealand (Māori and non-Māori). Furthermore, Barczyk et al., (2019) reported that Māori were more likely to be prescribed stimulants than Europeans. Dey, Menkes, Obertova, Chaudhuri and Mellsop (2016), who also investigated the prescription of antipsychotic medication in New Zealand across three regions, did not find an ethnic difference in prescribing patterns for antipsychotic medication. It is noted that one of these regions was Waikato which also forms the core area for this paper and the location of two of the three prisons in the study. They did however report that Māori were prescribed clozapine, a medication used to treat resistant psychotic features, at a higher rate than non-Māori. Dey and colleagues (2016) explain that the higher rate of clozapine was closer to recommended best practice and on this basis concluded that Māori had equal access to antipsychotic treatment. However, Wilkinson and Mulder (2018) report that Māori and Pasifika males are being disproportionately prescribed clozapine.

In their recent study investigating the differences in rates of schizophrenia in ethnic subgroups, Mellsop and Tapsell (2019) and Mellsop, Tapsell and Menkes (2019) demonstrated that ethnic subgroups including Māori face a significantly increased prevalence and incidence of schizophrenia compared to the remaining New Zealand population. As suggested by Mellsop and Tapsell (2019) this likely reflected particular stressors (such as marginalisation and structural racism) on these groups. It is also important to acknowledge that Das-Munshi, Bhugra and Crawford (2018) in a study of the main ethnic minority groups in the UK documented that marginalised ethnic groups are more likely than the general population to experience coercive and complex pathways into care.

Waikeria Mental Health and Addiction Service. In recognition of this escalating mental health need, including for Māori prisoners, the New Zealand Government in 2018 announced plans to build a 100 bed dedicated Mental Health Facility (known as Waikeria Mental health & Addiction Service [WMHAS]) a ‘within the wire’ as part of the Waikeria Prison new prison build (Walters, 2018). This is the first within prison dedicated mental health facility for New Zealand.

This is designed to be a regional service provided to men placed into Waikeria Prison, Spring Hill Corrections Facility and Tongariro Prison. The project is being undertaken in partnership with Waikeria mana whenua4 (Raukawa and Ngāti Maniapoto the Māori tribes associated with the land at Waikeria), the Waikato District Health Board (DHB) and the Department of Corrections. The DHB providing the

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4 Mana whenua translates from Maori as territorial rights, power from the land, authority over land or territory, jurisdiction over land or territory - power associated with possession and occupation of tribal land. The tribe’s history and legends are based in the lands they have occupied over generations and the land provides the sustenance for the people and to provide hospitality for guests. https://maoridictionary.co.nz
specialist staff who will be needed for the delivery of mental health services. Construction of the new prison including the WMHAS facility began on-site in 2018, with the facility scheduled for completion in mid 2022. The expectation from the government was that the service would be focused on men held in prisons in the Central Region, involve a Māori informed model of care, and would be whānau focused.

The research reported in this article was generated as part of the WMHAS project to better understand the mental health needs across prisons in the Corrections Central Region using the current population of men in these facilities. The over-representation of Māori in mental health need within both the general community but also within the prisons managed by Corrections meant that the role of ethnicity was a critical element to this research (Walters, 2018).

The WMHAS will also put in place the values recently adopted to guide Corrections that were detailed in the department’s strategic policy document titled Hokai Rangi (Department Of Corrections, 2019). These values support why a MoC designed for Māori is likely to work for all in New Zealand prisons; Kaitiaki/ Guardianship - we are responsive and responsible; Manaaki/Respect- we care for and respect everyone; Rangatira/ Leadership - we demonstrate leadership and are accountable; Wairua/ Spirituality - we are unified and focused in our efforts; and Whānau/Relationships - we develop supportive relationships. To this list the WMHAS added one other, Oranga/Wellbeing to reflect the focus of this specialist mental health service.

Study One: Special Management Unit Placement
This research sought to establish a top level initial analysis of prisoners who were placed into special management units (SM) in the three male prison facilities located across the Corrections Central Region. Placement in these units was a result of mental health and or behaviour problems associated with wellness issues including personality disorder and substance abuse. The development of the WMHAS Model of Care (MoC) required an understanding of who may need treatment, their varied needs, and security management issues.

Study one sample. The sample covers all prisoners who were placed for a period or repeated periods into an ARU (At Risk Unit), MU (Management Unit), or SEPS (Segregation unit) unit during the 2018 calendar year. The 2018 calendar year was selected as the most recent period for which information was available to best guide on the likely prison population to be served by the WMHAS. In addition to a broad picture of this population, more detailed analysis was conducted of those located in the ARU’s which are units designed to manage those who are at risk of self-harm, or are suffering acute mental health issues requiring forensic mental health care. The SEPS units cater for those placed on involuntary segregation for behavioral issues for periods of up to 14 days, and the MU is used for those with serious discipline problems relating to violence in facilities. Population descriptive, risk of offending, and mental health issue information (custodial management ‘flags’) was gathered from the Corrections integrated computer management system on those placed into one of the specified units in the period between 1st January 2018 and the 31st December 2018. This selected those in Corrections care who were resident in one of the SM units located at Tongariro, Waikeria, or Springhill prison facilities. IBM Statistical Package for Social Sciences (SPSS) version 25 was used for all statistical analyses.

5 Whānau is the Maori word for an extended family or community of related families who live together in the same area
A total sample of 1,359 individuals in these prisons who spent a period of a day or more in these SM units during 2018 was obtained (ARU n = 459; MU n = 337; and, SEPS n = 563). It should be noted that the Central Region’s three prison facilities can collectively house approximately 2,000 men. The majority of the sample came from Springhill and Waikeria Prisons. With only around 40 from Tongariro reflecting the nature of these facilites, with Tongariro housing only sentenced prisoners, in many cases with long sentences while the other prisons housed greater numbers of remandees and those on shorter sentences.

**Study one results**

**Demographic differences.** The population across the special management (SM) units were found to be young (mean age of 31) with the majority aged 21-41 years of age. Surprisingly few older adults (55 years and older) were in the SM sample (see Table 1) especially when it was expected that more may have experienced acute mental health issues including self-harm concerns. While the New Zealand prison research on mental health need only had small numbers of aged prisoners in their analysis, a U.K. study by Fazel, Hope, O’Donnell, & Jacoby (2001) examined the prevalence of psychiatric illnesses in a sample of 203 male prisoners aged 60–88 years old. They found that 29.6% of older male prisoners were diagnosed with depressive disorder, 30% with personality disorder, and 8.3% displayed antisocial personality disorder.

The static risk of serious reoffending for those in study one was analysed using a computerised risk measure based on an individual’s official criminal history that has been developed and validated by New Zealand Corrections. This tool is called RoC*RoI, (Risk of reConviction X Risk of reImprisonment) and provided for all in the study a probability of reoffending (0 to 100%) over a five years post release for a new offence that would result in reimprisonment (Bakker, Riley & O’Malley, 1999). The mean RoC*RoI score was moderate-high in the sample at 56% risk of reimprisonment with the majority having a risk profile between 34% through to 79% risk of reimprisonment within five years of release. The mean score may indeed be higher as 143 cases were on remand with the new offence not recorded in a new of resived RoC*RoI score. Finally, in terms of previous placement periods in one of the SM units before the study period of 2018, there was a wide range from no previous contact up to

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6 RoC*RoI In developing the measure Bakker et al., 1999) used the following predictor variables: Personal characteristics (Gender; Age [continuous]; Age at first offence; Frequency of convictions;Number of court appearances and convictions [running total]); Jail and time at large (Total estimated time (yrs) spent in prison; Number of previous imprisonment sentences; Indicator that punishment for most recent crime was imprisonment; Maximum sentence length handed down to offender in past [yrs]; Time at large [length of offenders most recent time at large]); Seriousness of offence (Sum of seriousness ratings for all crimes (seriousness defined by average length of sentence in days a person receives if convicted of a crime); Weighted past seriousness measure [places greater weight on seriousness of most recent offence]; Maximum serious measures for the past time period; Mean seriousness measures for the past time period); Offence type (Offence category [10 possible, e.g., violent, disorderly conduct, sex]; Number of convictions in crime category. The complete criminal histories of more than 133,000 offenders (those convicted of an imprisonable offence were used to develop RoC*RoI which was then tested on a separate sample of 46,000 cases. Each piece of data is weighed up and balanced against other pieces of factual information in an objective way to produce a statistical probability of reoffending (score range is 0.0 to 10, representing 0 risk to 100% risk of serious recidivism). The RoC*RoI model was found to have moderate to moderate high predictive validity.
133 separate periods for one man in an At Risk Unit. The mean number of prior admissions before 2018 was 5.5% ($SD = 9.5$).

In terms of ethnicity distribution, the majority of the sample drawn from across the SM units were indicated to be Māori at 68%. Table 2 shows the distribution of ethnicity across the total sample with 8% indicated as Pacifica and 20% as European. This high proportion of Māori is unfortunately not surprising when the disproportionate numbers of Māori in New Zealand prisons is considered, along with the higher number housed in New Zealand North Island prisons (Wilson, 2004).

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<th>Ethnicity</th>
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Table 2: Distribution of recorded ethnicity across the total SM unit sample ($N = 1,359$)

In terms of sentence status of the total sample across all the SM units, 36% were classified as remand-accused and 14% as remand-convicted for a total of 50% on remand, and the remaining 50% on sentence. In terms of sentence length (classified by being over or under two years) 69% were long term and only around 30% short term. It is noted that there were 3% on indeterminate sentences of imprisonment (murder or preventive detention for repeat sexual crimes). The lead criminal act that resulted in these SM placement men coming into the Central Region prisons was mainly for violence at 57% (includes sexual violence and weapons use). Other lead crimes of interest were the relatively high rate of burglary at 15% which may be indicative of other issues such as substance abuse.

**Management Unit (MU).** MU placement men were found to be younger than those in the overall SM units sample with a mean age of 29 ($SD = 10$), with slightly higher recidivism risk ($RoC\times RoI M = .58; SD = .21$) and a higher number of repeat SM unit placements ($M = 6; SD = 8.6$) in 2018. When placed in the MU, 45% spent only one day, with 30% spending 10 or more days and a very small group, 5% 20 or
more days. An examination of the ethnicity distribution of the MU sample found Māori comprised 61%,
European 17%, and Pacifica 15%. In terms of mental health indicators for the MU, 8.3% were having
contact with the District Health Board forensic mental health services and 18.7% were identified as
at risk of self-harm or suicide (see Table 3). A multivariate analysis of all the variables in the MU
database to predict who would be in the 12.8% with a suicide ‘flag’ found that an elevated RoC*RoI
score \( (F = 17.14, \ p = .000) \) and greater number of prior admissions to an SM \( (F = 27.36, \ p = .000) \) were
the only significant predictors. It was noted that neither age nor ethnicity were significant predictors
of this risk. Almost half of the MU sample (48%) were sentenced, with 36.8% classified as remand-
accused, and 15% as remand-sentenced. In keeping with the total sample analysis, the most frequent
lead offence was for violence (57.3%).

Directed segregation unit (SEPS). The SEPS sample was the largest sub sample of the SM group at
563 men in our care. In terms of age there was a slightly older mean of 30 years of age \( (SD = 9) \), and
a similar RoC*RoI score as with the MU \( (M=60 \text{ or } 60\%; SD = 18) \). The men in the SEPS had a mean
number of five \( (SD = 7) \) prior placements in a SM unit before being admitted to SEPS in 2018, and most
spent around nine days in the unit. One hundred and ninety eight or 35% had one further admission
to a SM unit after their initial SEPS stay, however this dropping rapidly with only 2.8% having a
fifth admission, and no one having more than seven re-admissions. This lack of more re-admissions
perhaps due to the 12 month time frame or release.

An examination of the ethnicity distribution of the SEPS sample found this was very high for Māori at
80% and when combined with the 6.5% for Pacifica meant only 12% were identified as European. This
is a higher level of Māori ethnicity than the main SM sample, or as will be shown, in the ARU sample.

Overall the Corrections computer system ‘flags’ indicating some mental health or acute risk to self
were also high across the SEPS sample. While only 5.7% of the SEPS sample were indicated as being
seen by the District Health Board forensic mental health service, the number with flags indicating
concern for suicide risk was far higher at 19%. Multivariate analysis of all the available variables
was carried out to see what would predict who would have a suicide flag. This analysis again found
an elevated RoC*RoI score and a greater number of prior admissions to a SM were the significant
predictors. The majority of the SEPS sample (66%) were sentenced, with 34% classified as remand.
This was similar to that found for the total MU sample but differed substantially from the ARU
sample which had a higher percentage of those on remand. In keeping with the total sample offending
analysis, 54.4% of the MU were in prison for violence.

At Risk Units. In total, 459 men were recorded as having spent time in an At Risk Unit in 2018 at either
the Spring Hill or Waikeria Prison sites (Tongariro does not have a ARU). It should be noted however,
that these men may have spent time outside of 2018 in either a MU or SEPS units. In a similar fashion
to the distribution of age across the three types of SM placement, those placed into the ARU also
tended to be younger \( (M = 34; SD = 12) \) than the total SM sample with 29% under 25 years of age and
62% under 35 years of age (Table 3). Only 5% of the ARU sample were aged 55 years or more. This
may indicate that older adults with mental health issues may be being managed or treated elsewhere.
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<td>Sentenced</td>
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Overall those regarded as aged in prisons in New Zealand based on the aged classification make up around 9.7% ($n = 975$) of those currently in Corrections care ($N = 10,040$; range 55-88 years; muster as at 8/4/19, Department of Corrections Statistics).

The ethnicity distribution was different for the ARU unit sample. Instead of the 69% found across all SM units this had fallen to 57.5% for Māori and 4% for Pacifica, although Māori men were still the majority of admissions. When one considers the role of the MU and SEPS in managing overt violence versus a focus on the vulnerable, acutely unwell and at risk, the over representation of Māori in violent crime in New Zealand meant this result is not unexpected (Ioane, Lambie, & Percival, 2016; Wilson, 2004).

Those placed in the ARU’s were typically on remand, either remand-accused (55.6%) or remand-convicted (12.2%), meaning overall 68% had a remand status when placed into the two prisons in the study with these units during 2018 (see Table 3). While as indicated earlier in this article while the overall sample across all the SM units had a high rate of those on a remand sentence (50%) this was still far lower than for the ARU’s.

The ARU sample was lower in terms of RoC*RoI mean score compared to those placed in the Management or SEPS Units. In the ARU, a more normal distribution of risk of reimprisonment was observed, with a RoC*RoI mean of 49% probability of returning to prison (see Table 3). However, it is also noted that as a large number of those in the ARU were on remand RoC*RoI scores were only available for 81% of the sample ($n = 374$) as scores are based on convictions and sentence. In looking at the lead offence for the ARU sample, when the categories of violence, weapons, and sexual offending are combined, this identified 56.6% of the sample. In comparison those from the Management Unit and SEPS using a similar classification approach found broadly similar results, 57.3% and 54.4% respectively.

Using the indicators from the Corrections computer system of past contact, along with ‘flags’ indicating forensic contact, risk of self-harm and risk of suicide, and custodial case notes, a large number of those in the ARU sample were found to have acute mental health need. Eighteen percent had on-going contact with forensic services, 91% were at risk of self-harm and 44% regarded at risk of suicide. This risk to self is at a higher rate than that reported earlier in this paper for the MU and SEPS samples, and reflects the high and acute mental health needs for those appropriately placed in the ARU.

When prior contact to 2018 with a special management unit was examined in the ARU sample this ranged from 41.4% with none, right through to 10% with 15 or more prior admissions. The length of stay after admission to the ARU in 2018 differed markedly with 24% admitted for only one day before being placed elsewhere, and 68% in the unit for 10 days or less. Around 20% of those admitted to the ARU spent 17 days or longer, with the longest single stay being for 181 days. Around 6.5% of the sample spent 50 days or more after initial admission to an ARU ($n = 30$), therefore these would be regarded as long term ARU residents. The ARU regime is designed for short terms periods of admission with those spending long periods subject to less access to rehabilitation, time outside cells, and a generally passive rather than active management approach. The principal author of this paper has found in clinical practice that a number in the ARU do not meet the criteria for transfer to
the DHB secure mental health facility but also are unable to manage a ‘mainstream’ custodial regime, highlighting the need for the WMHAS to provide step down care and a service that follows them across their sentence.

**Study two: Psychotropic medication distribution**

The sub population selected \((N = 1,359)\) from the Corrections data for the three Central region prisons who were placed into the SM units provided a broad picture of those with acute, overt mental health or serious behavioural concerns. However, as these units were focused on the management of those with severe mental health needs, the acutely unwell, and those with serious behavioural issues, it was not believed to capture the whole population of those who may require services from the future WMHAS. The WMHAS project team were aware of larger numbers of men in prison across the Central Region facilities who are managed within mainstream placements on some form of psychotropic medication for apparent mental health issues. This ranged from those on antipsychotics through to a larger number on antidepressants and a few on anxiolytic’s.

**Sample study two.** Prescription data was selected from the Corrections MEDTEC’ database for a 12 month period covered 1 June 2018 through to 30 May 2019 for all those in prison in the Tongariro, Spring Hill and Waikeria custodial facilities. The WMHAS is required to provide services to not just the 100 bed facility but also all prisoners with mild to moderate mental health needs within the three prisons. The prescription data included both psychotropic medications (related to mental health) and primary medical medications. The raw data selection included 19,533 prescriptions which covered everything from aspirin through to medications for severe physical illnesses, and mental health disorder such as psychosis. The total prescription data for the 12 months across the three prison sites included 1,437 men in Corrections care, with the number of prescriptions per person ranging from one, right through to 230 \((M = 215, SD = 31.8)\).

**Results study two.** The most frequently prescribed drugs were antidepressants, with Amitriptyline (a tricyclic medication) prescribed more than any other. The most prescribed antipsychotic was Quetapen, a general drug that belongs to a group of medicines known as atypical antipsychotics, designed for use with both schizophrenia and bipolar disorders. The focus of this analysis was on mental illness, thus all relevant psychotropic medications were identified under the classifications of antipsychotics; stimulant, antidepressant, and antianxiety agents. In total, 390 men in Corrections care in the three prisons received psychotropic medication(s) that fall within one of these four broad drug classifications. This approach identified that 27\% of all those receiving medication \((N = 1, 437)\) did so for an apparent mental health issue. It was unclear from the information available however, whether these individuals met mental health diagnostic criteria, as only 69 of the 390 men where indicated as under DHB Forensic Mental Health care/oversight. It is acknowledged that the Forensic Mental Health service is focused on those in an acutely unwell state rather than those believed to be coping. However, even with these limitations this is a substantially higher rate of mental health medication than expected from equivalent community samples (Fazel et al., 2016).

In terms of descriptive information on the 390 men in study two they had a mean age of 38 (range

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7 MEDTEC is the computerised health database where all relevant medical information including mental health medication and diagnosis is recorded across all prisons within Corrections New Zealand. MEDTEC is accessed and updated by medical staff involved in the care of all those placed into prison facilities.
18-77 years); and a mean RoC*RoI of .51 or 51% risk of reimprisonment, while sentence lengths ranged from 60 days to 6235 days (17 yrs) (see Table 4). So overall, an older and lower risk group on varying sentences than that placed into SM units, but with a RoC*RoI score distribution that was bimodal, identifying lower and higher risk groups.

The marked range of sentence length was a result of a sample made up of some on very long sentences for sexual crimes and murder, in comparison to those on shorter sentences for violence, much of it domestic in nature or for dishonesty and driving related convictions. It is noted that those on longer sentences for sexual crimes, especially those against children were not as prominent in the acute SM unit analysis reported in study one. The distribution of criminal offence types across the sample identified three groups of particular interest for mental health services. Those with sexual convictions mainly against children (21%), with serious violence (28%), and men with domestic violence convictions (18%). In terms of sentence/security classification, the majority of the men in the prescription sample were sentenced (83%), with only 17% on remand, and the majority managed on lower security classification.

Analysis of online case notes found the majority were compliant with the custodial regime within the facility (62%; n = 242), with a smaller group with behaviour rated as good (11.5%; n = 45) and only 17.7% regarded as mixed and 8.7% as poor (see Table 4). This means in terms of management that most appear to be coping with being in a prison facility, although whether this is due to adjusting to
the facility and custodial management, the impact of their medication regime or other factors is not clear.

In terms of the distribution of psychotropic medication by type or category for the 390 men, 5.6% ($n=22$) were on stimulant medication, 77% ($n=301$) on antidepressants, 39% ($n=151$) on antipsychotics, and 3.6% ($n=14$) on anxiety medication (see Table 4). While 77% ($n=299$) were only on one category of medication, some men were on more than one, with 21.5% on two ($n=84$), and a small group of 2% ($n=7$) on three medications. While there is a case that those on two or more types of medication for mental health issues were likely to have some significant issues, the study did note some of those on a single type were in receipt of a high dosage of the particular medication over time, so also likely to have high or chronic needs.

A ‘rough’ classification of mental health need was applied in the study based on number of repeated prescriptions for psychotropic medication overtime, along with whether they were on multiple types, or a high dosage. This in practice meant those with 1-4 repeated prescriptions were in the low need group ($n=175; 45\%$); 5-12 repeated prescriptions in the moderate need group ($n=119; 30\%$); and 13 plus in the high need group ($n=96; 25\%$). While this is ‘rough’ classification it did identify 215 men (Moderate and High need) who may need to receive either in bed or out-of-reach mental health services, or both levels of services to assist in their journey to wellness.

Ethnicity across the 390 men in the medication study varied with 57% ($n=223$) identifying as Māori with the next largest group being those classified as European 38% ($n=148$). When ethnicity is considered in terms of numbers of mental health related prescriptions, age, and RoC×RoI scores or even by mental health need classification, there were no significant differences based on ethnic group. However, there was a significant difference identified between Māori and Europeans on sentence length with Europeans having a higher mean number of days of imprisonment (Māori $M=1468$; Europeans $M=1618$ [F = 12.19, $p = .001$]). This is likely due to higher numbers of Europeans sentenced for child sexual offences that typically receive a longer sentence tariff.

When consideration was made in relation to the classification of psychotropic medications, a key difference based on ethnicity was identified. While no significant statistical difference was found in the distribution of prescription of antidepressant medications between Māori and European prisoners, a difference was identified in relation to antipsychotic medication. Specifically, Māori prisoners ($n=99$) appeared twice as likely to be prescribed this type of psychotropic medication than European men ($n=48$) ($\chi^2 = 13.32$, $df = 6$, $p = .038$), although no difference in dosage was indicated. While the distribution is visually quite different in Figure 1, this is only just statistically significant when the difference in sample size between Māori and European was considered.

Care is needed in relation to interpreting these results as other variables may explain the difference in antipsychotic distribution other than ethnicity. Further analysis of this difference found no statistical evidence for an ethnicity bias based on actual versus expected distribution in type of antipsychotic medication, dosage, time of day administered, or rationale given for the prescription or on sentencing status (sentenced or on remand). There was also no evidence found for the use of antipsychotic medication as a chemical restraint for aggressive behaviour. The difference is also confounded by high rates of antipsychotic prescriptions, in particular use of Quetiapine in the study, where the anti-
psychotic medication in sub-clinical doses was used as a sleeping aid.

Discussion
The two studies conducted to inform the services for the WMHAS in New Zealand found a large group of men across the three Central Region prison facilities both within special management units but also from more mainstream prison placements who are likely to require a degree of service for mental health issues. In terms of current New Zealand Corrections management this is noted in many cases in the SM units to be either passive external management approaches where time and elimination of ability to harm themselves or others is used, or if placed in mainstream custodial facilities to principally through the use of psychotropic medication. As a group, the men in the two studies were characterised in the main by being young, of medium to higher risk of serious reoffending, and importantly for the WMHAS care model to be of Māori ethnicity.

In terms of the men across the two studies being either sentenced or on remand, marked differences were found with those remanded in prison more likely to be presenting with more acute mental health needs and risk of self-harm and harm to others compared to those on sentence. There is no corrections policy that would only see those on remand with mental health issues placed in the SM units. Therefore, the difference is more likely due to a range of issues for those on remand from separation from family and community structure, to substance withdrawal, and the high level of uncertainty over court processes. A UK study by Lamiece et al. (2011) found a similar difference in mental health need between those on remand and convicted prisoners with 44% of remand and 28% of convicted prisoners meeting the General Health Questionare prison cut-off for accepted standardized diagnostic criteria for mental health issues. Clinical symptoms of suicidality were also significantly more prevalent in this study among remand than convicted prisoners when first placed into prison, although this reduced over time.
It is also apparent from the distribution of risk scores on RoC*RoI, along with the majority having violent crimes, that in addition to mental health issues many of these men will require intervention for their criminogenic needs. This intervention could involve medium to long intensity specialist programme completion, reflecting the range of risk scores. This would see mental health services needing to follow the men receiving services as they address their offence related and rehabilitation needs once these are identified. Especially as treatment for offence related needs in New Zealand Corrections are typically delivered in group setting and involve a degree of challenge and revisiting traumatic events, all risk issues for an increase in mental health issues. For some men treatment programmes may need to be delayed until their mental health issues are well managed or, that some may require treatment approaches which take better account of their underlying mental health conditions.

**Study one, Special Management Units.** The key implication from the ethnicity breakdown of the SM units sample is that the mental health services provided by the WMHAS will need to be developed with the knowledge that two thirds of the men will likely be Māori and one third European or other ethnicities. This result may appear to reflect the normal distribution of ethnicity keeping in mind the over representation of Maori in New Zealand prisons and that most Maori live in the North Island in which the Central Region prisons are located. However, it was necessary to identify whether their needs for mental health intervention reflected this distribution. Inclusion of a Model of Care (MoC) that recognises that the majority of those requiring care will be Māori is therefore supported. This will ensure this over represented group receives services that are equitable, effective, and understands and values a Māori world view. This approach will necessitate services being developed for the WMHAS that go beyond a European centric, medication only, model for mental health care.

Other key results from study one were that those placed in special management units for mental health issues were younger; of higher risk of reimprisonment, and had repeated placement in these units. This means in terms of mental health services that the WMHAS will have to ensure that age related needs for high levels of activity and targeted mental health service is provided, as well as ensuring that the safety of those in the care of the service and staff is addressed. Those with higher RoC*RoI scores typically have histories of violent crimes and this requires both services to address violence risk but also a need to recognise their risk to others and indeed themselves (Wilson, 2004). The repeated placement of those in care back into SM units reflects both the current static model of care and supports the need for the WMHAS to provide services that follow the person outside of the 100 bed facility, both into other prison placements but also into the community. The high number of those on remand does present issues for the proposed 100 bed WMHAS specialist unit in terms of mixing sentenced and those yet to be sentenced. However, when mental health issues are the focus then the expectation is that their common health need is the priority rather than their sentence status. Corrections in New Zealand currently allows mixing of remand and sentenced prisoners for health related interventions on this basis. If any risk or need issues from this mixing occurs, the design of the WMHAS 100 bed facility with 12 separate accommodation wings is flexible enough to cope.

**Study two, psychotropic medication use.** The analysis of the medication data supports that there is a sizable group \(N = 390\) of men in care across the three Central Region prison facilities who would be regarded as having mild to moderate mental health needs based on the psychotropic prescription distribution. There are also likely to be some men that could be classified as having severe mental...
health needs based on the level of medication they have been placed upon and their diagnosis with psychiatric illness. This, in the opinion of the authors, does indicate that in addition to those previously identified in the analysis of the SM units with acute needs, a large group of men in mainstream prison facilities exists who would benefit from consideration in the MoC for the WMHAS.

The services delivered by the WMHAS may well be dictated by the analysis indicating particular subgroups based upon offence type (i.e., child sexual offences; serious violence or domestic violence) or their sentence lengths or particular mental health need/severity. The men’s functioning in mainstream facilities also opens up a MoC which could include their placement in the 100 bed facility for short periods in a ‘block’ course approach or to receive services on a day attendance or outreach basis (where service follows the person via mobile teams). This is encouraging in terms of best use of these expensive specialty mental health beds and services across as many men in Ara Poutama care as possible and to maintain journeys through prisons. The WMHAS facility under construction splits the 100 available beds across 12 separate wings (number of bedrooms ranging from 7 to 9 in a wing), with six wings in each of two main facility accommodation blocks that are separated by an administration and staff support space. This design supports delivery of specific services to small groups of men separated by need and degree of mental illness, as well as addressing security concerns and safety requirements.

It was a positive result that differences based on ethnicity were not found in terms of antidepressant, stimulant and antianxiety medication or indeed dosage. The finding of a marked significant difference in the distribution of antipsychotic medication with higher rates for Māori versus European men in this study was concerning. After further analysis it did not appear that diagnosis classification was based on ethnicity. However, biases may lie in the treatment options made available to or recommended for Māori men by health care staff. Future qualitative research interviewing European and Māori men in the care of Corrections who have been prescribed anti-psychotic medication will be conducted to investigate and compare the experiences and preferences of these men.

Qualitative research interviewing medical staff will also be conducted to better understand standard practices, and rationales behind the prescription of anti-psychotic medication, and whether this results in ethnic biases in prescribing behaviours. In particular, the practice of using sub-clinical doses to apparently assist in sleep issues. This is of particular importance when the recent literature suggests that use of antipsychotics to aid sleep has some dangerous side effects (tension and restlessness, tremors, weight gain, high blood sugar, new or worsening diabetes, and more rarely heart arrhythmia) (Hirsch, Patten, Bresee, Jette, & Pringsheim, 2018). While it is not clear how antipsychotics have become so frequently prescribed for sleep difficulties, some point to aggressive marketing and descriptions of quetiapine as a “mild, not harmful” drug that seems to help with sleep. Hirsch and colleagues (2018) noted a 300% increase in use of atypical antipsychotics such as Quetiapine in a Canadian population study over just a seven year period.

Limitations of the research
The principal limitation in the two studies related to availability of data on diagnosis and medications. While the Corrections MEDTEC system records most medical information, there were gaps in information identified. These mainly related to information from men being seen by the DHB Forensic mental health team who recorded some information only in paper form on prison health files in
addition to the separate DHB computerised patient system, both of which the researchers could not access for this study. Nor was it possible to include specialist information on those with cognitive issues, either related to intellectual disability, or from brain injury.

Another related limitation for this study is the impact of offsite treatment and support processes. When there was a need for specialist off site mental health treatment, these men in the care of Corrections were transferred to community DHB hospital mental health secure facilities removing them from consideration in this research. These data access limitations in terms of the two studies in this paper may mean a likely under estimate of the numbers of the men who require mental health services in the Corrections Central Region.

Finally, a key limitation of the study into prescription use was the assumption that the provision of a prescription for psychotropic medication related to a mental health need, especially in the absence of a diagnosis. As discussed antipsychotics may have been prescribed for a variety of other reasons such as sleep issues, drug withdrawal and similar issues are present for antidepressants being used beyond intervention solely for depression.

**Conclusions**

The results from the two studies conducted with a representative population of those in the care of prison facilities in the Ara Poutama Central Region of New Zealand supports the initiative to build a specialist mental health facility but also to develop a service that follows the person. The varied nature of mental health need, as well as security level and associated crimes supports the design of the WMHAS in regards to an ability to provide different levels of varied services both inside the 100 bed facility but also out into mainstream beds and the community.

In recognition of the high percentage of Māori who are over represented in both prison and in regard to mental health needs, the WMHAS will operate with a Māori lens focused on whānau and cultural connections and services. While the WMHAS MoC will have a Māori focus, it is a service for all and will be based on the belief that what works for Māori works well for everyone, recognising that culture is a responsivity factor, as well as a potential wellness outcome. The WMHAS recognises the need for equity with Māori in Ara Poutama care and that different people with different levels of advantage require varied approaches and resources to achieve equal health outcomes.

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Abstract

Over the past 25 years the prison population of England and Wales has doubled and this has resulted in a significant proportion of the prisoner population suffering from mental ill-health. This paper considers the position of an under-researched group within the prison population in England and Wales, that of the Irish prisoner population. 37 semi-structured interviews were undertaken with recently released (within 2 years) Irish prisoners in England and Wales who were asked to reflect on their experiences of incarceration. It considers how themes of depression, paranoia and fear, and loneliness and isolation, all of which were identified as major factors within their experience of imprisonment in England and Wales, relate to the overall experience of incarceration.
Introduction
The term crisis is synonymous with the prison system in England and Wales, and has been common currency in both media and academic accounts of the prison system for decades (Loader, 2013; King and MacDermott, 1989; Bottoms and Preston, 1980; Sparks, 1971). Such crises have included the high prison population, overcrowding, bad conditions, understaffing and staff unrest, poor security, and the ‘toxic mix’ of long-term and life sentence prisoners and those experiencing mental ill-health (Cavadino et al, 2013). Prisons throughout England and Wales are overpopulated with people experiencing mental ill-health (National Audit Office, 2017a; Her Majesty's Inspectorate for Prisons, 2007; Fraser et al, 2009), and in the vast majority of cases, prison is not the appropriate setting in which to receive treatment (Department of Health, 2001; Salize et al, 2007). Those who go through the criminal justice system are more likely to suffer from depression, personality disorder and substance abuse problems, and pose a much higher risk of self-harm and suicide than the general population (Liebling, 1993, 1995; Singleton et al, 1998; Singleton et al, 2001; Fazel and Danseh, 2002). This paper uses the mental health crisis in English and Welsh prisons as a contextual backdrop in providing a reflective account from a small sample of Irish ex-prisoners on their experiences of depression, paranoia, fear, loneliness and isolation, while in prison. The findings in this paper are taken from the author’s doctoral research which examined the lived experiences of Irish prisoners in England and Wales in the context of their mental health, and was the first ever study to specifically examine the mental health of this population of prisoners.

Irish prisoners are perhaps the oldest minority group likely to be found in the prison system in England and Wales (Borland et al, 1995) and they are now the third most represented foreign nationality in the prison system after Romanians and Poles (Allen and Watson, 2017; Ministry of Justice, 2019). On 31 December 2019 the prison population in England and Wales stood at 82,868. Of this figure there were 721 prisoners whose nationality was recorded as Irish (Ministry of Justice, 2019). Irish prisoners represent approximately 0.9% of the total prison population and 7.8% of the foreign national prisoner population, however this is likely to be an underestimate. There are also at least 1,500 Irish Travelers in prison in England and Wales. Irish Travelers are a community of people who have been a part of both Irish and British society for centuries and in the UK they are recognized as being a distinct ethnic group under the Race Relations Act 1976 (as amended in 2000), the Human Rights Act 1998 and the Equality Act 2010. Irish Travelers suffer from social exclusion, racism and discrimination based on their ethnicity, and Traveler life is associated with many risk factors, including substance abuse, mental ill-health, unemployment, racism and a lack of education. All of these factors relate closely to the additional risk of an individual being involved, at some level, with the criminal justice system, “and it can be argued they contribute to the over-representation of Travelers in the criminal justice system, both in Ireland and in England and Wales” (Gavin, 2019, 138). The Irish population in Britain have, historically, been rendered as an invisible group in the context of being an ethnic minority, and have all too often been “neglected in consideration of race and cultural diversity” (Parekh, 2000, 31). Irish prisoners in Britain have also been ignored in the context of studies of ethnic minorities and the criminal justice system (Cheney, 1993; Hickman and Walter, 1997) and have been described as the invisible minority (Murphy, 1994). The aim of this paper is, therefore, to shine a light on some of the experiences of this invisible group in the prison system.

Mental health in prison in England and Wales
The over-representation of mental health problems amongst prisoner populations is well established
Article 5: Irish ex-prisoner reflections on their psychological wellbeing whilst in prison in England and Wales

internationally. Studies from Australia (Australian Institute of Health and Welfare, 2015), New Zealand (Brinded et al, 2001), the United States (Corrado et al, 2000; Schnitker et al, 2001; Steadman et al, 2009) and Canada (Simpson et al, 2013) have all confirmed this. European countries are facing an increase in the population of prisoners with mental health problems (Blaauw et al, 2000; Human Rights Watch, 2015; Lehmann, 2012; Salize et al, 2007). It is estimated that there are approximately two million prisoners in Europe and at least 25% of them suffer from a significant mental disorder (Fraser et al, 2009). Salize et al (2007) found there to be shortages in the area of prison mental healthcare throughout European countries. In England and Wales they found there to be insufficient and inadequate psychiatric services to diagnose illness, long referral delays due to shortage of psychiatric beds in the National Health Service (NHS), an absence of treatment for minor mental disorders, and a wholly inadequate aftercare system. Fazel and Danesh’s (2002) examination of serious mental disorder from a sample of 23,000 prisoners from 12 countries (Australia, Canada, Denmark, Finland, Ireland, the Netherlands, New Zealand, Norway, Spain, Sweden, the United Kingdom and the United States) found that 4% of male and female prisoners had psychotic illnesses, 10% of male and 12% of female prisoners had major depression, and 65% of male and 42% of female prisoners had a personality disorder.

The composition of prisons in England and Wales does not reflect a cross section of society, and the most consistent factor of the typical prisoner is "unambiguously one of relatively severe personal and social disadvantage" (Kirwan, 2013, 41). These disadvantages can be linked to the following factors that impact on the likelihood of both offending and reoffending: education, employment, drug and alcohol abuse, mental and physical health, attitudes and self-control, institutionalization and life skills, housing, financial support and debt and family networks (Social Exclusion Unit, 2002). When compared with the general population, it is apparent that the vast majority of prisoners have experienced a lifetime of social exclusion, and are over-represented in terms of negative experience of these nine factors. For example, levels of drug and alcohol abuse are significantly higher for the prison population and there are far higher levels of mental ill-health in the prison population than in the general population. 72% of male and 70% of female sentenced prisoners suffer from two or more mental disorders, compared with only 5% of males and 2% of females in the general population (Social Exclusion Unit, 2002).

The impact of imprisonment on mental health is not positive and prisoners are particularly vulnerable to developing mental health problems (Birmingham, 2001, 2003; Durcan, 2008; Bradley, 2009). This is significant since people with pre-existing mental health problems are more vulnerable to custody, as diversion initiatives are not always successful (Birmingham, 2001). There are many factors in prison which can contribute to mental ill-health, including overcrowding, violence, solitude, lack of privacy, lack of activity, isolation, insecurity, inadequate health service provision and the availability of drugs (Fraser et al, 2009). Durcan (2008) also referred to these, but also identified other factors including bullying by other inmates, concerns about family, having little meaningful activity, substance misuse; incompatibility with cell mates; poor diet; limited access to physical activity; unresolved past life traumas, and difficulty in accessing, healthcare and counselling services. There are also specific concerns and management needs associated with prisoners who are subject to Indeterminate Sentences for Public Protection (IPP). Examination of the mental health of prisoners who were subject to such sentences found that out of 2,204 prisoners assessed, 18% had received psychiatric treatment in the past, compared with 9% of the general prison population, and 21% were receiving medication
for mental health problems. Furthermore, 66% required a clinical assessment for personality disorder, compared with 34% of the general population. Prisoners interviewed spoke of occasions when they heard voices, as well as experiencing mental health conditions such as bi-polar disorder and schizophrenia. (Sainsbury Centre for Mental Health, 2008) and research has found that prisoners in England and Wales are over-represented when compared with the general population in terms of suffering from schizophrenia, psychosis, delusional disorder, personality disorder, drug dependency and alcohol dependency (Singleton et al., 1998; Singleton et al., 2001). Furthermore, in England and Wales it is estimated that up to 30% of all prisoners have engaged in deliberate acts of self-harm at some point during their incarceration (Brooker et al, 2002; Borrill et al, 2003), and many do so for the first time in prison. During the period September 2017 - September 2018 there were 52,814 incidents of self-harm, a 23% increase from the previous year, and a new record high. During the period December 2017- December 2018 there were 92 deaths by suicide, up from 70 in the previous 12 month period (Ministry of Justice, 2019). Death by suicide often reflects “a crisis of desperation” (Rickford and Edgar, 2005, 73), and in 2016 the Prisons and Probation Ombudsman noted that suicide in prison is typically the result of a “culmination of personal crises in individual lives” (House of Commons Justice Committee, 2016, 19). Suicide is “the most tragic consequence of mental illness” (Gunnell et al 2011, 343) and it can be argued that this crisis is present beyond the individual, but is also present in the prison as an institution and throughout society as a whole.

Since 2003 the provision of healthcare in British prisons has rested with the NHS. Healthcare professionals in prison are now employed by the NHS and are commissioned by the local Primary Care Trust (Durcan, 2008). The NHS has been in sole charge of commissioning and delivering mental health services in prisons since 2013 (NHS Commissioning Board, 2013) and it aims to deliver healthcare in prisons based on the principle of Equivalence of Care, as per the recommendation made by Her Majesty’ Inspectorate of Prisons (1996), whereby prisoners are to receive the same standard of healthcare as those in the community. This principle is a well-documented right and is recognized by both the United Nations Mandela Rules (2015) (Rule 24) and the Council of Europe (2006). While a period in prison "should present an opportunity to detect, diagnose and treat mental illness, in a population often hard to engage with NHS services" (Reed and Lynne, 2000, 1031), the reality is quite different. For example, large numbers of prisoners are entering prisons with pre-existing mental health conditions, and these are not being identified upon arrival at prison reception (Brooker and Ullman, 2008; Offender Health Research Network, 2008; Birmingham, 2003). This was recently highlighted in evidence submitted to the Public Accounts Committee, where it was stated that 75% of the prisoners with mental health problems are not being detected through prison reception screening (Public Accounts Committee, 2017). This results in many prisoners serving their sentence while experiencing mental ill-health and not receiving the level of treatment that they need.

Many mental health issues often go undetected and untreated in prison (Offender Health Research Network, 2009) and it is well documented that the prevalence of psychiatric morbidity in the prison population is much higher than in the general population (Singleton et al, 1998; Fazel and Danesh, 2002; Grubin, 2010). Furthermore, some prisoners may have mental health problems which require them to be transferred to a secure hospital away from the prison. The Department of Health recommends that this process should take no longer than two weeks: prisoners should receive their first assessment within two days of a mental health problem being identified, their second assessment within nine days, and the Secretary of State should be able to sign the warrant for their
transfer within 14 days. The reality is somewhat different. The National Audit Office (2017a) reported that of all prisoners transferred in 2016-17, only 34% were transferred within the 14-day period, and 7% had to wait for more than 140 days. It found that in 2016 “prisoners had waited an average of 47 days for their first assessment, a further 36 days for their second assessment and a further 13 days for the Secretary of State to sign the warrant for them to move to a secure hospital” (46). One of the reasons why such delays occur was touched upon by the National Audit Office (2017a) report, which stated that there were “examples of patients receiving multiple assessments from different hospitals without being able to secure a bed” (46) which suggests a lack of coordination between prison health services and the NHS provider as well as a lack of capacity for mental health patients in the overall health service. The National Audit Office (2017a) has been highly critical of the provision of mental healthcare in the prison estate. It found there to be a lack of clarity over how mental healthcare was to be provided, a lack of data on mental healthcare in prisons, and it referred to a prison system under considerable pressure due to drastic spending and staff cuts. The report admitted that the Government simply does not know how many people in prison have a mental illness, how much it is spending on mental health in prisons or whether it is achieving its objectives (National Audit Office, 2017b). In 2017 there were 31,328 people in prison who reported having mental health issues at any one time. 7,917 people were recorded by the NHS as receiving treatment for mental health illnesses in prison in England and Wales in March 2017. This equates to a treatment rate of 25%. Furthermore, 40% of prisons did not provide refresher mental health awareness training to prison staff (National Audit Office, 2017a). The overall lack of data on mental health in the prison system demonstrates the importance of research in this area. This study identifies issues relevant to a small, yet significant proportion of the prisoner population in England and Wales, one that is hiding in plain sight, that of the Irish prisoner population.

This study
Since qualitative research is focused on the world of lived experience (Denzin and Lincoln, 2011), this research considers the term mental health as well as related themes identified, in the context of participants’ subjective understanding of these terms, thus adopting a social constructionist stance. 37 semi-structured interviews were undertaken with recently released (within two years) prisoners in England and Wales as a part of the author’s doctoral research. The overall research sample (n=37) was 92% male and 8% female. Ages ranged from 18 to over 50, the majority (57 %) being aged between 24 and 40. Interviews were conducted over a 12-month period, from March 2014 to March 2015. It should be noted at this point that there are limitations on this study. For example, it is not reasonable to assume that this small sample and the findings ascribed to it are representative of the entire Irish prisoner population in England and Wales. Furthermore, while eight Irish Travelers did agree to participate in aspects of the wider research project, they were very reluctant to discuss aspects of their mental health. This must also be noted as a limitation on the findings of this paper.

Prior to the commencement of the research, ethical approval was sought and approved by the relevant ethics committees at the author’s academic institution. Purposeful sampling was used to identify participants. This involves identifying and selecting participants who have good knowledge or understanding about an issue or who have experience with the issue being researched (Creswell and Plano-Clarke, 2011), in this case the knowledge and experience was of imprisonment. The format chosen for this research was that of semi-structured interviews with an informant led interview style, which are concerned with “the interviewee’s perceptions with a particular situation or
context” (Robson, 1995, 231). Non-directive probing questions were used to encourage and motivate participants to provide clarifying information without influencing their answers. Such an approach is designed to be neutral in order to avoid increasing the probability that any specific type of answer is encouraged or discouraged from respondents.

Thematic analysis was used to analyze interview notes (Braun and Clarke, 2006; Caulfield and Hill, 2014). This is a six-stage process consisting of the following: familiarization with data; generation of codes; searching for themes; reviewing themes; defining and naming themes and producing the research report. Thematic analysis is generally considered to be suitable for analyzing any type of qualitative data (Caulfield and Hill, 2014). While the process broadly followed the six-stage process, it did not do so in a linear process. Fortunately, the six-stage process is flexible as there is no actual standardized approach to carrying out thematic analysis (Howitt and Cramer, 2008).

The first step was to familiarize myself with the data and this was done by reading and re-reading my interview notes. They were then typed up and again reviewed. Additional notes were also taken, as thoughts and ideas developed during the reviews. Coding is “the formal representation of analytic thinking” (Maxwell and Rossman, 1999, 155) and this research adopted a data and a theory led approach to coding. In order to search for and identify themes, a color coding system was used. Codes were ascribed for themes that were theory led and which were evident from reviewing the notes. These were essentially themes that participants were asked about based on the literature, for example, mental health, addiction, homelessness and education. Whenever a particular theme was referred to it was highlighted with its relevant color code. In order to search for data led themes, these themes were then grouped into coded data streams. These data streams were reviewed which allowed for more themes to be identified. For example, under the code for mental health, various themes emerged such as depression, paranoia and fear, and loneliness and isolation. These themes were ascribed their own new code and copied and pasted into a new document which was dedicated to that particular code and the identification of these themes form the basis of this paper.

Findings

(1) Depression
Depression can affect people in different ways and can cause a wide variety of symptoms. They range from lasting feelings of unhappiness and hopelessness, to losing interest in the things you used to enjoy and feeling very tearful. Many people with depression also have symptoms of anxiety. There can be physical symptoms, fatigue, poor sleep patterns, poor appetite, low libido, and various aches and pains. Symptoms of depression range from mild – perhaps feeling persistently low in spirit - to severe - which can make you feel suicidal. Most people experience feelings of stress, unhappiness or anxiety during difficult times. A low mood may improve after a short period of time, rather than being a sign of depression (NHS webpage on clinical depression, n/d).

Depression was a major concern for participants, both prior to and during imprisonment. Many noted that although they suffered from depression prior to imprisonment, in most cases, imprisonment made it worse, with one stating that he “was not sure where the depression came from” and that “the depression crept up on me bit by bit” (Male, aged 35-39). This supports the contention that prison exacerbates mental ill-health. Some noted that although they may have suffered from depression
prior to prison, it was not until they arrived in prison that it was diagnosed or they received treatment. One participant stated that while he “suffered from depression from my early teens and have had many very low points in my life... it wasn’t until I came into prison that this was diagnosed” (Male, aged 25 - 29). The nature and the environment of the prison itself were referred to as being depressing in itself. Several participants referred to the environment of prison – the physical place itself – as being depressing and having an effect on them. When discussing the relationship between the prison environment and depression one participant stated that “you do get down in prison. The place just has that about it” (Male, aged 35-39). One participant noted that depression was linked with the inherent nature of imprisonment itself, stating “it’s the nature of imprisonment. It’s the environment. If you think about it too much it gets to you and you end up feeling shit about yourself” (Male, aged 35-39), while another spoke of the surroundings, the place and the environment as being “a depressing place” (Male, aged 18-23). Depression often resulted in participants in this study engaging in acts of self-harm, or even attempting suicide, and the treatment available was considered to be inadequate. One participant spoke of the link between his depression and suicide attempt, stating, “I had reached a stage where the depression had set in...There was no hop, no light at the end of the tunnel for me. So I decided that I had enough and that I was going to kill myself” (Male, aged 50+).

(2) Paranoia and Fear
A person experiencing paranoia may exhibit certain features. These include thinking other people are lying to them or trying to manipulate them, feeling they cannot really trust their friends and associates, worrying that any confidential information shared with others will be used against them, thinking there are hidden meanings in remarks most would regard as innocent or worrying that their spouse or partner is unfaithful despite a lack of evidence. (NHS webpage on personality disorder, n/d).

Paranoia is characterized “by suspicion of others’ motives and self-referent interpretation of other people’s intentions and behavior” (Brotherton and Eser, 2015, 1). Paranoia was a concern raised by several participants and it fed into the fear that some felt. Entering prison can be a daunting experience (Ratcliffe, 2005) and fear upon arrival into prison may be heightened for those who are experiencing it for the first time (Ratcliffe, 2005; Pogrebin and Dodge, 2001). For some who have been in prison previously, returning may not be such a fearful event (Ratcliffe, 2005; Pogrebin and Dodge, 2001). Some may have developed coping mechanisms, and to some extent, having been through it before, will know what to expect (Cooper and Livingston, 1995; Rocheleau, 2014). Knowing what to expect may, however, also strike fear into the hearts of those who have already been in prison. One participant stated that prison was a “harsh environment and in a place where life is not worth much. It’s a place of fear and paranoia” (Male, aged 50+), while a female participant felt that experiencing paranoia was quite normal for prisoners: “I suffered from paranoia for a while. Like people were out to get me. I think that’s pretty normal in prison” (Female, aged 30-34). Participants also linked paranoia with feelings of anger and frustration, especially when on lockdown. One participant stated that “when you’re on 23-hour lockdown you get paranoid. You get angry and frustrated” (Male, aged 18-23). Paranoia was often related to fear of violence and death. One participant stated: “I thought everyone had it in for me, that they were all talking about me. If I heard someone talking outside the door, I was sure that they were talking about me. There was a fear that I was going to be killed. I didn’t know what was happening in my head at all” (Male, aged 35-39).

Participants also spoke of the relationship between their paranoia and self-harming. In both of these
cases participants were highly critical of the treatment that they received. One stated that the impact of his paranoia “was lethal. I just broke the bit off my zip, sharpened it and started poking my arms. They took me out, bandaged me up and just gave me an aspirin and sent me back” (Male, aged 50+). Another participant spoke of a similar experience: “I cut my hands really deep about five times. They put me into the hospital part of the prison, stitched me up and after a few days I was back on the wing. They said I was alright but I wasn’t alright at all” (Male, aged 35-39). Such poor treatment is not surprising as similar findings were recorded by Marzano et al (2012) who found that prisoners’ experiences of prison staff responses to incidents of self-harm were generally negative.

(3) Loneliness and isolation

Loneliness can be defined as “distressful consciousness of an inner distance to other humans and thus as a desire for satisfying and meaningful relations” (Lamster et al, 2017, 51). It is a subjective, emotional and cognitive appraisal of a person’s environment. As with paranoia, loneliness and isolation were associated with periods of lockdown, which was identified as a dangerous time for those experiencing mental ill-health. One participant identified this relationship in the following terms:

“Isolation inside is a big problem. When you’re locked up, alone with no company, sure it’s no wonder that some lads who maybe aren’t strong willed breakdown and end up talking to imaginary people. This is a very dangerous position to be in...I was on lockdown sometimes for 23 hours a day. That shit destroys a person’s mind.” (Male, aged 50+)

A female participant noted that being alone in prison is often followed by “a lot of loneliness and hopelessness” (Female, aged 30-34), while a male participant described being alone in prison, with little to do but reflect, can be dangerous. He stated that “you can get caught up in negative thoughts and emotions and that can be a bad road to go down” (Male, aged 50+). The silence associated with isolation was referred to by another participant who also viewed any resulting descent into self-examination in a dangerous light. Again, lockdown was referred to as a contributing factor to deteriorating mental health:

“Sitting alone in your cell dwelling on the past can lead you down a bad road. When you’re alone at night with your thoughts it’s hard not to think of what you done or what was done to you, what you’re missing, and what you lost. Thinking about it can get you in a lot of trouble. It can ruin your mind and you get obsessed with it...Some places have you on 23-hour lockdown and others have a bit more regular routine...the places on lockdown could drive fellas mad, being stuck in your cell all the time looking at the four walls. You’d go crazy after too long. It’s inhumane to do this to anyone.” (Male, aged 50+)

Discussion

Depression, paranoia, fear, and loneliness and isolation can all be viewed as a crisis for the individual who is experiencing them. Perhaps more important is how an individual deals with these factors – whether they can manage and cope and get through their crisis, or whether the crisis gets the better of the individual. When factors such as depression, paranoia, fear, and loneliness and isolation come to the fore, and when an individual cannot cope with them, this may result in a new crisis, where the individual engages in acts of self-harm or attempts to commit suicide.
Depression is one of the most common mental illnesses in prison and it is much more prevalent in the prisoner population than in the general population (Gusak, 2007; Leigh-Hunt and Perry, 2014). Light et al (2013) found that 65% of female and 37% of male prisoners suffered from depression. Leigh-Hunt and Perry (2014) estimated that up to 75% of the entire prison population in England and Wales suffer from some level of depression, with higher rates in young women, the elderly and remand prisoners. Several participants in this study claimed that their depression was a direct contributing factor to committing acts of self-harm and attempting suicide. Participants in this study also linked depression with the prison environment, and research has found that “mental disorders may develop during imprisonment itself as a consequence of prevailing conditions” (World Health Organisation / International Committee of the Red Cross, 2005). These conditions “can, and most likely do, contribute to poor prisoner mental health” (Armour, 2012, 886). There are many reasons why the prison environment, with its rules and regimes, may have a detrimental impact on mental health (Birmingham, 2003). Imprisonment separates individuals from their families and friends and places them in an environment where stress, boredom and bullying are commonplace (Heidari et al, 2014; Offender Health Research Network, 2010; Pogrebin and Dodge, 2001). Research has found that long periods of isolation, such as being on lockdown, accompanied by minimal mental stimulus, contributed to poor mental health as well as feelings of intense anger, frustration and anxiety (Nurse et al, 2003). Overcrowding in prisons has been linked with psychological distress and has a significant negative impact on the provision of mental healthcare (Evans, 2003; Walmsley, 2005).

The degree of paranoia that was experienced by participants in this research ranged from being convinced that other people were talking about them, to a fear of being killed by other prisoners or by prison officers. Paranoia was highlighted in prison-based research as one of the greatest factors that affect prisoners – the other was boredom (MacGuinness, 2000). It was stated that both “breed frustration, and some sort of displacement is needed, if only to satisfy psychological needs” (MacGuinness, 2000, 95). Furthermore, this research found that the conditions of imprisonment, for example being on lockdown, were associated with a sense of paranoia. This should come as no surprise as Haney (2003) has noted that when prisoners are deprived of normal human interaction, many suffer from mental health problems including anxiety, panic, insomnia, paranoia, aggression and depression. Furthermore, inter-prisoner violence is not uncommon, and therefore being paranoid may in fact be a survival mechanism that some utilise, whereby a constant fear of violence might ensure that they are vigilant and aware of their surroundings at all times. In England and Wales there were 22,374 prisoner-on-prisoner assaults in the 12 months to March 2018, up 16% from the previous year. Of these, 3,081 (14%) were serious assaults, an increase of 9% in the number of serious incidents from the previous year and both of these figures are record highs (Ministry of Justice, 2018). Paranoia may also be linked to a real issue such as being a victim of crime in the past.

Participants in this research cited fear as a major factor upon arrival into prison. This can be linked to the fact that prisoners are often at their most distressed on entry to prison, especially those who are experiencing prison for the first time (Liebling et al, 2005, as cited in Jacobsen et al, 2008). Paranoia has been also linked with fear (Binswanger et al., 2011) and vulnerability (Boyd and Gumley, 2007), both of which were reported by participants, and boredom, which has also been linked with paranoia (Brotherton and Eser, 2015). Von Gemmingan et al. (2003) suggest that people who are easily bored have a greater predilection towards negative rather than positive affect. They argue that individuals who exhibit mild levels of paranoia are prone to experiencing boredom, and a bored mind has been
found to be “the logical starting point in a pattern that predicted that individuals would be more apt to creating stimulating information, fixate on thoughts concerning the self, and be anxious about how they are viewed by others” (916). Paranoia has been found to be at its worst when those experiencing it are isolated, allowing their “imagination to run riot” (Boyd and Gumley, 15). Research has shown that long isolative periods, such as that time prisoners referred to on lockdown, can negatively impact upon mental health, creating feelings of anger, frustration and stress (Goomany and Dickinson, 2015). De Veaux (2013, 257) noted that conditions in lockdown “can cause such symptoms as perceptual distortions and hallucinations, massive free-floating anxiety, acute confusional states, delusional ideas and violent or self-destructive outbursts, hyper-responsivity to external stimuli, difficulties with thinking, concentration and memory, overt paranoia and panic attacks.” Several participants in this research highlighted the links between lockdown and paranoia.

For some, depression and paranoia may have been pre-existing conditions which were not identified at prison reception, and for others, they may have developed these conditions for the first time after entering prison. This may be linked to the isolation that participants referred to experiencing while in prison. Participants linked depression and paranoia with incidents of attempted suicide and self-harm. Research on prison suicide has described the hopelessness often caused by depression as being the “single most important predisposing variable in prisons/clinical and community samples” (Palmer and Connelly, 2005, 165). When an individual loses control over their environment such as during prison lockdown, this can often result in feelings of hopelessness, which may result in incidents of suicide and self-harm (Palmer and Connelly, 2005). Participants also spoke of the poor treatment they felt they received after an incident of self-harm, with several claiming that they were bandaged up and returned to their cells. This bears resonance with findings from earlier research where one participant stated: “I get no help whatsoever...they bandage me up and put me back in my cell” (Marzano et al 2012, 6). Self-harming and suicide (as well as attempted suicide) can often relate to a person feeling socially alienated (Furnivall, 2013; van Orden et al, 2010) and these links are well established. Foucault (1988) noted the links between imprisonment and alienation stating that “confinement causes alienation” (227).

One female participant in this research spoke of medicalized prescription based treatment being the limit of what was available, and claimed that talking therapies would have been more beneficial but were never offered:

“There’s no interest in talking therapy, trying to get to the root of a person’s problem. Medication is what they do...All they want to do is keep you medicated instead of looking into someone’s problems” (Female, aged 30-34).

Feelings of loneliness and paranoia are closely related, and research has found that a reduction in feelings of loneliness can reduce paranoid thoughts (Goomany and Dickinson, 2015). Lamster et al (2017) have found loneliness to be a potential cause of paranoia, and isolation and loneliness have also been linked with depression in prison in several studies (Chamberlain, 2015; DeVeaux, 2013; Harris et al, 2006). Recalling his experience of imprisonment DeVeaux (2013, 267) stated that “Isolation did not help my mental state. More than anything else, I recall feeling sad and depressed. I felt caged, alone and helpless.” Foucault (1977) noted that isolation was one of the very first principles of imprisonment, whereby prisoners were to be isolated from the external world, from the motivations of
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their offence and from other prisoners. Thus “not only must the penalty be individual, but it must also be individualizing” (Foucault, 1977, 238). Such individualizing was expected to have a transformative effect on the prisoner:

"Alone in his cell, the convict is handed over to himself; in the silence of his passion and of the world that surrounds him, he descends into his conscience, he questions it and feels awakening within the moral feeling that never entirely perishes in the heart of man… the walls are the punishment of the crime; the cell confronts the convict with himself; he is forced to listen to his conscience“ (Foucault, 1977, 238-239).

However participants in this research questioned the value of such reflection, with several using the term “bad road” to describe the emotional and mental journey that such introspection can lead a person on.

Conclusion
This paper has attempted to shine a light on the experiences of a small, yet significant proportion, of the prison population in England and Wales: the Irish prisoner. Anecdotal evidence suggests that there may be over 1,000 Irish prisoners in England and Wales and yet research on this group is negligible. Coupled with at least 1,500 ‘Irish Travellers’, the number of Irish prisoners in England and Wales is likely to be approximately 2,500. This would make them the largest foreign national group within the prison system by far. This research identified themes of depression, paranoia and fear, and isolation and loneliness as impacting upon Irish prisoners in England and Wales. Depression in the prison population is common and it may often be related to feelings of paranoia, fear, loneliness and isolation. On its own, it might be easy to dismiss levels of depression in the prisoner population as everyone gets a bit down sometimes, especially in prison, given the environmental factors which were referred to in this paper. However, if depression is combined with feelings of paranoia and isolation, as discussed by participants, then this may result in a situation where a person’s view of their future is one of hopelessness, and this is a major concern when it comes to self-harming and suicide, both of which are increasing in at record levels in prisons across England and Wales. All prisoners, irrespective of their nationality, are impacted upon by this. There is, however, no reason to suggest that Irish prisoners in England and Wales suffer disproportionately from depression, paranoia and fear, and isolation and loneliness, when compared with the general prisoner population. However, the lack of data in this paper from Irish Travelers again needs to be acknowledged. Gavin (2019) has found that Irish Travelers suffer from racism, bullying and discrimination in the prison system in England and Wales, and such mistreatment is likely to have an impact on their mental health. An examination of the mental health of this group would be merited in the future.

While Irish prisoners do make up a significant percentage of the overall foreign national prisoners population, they do, by in large, remain a somewhat invisible group within the prisoner population for several reasons. Typical concerns for foreign nationals include language, family contact and immigration (Richards et al, 1995). Irish prisoners do not suffer to the same extent as other foreign nationals, as there is no language barrier and Irish nationals are considered for deportation only in the most exceptional circumstances, and are typically treated as a special case in order to reflect the close “historical, community and political ties between the United Kingdom and Ireland, and the existence of the common travel area” (Harvey, 2007, 209). Maintaining family contact is a concern for all prisoners,
not just foreign nationals. It is not unreasonable to assume that if a prisoner’s family is in a foreign country it is more difficult to keep in contact with them, than if they are in the same country. On that note, it can be said that Irish prisoners whose family are in Ireland do share a common experience with foreign national prisoners. It should, however, be noted that there is probably a large percentage of Irish prisoners whose families are also living in England and Wales and therefore family contact is less of an issue in certain cases.

Moving forward, more needs to be done for all prisoners with mental health problems, and there are various ways in which this could be done. Prisoners who are serving Indeterminate Sentences for Public Protection are a group which experiences high levels of anxiety, depression and who are at a high risk of self-harming. Approximately 2,100 of these prisoners are still serving an indeterminate prison sentence, despite their tariff already having expired. They should be released immediately as this could free up mental health resources in the prison system which are needed elsewhere. Participants in this research were critical of staff responses to mental health issues as well as the availability of treatment. While prison officers receive basic training on mental health when hired, recent research has shown that 40% of prisons do not offer a refresher mental health training to staff (National Audit Office, 2017a). This should be rectified and staff should be continually trained and upskilled in this area. Furthermore, since May 2017 all new prison officers receive a four hour training session entitled “Introduction to mental health”. More than four hours training may prove useful. There is also a growing Mindfulness movement developing worldwide. A study of a modified Mindfulness program offered to 2,000 prisoners in Massachusetts found that 1,350 completed the program and reported less hostility, improved self-esteem and better emotional control (Samuelson et al, 2007). A similar program was launched on a pilot basis in England and Wales using yoga. Participants reported increased positive emotions and reduced stress (Bilderbeck et al, 2013). This is something that could be rolled out nationally.

Finally, at the time of writing (March 2020) all prisons in England and Wales have gone into a state of lockdown as a result of the COVID-19 pandemic. Prisons pose an acute risk of the virus spreading at a particularly fast rate, in a process referred to as cluster amplification. COVID-19 has been detected in the prison population in England and Wales. Two prisoners have died, at least 13 prisoners have tested positive for the virus and 4,000 prison staff are now self-isolating (Grierson et al, 2020). The spread of the virus and the reduction in staff numbers has resulted in social distancing measures being introduced, the cancellation of association, the cancellation of educational and training programs, and a general position of prisoners spending a lot more time in their cells. This will surely have an impact on the mental health of the prison population. As well as releasing all prisoners who are serving an IPP sentence post-tariff, consideration should be given to releasing all prisoners who are serving a prison sentence of up to 12 months for non-violent and non-sexual offences as well as older prisoners who pose no risk to themselves or others. There are currently over 5,000 prisoners over the age of 60 and releasing them would free up a significant amount of space in the prison system and could ease the potential spread of COVID-19 throughout the prison estate.
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About the Author

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ARCHITECTURAL DESIGN FOR MENTAL HEALTH TREATMENT: PRELIMINARY FINDINGS OF SERVICE PROVISION USING A SPACE, LAYOUT, AND SETTING FRAMEWORK

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Abstract

In the United States, jails have become the largest mental health institutions and have come under public scrutiny regarding the accessibility and quality of the mental health services provided. Research supports that the architectural design of a correctional facility influences the behaviors and wellbeing of an incarcerated person, including the treatment and services received while incarcerated. This pilot study utilizes the Space, Layout, and Setting (SLS) framework to investigate the impact of New York City’s jail design on an incarcerated person’s access to mental health services. Results approaching statistical significance show that jails concentrated with mental health services are more likely to have mental health appointments completed compared to jails that are not. This holds true when controlling for jail capacity and the number of mental health appointments scheduled. Whilst it is best practice to have mental health services provided outside of the correctional setting, correctional administrators that seek to better serve their mental health population may consider exploring the designs of their facilities to be more treatment oriented.

Keywords: Mental Health, Corrections, Architecture, Design
Introduction

Jails have become the largest mental health institution in the United States (Holiday et al., 2020), with jails in large urban areas capturing the bulk of persons who are mentally unwell (Sayers et al., 2017). This becomes a larger concern when one considers that correctional facilities have an extensive history of poor mental health service provision (Blumstein et al., 2000; Carter, 1998; Elliot, 1997; Haney, 2006; Haney, 2017; Schaefer & Stefancic, 2003), at times worsening mental health issues among occupants (Schaefer & Stefancic, 2003; Yi, Turney, Wildeman, 2017). In response, researchers have continued to strategize on ways to address the issues surrounding growing mental health populations in correctional settings (Haney, 2017). While it is best practice to have mental-health services provided outside of the correctional setting, this pilot study investigates how correctional design can be leveraged to improve access to mental health services. This paper descends directly into the matter, introducing the SLS design framework, the pilot study based on New York City’s jail system, and the preliminary results.

Architectural Design: Space, Layout, and Setting (SLS)

Architecture is defined as “the art or science of building; specifically: the art or practice of designing and building structures and especially habitable ones (Architecture, 2020). Altering the built design of a correctional facility (jail or prison) to influence the perceptions, behaviors, or behavioral intent of people in custody is no new endeavor (Fairweather & McConville, 2000; Flynn & Moyer, 1971; Foucault, 2012; Gill, 1962; Johnston, 1961, 2000; Lutham et al., 2016; Rosen, 2017). In fact, the mere consideration of this idea has inspired strong arguments in support, against, or otherwise critical of the physical redesign of correctional institutions (Brown & Smith, 2018; Kurti & Shanahan, 2018; Moran, Jewkes, & Lorne, 2019; Stevens, Toews, & Wagenfeld, 2018; St. John & Blount-Hill, 2019; Toews, 2016; Wagenfeld et al., 2018; Wener, 2012).

Furthering the relevance of correctional architecture are research studies that link the architecture of correctional institutions to variations in misconduct (Morris & Worral, 2014); escapes (Scott, Petrossian, & Mellow, 2018); healthy relationships formed between correctional officers and people in custody (Beijersbergen, 2016); and the health of persons in custody (Schaeffer et al., 1998). Unfortunately, while theories, frameworks, and discussions around correctional architecture are present, empirical examinations of the impact or effect that correctional architecture has on mental health services are scant (St. John et al., 2019).

At the annual meeting of the Academy of Criminal Justice Sciences in 2016, the Space, Layout, and Upkeep model for correctional design was introduced as a framework for building humane facilities for housing court-involved youth and young adults (St. John, 2016). The framework rests on the premise that a facility’s capacity and location (both components of space), layout, and upkeep are factors that condition the successful rehabilitation of an occupant, and that these features can be manipulated to increase or decrease the chances of successful rehabilitation. Further developing this model, St. John et al. (2019) proposed space, layout, and setting (SLS) as key components to consider in designing for correctional rehabilitation. In their study, St. John et al. provided qualitative support for the notion that the spatial capacity, spatial location, facility layout, and the sensory conditions of jail and prison influence the delivery of services (e.g., mental health or educational services) that incarcerated persons receive. However, the generalizability of the study’s findings is limited given the qualitative
design used to substantiate the framework. This pilot study utilizes the SLS framework to inform a quantitative exploration of how a facility’s spatial features predict the successful delivery of mental health services in New York City jails.

Space and Mental Health Services

“Space is defined as ‘a limited extent in one, two or three dimensions,’ that extent being ‘set apart,’ and determined, in part, by how ‘objects and events occur and have relative position and direction’ (see Space, 2016). This includes ‘the distance from other people or things that a person needs to remain comfortable.’ As a concept, space influences an incarcerated person’s rehabilitation through determinations of capacity and location” (St, John et al, 2019, p. 750)

Pulling from the SLS definition, space in the correctional setting is best understood as the physical capacity and the location of people, things (including buildings), or events. Research has shown that the physical capacity or spatial density of a facility is predictive of occupant behavior and wellbeing (Schaeffer et al., 1988; Sibley & van Hoven, 2009; Lawrence & Andrews, 2004). For example, Schaeffer et al. (1988) linked increases in catecholamine (a hypertension causing hormone) to the social and spatial density of the built environment. Furthermore, in many instances, the overcapacity of facilities directly changes the practices and policies under which entire correctional systems are operated (e.g., California’s AB109 legislation, see Pitts et al., 2014). Moreover, the physical location of persons, places, or things is a criminological underpinning for many violence and victimization strategies in the community (Brantingham & Brantingham, 1999; Casteel & Peek-Asa, 2000) and within correctional facilities, such as special housing under the Prison Rape Elimination Act (Thompson et al., 2008), for youth and young adults (NYC Department of Correction, 2018), for individuals of different security levels (Quay, 1984), for problematic incarcerated persons (Beck, 2015), and more. Therefore, it is no surprise that the location of mental health services and a facility’s capacity are factors practitioners, policymakers, and stakeholders bring forth when discussing mental health services. For example, in New York City, specialized mental health units are constructed within jails to place mental health services closer to the population in need (Anthony-North, Roberts, & Sullivan, 2017). Drawing upon this logic, one may expect that the access to mental health services or the quality of mental health services to worsen when mental health services are not near those who need them or when facility capacity is higher. This pilot study explores the impact of capacity and location on mental health service provision.

Pilot Study

Research Question and Hypotheses

The primary research question of this pilot study was: how do the properties of spatial capacity and spatial location impact access to mental health services? The associated hypotheses are: Hypothesis 1) Facilities with a higher number of individuals residing in them are less likely to have scheduled mental health appointments completed; and Hypothesis 2) Facilities with a physical concentration of mental health services embedded within them are more likely to have scheduled mental health appointments completed.
Research Design and Method
A repeated measure design was used to sample all jails in New York City. Between January 2017 and June 2019, repeat monthly observations for 13 facilities were gathered from public facing reports produced by the local correctional health authority. The sampling frame of city jails included: George Motchan Detention Center, Otis Bantum Correctional Center, George R. Vierno Center, Eric M. Taylor Center, Anna M. Kross Center, Vernon C. Bain Center, Manhattan Detention Complex, Brooklyn Detention Complex, Rose M. Singer Center; Robert N. Davoren Complex, West Facility, and North Infirmary Command. Horizon Juvenile Center was also added to the list of facilities given that some individuals in this facility were still under the custody and care of the Department of Correction and Correctional Health Services at the time of this analyses. Due to periodic opening and closures of facilities, the sample totaled to 306 monthly observations from all jails. A subsequent removal of missing observations reduced the final sample to a total of 282.

Variables
The dependent variable in this study are the number of scheduled mental health services that were completed. This is measured by the number of appointments where an incarcerated person with a scheduled appointment was seen by a clinician. Predictor variables in the model include a) the season; b) month; c) unique facility characteristics; d) the facility average daily population (i.e., spatial capacity); e) the number of scheduled appointments; and f) whether a facility was Mental Health-Centric (a proxy for spatial location). Specifically, Seasonality was coded 0 to 3 for the four seasons; Month 0 to 11 for the 12 calendar months; Unique Facility was coded 0 to 12, assigning each number to represent a specific jail in New York City; Facility Average Daily Population was a raw count of the average number of incarcerated persons within a facility for a given month; Scheduled Appointments was measured by the raw count of scheduled mental health appointments; and Mental Health-Centric was a binary code for whether a facility was specifically redesigned to incorporate units that spatially locate staff and resources closer to the mentally unwell (i.e., did these jails have the Program for Accelerated Clinical Effectiveness (PACE), Clinical Alternatives to Punitive Segregation (CAPS), and/or Restrictive Housing Unit (RHU) units).

Mental Health-Centric
The categorization of ‘Mental Health-Centric’ is best interpreted as whether a facility had the presence of one or more specialized mental health units built within them. In this study, New York City’s PACE, CAPs, and RHU units are three specialized units for persons with a serious mental illnesses (SMI) or deemed mentally unwell, by a clinician, to be placed in punitive segregation housing. First, the PACE units are tailored for individuals diagnosed with SMIs who require an in-patient level of care. PACE units are intensive-care mental health units that promote adherence to treatment, including medication and jail rules, for persons with chronic mental illness, at risk of acute psychiatric decompensation, and/or behavioral disruption. Consistent mental health and security staff, as well as nurses and mental health treatment aids are present within the unit (New York City Department of Correction, 2020; City of New York, 2016).

Secondly, CAPS is a specialized housing unit for people with SMIs who have been issued a sanction requiring them to spend time in punitive segregation. As an alternative to punitive segregation, patients in CAPS receive in-patient levels of care, consisting of intensive therapeutic schedules that include group programming, one-on-one sessions with mental health providers, and art therapy. Upon
successful completion of treatment, the punitive segregation sanction is removed (Anthony-North, Roberts, & Sullivan, 2017). The CAPS treatment model also incorporates an incentive-based structure to keep an individual adherent to their prescribed medication schedules (City of New York, 2016).

Lastly, the RHU is a punitive unit that is designed for incarcerated persons who the Department of Correction found guilty of a violent infraction, but who Correctional Health Services deemed mentally unfit for punitive segregation. Although these individuals are mentally unwell, they are not diagnosed with an SMI. The unit provides mental health support that includes group therapy, art therapy, and other mental health programming from Correctional Health Services (NYC Department of Correction, 2020). While persons in RHU do not have an SMI, the intervening by Correctional Health Services and the cooperation of the Department of Correction to place these individuals into a special treatment unit of their own justifies the decision to group RHU as a Mental Health-Centric facility. See Appendix A for additional descriptions of these specialized units.

All in all, the PACE, CAPS, and RHU units all share the commonality of a treatment oriented and incentive-based model, with varying degree of differences in how intensive treatments are, but distinct enough from the rest of the Department of Correction units (e.g., General Population, Protective Custody, etc.). Arguably, spatially locating mental health staff, programming, and overall treatment resources in units where persons who are mentally unwell are concentrated should yield positive outcomes for incarcerated persons within these units. The ‘Mental Health-Centric’ variable captures facilities with these specialized units so that the principle of spatial location can be explored.

Analytical Plan
All analyses were conducted using Stata statistical software. After analytical diagnostics\(^1\), several analyses were deemed necessary to explore. The first two analyses were descriptive analyses that examined the completed scheduled mental health appointments across facilities and examined completed mental health appointments by whether a facility was Mental Health-Centric or not. However, any observance of differences in percentages are at best summations and cannot be generalized to an entire population, therefore requiring a more rigorous analyses when applicable. The subsequent analyses were Negative Binomial Analyses, which are predictive analyses that allow us to test the significance of relationships observed among these variables, and state whether any observed differences are occurring by random chance and generalizable to the entire population.

Preliminary Results

Descriptive Analyses
Figure I illustrate that across the sample of New York City facilities between 2017 and 2019, the

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\(^1\) Analytical diagnostics of the dependent variable Completed Mental Health Appointments, show that the variable is not normally distributed and significantly positively skewed, removing the option for parametric modeling. Additional testing for autocorrelation and multicollinearity among all variables were conducted, yielding a need to separate Facility Average Daily Population and Scheduled Appointments into separate analytical models due to high variance infation factor scores when together. Ultimately, negative binomial models were determined to be most appropriate, with model statistics ruling out the use of Poisson analysis and substantiating the fitness of the Negative Binomial. Lastly, standard errors were bootstrapped 1000 times to further address concerns of heterogeneity and spatial correlation. The results and interpretation of both models are provided in the following section.
average percentage of completed mental health appointments was 64%. A total of eight facilities had an average completion of scheduled mental health services that were equivalent to or above the facility-wide completion average. RMSC had the highest percent complete (77%).

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Average MH Scheduled</th>
<th>Average MH Seen</th>
<th>Percent Complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMKC*</td>
<td>6,850</td>
<td>4,362</td>
<td>64%</td>
</tr>
<tr>
<td>BKDC</td>
<td>1,206</td>
<td>641</td>
<td>53%</td>
</tr>
<tr>
<td>EMTC*</td>
<td>1,845</td>
<td>1,096</td>
<td>59%</td>
</tr>
<tr>
<td>GMDC</td>
<td>1,016</td>
<td>727</td>
<td>72%</td>
</tr>
<tr>
<td>GRVC*</td>
<td>2,354</td>
<td>1,664</td>
<td>71%</td>
</tr>
<tr>
<td>MDC</td>
<td>1,116</td>
<td>715</td>
<td>64%</td>
</tr>
<tr>
<td>NIC</td>
<td>527</td>
<td>389</td>
<td>74%</td>
</tr>
<tr>
<td>OBCC</td>
<td>2,188</td>
<td>1,362</td>
<td>62%</td>
</tr>
<tr>
<td>RMSC*</td>
<td>2,714</td>
<td>2,080</td>
<td>77%</td>
</tr>
<tr>
<td>RNDC</td>
<td>1,538</td>
<td>770</td>
<td>50%</td>
</tr>
<tr>
<td>VCBC</td>
<td>1,051</td>
<td>588</td>
<td>56%</td>
</tr>
<tr>
<td>WF/CDU</td>
<td>551</td>
<td>358</td>
<td>65%</td>
</tr>
<tr>
<td>HOCJ</td>
<td>809</td>
<td>539</td>
<td>67%</td>
</tr>
<tr>
<td>Total</td>
<td>23,765</td>
<td>15,291</td>
<td>64%</td>
</tr>
</tbody>
</table>

Note. Completions indicate that an individual with a scheduled mental health appointment was seen by a mental health clinician. * = Mental Health-Centric Facility. Green => Total Average Completion Percentage, and Red < Total Average Completion Percentage.

Figure I: Scheduled Mental Health Appointments Completed by Facility

Figure II illustrates a difference in completions between Mental Health-Centric facilities compared to all other facilities. Specifically, 67% of scheduled mental health appointments for Mental Health-Centric facilities were completed. Non-Mental Health-Centric facilities had an average of 61% scheduled mental health appointments completed, a 9% decrease compared to Mental Health-Centric facilities, and 4.7% decrease than the overall facility-wide average.

<table>
<thead>
<tr>
<th>Facility Type</th>
<th>Average MH Scheduled</th>
<th>Average MH Seen</th>
<th>Percent Complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health-Centric</td>
<td>13,763</td>
<td>9,202</td>
<td>67%</td>
</tr>
<tr>
<td>Non Mental Health-Centric</td>
<td>10,002</td>
<td>6,089</td>
<td>61%</td>
</tr>
<tr>
<td>Total</td>
<td>23,765</td>
<td>15,291</td>
<td>64%</td>
</tr>
</tbody>
</table>

Note. Completions indicate that an individual with a scheduled mental health appointment was seen by a mental health clinician. Green => Total Average Completion Percentage, and Red < Total Average Completion Percentage.

Figure II: Scheduled Mental Health Appointments Completed by Spatial Location
Further Statistical Analyses

These preliminary descriptive findings show that Mental Health-Centric facilities may be better equipped for facilitating the completion of scheduled mental health services in jails. However, when controlling for the number of scheduled mental health appointments it appears the relationship disappears. This is to be expected since the more scheduled appointments that a facility has increases the chances that there will be a higher number of completed services – a relationship that is not central to the original investigation of this study because of it already being a quantitatively logical assumption (i.e., more scheduled appointments lead to more completions). Potential facility-level characteristics may also account for variations in completed mental health appointments and these may include: the ratio of correctional officers to people in custody, the security statuses of persons held within facilities, number of trained mental health staff, or the custody status composition of persons within a jail (i.e., a person sentenced or a person detained). These factors are discussed further in the study’s discussion.

Given these possible confounding factors, another statistical analysis was conducted to examine the relationship between Mental Health-Centric facilities and completed mental health services when controlling for both Scheduled Appointments and Facility Average Daily Population. The results are shown in Table 1 below. Specifically, jails that were Mental Health-Centric increased the odds ratio of mental health services being completed by 700% (IRR 7.954, p = .07) when controlling for scheduled appointments, average daily population, unique facility characteristics, month, and seasonality.

Table I: Predictors of Completed Mental Health Appointments

<table>
<thead>
<tr>
<th>Model I</th>
<th>Controls</th>
<th>IRR</th>
<th>SE</th>
<th>P</th>
<th>95% C. I</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Seasonality</td>
</tr>
<tr>
<td></td>
<td></td>
<td>.998</td>
<td>.005</td>
<td>.738</td>
<td>.988 – 1.008</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Month</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.000</td>
<td>.001</td>
<td>.842</td>
<td>.997 – 1.003</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Unique Facility</td>
</tr>
<tr>
<td></td>
<td></td>
<td>.994</td>
<td>.171</td>
<td>.976</td>
<td>.709 – 1.393</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Scheduled Appointments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.000</td>
<td>.000</td>
<td>.019</td>
<td>1.000 – 1.000</td>
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<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Spatial Capacity</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Facility Average Daily Pop</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.000</td>
<td>.000</td>
<td>.872</td>
<td>.999 – 1.000</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Spatial Location</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Mental Health-Centric</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7.954</td>
<td>9.330</td>
<td>.077</td>
<td>.798 - 79.258</td>
</tr>
</tbody>
</table>

Note. *p<.05, **p<.01, ***p<.001. N = 282 observations, 13 panels. Prob>=chibar2 = 0.03. Model uses 1,000 bootstraps for standard errors (SE). Facility Average Daily Population and Scheduled Appointment are multicollinear, and statistics should be ignored.

Discussion

The use of architectural design to better facilitate the treatment of correctional occupants is an area that is studied few and far between. The preliminary results from this study further highlight the complexity of studying these relationships and the need for researchers to continue to investigate the matter. If it is the case that one can design facilities to become more conducive of mental health service provision (e.g., spatially locating mental health services and staff closer to occupants), then it becomes of salience to bridge the gap between research and practice, creating and tailoring design frameworks that address the need to support people in correctional custody that have mental health
needs and the staff members that interact with this population. This pilot examination of the SLS framework is one attempt, and as with all research it is faulted with limitations and requires further investigations before it can reach a threshold of best practice.

**Study Limitations and Future Investigations**

*Omitted Variable Bias*

First, this study is limited by the range of variables that were accessible by the researcher to examine, essentially excluding other metrics that may account for fluctuations in completed scheduled mental health services. For example, potential facility-level characteristics that may also account for variations in completed mental health appointments may include: a) the ratio of correctional officers to people in custody, which could help or hinder the amount of persons escorted and produced to correctional health services; b) the security statuses of persons held within facilities, which may require more or less resources for movement within a facility (e.g., multiple staff escorts for one person, additional searches, or added restraints); c) the custody status composition of persons within a jail (i.e., a person sentenced or a person detained), which brings up differences in daily routines (e.g., having a court date vs. not having a court date) that can conflict with a person seeing a clinician at a pre-scheduled time; or d) the number of mental health trained staff. Additionally, capturing only the facility-level variables does not allow an investigation into the nuances at the unit-level. Specialized mental health units may be successful in completing mental health services within the unit, but this may not necessarily extend to the entire jail population, especially when one considers that jails may have various types of units (e.g., general pop, protective custody, or units for persons with non-serious mental health issues). Furthermore, the variations at the individual level are not accounted for, including an individual’s age, gender, race, mental health history, socioeconomic status, education, or criminal justice history.

This limitation is also evident in the analytical findings that illustrate variations at the facility-level. For instance, the first crosstabulation (see Figure I) shows that one of the Mental Health-Centric facilities—(i.e., EMTC), had a percentage of scheduled appointment completions lower than non-Mental Health-Centric facilities. Also, it is important to note that the results in another analytical model showed that the variable *Unique Facility* approached statistical significance, meaning that distinct characteristics of the facility (not represented by the variables present) may also impact completions. Such findings cast doubt on the assumption that simply investing resources to design specialized mental health units will improve mental health service completions within a facility, and highlights that in addition to constructing specialized units, other factors are at work.

*Approaching Statistical Significance*

Secondly, none of the independent variables reached the traditional statistical significance threshold of .05 (Cowles & Davis, 1982), which would have meant that 95% of the time or better, the relationship observed between the variables would occur and not by random chance. Instead, Mental Health-Centric was one out of the two independent variables that approached this threshold, with a significance of .07, meaning that 93% of the time the relationships observed would occur and not by random chance. Moreover, when a significance value is paired with the novelty of findings and real-world costs and benefits, research supports the need to further consider relationships that approach the traditional cut-off of .05 (McShane et al., 2019).
Qualitative Data

The third limitation to this study is that no use of qualitative information is present. The relationships quantified and observed do not allow for insight on how or why the architectural design impacts service completion. The ability to understand elements such as the facility culture; specific policies, practices, and protocols; or the perceptions of incarcerated persons, correctional staff, and health care staff would provide insight into the contextual elements (not limited to the built design) that also facilitate the completion of scheduled mental health appointments, arguably adding the most value for practitioners seeking to implement institutional changes.

Future Studies

Though additional variables that one may think predicts completions were either non-existent due to limitations in the data that was accessible or statistically insignificant in the current study, researchers should still consider these variables in future studies until the empirical investigations into scheduled mental health completions in jails replicate similar findings. Specifically, future studies should: a) explore administrative data at the facility, unit, and individual level; and b) incorporate qualitative methods, such as document reviews, observations, surveys, and/or interviews with correctional personnel, incarcerated persons, and correction health care service providers. In many ways, closer collaborations among correction departments, correctional health care providers, and researchers would troubleshoot these limitations and pave the way for novel approaches that may improve the mental health outcomes of people in custody.

Closing Remarks

It is of salience to close by highlighting that it is generally best practice for persons to receive mental health services within the community or outside of penal institutions. In part, jail and prison environments may worsen the mental health of occupants, cause relapses, deteriorate necessary social support systems for mental health treatment, and in severe instances contribute to suicide (Bonner, 2006; Schaefer & Stefancic, 2003; Yi, Turney, Weisman, Lamberti, & Price, 2004; Wildeman, 2017). Unfortunately, for some, penal institutions are the sole source for accessing mental health services due to barriers to mental health care access in the community, particularly for formerly incarcerated persons without stable housing, health care coverage, employment, or for persons who are treatment resistant (Barr, 1999; Weisman et al., 2004). Therefore, it becomes crucial to implement mechanisms (e.g., discharge planning or continuum of care models) to assist in the quality and consistency of mental health services a person receives both within and outside of a facility (Barr, 1999; Lincoln et al., 2006). Here, changes to the built design of correctional facilities become relevant to improving the accessibility of mental health care services, especially for persons who do not have the resources to engage in community inpatient or outpatient clinical services. Apart from improving access to services through facility design (e.g., by spatially locating necessary services near persons who need services the most), the physical setting or sensory conditions of successful clinical environments in jail and prison are features that require more unpacking—features outside the scope of this pilot study.
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Release into Community Services.


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## Appendix A: Specialized Units

### New York City Specialized Mental Health Units and Descriptions

<table>
<thead>
<tr>
<th>Specialized Mental Health Units</th>
<th>Unit Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>RHU</td>
<td>Restrictive housing unit (RHU): A punitive segregation unit designed for some people with mental health needs (but not diagnosed with a serious mental illness). The unit employs a level system that allows individuals to work their way from the most restrictive form of segregation (cell lock-in for 23 hours a day) to 20 hours of cell lock-in.</td>
</tr>
<tr>
<td>PACE</td>
<td>Program for Accelerated Clinical Effectiveness (PACE): The PACE program works with individuals diagnosed with SMIs who require an in-patient level of care but for whom CAPS is not an appropriate placement (because they have not been found guilty of committing a rule violation). The program design is based on the CAPS treatment model and is intended to encourage individuals to take prescribed medication through the provision of various incentives and rewards.</td>
</tr>
<tr>
<td>CAPS</td>
<td>Clinical Alternatives to Punitive Segregation (CAPS): A specialized housing unit for people with serious mental illnesses (SMIs) who have been found guilty of an infraction and issued a sanction to punitive segregation. Patients in CAPS receive in-patient levels of care, consisting of intensive therapeutic schedules that include group programming, one-on-one sessions with mental health providers, and art therapy. By program design, people with an SMI who have committed a rule violation and are sentenced to punitive segregation time have their time suspended until they successfully complete the CAPS program, at which time the punitive segregation time is expunged. If the CAPS program is not successfully completed, the Department and a mental health provider work together to find a suitable alternate housing placement. CAPS is not considered a form of punitive segregation and is not restrictive.</td>
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MENTAL HEALTH SERVICE DELIVERY IN CANADIAN FEDERAL PRISONS:
A PRISON OMBUDSMAN’S PERSPECTIVE

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&
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Office of the Correctional Investigator.

Abstract

This article looks at the challenges faced by the federal correctional system in Canada as it responds
to a growing population of inmates with mental health needs. Adopting the position that access
to mental health care is a human rights issue, the article situates the legal, policy, and operational
contexts (and constraints) in which mental health services are delivered in Canadian federal prisons. It
then offers some reflections on prison health care reform in Canada, and how these reforms measure
up to international standards, specifically, the Mandela Rules. The article draws from previous
investigations conducted by the Office of the Correctional Investigator to identify areas of concern,
and to offer practical directions for reform.
After visiting Canada from November 5 to 6, 2018, the UN Special Rapporteur on the Right to Health, Mr. Dainius Pūras, made the following observation: “Canada’s international cooperation should be directed to the provision of rights-based mental health services...” (Puras, 2018). In the context of federal corrections, the right to health implies a recognition that every inmate retains the right to “enjoy the same standards of health care that are available in the community...” (Standard Minimum Rules for the Treatment of Prisoners, or the “Mandela Rules”, United Nations, 2015). The Office of the Correctional Investigator (OCI, or Office) continues to work towards this objective by contributing to safe, lawful, and humane corrections through the independent oversight of Canada’s federal correctional system. In this article, the Office situates the legal, policy, and operational contexts in which mental health services are delivered in Canada’s federal prisons. It then discusses to what extent federal prisons in Canada are meeting international standards such as the Mandela Rules, and illustrates how even advanced and well-resourced democracies struggle at times to meet those standards.

**Legal, Policy, and Operational Context**

In Canada, federally sentenced offenders include persons serving a sentence of two years or more. These sentences are administered by the Correctional Service of Canada (CSC, or the Service). Inmates in federal penitentiaries (numbering about 14,000 on any given day) are excluded from the Canada Health Act and are not covered by Health Canada or provincial health care systems. By law (s. 86, Corrections and Conditional Release Act; CCRA), CSC is obligated to provide “essential” health care and ensure prisoners have “reasonable” access to non-essential health care services. The CCRA defines health and mental health care as displayed in Figure 1.

**Figure 1: Health and Mental Health Care Definitions from Section 85 of the CCRA**

<table>
<thead>
<tr>
<th>Health care means</th>
<th>Mental health care means</th>
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<tbody>
<tr>
<td>medical care, dental care and mental health care, provided by registered health care professionals or by persons acting under the supervision of registered health care professionals.</td>
<td>the care of a disorder of thought, mood, perception, orientation or memory that significantly impairs judgment, behaviour, the capacity to recognize reality or the ability to meet the ordinary demands of life.</td>
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</tbody>
</table>

Legislation directs that health services in federal corrections be provided in conformity with professionally accepted standards of practice. Broadly speaking, CSC aims to provide health services that are accessible, affordable, and appropriate to the correctional context. CSC is required to consider an offender’s state of health and health care needs in all decisions, including those related to placement, transfer, confinement in restrictive housing (e.g., Structured Intervention Units), and disciplinary matters, as well as decisions pertaining to release planning and community supervision. CSC is solely responsible for determining what qualifies as an essential or non-essential health care service.
To manage the rising number of offenders with mental health issues, contain costs, and better match services with the level of need, CSC has implemented a Continuum of Care model for mental health care (CSC, 2012). This model has six components:

1. Assessment and screening at intake;
2. Primary care (mainstream institutions);
3. Intermediate mental health care (chronic or sub-acute conditions);
4. Psychiatric hospital care (acute/clinical care in a Regional Treatment Centre);
5. Clinical discharge planning (transitional services to support reintegration); and,
6. Community mental health (risk management in the community).

To fund its Continuum of Care model, CSC began to “de-list” or “repurpose” bed space at its five Regional Treatment (psychiatric hospital) facilities in 2014. These hybrid facilities (penitentiary/hospitals) previously had the clinical bed capacity to treat about 700 patients. The repurposing, or elimination, of psychiatric bed space and the savings generated allowed for the creation of intermediate mental health care capacity (previously an unfunded initiative in CSC’s mental health care strategy). Today, there are about 200 in-patient acute care clinical beds remaining in federal correctional facilities, and approximately 600 intermediate mental health care beds dispersed across mainstream penitentiaries and the Treatment Centres. CSC’s health care budget was roughly $260 million in 2019-20.

Mental Health Indicators in Federal Corrections
Federal inmates have a much higher prevalence of mental health-related issues compared to the Canadian average (see Table 1).

The national rate for a current diagnosis of a major mental illness (e.g., bipolar disorders, major depression, and psychotic disorders) among newly admitted federally sentenced offenders has been estimated as 12.4% for men (Beaudette & Stewart, 2016), and 17% for women (Brown, Barker, McMillan, Norman, Derkzen, & Stewart, 2018). Most if not all of these rates are disproportionately higher for both federally sentenced women and Indigenous Peoples. For example, 79.2% of women and 95.6% of Indigenous women meet the criteria for at least one current mental disorder (Brown et al., 2018).

Mental Health and Federal Correctional Outcomes
As the data clearly show, the mental health needs of federally sentenced inmates are extensive and complex. This pattern is not unique to Canada (Fazel & Seewald, 2012). Prisons have essentially become the “dumping grounds for many individuals who could be better served through early intervention in noncustodial environments because other options are just not available” (Gondles Jr., 2005).

This emerging reality has prompted some to reframe the mental health “crisis” in corrections as a public safety issue, implying that without adequate stabilization and treatment, individuals with mental health needs are at heightened risk for recidivism (Adams & Ferrandino, 2008; Brandt, 2012; Knoll, 2006). This is not to say that mental illness is criminogenic; rather, offenders with mental health issues seem to carry the burden of “more general risk factors for recidivism than their
counterparts without mental illness” (Skeem, Winter, Kennealy, Louden, Tatar, & Joseph, 2014). In the Canadian context, researchers have found that federally sentenced men with comorbid mental disorders had the “poorest outcomes” within the institution (Stewart & Wilton, 2017) and in the community (Stewart, Gamwell, & Wilton, 2018). For example, inmates with comorbid mental disorders are more likely to be:

- involved in institutional misconducts and violent incidents;
- transferred to administrative segregation;
- victimized in the institution; and,
- revoked for technical violations of parole conditions.

The demands on federal correctional mental health care are compounded by the challenge of recruiting and retaining highly qualified mental health care staff (particularly in the rural communities where many facilities are located). As a result, the correctional mental health care system is taxed, and on occasions rolled-out inconsistently across the country.

**Challenges Faced by Mental Health Services in Federal Corrections**

Admittedly, mental health service delivery in a decentralized correctional system is a complex endeavour that requires innovative, flexible, and durable solutions. The OCI is well positioned to report on the challenges faced by correctional institutions and, where patterns emerge, make recommendations to ensure compliance with legal obligations. In its Annual reports to Parliament, the Office has documented a series of systemic concerns regarding CSC’s capacity and response to mental health service delivery. For example:

- Reliance on use of force and control measures involving inmates with mental health issues;
- Psychological and behavioural impacts of restrictive confinement practices;

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1 Canada’s version of “restrictive” or “solitary” confinement until November 2019

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**Table 1: Comparison of Prevalence Rates for Mental Health Issues among Federally Sentenced Individuals Compared to Canadian Estimates.**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Federally Sentenced Men (%)</th>
<th>Canadian Estimate (%)</th>
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<tbody>
<tr>
<td>Any mental disorder - current</td>
<td>73a</td>
<td>10b</td>
</tr>
<tr>
<td>Psychotropic prescription drugs - current</td>
<td>30c</td>
<td>8c</td>
</tr>
<tr>
<td>Alcohol or substance use disorders - current</td>
<td>50a</td>
<td>4b</td>
</tr>
<tr>
<td>Antisocial personality disorder – lifetime</td>
<td>44a</td>
<td>2d</td>
</tr>
<tr>
<td>Anxiety disorders – current</td>
<td>30a</td>
<td>3b</td>
</tr>
<tr>
<td>Borderline personality disorders – lifetime</td>
<td>16a</td>
<td>5c</td>
</tr>
<tr>
<td>Mood disorders – current</td>
<td>17a</td>
<td>5b</td>
</tr>
<tr>
<td>Fetal Alcohol Spectrum Disorder</td>
<td>10-23f</td>
<td>1g</td>
</tr>
</tbody>
</table>

• Security rather than health-centered responses to mental health crises such as self-injury or attempted suicide;
• Inadequate and antiquated infrastructure (one facility, Dorchester Penitentiary, was opened in 1880, and two others are more than 50 years old);
• Lack of 24/7 health care coverage; and,
• Lack of alternatives to incarceration to manage severely mentally disordered, suicidal, or chronically self-injurious individuals.

Infrastructure and resourcing indicators at the Regional Treatment Centres (RTCs) and the disproportionate occurrence of ‘use of force’ incidents involving individuals with mental health needs serve as illustrative examples of the challenges for mental health service delivery in Canada’s federal institutions.

**Regional Treatment Centres**
CSC’s five RTCs primarily serve as inpatient mental health facilities or psychiatric hospitals. As mentioned earlier, there are now about 200 psychiatric hospital beds for men and 20 inpatient psychiatric beds for federally sentenced women.

According to a recent external evaluation commissioned by the Service\(^2\), the overall ratio of clinical staff (Psychiatrists, Psychologists, and Nurses) to psychiatric beds is well below expected or acceptable standards for inpatient psychiatric hospital care (i.e., 1 to 48.5 beds for Psychiatry; 1 to 32.5 beds for Psychology, and; 1 to 51 beds for Nursing). According to the independent reviewer, these low staffing to patient ratios can result in the overuse of segregation and clinical seclusion practices. In comparison, a recent Auditor General’s report from the province of Ontario (2016) showed a combined staff to patient ratio of two staff to three patients across four hospitals over a five-year period. Even with this comparably “high” ratio, provincial survey results reported that half of staff “do not have enough time to do their job” and almost two-thirds of patients indicated that there were not enough organized activities (e.g., group therapy). The fact that the same sorts of challenges can be found in external psychiatric facilities does not negate the point that these issues must be rectified in federal corrections. Other findings of concern that were reported in the evaluation by Dr. Bradford include:

• Correctional and mental health staff were lacking in the skill sets required to deal with forensic patients;
• The selection of security personnel (Correctional Officers) to work in the Treatment Centres seemed unrelated to the needs of patients and was inconsistent with a psychiatric hospital environment;
• Physical infrastructure was “seriously problematic” and unsatisfactory for the delivery of mental health services; and,
• The assessment tools used to screen for mental health conditions and to admit patients to the Treatment Centers were regarded as limited or not clinically relevant.

These and other findings generally reflect areas of concern identified by the OCI over the years, though the external review contains some bold new proposals for reform. For example, Dr. Bradford’s report recommends replacing the RTCs with state-of-the-art, custom designed, inpatient facilities.

\(^2\) Conducted in 2017 by Dr. John Bradford, an eminent Canadian forensic psychiatrist.
However, re-profiling existing resources and outsourcing the care of an additional two or three dozen complex needs individuals to existing external forensic hospitals seems to be a more effective (and humane) use of resources than funding new CSC infrastructure. In any case, following the “de-listing” of bed space at the RTCs in 2014, CSC relied on Dr. Bradford’s 2017 report of the RTCs to secure an additional $228 million in funding for mental health care between 2017 and 2018 (CSC, February 11, 2019).

Use of Force Involving Inmates with Mental Health Issues
As reported in the OCI’s latest Annual Report (2018-19), some of the most troubling use of force incidents in federal institutions deemed unnecessary and/or inappropriate involved patients residing at the RTCs or psychiatric hospitals. As a whole, the five RTCs accounted for roughly 20% of all use of force incidents reviewed by the OCI in 2018-19 (296 out of 1,546). One out of ten incidents at the treatment centres was deemed unnecessary and/or inappropriate.

The level and rates of use of force at the RTCs raise a familiar issue; namely, the competence and training of frontline security staff. The Office raised this concern in its 2017-18 Annual Report, recommending that: “CSC ensure security staff working in a Regional Treatment Centre be carefully recruited, suitably selected, properly trained and fully competent to carry out their duties in a secure psychiatric hospital environment.” It is appropriate to equip correctional officers with training in basic psychosocial rehabilitation or cognitive behavioural therapy to foster therapeutic relationships and encourage interpersonal skills (Anthony & Carkhuff, 1977; Dvoskin & Spiers, 2004). Moreover, Dvoskin and Spiers argued that “the simple provision of information, or simpler yet, listening to an inmate’s concerns, can diffuse a potentially difficult situation,” and stated that the most important “treatment” in corrections might be “basic human respect and concern.”

Informational training on mental illness has also been shown to be effective at reducing institutional incidents. For example, in 2003 the National Alliance on Mental Illness (NAMI) was invited by the superintendent of the Carlisle special housing unit – a high-medium security institution managed by the Indiana Department of Corrections³ – to develop and provide training on mental illness for correctional staff (Parker, 2009). The training consisted of five two-hour sessions introducing correctional officers to the major categories of psychiatric disorders; the biology of mental illness; treatment of mental illness; and how to interact effectively with people suffering from mental illness. Over the nine months after the training, the researchers observed a significant decline in the total number of incidents, the number of incidents involving use of force, and incidents of battery by bodily waste, compared with the nine months prior to training.

In addition to providing adequate training to correctional staff, every effort should be made to ensure that mental health staff are among the first responders to incidents involving behaviours that stem from underlying mental health issues. Punitive responses (e.g., restraints, isolation and observation, force and/or other disciplinary actions) to stop self-harming behaviours can further aggravate the situation (Deiter, Nicholls, & Pearlman, 2000; Rayner, Allen, & Johnson, 2005; OCI, 2013; Smith & Kaminski, 2011; Walsh, 2007). Walsh warns that any attempt to force individuals to cease self-injury might be viewed by clients as an “implicit form of condemnation.” Instead, he says that a more

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³ Carlisle special housing unit had a capacity of 280 in 2004. The number of offenders with mental illness at this facility was 173 in 2003 (or 62% of capacity).
effective strategy is to employ a dispassionate approach of emphasizing emotional self-regulation, and teaching new skills towards this end.

In order to carry out these therapeutic interventions – especially in situations where the behaviour is likely to escalate – mental health staff need to feel confident in their autonomy and clinical independence. It is for this reason that many mental health staff were encouraged by the reforms recently enacted into Canadian legislation. These amendments enshrined the independence of health care staff and also included various provisions to protect vulnerable inmates.

Bill C-83 and Reforms to Canadian Corrections

1. Elimination of Segregation or “Solitary Confinement”
On June 21, 2019, Bill C-83 An Act to amend the Corrections and Conditional Release Act and Another Act, received Royal Assent. It promised to make “transformational changes” to the federal correctional system. The legislative intent of C-83 was to replace the practice of segregation (both administrative and disciplinary) with Structured Intervention Units (SIUs), thus abolishing solitary confinement in federal corrections as defined by the Mandela Rules: confining inmates for 22 hours or more a day without “meaningful human contact”.

The grounds for prohibiting the placement of mentally ill people in conditions of restrictive confinement seem unequivocal. Unfortunately, the legislation does not include such prohibitions, nor does it place hard caps on how long individuals can be kept in restrictive confinement environments.

2. Meaningful Human Contact
Bill C-83 stipulates that an inmate in a SIU must be provided an opportunity for “meaningful human contact.” It legislates four hours of out-of-cell-time and:

... the opportunity to interact, for a minimum of two hours, with others, through activities including, but not limited to, a) programs, interventions and services that encourage the inmate to make progress towards the objectives of their correctional plan or that support the inmate’s reintegration into the mainstream inmate population, and b) leisure time.

CSC policy further defines meaningful human contact as “…the opportunity for human interaction with others that is conducive to building rapport, social networks, or strengthening bonds with family or other supports” (Commissioner’s Directive, 711). However, with no practical examples to draw from, it is not clear exactly how this concept is to be applied in restrictive confinement settings. Though these are still the early days of implementation, the OCI has since observed that both the legislation and policy have been largely reduced to “time out of cell” in the institutions, and meaningful contact is largely limited to interactions between inmates in small austere spaces.

To get to the point of the matter, it is the quality not quantity of human contact that counts, as well as the forms through which humanity is mediated in a prison setting. Policy should articulate and define what the law prescribes. Failing to operationalize “meaningful human contact” means that staff are left without guidance on their legislated obligations. Some practical examples might help to illustrate the point:
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Is it enough to use fencing fabric in lieu of solid physical barriers to facilitate “meaningful” contact with other inmates in adjacent SIU yards?

Will non-contact visits be considered “meaningful”?

When a self-injurious inmate is counseled through or communicates via a food slot, will this contact be considered “meaningful”?

Will video visits meet the standard? What about watching TV alone, in a cell, or with others?

Does the inmate’s perception of “meaningfulness” count, or does any out-of-cell contact facilitated by correctional staff meet the test?

Given that the term “meaningful” is subjective and open to debate and interpretation, the Office has suggested that CSC look elsewhere for inspiration. For example, the Essex body of international experts has defined “meaningful human contact” as follows:

Such interaction (meaningful human contact) requires the human contact to be face-to-face and direct (without physical barriers) and more than fleeting or incidental, enabling empathetic interpersonal communication. Contact must not be limited to those interactions determined by prison routines, the course of (criminal) investigations or medical necessity.

However the term is operationalized, significant thought must be given to opening up restrictive housing units to non-correctional personnel – outside groups, associations and stakeholders – who have proven and established rapport and trust among inmates. Expanding the range and opportunity for meaningful human contact in a maximum-security setting means going beyond the provision of CSC interventions (or singular engagements), in which staff cumulatively record an inmate’s time-out-of-cell, daily, on an Android phone app (a recently implemented measure). Inmates who find their way into these units are not likely to be overly responsive to staff overtures, luring them to participate in correctional programs and interventions. As it stands, all the time-out-of-cell examples, including access to programs, interventions, educational, cultural, spiritual, and leisure opportunities contemplated in policy, are defined and determined by internal prison rules and institutional routines. It is not at all clear that inmates in these units will see any of these measures as “meaningful” to them.

It is, perhaps, easier to identify what is not meaningful human contact. As Dr. Sharon Shalev, an internationally recognized expert in monitoring and evaluating the effects of solitary confinement has observed, “…´meaningful´ contact is one of those things that you recognize in its absence” (Shalev, 2019).

3. Clinical Independence and Autonomy

With the passage of Bill C-83, the Service is now obligated to support the professional autonomy and the clinical independence of registered health care professionals, including their freedom to exercise, without undue influence, their professional judgement in the care and treatment of patients. Providing a legislative foundation for these principles better aligns correctional health care practice with international standards, including Rule 27 (2) of the Mandela Rules: “Clinical decisions may only be taken by the responsible health-care professionals and may not be overruled or ignored by non-
medical prison staff.”

In practice, however, certain aspects of both legislation and policy contravene the intent requiring CSC to support the professional autonomy and clinical independence of registered CSC health care professionals. Consistent with Mandela Rule 33, the new legislated reforms include provisions that require registered health care professionals to advise the institutional head if they believe that the conditions of confinement in a SIU should be terminated or altered for physical or mental health reasons (CCRA, s. 37.2). Even so, the health care professional only has the power to recommend. The power to accept or reject the advice of the registered health care professional remains with the Warden, and the clinician’s recommendation is subject to several levels of review and delay.

Correctional health care providers constantly face dilemmas of “dual loyalties” in the prison environment. There are many areas of correctional health care practice that give rise to clinical role conflicts or ethical dilemmas, where clinical independence and professional autonomy may be impaired or impeded, or where health care providers may feel compelled to follow correctional authority rather than health care standards. Some practical examples of dual loyalty conflicts faced by health care staff include:

- Assessing inmates as medically or mentally (un)fit to participate in work or to extend restricted confinement, either for disciplinary or operational purposes;
- Applying, removing, adjusting or monitoring physical restraints to prevent self-injurious behaviour;
- Conducting body cavity searches where there are no medical indications for such actions;
- A restrictive National Drug Formulary that may limit a physician’s prescribing and treatment options;
- Informed versus implied or compelled consent to treatment; and,
- Post-use of force health care assessments.

This situation necessitates robust accountability and rigorous oversight of full clinical independence and undivided loyalty to patients duly exercised at the national level (Pont, Enggist, Stöver, Williams, Greifinger, & Wolff, 2018). Although these standards are recognized internationally, many correctional jurisdictions struggle to consistently meet them because of a “lack of awareness, persisting legal regulations, contradictory terms of employment for health professionals, or current health care governance structures” (Pont et al., 2018). This is also the case for CSC.

Although new legal provisions of the CCRA are gradually making their way into CSC’s internal policies and operations, it is unlikely that they will achieve the standard of full clinical independence as described by Pont et al. (2018). The fact of the matter is that CSC’s Health Services is not fully independent from CSC operations. At the very least, full clinical independence would require prison health care staff to be employed by the provincial health body or the national health authority.

4. Patient Advocacy
As CSC moves towards implementing newly legislated health care reforms, one additional safeguard is required to ensure that inmates have access to quality and timely health care – external and independent patient advocacy. Patient advocacy services were included as part of the menu of reforms enacted through Bill C-83. Specifically, section 89.1 of the CCRA requires the Service to provide access to patient advocacy services to support inmates in relation to their health care matters; and to enable
inmates … to understand the rights and responsibilities of inmates related to health care.” This is an important and necessary measure. CSC needs a Patient Advocate model to protect the rights of patients; help patients explore all available alternatives; and to ensure that they fully understand the implications of their decisions without compulsion. Further, the Office is of the opinion that patient advocates should be external and functionally independent of the CSC. Such a model would better support the legislative intent of C-83 and would be more aligned with the spirit of the Mandela Rules.

The recommendation for a Patient Advocate model reaches far back before Bill C-83. The Office’s report titled, “Risky Business: An Investigation of the Treatment and Management of Chronic Self-Injury Among Federally Sentenced Women Final Report” (September 30, 2013), first recommended that CSC should appoint an “independent” patient advocate at each of the five RTCs. This recommendation echoed a similar measure (i.e., the Independent Rights Advisor and Inmate Advocate) identified in the Ontario Coroner’s inquest into the preventable death of Ashley Smith (December, 2013).

Conclusion
What should be clear is that the delivery of mental health services in federal corrections is not only good public health policy. It is also a matter of human rights. The issues involving free, voluntary and informed consent, and clinical independence are magnified in a correctional setting and extend equally (if not more so) to individuals with mental health issues. Even in a generally well-resourced correctional agency like the CSC, and despite the correctional reforms implemented to date, there remain challenges in complying with international standards, and the fundamental principles of humane care and custody. It is for these reasons that Canada’s federal prison service needs to heed the following guidance offered by Mr. Pūras: “Canada is yet to take the leap to comprehensively incorporate a right to health perspective, fully embracing the understanding that health, beyond a public service, is a human right.”

LIST OF REFERENCES


About the Authors

Dr. Ivan Zinger received his degree in Common Law from the University of Ottawa in 1992, and completed his articles of clerkship at the Federal Court of Canada. In 1999, he obtained his Ph.D. at Carleton University (Ottawa) in Psychology of Criminal Conduct. He is an Adjunct Professor with the Law Department at Carleton University. Dr. Zinger joined the Public Service of Canada in 1996. He held a variety of senior managerial, policy and research positions in public safety-related federal departments and agencies. In 2004, he joined his current employer, the Office of the Correctional Investigator (Federal Prison Ombudsman), and in 2009 he became the Executive Director and General Counsel. On January 1, 2017, Dr. Zinger was appointed as Correctional Investigator of Canada pursuant to section 161 of the Corrections and Conditional Release Act, and he was reappointed for a 5-year term on January 1, 2018.
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Emad Talisman holds an Honours degree in Psychology from Mount Saint Vincent University, and completed his Master degree in Experimental Forensic Psychology in 2016. During the later part of his Master’s program, he worked in the Research Branch at the Correctional Service of Canada as a student. In 2016, Mr. Talisman began his career in the public service and held various research and policy positions at Public Safety Canada, exclusively within the domain of corrections and crime prevention. In 2018, Mr. Talisman was hired as a Policy and Research Analyst for the Correctional Investigator of Canada.
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Practice Innovation in Corrections
RAVENHALL CORRECTIONAL CENTRE: THE MASTER PLANNING AND ARCHITECTURAL DESIGN OF A MULTIFACETED, PEOPLE-ORIENTED PRISON FOR MEN WITH COMPLEX PHYSICAL AND MENTAL HEALTH NEEDS IN VICTORIA, AUSTRALIA

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Abstract

People with mental health issues are vastly overrepresented in the Australian prison system. This paper discusses the master planning and design of Ravenhall Correctional Centre in Victoria, Australia to increase outcomes for male prisoners living with physical, mental health disability and other conditions. Major innovations in the design of Ravenhall Correctional Centre have included a forensic mental health unit on site, and the master planning of the prison into separate communities with a variety of housing types to provide prisoners opportunities to experience various levels of self-care and greater autonomy. The prison was designed to increase feelings of wellness, to provide program and training spaces to service various groups, and to allow prisoners to experience greater levels of individual control. The project is discussed through an architectural lens to allow readers to understand the complexities of master planning and designing a major people-oriented, multi-faceted prison with a forensic mental health unit within the perimeter. The paper notes that large scale prisons may be designed in a more therapeutic manner where accommodation, facilities and programs can provide prisoners opportunities to connect with external environments, engage in meaningful activities and retain a level of autonomy and individual control. The integration of the forensic mental health unit means that greater numbers of prisoners are able to access in and outpatient services. The paper concludes that since the prison was commissioned in 2017, the prisoner cohort has changed, resulting in a deviation from the intended purpose of focusing on innovative programs for sentenced prisoners. This may have diminished the capacity for prisoners to effectively engage in the programs for which the prison was designed.

Key words: prison architecture, therapeutic design, prison design, mental health, forensic mental health design, mental health, disability architecture.
Article 8: Ravenhall Correctional Centre: The master planning and architectural design of a multifaceted, people-oriented prison...

Introduction
The number of people incarcerated with mental health issues has been growing for approximately four decades. The deinstitutionalisation of mental health services and the replacement of long-stay psychiatric hospitals with community mental health services (White & Whitford 2006), socio-economic factors, access to appropriate mental health care, secure housing and social services, use and availability of certain illicit drugs and crime ‘control’ policies have resulted in increasing numbers of people with mental health issues entering and cycling through the criminal justice system (Mauer 2006; Fichtner & Cavanaugh 2006).

The consensus is that larger investments must be made in treating people with mental health issues in the general community (Lurigio 2011) to prevent people entering the criminal justice system (Koyanagi 2007). It is not optimum for people living with mental health issues to be incarcerated. Given the increasing number of such people who are incarcerated, there must be a discourse on the design of Australian prison environments in order that they may become more therapeutic to meet the needs of this growing cohort.

Ravenhall Correctional Centre is a significant new development in the Australian correctional landscape, with the master planning and design focused on meeting the needs of male prisoners living with physical disabilities and mental health issues. This paper discusses the background to the project, master planning and architectural design that seeks to create a more therapeutic prison environment.

Background
The Victorian State Government’s plans for a new prison at Ravenhall sought to address the lack of male medium-security prison accommodation accessible by private and public transport from Melbourne, the State’s capital (State Government of Victoria 2016). As the project progressed, recognition of the number of people living with physical and psychosocial disabilities became integral to the planning and design. Ravenhall was initially planned to house 1000 sentenced prisoners, which was later increased to house 1300 prisoners. It was imperative to the success of the Ravenhall that the prison should house sentenced prisoners, as this group is stable and able to engage in work and programs (Victorian Auditor-General's Office 2020).

The Victorian State Government works within frameworks (see State Government of Victoria 2006; 2009; 2012; 2014) that consider the needs of people in custody living with a disability1. These frameworks exist to promote equality and protect the rights of people in custody living with a disability, and impact the planning and design of all prison facilities.

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1 There are various definitions of disability used across Australia. Accessing services (particularly NDIS services) under some definitions may be onerous, as they require the person to prove that their ‘disability’ is permanent. The Corrections Victoria Disability Frameworks (State Government of Victoria 2006; 2009; 2012; 2014) use the definition of disability outlined in the Disability Discrimination Act 1992. This definition uses the four main categories of disability: cognitive impairment (intellectual disability and acquired brain injury), physical disability, psychiatric disability and sensory impairment. Importantly, it notes that a disability may be permanent or temporary and visible or hidden (State Government of Victoria 2014). Thus, it may be presumed that Corrections Victoria is required to provide disability services to people living with certain conditions (e.g. drug psychosis) who may not qualify under some definitions used for service provision in the wider community.
These frameworks are essential as a conundrum exists for people with disability in Australia's correctional system. Firstly, the provision of health care for prisoners is not included under Australia’s publicly funded, ‘universal’ Medicare health care system (see The Health Legislation Amendment (Improved Medicare Compliance and Other Measures) Bill 2018) and jurisdictions are required to fund health services for people held in custody (see Plueckhahn et al. 2015). Similarly, the National Disability Insurance Scheme (NDIS) was established to provide services to all Australians living with a disability. This includes people living with intellectual, physical, sensory, psychosocial or cognitive disabilities. However, as with Medicare arrangements, prisoners cannot be assessed or access NDIS services (see National Disability Insurance Scheme Act 2013 and Purcal 2016).

Mental health is fundamental to emotional, psychological and social well-being, and affects individuals, families, and the wider community (ABS 2018). Mental health issues may be time-limited or long term. For most people with psychiatric disorders, the symptoms are ongoing and interfere with the ability of the person to complete core activities. Long term mental health disorders include anxiety disorders, depression, bipolar and other mood disorders, eating and personality disorders, post-traumatic stress and psychotic disorders (e.g. schizophrenia). Consideration of people with cognitive disabilities is also essential, as people living with cognitive disabilities often need assistance with daily living (Ruggeri et al. 2000). This is most obvious in the case of people living with traumatic brain injuries and genetic disorders (e.g. foetal alcohol spectrum disorders, autism, Down Syndrome, traumatic brain injury, dementia), and the more subtle cognitive disabilities (e.g. attention deficit disorder, dyslexia, dyscalculia, and learning disabilities). Such conditions affect peoples’ ability to complete core daily activities (Nuckols & Nuckols 2013). Other mental health issues arise from grief and trauma, and alcohol and drug use. Whether long term or short term, mental health issues influence peoples’ physical health, thoughts, feelings, behaviors, stress levels, relationships, decision making and their ability to complete core daily activities (Beresford et al. 2002).

Estimates on the number of people in the prison system living with mental health issues in Australia vary. The Australian prisoner profile is characterised by social disadvantage—many people in the system have experienced homelessness, low education and employment outcomes, have poor family and social networks and are suffering the effects of substance abuse,—as well as living with other factors associated with poor physical and mental health and disability, such as poor communication, living and coping skills and low levels of resilience. The Australian Institute of Health and Welfare estimated that two in five people entering prison (40%) reported a previous diagnosis of a mental health condition (2019: vi), while other studies have stated that prevalence of mental health issues among prisoners is much higher. For example, in an in-depth study by Butler et al. (2006) the prevalence of any psychiatric illness was 80 percent among the prisoner population as compared to 31 percent in the community (Butler et al. 2006). It is estimated that 42 percent of male prisoners in Victoria are living with acquired brain injuries, and “30 percent of prisoners are living with intellectual disabilities and/or mental health conditions” (State Government of Victoria 2014). Specific cohorts are likely to have higher rates of mental health issues. Indigenous people living with mental health issues are overrepresented in the general community, and highly overrepresented in prison population (Baldry et al. 2012; Baldry & Cuneen 2014). The number of Aboriginal and Torres Strait Islander people held in prison custody has also nearly tripled. In 2008, six percent of the prisoner population identified as being or Aboriginal or Torres Strait Islander descent, as compared with nine percent in 2018.
There have been multiple studies regarding the design of institutional environments and their impact on physical and mental health and well-being (Baker et al. 1959; Foley & Lacy 1967; Hall 1973; Freeman 1978; Holohan 1976; Chen & Sanoff 1988; Ulrich 1991, 2000, 2001; Devlin 1992; Gutkowski et al. 1992; Cooper-Marcus & Barnes 1995; Beauchemin & Hays 1996; Kaplan 1996; Cohen-Mansfield & Werner 1998; Gross et al. 1998; Fottler et al. 2000; Dvoskin et al. 2002; Devlin & Arneil 2003; Evans 2003; Andes & Shattell 2006; Hartig & Marcus 2006; Costello 2007; Carter 2008; Daykin et al. 2008; Detweiler et al. 2008; Ulrich et al. 2008; Curtis et al. 2009; Golembiewski 2010; Huffcut 2010; Basinger 2011; Carr 2011; Caspari 2011; Connellan et al. 2011, 2013; Doherty & Sell 2011; Rice 2019 Verderber & Refuerzo 2019). The body of literature discusses developing therapeutic environments through focussing on environmental elements such as natural light, light quality, acoustics, thermal comfort, the inclusion of art; building scale, color, the sensory nature of the environment, air quality, connection to the natural world, symbolism and individual control. Environmental elements are each of importance, although if applied in isolation (for example, achieving optimum thermal comfort for residents whilst ignoring other elements), the well-being of users seldom changes. Environments need to be familiar, legible, meaningful, responsive and controllable and congruent to ‘fit’ with the behavior, personal needs, social norms, customs and beliefs of the users. Such stress reducing architecture eliminates negative environmental stressors, promotes positive social interactions, has sensory elements and allows high levels of individual control. This has been shown repeatedly to contribute to the well-being of users (Averill 1973). In contrast, incongruent environments typically lead to heightened stress responses for the user (Toch & Gibbs 1992), which affect motivation, clear thinking, somatic complaints, physical and mental health and mood changes (Grant 2008).

The following sections will discuss the master planning and architectural design of the prison to incorporate forensic mental health facilities, create positive social environments, increase individual control and incorporate environmental elements for increased mental health outcomes for prisoners.

Figures 1 & 2: Figure 1 shows the location of the Ravenhall Correctional Centre in relation to the Metropolitan Remand Centre and Dame Phyllis Frost Centre. Figure 2 shows the Masterplan for Ravenhall Prison showing separate communities each situated around a courtyard and all being situated around a central space. Note: Program and administration buildings are shown as blue and prisoner housing areas are marked in light brown (Images Google maps and Guymer Bailey Architects).
Master Planning

The Ravenhall Correctional Centre is situated on the Department of Justice prison precinct where the Metropolitan Remand Centre and Dame Phyllis Frost Centre (a women’s facility) have been operating as separate entities for some time. The site for Ravenhall Correctional Centre comprises of two land parcels, a greenfield site of approximately 40.5ha situated between the Dame Phyllis Frost Centre and the Melbourne Remand Centre, and second site of 20.83ha located to the east. The site is bordered by residential area buffered from the prison by a freeway and an industrial area separated by a conservation reserve and arterial road network. The buffers provide acoustic as well as physical barriers. The location, adjacent to the remand centre, allows male prisoners, people and resources to be moved seamlessly as needed.

In the master plan, ancillary buildings, an administration building and car parking were sited outside the 5.1-metre-high, 1.7-kilometre-long, solid concrete perimeter (this is topped by an anti-climb cylindrical cowl) (see figure 2). The concept of a secure perimeter is important, as it is argued that the location of a prison and control of entrances/exits and secure perimeters allows for a regime where internal spaces need not be as highly regulated (Alford 2000: 127) potentially enhancing the social environment and reducing the need for disciplinary measures. The Victorian State Government has shown a preference for constructing solid perimeters in preference to fences citing reasons including bushfire risk, sequestering prisons from the public gaze and to allow the security rating of a prison to be upgraded at a later date if required (Grant & Jewkes 2015: 13-14).

Central services for the facility include the gatehouse (which includes master control room, dual sallyport, staff training facilities and lockers; prisoner visits area (which allows separation of mainstream and protection prisoners to provide equity of access and space for children to play with parents); prisoner reception (which includes property storage and holding rooms), health and forensic mental health facilities and programs, multi-faith areas, recreation and industry buildings.

The prison complex is designed around a central courtyard. This is a common area with staff and

Figure 3: Aerial photograph of Ravenhall Correctional Centre highlighting the separate access to the sallyport, public entrance and carparking, and the communities clustered around a central green space (Image: Infrastructure Advisory Group Pty Ltd).
prisoners using it as a thoroughfare to access program and service areas, as a recreational and meeting area and outdoor retreat. This allows prisoners to move around the prison increasing their sense of personal control. All shared services buildings for the prison have dual entries, which in the overlay of a correctional environment adds significant complexity. Mainstream prisoners enter from one side with prisoners under protective status entering separately. The entries are supervised with an officer post to ensure separation between these prisoner cohorts.

A health facility contains 10 in-patient beds, with outpatient facilities including dental, x-ray, triage, treatment, consultation rooms, 10 individual therapy rooms, and a large health administration area. The prison also has a 75-bed specialised forensic mental health unit and outpatient services. The education building is accessed from the central court by prisoners, and has programs areas for education, computer access and a library. There are a number of other facilities for prisoner use, including indoor courts and gym, a cultural centre for performances and celebrations, a music room, arts/craft rooms, a barber and shop (designed to build financial literacy and life skills), an Indigenous meeting place connected to outdoor space, a multi-faith spiritual space and pastoral counselling area.

Mainstream prisoners have access to industry areas, designed to train people in woodwork, logistics, metal assembly, metal powder coating, packing, and construction. Prisoners under protective status have access to industry facilities including bakery, textile training and other vocational training. Facilities to service the prison were also included in the design. The commercial kitchen has the capacity to produce 1300+ meals twice a day. It is also a full training kitchen, site-wide food distribution area for the self-catered accommodation. A large commercial laundry was built to service the needs of the prison. These facilities provide opportunities for men to engage in employment and are designed so that prisoners move around the site with minimal staff escorts.

The total capacity of the prison is 1345 prisoners with the design capacity at 1300. In master planning, the architects separated prison accommodation into five residential communities sited surrounding a large green space. The communities were designated as:
Community 1: Men serving a short sentence (291 beds)
Community 2: Indigenous and/or young offenders (299 beds),
Community 3: Men exhibiting challenging behaviour and/or with specific cultural needs (299 beds),
Communities 4 & 5: Men under protective status (2 x 164 beds).

The residential forensic unit has a design capacity for 77 patients and there are another 25 beds for health, and 26 for close supervision. Prisons should operate at approximately 85-90 percent capacity to accommodate movements and the additional 45 beds allow for movements of prisoners. Preventing overcrowding is extremely important as numerous studies have shown that increased social density has significant negative effects on prisoners (McCain et al 1976; Paulus & McCain 1983; Cox et al. 1987; Baum & Paulus 1987; Paulus 2012; Wener 2012), and if more prisoners are placed into accommodation that other areas (e.g. employment, program, medical, recreational spaces) need to be expanded to meet prisoners’ needs.

Equity of access to all shared services for prisoners under protective status was also a driver in the masterplan. This required detailed design layouts of each of the shared services buildings. The design of two dedicated protective custody units at Ravenhall Correctional Centre seeks to reduce the differences between conditions for protected and/or high-profile prisoners making “...conditions of persons with protection status ...no more restricted than those within the mainstream prison populations” (DPP v Pell [Sentence] [2019] VCC 2602018: 25). The two units are sited to allow prisoners access to dedicated education and programs areas and move with some autonomy to access services. The two communities have also been designed to allow removal of the separation fence, should one large community be preferred at a later point.

Figure 6: Nature analysis which was used as the basis for the master planning of Ravenhall Correctional Centre (Image: Guymer Bailey Architects).
To allow users to differentiate between communities, landscape typologies were applied to each area, and architects developed a color palette, symbolism and imagery. The parti pris of connections to nature and local landscape attributes used the following four themes (see Figure 6):

1. Creek formation; for linear corridors with riparian vegetation,
2. Grasslands; for open fields, to promote views and vistas, with embedded rocks,
3. Woodlands; for the residential communities, closed and secluded, minimal mid-storey planting, calming, and
4. Fire; for spaces with interaction with family and cultural/spiritual interaction; fostering rebirth, renewal, restoration.

Each community was developed under one of the themes for increased wayfinding and user orientation.

To fulfil requirements outlined in Australian legislation (i.e. the Commonwealth Disability Discrimination Act 1992 (DDA) and international obligations (such as the Convention on the Rights of Persons with Disabilities and the Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT)), design stipulations as laid out in the National Construction Code of Australia’s Volume One: Disability and Australian Standard 1428 have been adhered to, with universal access across the site via continuous accessible paths of travel, with circulation spaces for people with mobility impairments, access and facilities for people with ambulatory disabilities; and access for people with sensory, visual and other impairments including hearing loops, visual differentiation between materials and tactile indicators.

Communities and accommodation design

The internal organization of space within a prison is important, the ways in which space is configured and allocated to prisoners affects levels of privacy, the desire or need to avoid or associate with others, and relationships between prisoners and officers must all be considered. (Van Hoven & Sibley 2008). There is consensus that prison design communicates meanings (Wortley 2002; Jewkes & Johnston 2007; Wener 2012; Fransson 2018) and behavioural expectations (Fairweather 2000; Lulham 2007; Lulham et al. 2016). Design matters (Sommer 1974), and normalised and human scale prison environments correlate to increased behavioral and wellbeing outcomes for staff and prisoners alike. Jewkes reiterates Sommer’s seminal work within the prison context stating:

‘hard architecture’ (bars on windows, concrete walls, hard-surface floors, drab colours, indestructible and uncomfortable furniture) not only destroys the prisoner’s ...self-esteem and influences the ways in which staff think of and behave towards the people in their custody and care but may also determine certain types of identity and behaviour (2018: 319).

The principles of people-oriented architecture were applied to housing in Ravenhall Correctional Centre. Five residential communities and a forensic mental health unit are set on the edge of the central green space area with campus-style circulation. The design of the communities is a major departure from traditional prison design in Australia where prisoners are generally accommodated in an autonomous unit in a cell block.
Two communities are designated for mainstream prisoners, one for Aboriginal and Torres Strait Islander prisoners and two smaller communities for prisoners being held under protective status. At the entry of each community, a color palette using pixelated images of various local Indigenous birds and hues from the feathers is employed (see figure 3).

The buildings in each community consist of a main cellblock, four-bedroom cottages and six-bedroom lodges in a mix of single and double-storey structures facing inwards to a large landscaped recreational courtyard area. The entry points to each community contain program, interview and multipurpose rooms.

The security elements are contained in the fabric of buildings rather than displayed externally, and bars and security grills eliminated. The siting of the housing uses principles from residential planning. All are arranged inward to the central courtyard, which contains gardens, recreational areas, including fitness equipment and sport areas as increased opportunities to practice sports in prison reduces context related stress insomnia of prisoners (Elder 2009: 74). Landscape, color and textural variations were used for increased legibility and wayfinding. The prison was designed so that prisoners needing to access services outside the community do by checking out via the gate entry/egress (see figure 6) mostly eliminating the need for staff escorts.

Effective communication is a factor affecting the well-being of people in prison. The importance of television for incarcerated audiences has been investigated by a number of authors (see Hagell & Newburn 1994; Jewkes 2002a, 2002b, 2007; Knight 2005, 2015, 2017; Grant & Jewkes 2013) and the general consensus is that the television is vital and contributes to reducing boredom and the health,
wellbeing and ontological security of prisoners. Every prisoner at Ravenhall has an interactive screen in their cell/bedroom, capable of streaming digital television, providing scheduling information for the prisoner’s upcoming activities, enabling internal (intranet) online shopping and providing customized educational and learning software tools. The in-cell personal computers are managed centrally with a secure and dedicated server.

There are three types of housing available within the five communities. This is a major departure from typical prison planning and means that prisoners can be housed in the type of housing which meets their capacity to self-care.

The first type of housing is double-storey cell blocks. These provide both single and dual cell accommodation, each fitted with a toilet, hand basin, and shower. Single cells are imperative in this context. Human Rights Watch notes “overcrowding can be particularly difficult for people who...
have psychosocial or cognitive disabilities.... Many [people] have a higher need for personal space or quiet, which cell sharing, or “doubling-up,” can impact. Sharing cells can also place prisoners with disabilities—already at risk of being manipulated or abused by others—at heightened danger of verbal, physical, or sexual violence.... ...Overcrowding is often accompanied by overstimulation—another common problem for people with psychosocial or cognitive disabilities” (2018: 60). At Ravenhall each cell is afforded an external view, with value placed on providing natural light. All cells adhere to safe cell design guidelines to reduce opportunities for self-harm, misadventure or fire. Obvious ligature points have been removed, all edges are rounded, all knobs and water taps are sloped, safety screws are used throughout, joints are sealed, and lighting is recessed. The cell blocks (and other housing types) are designed to reduce fire hazards through the provision of smoke detection sensors and alarms, additional exhaust equipment for smoke extraction and air circulation; and fire-rated walls, floors and ceilings. An accessible cell is located on the ground floor of every cell block. The accessible cells have a wider entrance door, adequate clear floor space, appropriate placement and models of fixtures and furniture, and grab bars for men living with mobility issues. Like other units built around Australia, the cell blocks operate under the principles of unit management, which includes dispersing the dining and recreation activities in units so that prisoners have access to communal space for recreation, dining, meal preparation and socialising.

The second type of housing option is six-bedroom lodges. These provide the opportunity for prisoners to step down from a fully supervised environment and begin to self-care, live with others and develop life skills. The lodges have separate bedrooms, each with a shared lounge, bathroom and kitchen where prisoners prepare their own meals and do their own laundry. The third housing option is four-bedroom cottages, again with a shared lounge, bathroom and kitchen enabling prisoners to self-care. In the latter two housing options, prisoners are locked down to the lodge or cottage rather than to individual rooms. The inclusion of different housing groups in one community in a correctional facility is a ‘world first’. It allows options in housing prisoners according to the prisoner’s capacity to self-care and live alongside other people.

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2 Cottage style accommodation was first employed as medium-security prison accommodation for men at Mobilong Prison in South Australia (see Grant 2005; 2006), HM Prison Loddon in Victoria and a number of other prisons across Australia now use cottage style accommodation as medium security housing.
The architects, Guymer Bailey Architects in collaboration with Peter Hunt Architects attempted to minimize conflict in group settings through careful internal planning of the lodges and cottages. Bedrooms (rather than cells) were placed at either side of the living area to minimize transitional spaces. The bedrooms are lockable to allow prisoners their own space and privacy. The occupancy for lodges was set at six, and the cottages set at four. Visual connection to external environments in prison environments is essential to feelings of safety, control and well-being, and decreases disorientation through the increased ability to visualize the environment and predict events, hence all rooms look into courtyards.

One community is a dedicated Aboriginal and Torres Strait Islander space. There has been a recognition that Aboriginal and Torres Strait Islander prisoners have varying and differing environmental needs, with those living with a disability likely to have differing understandings and experiences of disability than the wider community. Indigenous people face multiple barriers to addressing the challenges related to their disability (State Government of Victoria 2014: 8). Over the last decade, the numbers of Aboriginal and Torres Strait Islander people held in prison custody across Victoria has nearly tripled (Corrections Victoria 2019) and meeting the needs of Indigenous men in custody and providing opportunities to stop the intergenerational cycle of Indigenous imprisonment is paramount. The rationale for dedicated areas and housing for Aboriginal men has been well investigated. Grant (2006, 2008a; 2008; 2009; 2014) has outlined the need for Australian Indigenous peoples to be incarcerated alongside other Aboriginal people for support. Congruent spaces are needed for cultural practices to be performed to increase connections of Aboriginal prisoners to their cultures. Grant & Memmott (2008) have noted that a variety of housing options should be available to Aboriginal people being held in custody and debunked the commonly held view that Aboriginal men should be ‘double bunched’ in all circumstances. The Aboriginal and Torres Strait Islander community at Ravenhall following these principles provides a variety of housing options, allowing different groups of men to live together according to familial and cultural ties. The community also has a fire pit and other features installed into the courtyard area for cultural events and to allow Indigenous prisoners to stay connected to culture as it is an important component for Indigenous well-being.

![Figure 12: Fire pit and shelter area in the courtyard of the Aboriginal and Torres Strait Islander community at Ravenhall Correctional Centre (Photograph: Scott Burrows).](image)

![Figure 13: The Indigenous meeting space complete with display areas for artefacts and artwork (Photograph: Scott Burrows).](image)
Prisoners with concerns for their safety, due to the nature, notoriety or public profile of their offence, their former profession (e.g. police officers, informants, priests, members of the judiciary), with known adversaries or gay, transsexual, or transgender prisoners may ask to be put on a protection order. The management of a prison may also decide to put a prisoner in protective custody for the prisoner’s safety and/or the safe operation of the prison. Generally, prisoners in protective custody are housed in separate units, with separate eating facilities, shower areas, and visiting rooms and do not come into contact with other prisoners. Often prisoners in protective custody share facilities such as recreational areas and are allocated a certain time for use of that area. Often this requires complex movement rosters so mainstream prisoners and prisoners on protective custody orders are kept separate. In practice, the lack of facilities in most prisons, means that prisoners on protective custody orders are often housed in overly secure areas with limited opportunities to participate in programs, recreational activities and limited access to services. The design of two small communities with the same variety of diverse housing options allows prisoners under protective status to be offered the same options as other prisoners. The inclusion of separation circulation routes so that these prisoners can access services without escorts and move around the prison is innovative in Australian prison architecture.

**Ballerrt Yeram-boo-ee Forensic Mental Health Centre**

One of the main areas of difference in the design of the Ravenhall Correctional Centre is the inclusion of a forensic mental health unit within the prison. With few exceptions, forensic mental health centres have been located off or adjacent to prison sites. The Ballerrt Yeram-boo-ee Forensicare Mental Health Service is situated on site to expediently serve the needs of men living with mental health, psychosocial or cognitive disabilities and/or drug and alcohol issues.

The inpatient residential facilities include 77 dedicated forensic mental health beds. These are contained within a 25-bedroom specialist acute inpatient unit, a 30-bedroom specialist sub-acute inpatient unit, a 10-bedroom residential service for prisoners with a mental illness who have complex and challenging behaviors, and a 10-bedrooms in cottage style accommodation for prisoners with continuing psychosocial or cognitive disabilities who are transitioning to live back in the community. All prisoners live in single bedrooms, as research shows that the presence of a roommate is more likely to be a source of stress rather than support. There are associated benefits with single rooms such as less noise and increased privacy. Numerous studies have shown that loss of privacy is a critical feature of the prison environment that affects a prisoner’s ‘perceived’ threat to safety and has an impact on safety and well-being (see Moore 1981).

The service also provides outpatient services for 100 prisoners in the form of assessments on reception, ‘at risk’ and mobile crisis assessments, specialist consultations, intensive case management, specialist outreach services, community integration programs and pre- and post-release services for prisoners with mental illness who are at high risk of noncompliance with treatment post-release.

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3 Ballerrt Yeram-boo-ee (pronounced Balit Yerimboy) is an Aboriginal name meaning ‘strong tomorrow’. The name was chosen by Mr. Nevin Elder on behalf of the Wurundjeri Tribe Land and Compensation Cultural Heritage Council that represents the Traditional Owners of land where Ravenhall is built.
The architects used the principles of therapeutic architecture to guide the design of Ballernt Yerambi-ee. The design focuses on maximising natural light, eliminating environmental stressors (e.g. noise), safety, security, observation, avoiding of visual disturbances, and incorporating color, group interaction and access to nature and external environments. There are common spaces, dining, lounge and multi-purpose rooms with abundant natural light that lead to common courtyards. Wayfinding was also a critical element in the design, as legible environments reduce stress and increase health outcomes for people living with mental health conditions and psychosocial and/or cognitive disabilities.

The designers also had to consider patient safety and security, issues which are intrinsically linked. Safety issues are addressed through anti-ligature design, anti-slip surfaces, universal access, ergonomics and adherence to relevant standards. The facility is operated under a forensic mental health model (rather than a custodial model) and designed to have few custodial staff in the area. All the trained mental health staff interact with men on a continual basis. There is a small staff station and some offices, fully visible to prisoners from common areas so that they perceive staff to be part of the therapeutic environment. Good design allows the freedom of movement for patients within the limits of their condition, and the protection of staff, other patients and visitors.

The architects have dealt with the issue of prisoners displaying dangerous and/or risky behaviors in a number of ways. The unit includes a ‘listening’ room, located in close vicinity of the staff station. Prisoners may use this room at any time. The room is furnished with soft fittings and has opaque glass walls to allow other staff to observe the prisoner/staff interaction. If a situation is not defused, the client can be led into one of two secure isolation rooms located behind the ‘listening’ room. A multi-sensory room (also known as sensory rooms or Snoezelen rooms) is also included in the design to assist in the management and treatment of people with sensory disorders (see Martin 1998). Sensory processing issues represent a feature of a number of disorders, including anxiety problems, ADHD, (Ghanizadeh 2011), behavioral disorders, and autism spectrum disorders. (Kern et al. 2007; Lane et al. 2010) and sensory rooms are particularly useful in ‘calming people acting out’ The multi-sensory room has a full complement of lighting options, the ability to control natural light and has furniture and equipment to create a safe space to prevent and/or de-escalate a crisis, and to promote self-care/
Recent Developments

Critical to the successful outcomes for Ravenhall Correctional Centre was that sentenced male prisoners were the primary cohort. This is a group sentenced for a certain period and able to be engaged in appropriate programs. In Australia, people being held on remand are unsentenced and are innocent until proven guilty. Remand prisoners are offered the opportunity but are not obliged to work. They cannot participate in certain programs addressing criminological behaviors and are not obliged to participate in other programs.

The toughening of parole and restrictive new bail laws across Victoria (Bartels et al. 2018) resulted in the Victorian State Government ordering that nearly half of the beds at Ravenhall be converted to house remand prisoners (Australian Broadcasting Commission 2017). Data from January 2019 to December 2019 shows that remand, together with sentenced short-stay prisoners (who serve less than three months) made up approximately 70 per cent of Ravenhall’s prisoner population (Victorian Auditor-General’s Office 2020). This has resulted in fewer people being able to participate in programs and a significant deviation from the intended purpose of Ravenhall Correctional Centre in focusing on innovative programs to address mental health and reintegration for sentenced prisoners. Also integral to the success of the prison is having single cells accommodation. Double-bunking cells has long been opposed by Corrections Victoria as it considered to be linked to rises in violence between prisoners and against staff and stretched resources. The prison was originally planned to hold 1000 male prisoners. This grew to a population of 1,300 men during the design process and this will rise by 23 per cent to 1,600 with double bunks installed in single-occupancy cells and new buildings built on common spaces. If this occurs, the levels of autonomy and self-control experienced by prisoners are likely to decrease.

Conclusion

Governments face unenviable challenges in the provision of prisons in Australia in balancing the public appetite for prisons to be punitive environments on the one hand, and the changing needs of prisoners, human rights and legislative obligations on the other. Prisoner mental health and well-being is a major concern and an oft-neglected area of prison design.

Developments such as Ravenhall Correctional Centre demonstrate that there is a range of options available to design large scale prisons in a manner that accommodation, facilities and programs provide the prisoner with opportunities to connect with external environments, engage in meaningful activities and retain a level of autonomy and individual control.

Given that increasing numbers of people with physical and mental health conditions are entering Australian prison systems, new approaches to conceptualising and designing prisons are needed. Research has long shown a correlation between the individual’s wellbeing and the design of institutions. The inclusion of forensic mental health units within prisons may enable more in and outpatient services to be delivered. The architecture of Ravenhall Correctional Centre conveys a sense of hope, that the architecture of prisons can be people centred.
Since commissioning, the prisoner cohort has changed and the target group for whom the prison was designed are unable to fully take advantage of the environment, services and programs. It will be a test of time as to whether Ravenhall Correction Centre will be able to provide the level of care and the therapeutic environment desperately needed by incarcerated men living with physical and mental health issues.

Acknowledgements
The author would like to acknowledge the extensive assistance of Kavan Applegate, Director of Guymer Bailey Architects with preparing this paper, architect Lin Kilpatrick for commenting on drafts of the paper, and to the staff and management of Corrections Victoria and GEO Group Australia for access to the project.

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Advancing Corrections Journal: Edition #9-2020


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Psychologist, 39(10), 1148.


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MANAGING INMATES WITH MENTAL DISORDERS:
THE PSYCHIATRIC HOUSING UNIT IN SINGAPORE PRISON SERVICE

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Abstract

Inmates with mental disorders present as a population that requires extensive resources to manage and treat. Furthermore, these individuals tend to commit disciplinary infractions and reoffend at a higher rate than the mainstream incarcerated population. This poses a challenge to correctional facilities all over the world and best practices on the management and treatment of this specialised population are widely sought after. In 2011, the Psychiatric Housing Unit under the Singapore Prison Service (SPS) commenced operations with the admission of inmates with mental disorders into the facility. This article seeks to document the background and key processes within this specialised housing unit, specifically in the management and treatment of inmates with mental disorders.
Introduction

It is widely acknowledged that the needs of offenders with mental disorders have become increasingly difficult to manage, requiring an overall increase in resources. Moreover, in many countries, prisons have now been labelled as the ‘New Asylums’ (Konrad, 2002; Nicholas & Bryant, 2013), housing inmates with mental disorders.

According to the Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM-5; American Psychiatric Association, 2013), a mental disorder is marked by “clinically significant disturbance in an individual’s cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning”. Generally, presentations of inmates with mental disorders within the forensic setting requires a more focused level of expertise in terms of treatment as well as increased levels of physical security (McFadyen, 1999).

Recent research studies have also documented the rise in mental disorders among the incarcerated population. With reference to a report on intervention strategies for inmates with mental disorders, the statistics show that individuals with serious mental disorders are three times more likely to be housed in prisons than in hospitals (Nardin et al., 2017). A prevalence study of inmates with psychotic disorders in Finland showed a ten-fold rise in the number of inmates with psychotic disorders in the past decade (Juriloo, Pesonen & Lauerma, 2017).

Not only is there a rise in numbers of mentally ill inmates, these individuals also tended to reoffend at a higher rate than offenders without any mental health conditions (Cuddleback et al., 2019; Baillargeon et al., 2010; Cloyes, Wong, Latimer & Abarca, 2010). This is likely due to the treatment barriers and challenges posed by the underlying mental disorders of these inmates. Specifically, inmates with severe mental disorders and are convicted of sexual and violent offences have been found to present with complex challenges to mental health providers, sex and violent offender treatment programmes and community supervision (Fazel at al., 2016; Cuddleback et al., 2019). As such, it is vital that treatment and intervention for this group of offenders during their incarceration be comprehensive and targeted, aiming to reduce their reoffending rates, and to support their reintegration in the community.

Apart from higher recidivism rates, inmates with mental disorders also have a higher propensity towards committing disciplinary infractions, which include aggression towards self and others. These disruptive and risky behaviours are problematic and pose as a challenge to manage these inmates in a safe, humane and non-punitive manner (Adams & Ferrandino, 2008; Konrad & Opitz-Welke, 2014; Meyers, Infante & Wright, 2018).

This article seeks to provide an overview of the philosophy and objectives in managing inmates with mental health issues within Psychiatric Housing Unit (PHU) of Singapore Prison Service (SPS), the profile of inmates housed in this housing unit and its collaboration with external agencies such as the
Inmates of Mental Health (IMH) and other community aftercare agencies as part of a throughcare approach. Key processes, activities and programmes will also be reported to illustrate how treatment and management of these inmates are conducted.

The Psychiatric Housing Unit (PHU) in the Singapore Prison Service

PHU comprises two specialised housing units situated in two prison institutions (one that houses male inmates and the other houses female inmates), for the purposes of providing gender-specific psychiatric intervention and correctional rehabilitation for male and female inmates with mental disorders. The PHU is currently managed collaboratively by SPS and IMH, a contracted external mental health agency under the National Healthcare Group (NHG).

Inmates in the PHU undergo a comprehensive treatment programme, which includes pharmacotherapy, psychotherapy, counselling and other rehabilitative programmes based on their needs, risk and responsivity (RNR; Andrews, Bonta & Wormith, 2011). This is conducted by a Multi-Disciplinary Team (MDT) comprising prison officers, the IMH’s psychiatric team (consisting of psychiatrists, psychologists, occupational therapists, registered and advanced practice nurses), and prisons psychologists.

Background and history of the PHU

In August 2006, a Government Inter-Ministry Committee (IMC) tasked to study the management and

1 The Institute of Mental Health is the first mental hospital in Singapore. It is currently established as an acute tertiary psychiatric hospital and offers a comprehensive range of psychiatric, rehabilitative and counselling services for children, adults, and the elderly. Under the arm of forensic psychiatric services, IMH has provided psychiatric care services to SPS through the PHU programme since 2011.

2 Each prison institution is situated within a multi-storeyed institution and comprises several residential sections, which are termed housing units.

3 Whilst both male and female inmates are being treated in the Singapore Prison Service, the paper is largely focused on the treatment of male inmates.
treatment of inmates with mental disorders proposed the setting up of a specialised psychiatric facility within the SPS. This facility was to serve as an alternative place of incarceration and to provide appropriate psychiatric and rehabilitative interventions for inmates with mental disorders who could not be adequately managed and treated within the mainstream prisons.

As such, SPS took up the recommendation by the IMC and sought to acquire the capabilities for psychiatric treatment by setting up a PHU in prisons. The IMH, the main provider of mental health services in Singapore, was proposed to be a suitable partner for this project and played an important role in the inception, development and delivery of clinical services in the PHU. In April 2011, the PHU commenced operations and admitted inmates with mental disorders into the facility.

**Philosophy and Approach of the PHU**

The operationalisation of PHU permitted inmates with mental disorders who require dedicated treatment, to be managed effectively in a separate facility under a different operating philosophy. The main goal of the PHU is to ensure that inmates with mental disorders are rehabilitated in a safe and secure environment during their incarceration, without disrupting the daily operations of the mainstream prisons. Of utmost importance, the PHU also seeks to prepare these inmates for successful reintegration back to the society or mainstream prisons upon discharge from the PHU.

During their stay in the PHU, inmates attend intervention programmes designed and conducted by staff of IMH and SPS. These programmes aim to help inmates improve overall functioning skills, gain insight into their mental disorders and learn ways to manage their symptoms. At the end of these programmes, a reassessment of inmates’ functional abilities and level of insight will be conducted in order to develop appropriate reintegration plans. More recently in July 2018, a reintegration step-down unit was formed to provide an intentional platform to help inmates gradually reintegrate into the community upon their release.

**Multi-Disciplinary Approach**

One key modus operandi of the PHU is the multi-disciplinary effort within the housing unit. The psychiatric team (psychiatrists, nurses, occupational therapists, and clinical psychologists), prison officers, medical team (General Practitioners and general health nurses) and prison psychologists hold regular case conferences to discuss management, treatment and discharge plans. Invitations to case conferences are also extended to community aftercare agencies to discuss and develop effective reintegration plans for inmates who require additional support in the community. Pre-release decisions and risk management plans for inmates with potential risk of harm to the community are discussed at this platform to ensure safety plans are developed and followed through in the community.

The roles of each stakeholder within PHU is unique and it is vital that the team works collaboratively in accordance to their differentiated roles. For example, the differentiated roles between psychologists from prison and the appointed mental health provider, in this case IMH, follow the Magaletta and Verdeyen’s (2005) framework that delineates roles of psychologists in the correctional mental health setting. Psychologists from IMH carry out intervention that target inmates’ mental disorders; whereas, prison psychologists provide psychology-based intervention programmes that
target the inmates' criminogenic need and risk factors. Figure 2 reflects the different roles of PHU stakeholders.

### Throughcare Approach

PHU also adopts a throughcare system in managing inmates upon their admission into PHU. Risks and needs are identified early to project sufficient time for these areas to be addressed.

Key stakeholders, including inmates’ family members are engaged as early as possible to allow them to appreciate the challenges faced by the inmates during their incarceration given their mental health issues and to explore opportunities for collaboration in managing them more effectively. Closer to their release, aftercare plans are discussed with the inmates, their family members as well as community partners, depending on their risks and needs identified and addressed during their incarceration. The IMH’s Forensic Psychiatry Community Service (FPCS) supports ex-offenders with mental health conditions in their reintegration into the community.

### Management of inmates within the PHU

The management of inmates within PHU is resource-intensive as these inmates may present with a variety of presenting difficulties and behavioural issues. Research has shown that inmates with mental disorders have a higher frequency of disciplinary infractions within the prison setting and the order and safety of the prisons environment can be easily disrupted (Konrad & Opitz-Welke, 2014). As such, apart from the MDT and throughcare approach in ensuring the safe custody of these inmates, one of the key stakeholders in the management of inmates within the PHU are the prison officers. The day-to-day interactions of prison officers with the inmates are crucial in the management and

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4 **FPCS was established in September 2011 and is funded under Ministry of Health’s Health Services Development Programme Fund. The main aim of FPCS would be to support inmates in their reintegration to the community and to facilitate continued psychiatric treatment and care upon release from SPS.**
Article 9: Managing Inmates with Mental Disorders: The Psychiatric Housing Unit in Singapore Prison Service

Throughcare Approach

Figure 3: A Throughcare Approach in the PHU.
* New additions for the new psychiatric services contract planned commencement from FY2018

Figure 4: Engagement between inmates and prison officers
treatment of these inmates. In the PHU, a system that values the staff-inmate engagement precedes the effective management of inmates.

**Training and Preparation of Prison Officers in the PHU**

Prison officers are distinctively selected for their deployment in PHU. These selected officers are sent for relevant additional training to augment existing core competencies to perform their roles in PHU. Topics such as mental health disorders and skills to manage these inmates are also weaved into the Basic Officer Course (BOC) conducted at the Singapore Prison Training Institute (SPTI). Other additional mental health related workshops include evidence-based approaches such as Solution-Focused Brief Therapy (SFBT) and Cognitive-Behavioural Therapy (CBT). At present, the SPTI is also moving towards accrediting training modules for these officers. These trainings provide prison officers with an understanding of mental disorders in general. Prison officers also learn skills and strategies to communicate, manage and provide support to the inmates in their daily interactions with them. As a result, the officers are able to nurture a supportive and safe environment within the PHU that allows these inmates to seek help to improve their mental health condition(s).

In the PHU, inmates are able to have conversations with their Personal Supervisors (PS) or any PHU officers whenever they experience stress or are feeling anxious. Based on qualitative accounts, inmates have found engagements with prison officers who showed them respect and care to be helpful in alleviating their stress levels (Steiner & Wooldrege, 2018). This allows a healthy system of rapport and nurture a trusting relationship between prison officers and the inmates, thereby creating a more flexible and less punitive approach in staff-inmate engagement, which has an impact on the overall mental health of these inmates.

**Psychological Approaches to Help Specialised Housing Units (PATHS)**

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5 Inmates are assigned to Personal Supervisors (PS) within the housing unit. These Personal Supervisors are officers in the housing unit who manage inmates’ requests and rehabilitation process.
Psychological Approaches to Help Specialised Housing Units (PATHS) is a support system dedicated to support prison officers who manage inmates with mental health issues and present with persistently disruptive behaviours. PATHS commenced in 2018 and have been continuing its runs twice a year with prison officers from PHU and other specialised housing units. Each run comprises of six to eight sessions where prison psychologists from the SPS Clinical Psychology Unit facilitate the sessions. These sessions consists of components such as case discussions, learning different psychological approaches to manage inmates, as well as learning from other officers from various specialised housing units.

To deepen their learning, each prison officer is required to present a challenging case under their current management. Thereafter, with the guidance of prison psychologists, officers collaboratively formulate intervention plans and strategies to manage and engage the inmate through the imparted psychological skills. Further coaching or joint sessions with the prisons psychologists to engage the inmate are offered outside the PATHS sessions, to better support these prison officers. Generally, prison officers who participated in PATHS reflected that the sessions have given them confidence in applying these psychological skills in their work with inmates. In addition, PATHS provided them with support and validation of their experiences, knowing that prison officers from the other specialised housing units face similar challenges with disruptive and difficult inmates. Consequently, they are able to share best practices of inmate management techniques and strategies with each other.

**Key processes within the PHU**

This section of the paper seeks to document the key processes in managing inmates with mental disorders within the PHU. This includes the following stages: a) screening, admission and triaging, b) assessment, c) interventions and d) pre-release planning.

**Screening, Admission and Triaging Stage**

Inmates with mental disorders are admitted into the PHU through the workflow documented in Figure 6. Prior to admission, inmates will receive an official psychiatric diagnosis from the prison psychiatrist. Apart from receiving an official diagnosis, operational checks will be conducted on these inmates in order to ensure minimal housing difficulties or any other operational concerns. Subject to the approval of the Superintendent of PHU, the concurrence of the MDT stakeholders and the availability of space in PHU, the referred inmate will be transferred and admitted into PHU. Inmates who are referred typically should have at least a minimum of 6 months before their release date in order for meaningful intervention to take place. Nevertheless, more recently a PHU Abridged Programme was set up in 2019. This programme seeks to take in inmates who have only 3-4 months of remaining sentence in order to provide intervention to more inmates who may require dedicated intervention.

Inmates referred to the PHU go through different phases upon their admission. The four phases are: Observation Phase, Stabilisation Phase, Intervention Phase and Recovery Phase. Those referred to PHU will undergo an Observation Phase, where they will be assessed and monitored by doctors and advanced practice nurses for their suitability for admission to PHU. Upon admission, they will enter the Stabilisation phase to reduce the severity of their acute psychiatric symptoms through the appropriate course of psychiatric treatment. It also serves as a critical time of motivation for active participation in the PHU programme. At this stage, the Risks and Needs Assessment (RANA) will be administered in order to clinically manage the inmate, thereby facilitating necessary psychiatric care
Assessments

Upon admission into PHU, the Risk and Needs Assessment (RANA) would be administered to all inmates in order to assess and identify their clinical, mental health and reintegration needs. RANA is an assessment tool used to follow-up on presenting problems, issues and concerns that these inmates may face throughout their entire stay in PHU. RANA is updated on a 6-monthly basis and the information tracked on the RANA is presented at the MDT platform at various time points of their stay in PHU for further discussions and inputs from other stakeholders on the management and care needs of these inmates.

More specific to criminogenic risk assessment, SPS psychologists receive training in conducting assessment interviews utilising assessment tools such as the Historical Clinical Risk Management-20 Version 3 (HCR-20 V3; Douglas, Hart, Webster & Belfrage, 2013), the Sexual Violence Risk-20 Version 2 (SVR-20 v2; Boer, Hart, Kropp & Webster, 1997) and the Spousal Assault Risk Assessment (SARA; Kropp & Hart, 2015) to assess the offender’s risk of general violence, sexual violence and spousal violence respectively. These assessment tools, backed by research and informed by the clinical experience of clinicians are widely used across international forensic and correctional facilities (Buchanan et al., 2012; Helmus & Bourgon, 2011; Singh, Serper, Reinharth & Fazel, 2011). Using the Structured Professional Judgement (SPJ) approach with the abovementioned assessment tools, prison psychologists assess the offender’s violence risk, mental health needs, reintegration needs and
their strengths. Their assessments guide the intensity and level of treatment provided, and aid the psychologist in developing an initial treatment plan to address the offender’s criminogenic needs with the aim of mitigating his/her risk of re-offending.

Interventions Phase
The main aims of the intervention phase are to improve inmates’ insight into their own mental disorders, to increase cognitive skills, to enhance social skills and interaction and develop their self-esteem. For example, in this phase, the nurse educators typically conduct a mental illness management programme to help inmates who experience psychotic symptoms increase insight into the illness and to develop strategies to manage these ongoing symptoms. Criminogenic needs such as violence and sexual violence risk are also targeted in this phase. The intervention phase also consist of a component that seeks to help inmates reconnect and build prosocial support in their lives.

One recent initiative by the PHU officers would be the ‘PHU Family and Community Day’, which is part of the housing unit’s efforts in strengthening psychiatric intervention for these inmates. The aims of the programme include providing engagement opportunities for family members to interact with mental health experts and key community partners who support the caregivers of individuals with mental health issues. A typical programme outline for the day would include a sharing by a forensic psychiatrist from IMH on mental health, a presentation of services provided in PHU by the officer in-charge of PHU and lastly, family time. Officers also actively engage family members and inmates by having conversations with them and assessing for possible rehabilitation needs. Overall, the programme consists of targeted approaches to strengthen inmates’ social support and motivate them towards managing their mental health through the involvement of their loved ones. This platform further facilitates family members in having access to organisations in the community.

Ongoing Pharmacological Treatments
Inmates receive pharmacological treatments to manage their psychiatric symptoms based on regular consultations and reviews with psychiatrists. Inmates who require psychological intervention in managing their mental disorders may receive individual psychotherapy by IMH psychologists in helping them to cope better with their mental health issues.

Vocational Skills Activities and Basic Life Skills
Nurse Educators and Occupational Therapists (OTs) conduct classroom-based lessons and vocational skills activities that mirror basic life skills that are essential in day-to-day living. This includes basic area cleaning and maintaining personal hygiene, folding and distributing laundry in the dayrooms, and maintaining the books in the housing unit’s library. These guided day-to-day life skills activities are meant to instil the values of having a sense of routine, responsibility, emphasis on hygiene and to inculcate in the PHU inmates a sense of empowerment.

To enhance their overall wellbeing in the PHU, inmates also engage in therapeutic activities at the reading corner or engaging in indoor gardening. Overall, the activities available in PHU aim to increase inmates’ functioning in social and adaptive living skills that instil a sense of responsibility and empowerment.
Art Therapy Programme
Within the PHU, inmates have the option to attend art therapy programme facilitated by an external vendor. The main objective of the programme is to help inmates explore their feelings, thoughts and experiences through a thematic art approach. In general, the goals of the programme are to reduce anxiety, increase internal awareness of thoughts and emotions, as well as to develop social skills and confidence through the expression of art. Inmates were observed to be able to express their feelings and thoughts through their own personal art pieces and this in turn helped them to regulate their emotions and to engage with one another in a more meaningful manner during the sessions.

Figure 7: Art therapy session

Pre-release Phase
Upon completion of the stabilisation and intervention phase, the PHU inmates transit into a recovery phase where they attend a step-down care programme. Programmes includes activities and lessons that help inmates prepare for reintegration back to mainstream prison or the community. The interventions in at this phase is future oriented. A key feature of the pre-release phase would be the increase in MDT discussions on the inmates’ release plans.

Pre-release Program – Hope in Creating Meaning Experiences (HOME)
The pre-release programme ‘HOME’ was developed by the IMH psychologist, OTs and PHU officers in 2017 for inmates in the recovery phase. HOME is an individualised and customised programme comprising of five specific domains of reintegration needs – improved self-care, work, and familiarity with social support agencies, improved social and community living skills.

The HOME programme sessions are typically conducted by the IMH psychologist and occupational...
therapist. In general, the discussions led by the IMH psychologist centre on connecting or re-connecting with the community, mental health self-care, employment issues and emotional regulation. Sessions conducted by the OTs aim to build life skills such as navigating public transportation in Singapore, use of self-service banking, and accessing Government on-line services. These sessions include role-plays, simulating transactions and handling objects, designed to help them appreciate changes in contemporary society.

For the purposes of evaluating the programme, inmates are administered with a questionnaire at the commencement of the programme to establish their competence in these domains and again at the end to measure their progress. Presently, the qualitative evaluation outcomes have shown that the programme is well received and competencies have increased in the relevant domains.

**Therapeutic Gardening Programme**
A recent initiative to maintain wellness, the Therapeutic Gardening programme, was facilitated by OTs and PHU officers. The purpose of the programme was to help inmates in PHU learn new skills that can be applied after their released from prisons. Inmates were receptive to the programme, displayed enthusiasm in learning and were observed to have an increased sense of responsibility among themselves. They also took initiative by volunteering to clean the area after every session and were helpful and supportive towards each other. Structural changes were made in the PHU to create space for this garden. For example instead of standardised lightings for the gardening room, special ultraviolet lights were procured in order to enhance the plants’ growth.

**MDT Case Conferences**
Another key feature during the pre-release phase is the conduct of case conferences with key stakeholders to coordinate release plans for the inmates. This is aligned to the through care approach and the MDT efforts that PHU adopts. The case conferences aim to bring all relevant stakeholders together to discuss the inmate’s aftercare plans and to explore ways to manage them more effectively in the community. The case conferences would also discuss the need for referrals to relevant organisations in the community (e.g., accommodation, financial referrals).

Notably, FPCS social workers play an integral role in linking up community resources and enhancing social support via collaboration with community partners. They also serve as the contact points to the
family members and are instrumental in making home visits and checking in with the family on their readiness to take in the PHU inmate and caring for them in the community.

**Evaluation of the Effectiveness of PHU**

One of the key strengths of intervention programmes within SPS is the intricate processes and efforts dedicated to programme evaluation. It is vital that the effectiveness of PHU is thoroughly evaluated and investigated in order to improve care and management for these inmates with mental disorders. Evaluation of intervention in the PHU is ongoing.

Currently, SPS is collaborating with IMH in evaluating the effectiveness of PHU. Some of the outcome measures under consideration include recidivism rate, frequency on institutional misconduct, as well as types and dosage of medication administered in the PHU.

**Violent Offenders**

Due to the level of risk and criminogenic needs of inmates who commit violence and sexual violence offences, the process of treatment and intervention for this group differs from the mainstream PHU. SPS psychologists would typically conduct a separate triaging system aimed to address the inmates’ criminogenic needs. The system prioritizes correctional intervention for male offenders who present with a serious or persistent sexual and violent offending history. More emphasis is paid to this group because of the risk of harm they pose to the public in the community. Upon completion of the assessment phase, individual intervention would be provided for the rehabilitation of their criminogenic risks and needs as well as their mental disorders that are linked to their offending. These individual interventions are adapted from in-house evidence informed psychology-based correctional programmes that adhere to the Risks, Needs and Responsivity (RNR) model (Andrews, Bonta & Wormith, 2011) as well as the Good Lives Model (GLM; Ward, 2002; Ward & Maruna, 2007).

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### Therapeutic Gardening Programme

**Benefits**

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<tr>
<th>Psychological</th>
<th>Social</th>
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<tr>
<td>Improve Emotional Regulation</td>
<td>Improve Communication Skills</td>
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<tr>
<td>Improve Cognitive Abilities</td>
<td>Develop Social Skills - Teamwork</td>
</tr>
<tr>
<td>Learn Adaptive Coping Skills</td>
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**Skills development**

- Learn new gardening skills - to propagate plants & experiment the seed germination

**Self**

- Develop qualities – Patience, Diligence, Resilience, Discipline
- Promotes Self-Esteem & Instils Hope

**Figure 9: Therapeutic gardening programme**
Conclusion
This paper sought to document and outline the key processes pertaining to the PHU within SPS in terms of managing inmates with mental disorders and those who require specialised care during their incarceration. Across the years, prison officers and staff are faced with increased challenges in the need to maintain a safe and orderly prison while responding to the needs of these inmates who have mental health difficulties. Additionally, research on the general forensic population show that inmates with mental disorders tended to serve longer sentences, be victimised within the prison setting and are likely to engage in institutional misconduct, thereby requiring more effort and resources to manage (Meyers, Infante & Wright, 2018). Given these challenges, it is vital that the processes and capabilities in management of inmates, who may present with challenging disruptive behaviours and mental health issues, be constantly improved and evaluated. This is to ensure that such inmates in prison can receive adequate and appropriate standards and delivery of healthcare as well (Georgiou & Townsend, 2019). For example, based on a recent systematic review and meta-analysis of outcomes of psychological therapies for prisoners with mental health problems, it was suggested that the provision of specialist, targeted and individualised services should be considered for acute cases (Yoson, Slade & Fazel, 2017). Pertaining to the pre-release phase, research has also documented the need to provide intensive case management and enhanced support system for inmates who may not have the capabilities to arrange for their own aftercare release plans. Given SPS’ efforts in its throughcare and MDT approach within the PHU, it is hopeful that new initiatives will continue to develop, reducing recidivism rates and improving overall mental well-being of inmates within the PHU.

Future Directions
Prospective plans for the PHU include continued support and strengthening relationships with aftercare agencies that will support the reintegration needs of these inmates with mental disorders. Apart from collaborations with external agencies, an ongoing internal evaluation study on the effectiveness of interventions within PHU aims to identify treatment gaps and to improve outcomes and mental well-being of these inmates.

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Acknowledgements
Special thanks to Ms Lim Ka Woon from the Frontline Operations Branch, Operations Division of the Singapore Prison Service, Dr Jerome Goh and his team from the Department of Forensic Psychiatry of the Institute of Mental Health for their valuable contributions to this paper.
Call for Papers and Submission Guidelines
AIMS AND SCOPE OF ADVANCING CORRECTIONS
The ICPA believes that development of a professional and humane corrections should be grounded in evidence. Respect for evidence is a hallmark of the ICPA. But evidence is of little value unless it is understood and put into action. Our semi-annual Journal Advancing Corrections is intended to fill the need for researchers to speak more clearly to practitioners and practitioners to speak in a more evidence-informed way to their colleagues. We want to provide a forum for both researchers and practitioners from a wide range of disciplines (criminal justice, education, psychology, sociology, political science, economics, public health, and social work) to publish papers that examine issues from a unique, interdisciplinary and global perspective. Your paper could be an evidence-informed discussion of an important correctional issue, an overview of some new research findings and their implications for practice, a description of an innovative program or approach, or an informed commentary on some aspect of managing a key issue in corrections.

The Journal invites submission of papers that can be digested and appreciated by practitioners, managers, policy-makers, and other correctional professionals. Authors are welcomed to submit papers for one of three sections of the Journal. Featured Research Articles should be more research oriented and scholarly, including the usual practice of referencing the relevant literature. Another section called Views and Reviews welcomes shorter and thoughtful discussions of a particularly relevant or emerging issue/topic. And finally, a section we are calling Practice Innovation in Corrections would like to profile what is going on in a given agency/jurisdiction that is especially innovative and can be of interest broadly to others.

As the Call for Papers for this 10th Edition of Advancing Corrections is being issued, our world is being gripped by a global pandemic that will have deep though still uncertain repercussions for many aspects of our lives. The physical, mental and economic ‘RISK’ this virus poses has created a contagion of its own as discomforting anxiety and even panic spreads uncontrollably. The world is becoming suddenly very familiar with the notion of ‘RISK’ – trying desperately to understand this virus better, figure out how to assess it more easily and accurately, manage it in different contexts, and hopefully mitigate and reduce its impact. Although certainly at a different level and for different reasons, corrections professionals have had to routinely focus on Understanding, Assessing, Managing and Reducing RISK in their daily work for many years. This Edition of Advancing Corrections will be devoted to examining how well our field has advanced in dealing with RISK. We want to hear from both researchers and practitioners and we welcome both evidence and practice-informed discussions about how notions of RISK can be incorporated more effectively into practice. The focus of papers can range from:
Scholarly discussions regarding how we can better conceptualize and understand RISK, including RISK other than RISK of re-offending;

- Evidence-informed frameworks for understanding RISK that go beyond the traditional crimogenic RNR paradigm;
- Quantitative or qualitative research highlighting issues in how we assess RISK, and especially in examining the fairness and validity of our assessment tools for different populations (e.g., ethnic minorities, women);
- Research on the impact of professional development and/or specialist training of staff to incorporate RISK assessment into their decision-making;
- The range of issues faced in monitoring and responding to RISK both in prisons and under community supervision;
- Description of innovative approaches for managing and reducing RISK in particular jurisdictions, including research on improving assessment procedures, case management and/or sentence planning, programming or other broader service-delivery strategies;
- Attention to practice-culture and correctional environment issues more generally as effective ways to reduce or mitigate RISK;
- Any other correctional innovation, including application of new technology, which illustrates a purposeful strategy for more humane management of RISK; and last but not least,
- The voice of practitioners, researchers, senior corrections executives and administrators regarding 'lessons learned' in dealing with the public and political backlash when our RISK management strategies fail.

In summary, what we are looking for are clear examples of how our application of RISK concepts can have direct and practical implications for improving corrections operations and effectiveness, either in the prison or the community context.

In submitting your manuscript, we ask that you provide a succinct summary of how your paper relates to this theme. As with previous Editions of *Advancing Corrections*, preference will be given to manuscripts which show respect for evidence and where either qualitative or quantitative evaluation has been conducted.

**HOW SHOULD YOU SUBMIT YOUR PAPER?**

Manuscripts should follow the Guidelines for Authors for the Journal. Suggested page length is from 7 to 15 pages (about 2,000 to 5,000 word-count), although lengthier research-oriented manuscripts or reviews may be considered based on merit. Whenever appropriate, papers should include referencing of other related scholarly work, though it is emphasized that *Advancing Corrections* is not intended as an academic publication. Papers should be respectful of evidence but they should be written in a way that appeals to practitioners. Manuscripts should be submitted electronically to Dr. Frank Porporino, Ph.D., Chair of the ICPA Research and Development Network and Editor of *Advancing Corrections* ([fporporino@rogers.com](mailto:fporporino@rogers.com)). A copy should also be forwarded to the ICPA Communications Officer, Alex Petrov, at the ICPA Head Office ([alexpetrov@icpa.org](mailto:alexpetrov@icpa.org)).
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Advancing Corrections has an international Editorial Review Board and submitted papers will undergo a formal and rigorous 'peer review' process. The ICPA Research and Development (R&D) Network is committed to finding more and better ways of communicating research-informed knowledge to the ICPA membership. Many of the members of the group serve as reviewers of submitted manuscripts.

The Editor of Advancing Corrections will manage the process of selecting manuscripts for review and choosing the final set of papers to be included in the Edition. Papers that may not be suitable for the publication may nonetheless be posted on the ICPA Web Site or included in the ICPA Newsletter for the information of ICPA members.

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Editor Advancing Corrections and Chair, ICPA Research & Development Network
GUIDELINES FOR AUTHORS

-- For publication in ADVANCING CORRECTIONS --

JOURNAL OF THE INTERNATIONAL CORRECTIONS AND PRISONS ASSOCIATION

Aims & Scope
Advancing Corrections is a peer-reviewed publication that provides an interdisciplinary and international forum for the dissemination of new research, policies and practices related to advancing professional corrections worldwide. The aim is to provide an opportunity for both researchers and practitioners from a wide range of disciplines (criminal justice, psychology, sociology, political science, economics, public health, and social work) to publish papers that examine issues from a variety of perspectives in a unique, interdisciplinary forum. Your paper could be an evidence-informed discussion of an important issue related to the theme of our next ICPA Annual Conference, a summary of some new research findings and their implications for practice, a description of an innovative program or approach, or an informed commentary on some aspect of managing a key issue in corrections.

Review of Manuscripts
Article contributions will only be considered provided they have been edited and are ready for processing, namely: language edited, stylistically polished and carefully proof read in following the technical format and referencing guidelines as provided below. In submitting a paper author/s acknowledge that it is their own original work and that all content sourced from other authors and/or publications have been fully recognized and referenced according to the guidelines for authors.

Manuscripts will be submitted to referees (in a double blind review process) for evaluation and they may be altered or amended in the interests of stylistic consistency, grammatical correctness or coherence. The ‘refereeing’ process will be anonymous and the identity of referees will remain confidential. It remains the prerogative of the editors to accept or reject for publication any submission and their decisions are final. They will not enter into any debate or correspondence regarding any decision made. Evaluators agreeing to referee articles are requested to provide, where possible, critical and constructive feedback on the work of their peers.

Apart from scientific shortcomings or inconsistencies, the following evaluative criteria will be considered:

• The theme of the paper is significant and useful (timely, important, in need of addressing);
• The paper addresses (unpacks) themes logically, consistently and convincingly;
• The paper demonstrates an adequate understanding of the literature in the field;
• The paper demonstrates a critical self-awareness of the author’s own perspectives and interests;
• Conclusions are clearly stated and they adequately tie together the elements of the paper;
• The standard of writing (including spelling and grammar) is satisfactory and the style of writing is practitioner-oriented;
• Sources consulted are sufficiently acknowledged (included in a list of references).
Manuscripts that are submitted to Advancing Corrections should be accompanied by a statement that they have not been (or will not be) published elsewhere in the same version as submitted to Advancing Corrections. ICPA does not wish to curtail authors from publishing their work in other scholarly and academic journals or publications. However, the paper submitted to Advancing Corrections should be an original piece that will not be duplicated elsewhere without permission from ICPA. Prospective authors for Advancing Corrections should also register as Basic Members of ICPA so that their address is available for ICPA to forward a complimentary copy of the printed version of the Journal. Basic Membership in ICPA is available at no cost although authors are also encouraged to become Full or Professional Members.

Submission of Manuscripts
Manuscripts should be submitted electronically to Dr. Frank Porporino, Ph.D., Chair of the ICPA Research and Development Network and Editor of Advancing Corrections (fporporino@rogers.com). A copy should also be forwarded to the ICPA Communications Officer, Alex Petrov, at the ICPA Head Office (alexpetrov@icpa.org).

Papers that are submitted for consideration should adhere to the following minimum standards and technical and formatting requirements:

1. All parts of the manuscript, including referencing, should follow standard American Psychological Association (APA) format; the paper should be double-spaced, with margins of at least one inch on all sides and with manuscript pages numbered consecutively. Suggested page length is from 7-15 pages, double-spaced (about 2000 to 5,000 word-count). Each paper should be summarized in an abstract of not more than 100 words;
2. The title of the article (in Sentence Case, i.e. displaying words to be intentionally capitalised) and the author’s full first name and surname, designation, institutional affiliation, address & contact email should appear on the first page;
3. Font: Times New Roman 12;
4. Page numbers: are also TNR 12 font and centered in the footer section of each page;
5. Spelling: Please make use (choose this as your default option) of the North American spellcheck and NOT the UK one;
6. Use of quotes and italics: Long quotes are placed in a separate paragraph and must be indented from both sides.

ICPA wants to encourage authors to include references with their papers in order to allow readers to do follow-up reading on the topic in question. Manuscripts, including figures, tables, and references, must conform to the specifications described in the Publication Manual of the American Psychological Association.

Examples for Referencing:


**Illustrations:**
Illustrations submitted (line drawings, halftones, photos, photomicrographs, etc.) should be clean originals or digital files. Digital files are recommended for highest quality reproduction and should follow these guidelines:
- 300 dpi or higher;
- sized to fit on journal page;
- EPS, TIFF, or PSD format only;
- submitted as separate files, not embedded in text files.

Images should be submitted as separate files, where the filename matches the reference in the text. Embedded graphs and tables are acceptable if they follow the resolution guidelines.

**Tables and Figures:**
Tables and figures should not be embedded in the text, but should be included as separate sheets or files where possible. A short descriptive title should appear above each table with a clear legend and any captions or footnotes suitably identified below. Figures should be completely labelled, taking into account necessary size reduction.

Authors should not refer to images or graphs as 'above' or 'below' within the article but use references where needed, e.g. Figure 1, Table 1, etc.

If you have any questions regarding submission of your manuscript, please contact the ICPA Head Office at alexpetrov@icpa.org.
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ICPA, EuroPris and CEP in collaboration with the Portuguese Reintegration and Prison Service have decided to organize a third edition of the International Correctional Research Symposium in Portugal in the week of 2 March 2021, with the theme of ‘Motivation and Well-Being of Correctional Staff: How they matter and what can we do about it?’

www.icpa.org/crs2021

The Technology in Corrections conference has proven to be a hit among those working within the correctional technology realm. In collaboration with EuroPris we will seek to attract a core audience of those presently working within the prison and probation sectors who are involved in the advancement of their respective jurisdictions through the implementation of digital technology initiatives.

www.corrections-technology.com

At ICPA’s flagship annual conference you can meet and interact with more than 500 corrections professionals from across the world. Hosted by the Hong Kong Correctional Services Department we invite you to join us at the Nina Hotel in Tsuen Wan and take part in this exciting event. With a diverse programme covering a broad range of topics you should mark your calendar now and follow the latest updates on our website!

www.icpa.org/hongkong2021

View past events, videos, presentations, programmes, photos and attendee lists on www.icpa.org/icpa-events
Inside Rear Cover: Semi-Colon, Wimbledon Probation Service, newspaper and polystyrene on canvas board, 2019

Image courtesy of Koestler Arts. Koestler Arts runs the annual Koestler Awards, an annual awards programme for people in secure settings across the UK. The Awards encourage people in prisons, secure hospitals, IRCs and on community sentences to share their creativity, get feedback, and gain opportunities for exhibition, mentoring and publication. For more information about the charity see www.koestlerarts.org.uk

The semi-colon is the symbol used to represent mental health and suicide awareness following a popular social media movement by non-profit organisation ‘Project Semicolon’ in 2013. They describe themselves as a “movement dedicated to presenting hope and love to those who are struggling with depression, suicide, addiction, and self-injury. Project Semicolon exists to encourage, love, and inspire.”

“A semicolon is used when an author could’ve chosen to end their sentence, but chose not to. The author is you and the sentence is your life.” (see https://projectsemicolon.com)