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Georgia Department of Corrections
James Donald, Commissioner
2 Martin Luther King Jr. Dr. SE
East Tower, 7th Floor
Atlanta, GA 30334-4900

Dear Commissioner Donald:

I have completed my consultation to GDC, which was requested for purposes of evaluating the GDC mental health audit process (see Appendix I). During this assessment, I also briefly reviewed selected aspects of the mental health service delivery system at the Coastal State Prison during an April 30, 2007 site visit. I was also asked to provide consultation relevant to selective revisions in the standard operating procedures (SOPs).

Sources of information utilized during this consultation process included review of the following documents:

1. MH/MR Program Status Report Georgia Department of Corrections May 2, 2007 prepared by James DeGroot, Ph.D., and Eleanor Brown, M.A., L.P.C., which included statistics relevant to the following:
   a. overall audit scores by year (1998-2006),
   b. total self-injuries by year (2000-2006),
   c. total assaults by year (2000-2006),
   d. number of stabilization admissions by year between 2001-2006, and
   e. mental health grievances between 2001-2006,
   f. MH/MR caseload demographics,
   g. MH/MR staffing patterns, and
   h. SLU programming, training.

2. The central office audit reports for the following correctional institutions:
   a. Hays State Prison,

b. Phillips State Prison,
c. Pulaski State Prison,
d. Metro State Prison,
e. Augusta State Medical Prison,
f. Coastal State Prison,
g. Baldwin State Prison,
h. Calhoun State Prison,
i. Autry State Prison, and
j. Emanuel PDC.

I also site visited the Coastal State Prison during April 30, 2007 and the Georgia State Prison during May 1, 2007. In addition, during the three-day site visit I had the opportunity to interview key mental health administrators, correctional administrators and line mental health staff. As has always been my experience with the GDC, both correctional and healthcare staffs were very helpful throughout the assessment process.

The May 2, 2007 MH/MR programs status report prepared by James DeGroot, Ph.D. and Eleanor Brown, M.A., L.P.C. provided statistics and analysis very relevant to the GDC mental health program and essential for this consultation report. This report will provide some excerpts from their program status report.

Overview

The December 29, 2006 GDC inmate population was 51,698, which was an increase from the 47,654 count during December 2005. There were 18 GDC non-privatized MH/MR programs with allocated positions that include a MH/MR director, clinical director, and other staff including masters degree counselors, psychiatrists, psychologists, nurses, activity therapists and clerical staff. There were also 8 MH/MR PDC programs with staff including masters degree counselors, psychiatrists, psychologists and nurses. Appendix II provides a MH/MR count by institution and level of care for the month of March 2007 as well as relevant mental heath staffing statistics.

The percentage of GDC inmates (8054) receiving MH/MR services during December 29, 2006 was 15.6%, compared to 16.2% (7766 inmates) during December 2006. These figures are consistent with national statistics.

The mental health classification system remains as follows:

Level I --- no need for services
Level II --- outpatient services
Level III --- open residential placement
Level IV --- closed residential placement
Level V --- crisis stabilization
Level VI --- hospitalization

More detailed information relevant to these various levels are presented in the Appendix III.

Thirteen percent (13%) of the male population receive MH/MR services with 72% of these caseload inmates receiving level II services. 73% of the MH/MR inmates were prescribed psychotropic medications. Thirty-five percent (35%) of the female population receive MH/MR services with 95% of the female caseload inmates receiving level II services. 74% of the MH/MR females are being treated with psychotropic medication. These statistics are with little change from the previous year and consistent with national averages.

The types of mental illnesses exhibited by the GDC caseload inmates are summarized in the following chart. Updated information since April 2006 was not available.

	MALE						FEMALE				
Diagnoses	**8/02**	**8/03**	**8/04**	**4/05**	**4/06**		**8/02**	**8/03**	**8/04**	**4/05**	**4/06**
Psychotic Disorder	31%	30%	29%	28%	30%		14%	14%	13%	13%	13%
Bipolar Disorder	7%	7%	7%	9%	8%		11%	10%	9%	11%	17%
Depression	34%	35%	34%	33%	33%		52%	49%	57%	54%	49%
Anxiety Disorder	7%	8%	8%	4%	4%		13%	15%	12%	2%	1%
Adjustment Disorder	-	5%	5%	11%	9%		-	3%	4%	16%	12%

Mental Retardation	1%	1%	1%	1%	.30%		0%	0%	0%	0%	0%
Personality Disorder	4%	9%	11%	10%	4%		3%	3%	2%	2%	6%
Other Disorder	16%	5%	5%	4%	12%		7%	6%	3%	3%	2%

MH/MR Staffing Patterns

The following statistics are described in the May 2, 2007 MH /MR programs status report:

	Counselors (FTEs)	Psychiatry (Hrs)	Psychology (Hrs)	Inmates
August 1999	132	1307	1075	4425
August 2000	137	1276	1093	5255
August 2001	167	1564	1001	5685
August 2002	184	1225	1188	6123
August 2003	177	1085	830	6934
April 2004	175	916	830	7034
December 2004	178	950	840	7104
June 2005	176	912	920	7236
April 2006	189	891	811	7674
December 2006	188	950	880	8054

- Between August 1999 and January 2007, the number of MH/MR inmates increased 80% (from 4425 to 7968), the number of counselor positions increased 42.4%, the number of psychiatry and advanced practice nurse hours decreased 27.4%, and the number of psychology hours decreased 18.2%.

The above data in terms of FTE positions is as follows:

	Jan. 2007 FTEs	1999 FTEs	% Difference (2006- 1999)
Psychiatry	23.8	32.7	-31.8%
Psychology	22	26.9	-24.5%
Counselors	188	132	+43%

These statistics represent a slight improvement from the prior year.

As noted last year, the majority of these positions consist of unlicensed counselors, which continue to cause significant issues from a supervision perspective. Specifically, although state statute allows unlicensed mental health counselors to practice professional counseling in either GDC or DHR facilities, the Board of Examiners for Psychologists has made it clear in writing that supervision of these counselors would need to be in compliance with the Boards supervisor to supervisee required ratios or else the supervisor's license would be in jeopardy.

As a result of the above issue, very few unlicensed counselors in GDC are receiving clinical supervision. Most are receiving consultation as per SOP VG15-0001 (Clinical Consultation), which falls short of clinical supervision and raises serious risk management issues.

As summarized in prior reports, SOPs in effect during 1998, based on the *Cason v. Seckinger* Settlement Agreement had established staffing allocation ratios, which were subsequently changed as follows:

	1998			1999			2001			2002			2006		
	Levels			Levels			Levels			Levels			Levels		
MALES	II	III	IV	II	III	IV	II	III	IV	I I	II I	IV	I I	II I	IV
Psychiatry	1:150	1:150	1:150	1:200	1:150	1:150	1:290	1:150	1:150	No Ratios			No Ratios		

Psychology	1:150	1:150	1:150	1:200	1:150	1:150	1:265	1:150	1:150	No Ratios	No Ratios
	1998			1999			2001			2002	2006
	Levels			Levels			Levels			Levels	Levels
FEMALES	II	III	IV	II	III	IV	II	III	IV	I II IV	I II IV
Psychiatry	1:100	1:100	1:100	1:150	1:100	1:100	1:235	1:100	1:100	No Ratios	No Ratios
Psychology	1:100	1:100	1:100	1:150	1:100	1:100	1:200	1:100	1:100	No Ratios	No Ratios

The following chart compares current psychiatry and psychology FTEs to 1998 ratios determined FTEs:

	Current FTEs	1998 Ratio Determined
Psychiatry	22.3	41
Psychology	20.3	41

Appendix II, which summarizes relevant staffing statistics, includes the following information:

- The actual MH Counselors vacancy rate, which is based on current allocated and filled positions, was 14%. The functional vacancy rate, which is based on the actual vacancy rate and staffing allocation shortage, was 20%.
- Eight facilities had a functional mental health counselor vacancy rate > 25%. Another two facilities had functional vacancies rates of 23%.
- Annual staff turnover remains problematic: MH Directors – 39%, MH Counselors - 29%, Psychiatrists - 56% and Psychologists – 22%.
- The Behavior Specialist vacancy rate was 0%.
- The MH Nurse vacancy rate was 32%.
- The Activity Therapist vacancy rate was 18%.

Central Office MH/MR staff

Current central office staff allocations are as follows:

- 1.0 FTE Statewide MH/MR Supervisor
- 1.0 FTE Assistant Statewide MH/MR Supervisor
- A part-time Chief Psychiatrist (5-10 hours per week on average—twice per month on site for audits)
- A part-time Chief MH Nurse continues to provide 20 hours per week of service.
- A central office MH regional director position has been frozen (since July 2006)
- 4.0 FTE Regional Program Development Consultants (3 positions frozen since the summer of 2006 and 1 position frozen since 2005; 2 Morehouse graduate students (20 hours per week) in Public Health to start in one week to perform outcome studies re: Transitional Aftercare for Probationers and Parolees (TAPP)
- 2 Regional Clinical Directors (each 10 hours per week) (on site at Metropolitan State Prison and Georgia Diagnostic and Classification Prison at Jackson)
- 1.0 FTE Re-Entry Specialist

The health services 2006 annual report summarized the mental health staffing allocations as follows:

Categories	FY 2005	FY 2006
Central Office Administrative	10.75	5.00

Assessment: As stated in prior reports, the significant increase in the number of inmates placed in MH/MR caseload since 1995 and the decrease in mental health staffing during the same period of time remains very problematic from the perspective of providing clinical care. The staffing decrease has in part, been allowed related to the change in the SOPs concerning staffing allocation ratios as previously summarized. Such problems are exacerbated by the lack of clinical supervision for many unlicensed counselors and the nursing staff vacancy systemwide.

One of the strengths of the mental health program in the past had been its ability to adequately monitor itself via a strong central office directed CQI process that has progressively eroded since 1998. Prior to 1998, each prison mental health services

would perform comprehensive audits every six months in addition to a central office onsite audit annually. Corrective action plans would be developed and monitored by the central office staff following the annual audits. The first change was that the frequency of the prison mental health services' self-audits was decreased to annually. During the same period of time the central office audit team began to "borrow" staff from the field to participate in the audits. Approximately two years ago the central office audits became less timely related to a ban at that time on travel within the state due to budgetary issues. During 2006, the scheduling of the central office audits became controlled by the Office of Compliance and Investigations, which has determined that the audits will be scheduled on an every other year basis. For various reasons, this change in the management of the audits has significantly decreased the usefulness of the CQI process for mental health services.

Only 48% of the GDC prisons submitted self-audits during 2006 related to staffing allocation issues.

The management information system (Otis and OMS) began a transition to SCRIBE during the Spring of 2006. Unfortunately, the mental health module of SCRIBE has not yet been implemented despite OMS no longer functioning. As a result, there is not an adequate mental health management system in place (see Appendix IV), which has adversely impacted CQI and the ability to manage the mental health services both at the central office level and at the individual facilities. .

The percentage of inmates admitted to higher levels of care has steadily and significantly decreased as evidenced in the chart following chart:

Number of Stabilization Admissions per 100,000 Inmates by Calendar Year and Stabilization Tier

Stabilization Tier	2001	2002	2003	2004	2005	2006
Central State Hospital	531	580 (+9.2%)	458 (-21.0%)	183 (-60.0%)	16 (-91.0%)	8 (-50.0%)
Crisis Stabilization Unit	4797	5519 (+15.1%)	5173 (-6.3%)	4648 (-10.2%)	4306 (-7.0%)	3940 (-8.5%)

Acute Care	5624	6215 (_10.5%)	6448 (+3.8%)	7010 (+8.7%)	6254 (-11.0%)	5441 (-13.0%)
Total	10,952	12,314 (+12.4%)	12,079 (-1.9%)	11,841 (-2.0%)	10,576 (-11.0%)	9,389 (-11.2%)

It should be noted that there are approximately twenty Just Care inpatient beds available for inmates who have chronic and severe mental disorders that are unresponsive to available treatments within the GDC.

There are a number of possible explanations for the decrease in the numbers of inmates admitted to higher levels of care, which would include a good utilization management system, an adequate supportive living units treatment program, an adequate outpatient mental health services program, or problematic mental health services as characterized by not referring inmates in need of a higher level of care for various reasons. I think the initial decrease was related to implementation of a reasonable utilization management program, but think that the continued decrease is related to systemic problems within the mental health system that are summarized in this report.

Coastal State Prison

During the Morning of April 30, 2007 I site visited the Coastal State Prison. I met with the following key administrative staff:

1. Thalrone Williams, Warden,
2. James Deal, Deputy Warden of Security
3. Gregory Thomas, Deputy Warden of Care and Treatment,
4. Jane Weilenman, Ph.D. (Clinical Director),
5. Jack Carter, Unit Manager, and
6. Jim Ennis, Ph.D. (Clinical Director).

I also met with the line clinical staff in a group setting, which included the psychiatrists, mental health counselors, social worker, behavioral specialist, nursing staff and clerical staff.
Relevant statistical information included the following:

Institutional Bed Capacity

GP	240
Diagnostic	1024

Mental Health Caseload

Level II Diagnostic	335
Level II Permanent	25
Level III Diagnostic	13
Level III Permanent	176
Level IV	2

Permanent Level III inmates were housed in N Building with a capacity of 184. This was a change from prior housing which had consisted of dormitory housing associated with little correctional officer supervision. The housing now consisted of two man cells with a floor correctional officer present in each housing unit. There were also two group rooms available for programming purposes.

Diagnostic Level III inmates were housed in H Building on B-range with a capacity of 30.

G Building had five observation cells with cameras.

SOPs mandated 14.0 FTE counselor positions, although only 11.0 FTE counselor positions had been allocated with 2.0 FTE counselor positions currently vacant. The mental health counselor vacancy rate obviously impacted the clinical duties of the current mental health counselors, which was exacerbated by their custodial case management responsibilities. Caseloads per clinician for Level II inmates ranged from 61-91 inmates. Caseloads for Level III inmates average 38 inmates per clinician.

Correctional officer vacancies were problematic as evidenced by 33 FTE of 217 FTE correctional officer positions currently being vacant. These vacant positions had been frozen since January 2007 until two weeks ago. In addition, another 8.0 FTE correctional officer positions were functionally vacant related to either extended illness or military leave, which meant that the correctional officer functional vacancy rate at Coastal State Prison was about 40%.

The August 14, 2006 MH session MR program audit was reviewed. Twenty-eight percent (28%) of the total prison population at that time was receiving MH/MR services. Almost 70% of the inmate/MR population was being treated with psychotropic medications. Fifty-one percent (90/178) of the disciplinary reports were written on MH/MR inmates. During April 30, 2007, fifty-eight (58) of the 74 isolation cells were occupied by MH/MR inmates.

Medication management problems were described by staff which included issues relevant to medication noncompliance and continuity of medications. QI studies relevant to this area were not performed on a regular basis.

Issues relevant to therapeutic programming in the SLU were discussed. Tracking of therapeutic structured activities offered to the average inmate was no longer being done related to loss of the OMS. Staff estimated that, on average, SLU inmates were offered three hours per week of group psychotherapy. A high refusal rate was noted. Approximately 20 SLU inmates were assigned on an official basis to work details.

Issues related to the formulary were discussed with the two psychiatrists. Risperdal and Geodon were the only atypical antipsychotic medications on the formulary, although the formulary exception process appeared to be functional.

Staff described difficulties with the mental health referral process, which had also not been recently reviewed via a CQI process. Specifically, timely access to a psychiatrist appeared to be present, which was likely due to staffing allocation issues.

In general, the above findings were consistent with the August 2006 MH/MR program audit period

The clinical director informed us that the results of the August 2006 audit had never been forwarded to her. However, she had prepared a corrective action plan, based on the August 2006 exit interview during September 2006. Unfortunately, key elements of the corrective action plan had not been implemented.

Coastal SP does not have a CSU/ACU on site. The following are the number of

CSU/VCU referrals from Coastal SP from July 1, 2006 to the present:

July 2006	4
August 2006	15
September 2006	4
October 2006	3
November 2006	3
December 2006	5
January 2007	8
February 2007	5
March 2007	15
April 2007	9

During the afternoon of April 30, 2007 I interviewed inmates in the SLU in two large group settings. Inmates' report that, in general, they were offered one group therapy session per week was consistent with information obtained from the mental health staff. Very few inmates had job details. Inmates reported limited access to a psychiatrist. The sick call system was described as not being very functional.

Inmates reported restricted access to yard time. Correctional staff reported that the inmates generally received three to four smoke breaks (15 minutes per smoke break) per day and about 35-40 minutes of additional yard time for recreational purposes.

In general, inmates described the correctional officers in the SLU to be more understanding of their difficulties as compared to correctional officers in non-SLU GP housing units.

We also briefly of the five observation cells in G Building. One inmate was completely stripped without access to a paper gown for reasons that were unclear. This inmate had attempted to kill himself by hanging earlier in the morning. He was pending transfer to a CSU. The health care record of this inmate was reviewed. A progress note/initial assessment note had not yet been filed.
Another inmate had been in an observation bed for one week although he had not yet been seen by mental health based on review of his healthcare record. He

apparently had been placed in segregation due to safety concerns. A note was reviewed, which had not yet been filed.

One other inmate complained that he had not seen the psychiatrist since his admission ~ 3 weeks earlier despite his requests related to a significant reduction in his medication prior to his transfer to CSP. This information was consistent with review of his medical record.

The videomonitor for the safety cells were reviewed. The technical quality was poor.

Assessment: The treatment provided in the SLU was not consistent with SOPs and was not adequate for many of the inmates with serious mental illnesses. Medication management issues were apparent. The number of FTE psychiatrist hours being provided at Coastal State Prison was not adequate.

The need for an on-site CSU/ACU is also apparent as evidenced by the number of transfers to such levels of care that are previously summarized. It is likely that such transfers are underutilized related to logistical issues.

Georgia State Prison

During May 1, 2007 I site visited the Georgia State Prison. I had the opportunity to meet with the following key staff:

1. Stephen Upton, Warden,
2. Robert Stevens, Ph.D. (Mental Health Director), and
3. Bryn Higgins, M.A. (Unit Director).

I also met with the line mental health staff in a group setting.

The inmate count at CSP was 985 inmates with 397 (40%) of these inmates being on the mental health caseload. There were 716 inmates in lock-down at GSP with 86% of the mental health caseload inmates on lockdown status. Inmates housed in the lockdown units generally have lengths of stays that are measured in years. About 48% of all lockdown inmates at GSP were on the mental health caseload.

Mental health caseload inmates were classified as follows:

MH 2:	284
MH 3:	61
MH 4:	51

Ninety-one (91) MH 3 & 4 inmates were in lockdown beds. Seven MH 3 & 4 inmates were in the ACU for overflow housing purposes.

GSP also had three specialized housing units for mental health purposes. There were two 13 bed behavioral treatment units for inmates with excessive disciplinary reports and for inmates with self-injurious behaviors. There was also a 13 bed transition housing unit.

GSP had 2.0 FTEs (17%) of their 12 FTE allocated health counselor positions vacant. There was a 15% functional vacancy rate in the correctional officer staffing. GSP had also lost 60 FTE allocated correctional officer positions during the past month.

Approximately 2.5 years ago, eight or nine programming cells were set up for group therapy purposes for SLU inmates at GSP. Despite problems related to the construction (e.g., solid sides) of these programming cells and their 180° placement (in contrast to a semicircle), group treatment was provided on a limited basis. Staff described programming to have been beneficial but very short-lived, related to the subsequent lack of availability of correctional escort officers.

There continues to be a lack of out of cell structured therapeutic activities available to mental health caseload inmates in the lockdown units. In addition, all mental health contacts, except for those by the psychiatrist, are performed at the cellfront. Evaluations and treatment provided by the psychiatrist are conducted in a setting that allows for adequate sound privacy.

Inmates were reported to be offered five hours per week of outdoor recreational time in the individual yard pens. They were also reported to be offered showers on a seven day per week basis.

Mental health rounds occur on a daily basis for MH levels 3 & 4 inmates in the lockdown units, on a weekly basis for MH 2 inmates and on a monthly basis for MH 2 inmates housed in non-lockdown units (i.e., population inmates). Population inmates have clinical contacts conducted in a setting with adequate sound privacy.

Staff reported that a significant percentage of lockdown mental health caseload inmates have active psychotic symptoms. The vast majority these inmates were prescribed medications although staff indicated that compliance with these medications was very problematic as well as monitoring compliance due to the inherent problems associated with medication administration within a lockdown setting. About 39 inmates were receiving psychotropic medications on an involuntary basis.

Staff described positive aspects of the mental health program at GSP to include the treatment provided in a 13 bed acute care unit (ACU) and the six bed crisis stabilization unit (CSU). However, there were problems associated with inexperienced and/or lack of adequate mental health training for correctional officers within these units. Correctional officers are not permanently assigned to either the ACU or CSU, which exacerbates such problems.

Very limited access to inpatient psychiatric beds was reported by the staff.

Staff also described chronic issues with inmates exhibiting inappropriate sexual behaviors.

Staff described very briefly the behavioral-based treatment program within the two BTUs. Studies relevant to treatment outcomes have not been conducted primarily due to staffing allocation issues. It was common for inmates within the BTUs to be sleepers and/or overflow inmates in contrast to being admitted for treatment purposes, which has negatively impacted the treatment milieu.

During the afternoon of May 1, 2007 I served the mental health rounds in the self-injurious BTU. They were performed in a competent fashion. The health counselor clearly had a treat alliance with most of these inmates.

Assessment: There are significant problems with the mental health treatment services provided to inmates for serious mental illnesses at GSP, which were primarily related to mental health and correctional staffing allocation issues and physical plant issues. Specifically, many inmates with serious mental illnesses are not receiving adequate psychiatric care related to their locked down status.

MH/MR Audit Report Summaries

This section will address issues outlined in the consultation request as summarized in Appendix I.

1. Observation of the GDC auditors to analyze the GDC mental health audit process

The MH/MR audit report summaries for the eleven (11) GDC institutions, generated during 2006-2007 were reviewed. As in the past, the audit team was multidisciplinary in nature. The central office staff involved in the audits included the following persons:

Jim DeGroot, Ph.D.
Eleanor Brown, M.A., LPC
Ross Cox, M.D.
Lillian Werner, MS, RN
Michelle Martin, LPC
Sandra Harden-Reeves, Ph.D.

Key MHM staff regularly participating in these audits included Carole Seegert, Ph.D. and Ben Bennett, M.D. Other staff members from the field were temporarily assigned to participate with the central office staff in various audits.

Central office audits have been preceded by self-audits in all the audited institutions. There were 11 institutions that had been audited since my June 2006 consultation visit.

The central office audits, which were scheduled as part of the institutions comprehensive GDC audit, generally took 2-3 days. A written report was provided to the appropriate administrators at each prison, generally within 2-5

weeks of the audit. There have not been problems in providing timely reports to the audited institutions.

As in the past, team members were assigned to assess one or more the following domains:

1. administration,
2. identification of the mentally ill, and
3. treatment.

The central office team meets with key correctional staff (Warden, Deputy Warden of Care and Treatment) and the mental health staff during the review process. The audit instruments required review of many charts and files. Interviews with inmates occurred based on issues related to time and staff availability. In general, about 10% of the mental health caseload at the institution being audited is interviewed as part of the audit process.

The central office generated written audit reports followed a standard format that summarized current audit results along with a finding/recommendations section. The reports also attach the worksheets from the audit, which contain relevant findings. Corrective action plans (CAPs) are required, which are usually received by the central office within 3-5 weeks of the central office report submission date. However, related to central office staffing issues, follow-up of these corrective action plans by the central office has not occurred.

I did not have the opportunity to directly observe the central office staff perform an audit.

Appendix V provides a summary of compliance scores by domains and by institution. The overall SOP compliance score for fiscal year 2006 was 81%, which compares to 86% from the previous year. Little change from last year was found based on audit results from 11 facilities. The percentage of subdomains within the audits passed by less than 70% of the prisons was 37%. Specific subdomains were as follows:

Comprehensive Audits for FY 2006

Programming	**% Passed (percentage of facilities with a 70% or above score)**
.Correctional Officer Training	67%

•Disciplinary Report Evaluations	67%
•Comprehensive Treatment Plans	64%
•CSU Logs	60%
•1st Tier Cell Logs	60%
•Activity Therapy Documentation	60%
•Group Treatment	56%
•Treatment Plan Reviews	55%
•Medication Education	55%
•Safe Cell Logs	50%
•Laboratory Follow-Up	45%
•Discontinuing SMI/MR Services	44%
•Medical Records	36%
•Isolation/Segregation Evaluations	36%
•Duty Officer Log	20%
•SLU Programming	17%
•Nursing Supervision	0%
•Observation Cell Log	0%
•Observation Cell Stabilization	0%

Assessment: The comprehensive audit tool used during the past 12 months was not significantly different than the tool used the previous year.

These audits continue to be very important from the perspectives of needs assessment, quality improvement and sound management. However, the decrease in frequency of the scheduled central office mental health audits has weakened their impact, which has been exacerbated by the lack of capacity of the central office to follow-up the submitted corrective action plans and 42% of the prisons not performing self-audits during the 2006-2007 audit year.

I had previously recommended that the eight institutions that have a SLU, ACU & CSU levels of care at the facility be audited on an annual basis. This recommendation was partially implemented by auditing all institutions that have ACU and CSU levels of care at the facility.

2. Evaluation of the audit tools/instruments for process and assessment effectiveness

For reasons described in my July 2006 report, beginning July 2006 the scoring system reverted to the 2004 scoring system.

During June 2006 I recommended that the audit instrument include questions relevant to medication administration/distribution issues and adequacy of office/programming space. The criteria for adequacy should include sound privacy (when clinically appropriate), safety, size and temperature. This recommendation was implemented.

Assessment: The scoring system is reasonable. The revisions to the audit instrument have improved the effectiveness of the assessment process.

3. Evaluation of the debriefing process for effectiveness

The debriefing process has not changed since the last annual assessment. It generally consist of three separate exit interviews involving an exit interview with the entire MH/MR staff and nursing staff, a separate exit interview with the prison management team (i.e., Warden, Deputy Warden, MH/MR Unit Manager, etc.), and a large exit interview as part of the Office of Investigations and Compliance audit process, which is attended by the Commissioner and Division Directors.

A written report of the central office audit is provided at the central office to the Director of Health Services.

4. Review of the central office written report process

The central office audit reports continue to be generally well written and provide useful information relevant to the mental health system at the specific facility being reviewed. Mental health directors and psychiatrists interviewed during May 2, 2007 indicated that the audit process was useful from the perspectives of training and management.

These reports continue to include comparative data to other facilities with similar missions.

Dr. DeGroot currently receives a MH/MR monthly utilization review report on an electronic basis, although the reliability of many of these reports were

questionable since OMS is no longer used. These monthly reports are relevant to the following areas:

1. MH/MR count/medication report, and
2. MH/MR Counselor vacancy report.

In addition, Dr. DeGroot continues to receive a monthly self-injurious behavior report from each institution via a paper report although the accuracy of this information has been questionable for similar reasons.
CQI reports are no longer being regularly received and analyzed.

5. Review of the specific GDC Office of Health Services SOPs as they relate to mental health clinical outcomes in the auditing process

Revisions to policy, VG15-0001 (Clinical Consultation), were reviewed and discussed with staff. It was recommended that the definition of clinical supervision be clarified to include that one of its purposes was to ensure that the treatment being provided by the supervisee was clinically appropriate. Other revisions made to this policy were consistent with my recommendations from June 2006.

Discussion re: SOPs also focused on issues re: the definition of seclusion and suicide precautions. It was recommended that the restraint policy be revised to require constant observation of the restrained inmate by staff throughout the restraint process.

6. Review integration among the Office of Health Services (Physical Health Operations), Facilities division, GCHC, and MHM.

As in the past, Dr. DeGroot continues to have almost daily contact with key clinicians and administrators from the Office of Health Services, Facilities Division, GCHC, and MHM. This continues to facilitate integration among these divisions relevant to MH/MR services. There continues to be good working relationship at the central level between all of these entities.

7. Status review of the corrective action plans submitted as a result of the FY 2006 audit

a. *2004 report:* A major issue described in the fiscal year 2004 annual audit report involved the significant problems associated with the vacancy rates relevant to the MH/MR counselors and nursing staff, which were exacerbated by the reduction in the number of available hours provided by psychologists, psychiatrists, and clinical nurse specialists.

June 2005: These problems remain as previously described, which has had a significant negative impact on the mental health services being provided to many GDC inmates.

April 2006: No significant change as summarized.

Current status: No significant change in the vacancy rate as summarized in Appendix II. Further increases have been minimized by the conversion of vacant mental health counselor positions to MHM positions. MHM is better able to recruit for these positions related to better pay scales. The negative effects of the vacancy rates are exacerbated by the lack of proportionate increases in mental health staffing allocations as compared to the increases in the inmate population.

b. 2004 report: My 2003 report was referenced re: the following:

> The minimal amount of out-of-cell therapeutic programming being offered to SLU inmates in the two prisons (Valdosta S.P and Autry S.P.) visited during this review was very concerning. In general, this problem should be remediable without additional human resources although both creative scheduling and increased cooperation between custody and mental health staffs will be needed. In general, at least ten hours per week of out-of-cell structured therapeutic activities should be offered to SLU inmates. If the nonparticipation rate exceeds 25-30% of inmates, the nature of the structured therapeutic activity should be assessed because it is likely to be problematic and need to be changed. Data from other SLUs should be reviewed relevant to this issue and changes made when appropriate.

June 2005: This problem has no yet been resolved based on review of audit results at these two prisons. In fact, this problem has become more problematic systemwide as the following information documents:

In addition to the SLU issue, CQI program problems are apparent as the above data indicates. This appears to be primarily a staffing resource issue as is the decline with in-service training. The latter problem will continue to contribute to the staff turnover difficulty. The CQI problem will adversely effect effective management, needs assessment, and quality of care.

July 2006: Little change at VSP—see earlier VSP section. Autry SP has not been audited since my June 2005 report.

Current status: The most recent audit at Autry State Prison indicated that inmates were scheduled on average, four hours per day of structured therapeutic activities. However, this audit did not determine what percentage of scheduled out of cell therapeutic activities are actually offered and what percentage of structured out of cell therapeutic offered are actually attended by SLU inmates. The number of hours actually scheduled is encouraging but it is difficult to determine whether this number is meaningful. VSP is to be audited during June 2007.

Serious problems in this context were found at Coastal SP and Georgia SP as summarized in other sections of this report. The following chart provides additional data, although its meaningfulness is limited for reasons already summarized regarding the actual scheduling, offered, and used out cell structured therapeutic activities issues.

Average Number of Structured Activities for Supportive Living Units by Facility

FACILITY	**# OF STRUCTURED HOURS PER/DAY**
ASMP	2.7 hours
Autry State Prison	4 hours
Baldwin State Prison	2 hours
Central State Prison	-

Coastal State Prison	3.5 hours
Georgia Diagnostic & Classification Prison	-
Georgia State Prison	-
Johnson State Prison	-
Phillips State Prison	3.5 hours
Rutledge State Prison	-
Valdosta State Prison	-
Metro State Prison	3.3 hours

c. My *2003 & 2004 reports* included the following:

> The overrepresentation of mental health caseload inmates in the isolation segregation units remains concerning. A likely contributing factor to this overrepresentation is probably programming issues within the SLUs, although data was not obtained to confirm or reject this hypothesis. Such an overrepresentation is frequently associated with systemic problems within the mental health care delivery system. The annual audits should attempt to assess this issue on a local basis.
>
> The placement of mentally ill inmates in isolation segregation units becomes more problematic if the lengths of stay exceeding three or four weeks. Under such circumstances, there is frequently a need to provide a SLU level care for some of these inmates housed in isolation segregation units. Implementing such a program is expensive and difficult. The need for such programs can be significantly minimized by addressing the systemic problems contributing to an overrepresentation of mentally ill inmates being housed in the isolation segregation units.

June 2006: Since 2000 there has been an increasing trend in the percentage of disciplinary reports being issued to MH/MR caseload inmates as documented in the following table:

Current status: Unchanged.

MH DRs as a Percentage of Total DRs

Year	2000	2001	2002	2003	2004	2005	2006
% of DRs given to MH inmates	26	31	29	33	35	59	46

During the past year, the actual percentage of MH/MR inmates in segregation units has decreased, on average, from 59% in 2005 to 46% during April 2006.

A QI has not yet addressed this issue from a systemwide perspective.

This pattern is very similar to the overrepresentation of mental health caseload inmates in the segregation units systemwide (see Appendix VI), which is very problematic due to the lack of adequate treatment (due to staffing allocation issues and physical plant limitations) for many inmates with serious mental illnesses in these units. Remedies to this significant problem are needed but will be expensive.

d. ***June 2005:*** The current lack of timely access to inpatient psychiatric care for inmates requiring such treatment is very problematic. The question relevant to the need for reasonable access to inpatient psychiatric care in a system the size of GDC is not whether access to inpatient psychiatric care is needed but how many beds are needed.

It is also clear that there is a shortage of CSU beds within GDC, which is exacerbated by the lack of reasonable access to inpatient psychiatric beds.

June 2006: No change.

April 2007: Very limited access to inpatient psychiatric beds remains via the Georgia state hospital system. However, GDC now has access to about 20 inpatient beds through Just Care for inmates with serious mental illnesses that are chronic and unresponsive to treatment within GDC. Unfortunately, there is a need for more inpatient psychiatric beds.

SUMMARY

Since my June 2006 audit, the following has occurred:

Positive changes

- GDC now has access to about 20 inpatient beds through Just Care for inmates with serious mental illnesses that are chronic and unresponsive to treatment within GDC.
- Further increases in the number of mental health counselor vacancies have been minimized by the conversion of vacant mental health counselor positions to MHM positions. MHM is better able to recruit for these positions related to better pay scales. In addition, the new hires have licenses.

Little change

- Access to high end clinical services decreased
- High MH counselor functional vacancy rate remains
- Access to psychiatric hospitalization remains poor
- More crisis stabilization beds are needed
- Decreased SLU programming, staff training and CQI studies
- Decreased central office audits and oversight related to several different issues.
- Increased percentage among mentally ill inmates as compared to non-caseload inmates of disciplinary reports and isolation placement.

Negative changes

- Lack of adequate supervision for unlicensed mental health counselors related to Board of Examiners for Psychologists issues.

Recommendations

Staffing allocations

1. It is not acceptable to use unlicensed mental health counselors as clinicians without providing adequate clinical supervision. Providing supervision is not possible within GDC related to the lack of adequate numbers of licensed psychologists in the context of the Board of Examiners for Psychologists requirements relevant to supervision. I recommend privatizing the mental health positions through MHM with the requirement (already in place) that these positions be filled with licensed mental health counselors.

Current state employed unlicensed mental health counselors could be transferred to correctional case manager positions if such duties were removed from the mental health counselor positions. Such a change would have the effect of essentially increasing the total functional numbers of mental health counselor positions, which is needed related to the staffing allocations issues previously summarized in this report. Without increasing the functional number of FTE mental health counselor positions, it is unlikely that the recommendations that follow in this section can be implemented.

2. The staffing allocations for psychiatrists and psychologists needs to be increased for reasons that have previously been summarized related to the 80% increase in the inmate population and the ~combined 30% decrease in coverage hours provided by psychiatrists and psychologists during the same nine year period of time.

3. Central office mental health allocations need to be increased to allow for adequate monitoring, direction and technical assistance to the field.

Supportive Living Units

4. Increase the number of structured therapeutic out of cell activities offered to general population SLU inmates to at least 10 hours per week being offered to each SLU inmate. This will require close monitoring regarding the number of hours offered to each SLU inmate, on average, as well as the actual number of hours received, on average, by each SLU inmate. Such monitoring is logistically difficult, but essential for implementation purposes.

5. Increase the number of structured therapeutic out of cell activities offered to SLU inmates in lockdown units (e.g., isolation/segregation, etc) to at least 10 hours per week being offered to each SLU inmate in addition to offering 5-10 hours per week of unstructured time in the recreational pens to each of these inmates. This will also require close monitoring as previously described re: general population SLU inmates.

Implementing this recommendation will be both expensive and difficult for reasons that include the following:

a. need for additional mental health staff to provide these clinical activities,
b. need for additional correctional officers for escort purposes,
c. need for extensive physical plant renovations and/or construction of new space for programming purposes (i.e., out of cell structured therapeutic activities, individual mental health counselor contacts, etc.), and
d. institutional cultural barriers.

It is likely that the most efficient and effective remedy for the above is to obtain funding for construction and operation of the proposed 2000 bed prison with a primary mental health mission. There are currently ~1800 SLU beds within the GDC. Such a facility should have SLU Level III and IV general population and lockdown housing unit beds, as well as adequate numbers of ACU and CSU beds for this mental health caseload population.

Successful recruitment of staff would be dependent on the location of the facility and whether the salaries are competitive. Salaries are currently not competitive with either other state agencies (e.g., DHR) or the private sector. Experience nationwide has clearly demonstrated a direct relationship between successful staff recruitment and retention with competitive pay.

Mentally ill inmates in lockdown units

The 2000 bed "mental health" prison would be the long term remedy for providing adequate mental health treatment for mentally ill inmates in lockdown units, especially those requiring a SLU level of care.

6. A short term interim remedy will be equally difficult, but clinically necessary especially for SLU inmates in lockdown units. Such a remedy should include the following elements:

a. Space needs to be provided/constructed to ensure adequate access by clinicians to assess/treat inmates in an office-like setting that allows for both safety and sound privacy for clinical contacts with caseload inmates.

b. Space needs to be provided/constructed to ensure adequate programming (i.e., out of cell structured therapeutic activities) for SLU inmates in lockdown

units. This space should include therapeutic modules. The current therapeutic modules at GSP have significant structural flaws that should not be replicated. I can provide additional information as needed re: prototypes for therapeutic modules that have been developed in other correctional systems for similar purposes.

c. Access to unstructured yard time in the recreational pens should be increased to approximately 10 hours per week per SLU inmate.

The above recommendations are based on the accepted principle that many inmates with serious mental illness either clinically deteriorate or do not clinically improve when placed in locked down environments for prolonged periods of time. Appendix VII provides a summary of literature relevant to this principle.

7. The issue of overrepresentation of the mentally ill in the lockdown units needs to be more adequately addressed. I recommend the following:

a. Development of a case management committee (CMC) to begin to better manage the use of segregation beds. This committee should be comprised of both custody and mental health facility staff, and co-chaired by the facility's Deputy Warden of Security and the facility's mental health clinical director or their designee. This committee should meet every two weeks and make recommendations for appropriate placements (which would include suspensions or reductions of segregation time) if deemed appropriate by the team.

The committee would review and monitor the behavior and treatment plans of the mental health caseload inmates assigned to the lockdown units, with a focus on SLU Level III and IV inmates. The committee recommendations for custodial or treatment considerations would be presented to the facility Warden or clinical director for review and action. Action may include consideration for CSU/ACU admission, referral for inpatient treatment or request for segregation time cut. The CMC function should be made clear via a SOP.

The CMC concept is derived from a similar concept implemented by the New York DOC, in part, related to a class action suit that focused on mentally ill

inmates in the NY DOC segregation units (i.e., security housing units).

b. Standard operating procedure #VG34-0001 (MH/MR Discipline Procedures) was originally developed to minimize the inappropriate transfers of inmates with serious mental illness to lockdown units, especially if for a long duration. There are obvious implementation problems, although the causes are unclear related to inadequate analysis concerning the process. The likely causes include the quality of the mental health assessment and the use of the assessment (even if of high quality) by the hearing officers.

At the present time, I would not focus on this process, because it requires ongoing training and monitoring of both mental health staff and custody staff involved in the disciplinary reporting process. Although the process needs to be reviewed and fixed, it should not be made a high priority at the present time due to the multiple other systemic problems that have already been summarized that require more immediate attention.

Additional short term fix recommendations include the following:

8. In general, prisons with SLUs should also have CSUs in their facility. I recommend that at least 4 CSU beds be activated at Coastal SP.

9. Increased CSU and ACU beds should be activated systemwide. This may be more effectively implemented using the zone approach (i.e., regionalization of clinical resources) approach that is currently being considered.

10. Increased access to inpatient psychiatric beds is needed.
11. The mental health module of SCRIBE needs to be activated as soon as possible. Central office monitoring has been very limited since OMS was deactivated.

Central Office Leadership

As I have reported following other site visits, the leadership and integrity demonstrated by James DeGroot, Ph.D. continues to facilitate the operation of the mental health department's central office, which remains very hampered by decreased staffing allocations and vacancies as previously summarized. The ability

of the central office to identify, and generally fix, problems identified via the CQI process has continued to decrease for reasons that include decreased and limited central office staffing allocations, lack of an adequate management information system at the present time, and the staffing allocation issues in the field as described elsewhere in this report.

Please do not hesitate to contact me if I can answer any further questions.

Sincerely,

Jeffrey L. Metzner, M.D.
Diplomate, American Board of Psychiatry and Neurology

c: Georgia Department of Corrections
Attn: James DeGroot, Ph.D.
Statewide MH/MR Program Supervisor
2 Martin Luther King Drive, SE
Atlanta, GA 30334-4900

Appendix I

Appendix II

Appendix III

Appendix IV

Appendix V

Appendix VI

Appendix VII

EXECUTIVE SUMMARY

The percentage of GDC inmates (8054) receiving MH/MR services during December 29, 2006 was 15.6%, compared to 16.2% (7766 inmates) during December 2006. These figures are consistent with national statistics.

Mental Health Staffing

The following statistics are described in the May 2, 2007 MH /MR programs status report:

	Counselors (FTEs)	Psychiatry (Hrs)	Psychology (Hrs)	Inmates
August 1999	132	1307	1075	4425
August 2000	137	1276	1093	5255
August 2001	167	1564	1001	5685
August 2002	184	1225	1188	6123
August 2003	177	1085	830	6934
April 2004	175	916	830	7034
December 2004	178	950	840	7104
June 2005	176	912	920	7236
April 2006	189	891	811	7674
December 2006	188	950	880	8054

- Between August 1999 and January 2007, the number of MH/MR inmates increased 80% (from 4425 to 7968), the number of counselor positions increased 42.4%, the number of psychiatry and advanced practice nurse hours decreased 27.4%, and the number of psychology hours decreased 18.2%.

The above data in terms of FTE positions is as follows:

	Jan. 2007 FTEs	1999 FTEs	% Difference (2006- 1999)
Psychiatry	23.8	32.7	-31.8%
Psychology	22	26.9	-24.5%
Counselors	188	132	+43%

As noted last year, the majority of these positions consist of unlicensed counselors, which continue to cause significant issues from a supervision perspective. Specifically, although state statute allows unlicensed mental health counselors to practice professional counseling in either GDC or DHR facilities, the Board of Examiners for Psychologists has made it clear in writing that supervision of these counselors would need to be in compliance with the Boards supervisor to supervisee required ratios or else the supervisor's license would be in jeopardy.

As a result of the above issue, very few unlicensed counselors in GDC are receiving clinical supervision. Most are receiving consultation as per SOP VG15-0001 (Clinical Consultation), which falls short of clinical supervision and raises serious risk management issues.

Other relevant staffing statistics includes the following:

- The actual MH Counselors vacancy rate, which is based on current allocated and filled positions, was 14%. The functional vacancy rate, which is based on the actual vacancy rate and staffing allocation shortage, was 20%.
- Eight facilities had a functional mental health counselor vacancy rate > 25%. Another two facilities had functional vacancies rates of 23%.
- Annual staff turnover remains problematic: MH Directors – 39%, MH Counselors - 29%, Psychiatrists - 56% and Psychologists – 22%.
- The MH Nurse vacancy rate was 32%.
- The Activity Therapist vacancy rate was 18%.

The health services 2006 annual report summarized the central office mental health staffing allocations as follows:

Categories	FY 2005	FY 2006
Central Office Administrative	10.75	5.00

Assessment: As stated in prior reports, the significant increase in the number of inmates placed in MH/MR caseload since 1995 and the decrease in mental health staffing during the same period of time remains very problematic from the perspective of providing adequate clinical care. Such problems are exacerbated by the lack of clinical supervision for many unlicensed counselors and the nursing staff vacancy systemwide.

Access to higher levels of mental health care

The percentage of inmates admitted to higher levels of care has steadily and significantly decreased as evidenced in the chart following chart:

Number of Stabilization Admissions per 100,000 Inmates by Calendar Year and Stabilization Tier

Stabilization Tier	2001	2002	2003	2004	2005	2006
Central State Hospital	531	580 (+9.2%)	458 (-21.0%)	183 (-60.0%)	16 (-91.0%)	8 (-50.0%)
Crisis Stabilization Unit	4797	5519 (+15.1%)	5173 (-6.3%)	4648 (-10.2%)	4306 (-7.0%)	3940 (-8.5%)
Acute Care	5624	6215 (_10.5%)	6448 (+3.8%)	7010 (+8.7%)	6254 (-11.0%)	5441 (-13.0%)
Total	10,952	12,314 (+12.4%)	12,079 (-1.9%)	11,841 (-2.0%)	10,576 (-11.0%)	9,389 (-11.2%)

It should be noted that there are approximately twenty Just Care inpatient beds available for inmates who have chronic and severe mental disorders that are unresponsive to available treatments within the GDC.

There are a number of possible explanations for the decrease in the numbers of inmates admitted to higher levels of care, which would include a good utilization management system, an adequate supportive living units treatment program, an adequate outpatient mental health services program, or problematic mental health services as characterized by not referring inmates in need of a higher level of care for various reasons. I think the initial decrease was related to implementation of a reasonable utilization management program, but think that the continued decrease is related to systemic problems within the mental health system that are summarized in this report.

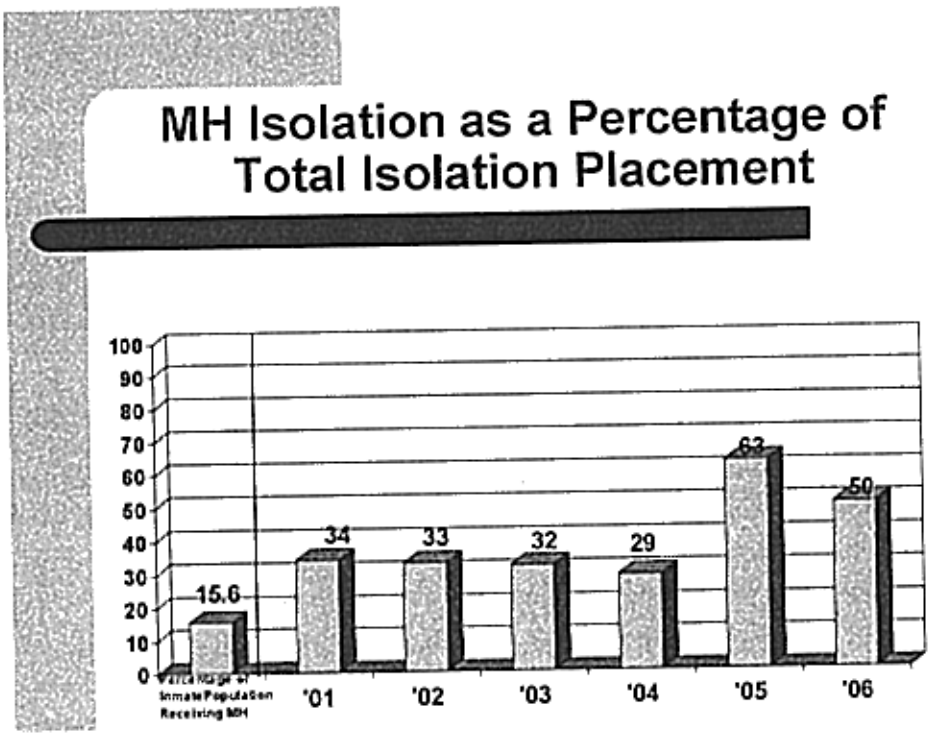
Supportive Living Units

Serious problems regarding the amount of structured therapeutic activities being offered to SLU inmates were found at Coastal SP (generally one hour per week per inmate) and at Georgia SP (zero hours per week).This problem was related to staffing allocations, competencies, physical plant limitations and custody escort shortages. Similar problems appear to exist at other GDC SLUs. SLU inmates should be offered at least 10 hours per week per inmate of structured therapeutic activities. In addition, SLU inmates in lockdown units should be offered about 10 hours per week per inmate of outdoor yard time in the recreational pens.

Overrepresentation of mental health caseload inmates in the isolation segregation units

MH DRs as a Percentage of Total DRs

Year	2000	2001	2002	2003	2004	2005	2006
% of DRs given to MH inmates	26	31	29	33	35	59	46



Although during the past year, the actual percentage of MH/MR inmates in segregation units has decreased, on average, from 63% in 2005 to 46% during

April 2006, it has been disproportionately elevated since 2001 as demonstrated in the preceding chart.

Remedies to this significant problem are needed but will be expensive. Specific recommendations are described in the "recommendations" section.

Since my June 2006 audit, the following has occurred:

Positive changes

- GDC now has access to about 20 inpatient beds through Just Care for inmates with serious mental illnesses that are chronic and unresponsive to treatment within GDC.
- Further increases in the number of mental health counselor vacancies have been minimized by the conversion of vacant mental health counselor positions to MHM positions. MHM is better able to recruit for these positions related to better pay scales. In addition, the new hires have licenses.

Little change

- Access to high end clinical services decreased
- High MH counselor functional vacancy rate remains
- Access to psychiatric hospitalization remains poor
- More crisis stabilization beds are needed
- Decreased SLU programming, staff training and CQI studies
- Decreased central office audits and oversight related to several different issues.
- Increased percentage among mentally ill inmates as compared to non-caseload inmates of disciplinary reports and isolation placement.

Negative changes

- Lack of adequate supervision for unlicensed mental health counselors related to Board of Examiners for Psychologists issues.

RECOMMENDATIONS

Staffing allocations

1. It is not acceptable to use unlicensed mental health counselors as clinicians without providing adequate clinical supervision. Providing supervision is not

possible within GDC related to the lack of adequate numbers of licensed psychologists in the context of the Board of Examiners for Psychologists requirements relevant to supervision. I recommend privatizing the mental health positions through MHM with the requirement (already in place) that these positions be filled with licensed mental health counselors.

Current state employed unlicensed mental health counselors could be transferred to correctional case manager positions if such duties were removed from the mental health counselor positions. Such a change would have the effect of essentially increasing the total functional numbers of mental health counselor positions, which is needed related to the staffing allocations issues previously summarized in this report. Without increasing the functional number of FTE mental health counselor positions, it is unlikely that the recommendations that follow in this section can be implemented.

2. The staffing allocations for psychiatrists and psychologists needs to be increased for reasons that have previously been summarized related to the 80% increase in the inmate population and the ~combined 30% decrease in coverage hours provided by psychiatrists and psychologists during the same nine year period of time.

3. Central office mental health allocations need to be increased to allow for adequate monitoring, direction and technical assistance to the field.

Supportive Living Units

4. Increase the number of structured therapeutic out of cell activities offered to general population SLU inmates to at least 10 hours per week being offered to each SLU inmate. This will require close monitoring regarding the number of hours offered to each SLU inmate, on average, as well as the actual number of hours received, on average, by each SLU inmate. Such monitoring is logistically difficult, but essential for implementation purposes.

5. Increase the number of structured therapeutic out of cell activities offered to SLU inmates in lockdown units (e.g., isolation/segregation, etc) to at least 10 hours per week being offered to each SLU inmate in addition to offering 5-10 hours per week of unstructured time in the recreational pens to each of these inmates. This will also require close monitoring as previously described re: general population SLU inmates.

Implementing this recommendation will be both expensive and difficult for reasons that include the following:

a. need for additional mental health staff to provide these clinical activities,
b. need for additional correctional officers for escort purposes,
c. need for extensive physical plant renovations and/or construction of new space for programming purposes (i.e., out of cell structured therapeutic activities, individual mental health counselor contacts, etc.), and
d. institutional cultural barriers.

It is likely that the most efficient and effective remedy for the above is to obtain funding for construction and operation of the proposed 2000 bed prison with a primary mental health mission. There are currently ~1800 SLU beds within the GDC. Such a facility should have SLU Level III and IV general population and lockdown housing unit beds, as well as adequate numbers of ACU and CSU beds for this mental health caseload population.

Successful recruitment of staff would be dependent on the location of the facility and whether the salaries are competitive. Salaries are currently not competitive with either other state agencies (e.g., DHR) or the private sector. Experience nationwide has clearly demonstrated a direct relationship between successful staff recruitment and retention with competitive pay.

Mentally ill inmates in lockdown units

The 2000 bed "mental health" prison would be the long term remedy for providing adequate mental health treatment for mentally ill inmates in lockdown units, especially those requiring a SLU level of care.

6. A short term interim remedy will be equally difficult, but clinically necessary especially for SLU inmates in lockdown units. Such a remedy should include the following elements:

a. Space needs to be provided/constructed to ensure adequate access by clinicians to assess/treat inmates in an office-like setting that allows for both safety and sound privacy for clinical contacts with caseload inmates.

b. Space needs to be provided/constructed to ensure adequate programming (i.e., out of cell structured therapeutic activities) for SLU inmates in lockdown

units. This space should include therapeutic modules. The current therapeutic modules at GSP have significant structural flaws that should not be replicated. I can provide additional information as needed re: prototypes for therapeutic modules that have been developed in other correctional systems for similar purposes.

c. Access to unstructured yard time in the recreational pens should be increased to approximately 10 hours per week per SLU inmate.

The above recommendations are based on the accepted principle that many inmates with serious mental illness either clinically deteriorate or do not clinically improve when placed in locked down environments for prolonged periods of time. Appendix VII provides a summary of literature relevant to this principle.

7. The issue of overrepresentation of the mentally ill in the lockdown units needs to be more adequately addressed. I recommend the following:

a. Development of a case management committee (CMC) to begin to better manage the use of segregation beds. This committee should be comprised of both custody and mental health facility staff, and co-chaired by the facility's Deputy Warden of Security and the facility's mental health clinical director or their designee. This committee should meet every two weeks and make recommendations for appropriate placements (which would include suspensions or reductions of segregation time) if deemed appropriate by the team.

The committee would review and monitor the behavior and treatment plans of the mental health caseload inmates assigned to the lockdown units, with a focus on SLU Level III and IV inmates. The committee recommendations for custodial or treatment considerations would be presented to the facility Warden or clinical director for review and action. Action may include consideration for CSU/ACU admission, referral for inpatient treatment or request for segregation time cut. The CMC function should be made clear via a SOP.

The CMC concept is derived from a similar concept implemented by the New York DOC, in part, related to a class action suit that focused on mentally ill inmates in the NY DOC segregation units (i.e., security housing units).

b. Standard operating procedure #VG34-0001 (MH/MR Discipline Procedures) was originally developed to minimize the inappropriate transfers of inmates with serious mental illness to lockdown units, especially if for a long duration. There are obvious implementation problems, although the causes are unclear related to inadequate analysis concerning the process. The likely causes include the quality of the mental health assessment and the use of the assessment (even if of high quality) by the hearing officers.

At the present time, I would not focus on this process, because it requires ongoing training and monitoring of both mental health staff and custody staff involved in the disciplinary reporting process. Although the process needs to be reviewed and fixed, it should not be made a high priority at the present time due to the multiple other systemic problems that have already been summarized that require more immediate attention.

Additional short term fix recommendations include the following:

8. In general, prisons with SLUs should also have CSUs in their facility. I recommend that at least 4 CSU beds be activated at Coastal SP.

9. Increased CSU and ACU beds should be activated systemwide. This may be more effectively implemented using the zone approach (i.e., regionalization of clinical resources) approach that is currently being considered.

10. Increased access to inpatient psychiatric beds is needed.

11. The mental health module of SCRIBE needs to be activated as soon as possible. Central office monitoring has been very limited since OMS was deactivated.

Central Office Leadership

As I have reported following other site visits, the leadership and integrity demonstrated by James DeGroot, Ph.D. continues to facilitate the operation of the mental health department's central office, which remains very hampered by decreased staffing allocations and vacancies as previously summarized. The ability of the central office to identify, and generally fix, problems identified via the CQI process has continued to decrease for reasons that include decreased and limited central office staffing allocations, lack of an adequate management information

system at the present time, and the staffing allocation issues in the field as described elsewhere in this report.

APPENDIX I

EXHIBIT "

SERVICES

#1. Contractor shall, on an on-going basis, provide telephone consultations with the OHS regarding the auditing process, specific SOP development and revision, and any pertinent national trends operationally relevant.

#2. Contractor shall provide on-site physical health auditing services at a minimum of one prison prior to June 30, 2004. This review will include (but will not be limited to):

- Analyzing the GDC mental health audit process;
- Evaluating the audit tools/instruments for process and assessment effectiveness;
- Evaluating the debriefing process for effectiveness;
- Reviewing/revising MH/MR SOPs;
- Reviewing integration among the Office of Health Services' Physical Health Operations, Facilities Division, GCHC, and MHM;
- Status review of the corrective plan submitted as a result of the FY03 audit;
- Evaluating the completed audit reports from July 1, 2003, and making operational and procedural recommendations based on overall audit findings at comparable facilities;
- Two (2) typewritten summary documents of each audit as follows:
  1. Facility specific audit status summary. (Within 15 working days to the Office of Health Services).
  2. Audit process evaluation summary. (Within 30 working days to the Commissioner of the Georgia Department of Corrections).

#3. This one lump sum payment will be inclusive of all associated expenses, i.e. travel, meals, lodging, etc., with the exception of transcription/clerical support which will be provided by the Office of Health Services Mental Health Secretary.

MH/MR Inmate Count vs. Number of Counselors
April 2007

Facility	*LII#	# Counselors needed	*LIII#	# Counselors needed	*LIV#	# Counselors needed	CSU/ ACU	Total # of counselors needed	Current # of counselor positions	-+ Number	Vacant #	Shortage/vacancy percentage
ASMP	224	4	8	.27	153	8	Y (1)	13	12	-1	0	8%
Autry	328	7	247	8	-	-	Y (1)	16	13	-3	3	38%
Baldwin	185	4	68	2	5	.25	Y (1)	7	9	+2	1	-
Calhoun	175	4	-	-	-	-	N	4	3	-1	0	25%
Central	135	3	139	5	-	-	N	8	9	+1	0	-
Coastal	325	7	164	6	10	.5	N	14	11	-3	2	36%
CRC	662	13	-	-	0	-	N	13	11	-2	3	39%
GDCP	275	6	45	2	8	.4	Y (1)	9	9	-	0	-
GSP	290	6	62	2	52	3	Y (1)	12	12	-	2	17%
Hays	245	5	-	-	-	-	N	5	5	-	0	-
Johnson	376	6	95	3	-	-	N	9	5	-4	3	78%
Phillips	86	2	105	4	118	6	Y (1)	13	14	+1	4	23%
Rogers	191	4	-	-	-	-	N	4	3	-1	0	25%
Rutledge	62	1	190	6	-	-	N	7	8	+1	0	-
Valdosta	149	3	261	9	1	.05	Y (1)	13	13	-	3	23%
Bainbridge	46	.92	-	-	-	-	N	1	1	-	0	-
IW Davis	53	1.06	-	-	-	-	N	1	1	-	0	-
Emanuel	117	2.34	-	-	-	-	N	2	3	+1	0	-
Patten	77	1.54	-	-	-	-	N	2	2	-	0	-
Whitworth	26	.52	-	-	-	-	N	1	1	-	0	-
Metro	405	10	53	3	35	2	Y (1)	16	16	-	3	19%
Pulaski	518	13	-	-	-	-	N	13	12	-1	0	8%
LASP	713	18	-	-	-	-	N	18	14	-4	3	39%
Bleckly	44	1.1	-	-	-	-	N	1	1	-	0	-
Women's	64	1.6	-	-	-	-	N	2	2	-	0	-
W. Central	83	2.08	-	-	-	-	N	2	1	-1	0	50%
Total	**5,484**	**127**	**1,437**	**50**	**382**	**20**	**8**	**206**	**191**	**-15**	**27**	**20%**

* March 2007 Count
April 2007 Counselor Data.

Ratios: Male – Level IIs – 1:50 Female – Level IIs – 1:40
Male – Level IIIs – 1:30 Female – Level IIIs – 1:20
Male – Level IVs – 1:20 Female – Level IVs – 1:15

CSU/ACU – 1:Unit

Appendix III

GDC Mental Health Classifications

Classification Levels	Description and Care Provided	Housing
Level I	• No mental health care needed	General Population – GDC facilities, private prisons, or county correctional institutions
Level II	• May show mild impairment in mental function • May need monitoring due to discontinuation of psychotropic medication or recent history of self-injury • Treatment usually provided on an outpatient basis to include various forms of counseling, therapy, and psychotropic medications	May live in General Population – GDC facilities or private prisons
Level III	• Shows moderate impairment of mental functioning such as impulsive behavior, delusional thinking, or a deterioration of emotional controls • At risk if left in the general population • Structured treatment program includes counseling, therapy, and psychotropic medication	Supportive Living Unit (SLU) – GDC facilities
Level IV	• Shows severe impairment of mental functioning • Has no activity in the general population • Limited ability to attend treatment and recreational groups • Ancillary services such as special education and psychotropic medications are provided in the residential living units. • May require an escort when moving through a facility	Supportive Living Unit (SLU) – GDC facilities
Level V	• Shows severe impairment of mental functioning that may include the need for more intensive psychopharmacological interventions • Infirmary-level care is needed	Crisis Stabilization Unit (CSU) – GDC facilities
Level VI	• Has severely debilitating symptoms that cannot be safely and adequately treated in a CSU or other unit	Hospital Services, such as Central State Hospital

Source: GDC Standard Operating Procedures

GEORGIA DEPARTMENT OF CORRECTIONS

Augusta State Medical Prison
3001 Gordon Highway
Grovetown, Georgia 30813
706-855-4700
Fax 706-855-4924

Sonny Perdue
Governor

James E. Donald
Commissioner

TO: Jim DeGroot, Ph.D.

FROM: Scott Wilkes, L.P.C.

DATE: 2/5/2007

RE: **Mental Health SCRIBE Needs**

Here is the information we discussed on 1/31/2007. I remain available if O.P.T. or O.I.T. need clarification regarding these issues.

1. Mental Health Alpha Roster. Alpha rosters that can be generated by using optional selection/keys would be most useful (ie. by MH Level and date of arrival or by dorm, etc.). The following are all variations of rosters OMS could print. If we can choose the fields we want to include in the report, we can customize each report to fit specific needs. These should be printed for 'today' as well as for 'monthly' or 'yearly' statistics.
   - Mental Health Levels.
   - Race.
   - Mental Health Diagnoses
   - Mental Health Counselor.
   - Psychiatrist
   - Mental Health inmates on medication.
   - Mental Health inmates not on medication.
   - Type Population (Permanent party, transient, med 4, diagnostic)
   - New mental health inmates added to the caseload this month.
   - Mental Health transfers to other institutions.
   - Mental Health releases that month.
   - Mental Health discharges (profiled level I—taken off MH) that month.
   - Mental Health Inmates by housing units.
- Non-Mental Health Inmates.
- Psychologist
- MH Inmates with detail assignments listed (printing each building assignment, housing unit, counselor, and/or MH level would be good as well as an overall list).
- List by Psychiatrist/ Psychologist of last scheduled appointment of each inmate on caseload.

2. Generate a mental health profile form for paper records.
3. Isolation/Segregation admissions for Mental Health inmates.
4. Isolation/Segregation admissions for Non-Mental Health inmates.
5. Total Isolation/Segregation admissions for the month.

MH/MR AUDIT SCORES 2006-2007
CHRONOLOGICAL MH/MR AUDIT SCHEDULE FOR: 2006-2007
(July – June)
**Received a CAP*
facilities with CSU – audit yearly

Facility	Audit Date	Admin. Compl. Scores	Ident. Compl. Scores	Treatment Compl. Scores	Overall Score
CRC					
Patten PDC					
D. Ray James CF					
Autry SP	2/20-22/07	69%	66%	73%	71%
	5/22-24/07				
Calhoun SP*	8/22-24/06	63%	54%	78%	67%
West Central PDC					
Bainbridge PSATC					
Central SP					
Ga. State Prison	5/8-10/07				
Baldwin SP*	1/23-25/07	78%	91%	91%	89%
Coffee SP					
Rogers SP					
Valdosta SP	6/26-28/07				
Phillips SP*	1/30-2/1-07	80%	88%	91%	89%
Rutledge SP					
Pulaski SP	3/6-8/07	79%	80%	84%	82%
Metro SP*	9/12-14/06	69%	84%	73%	76%
ASMP*	12/12-14/07	78%	83%	93%	88%
Wheeler CF					
GD & CP	6/5-7/07				
Whitworth PDC					
LASP*	10/17-19-06	76%	78%	77%	77%
Emanuel PDC*	11/29-30/06	82%	92%	89%	89%
Johnson SP					
Women's PDC					
Coastal SP*	8/8-10/06	79%	87%	76%	80%
IW Davis PDC					
Bleckley PDC					
Hays SP	4/3-5/07	67%	87%	81%	81%
Avg. Scores		**75%**	**81%**	**82%**	**81%**

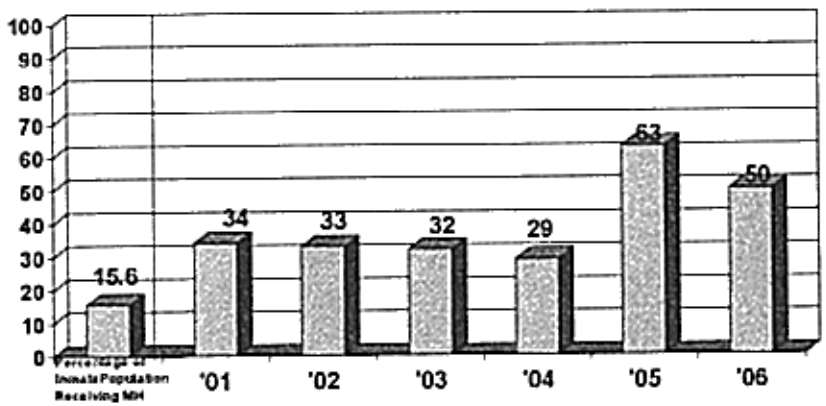
[redacted]

Placement of Total Disciplinary Reports and Isolation Placements Given to Mental Health Population by Facility

Facilities	Total Inmate Population (Dec. 2006 Data)	Total MH Population (Dec. 2006 Data)	% Receiving MH Services (based on Dec. 2006 Data)	% of Total DRs given to MH	% of total MH Isolation placement
Augusta State Medical Prison	1265	381	30%	41%	39%
Autry State Prison	1590	574	36%	46%	61%
Baldwin State Prison	1054	290	28%	32%	58%
Calhoun State Prison	1240	229	18%	28%	45%
Central State Prison	822	271	33%	64%	87%
Coastal State Prison	1501	508	34%	44%	45%
Central Region Complex	3903	667	17%	28%	26%
GD&CP	1978	352	18%	23%	33%
Georgia State Prison	1177	468	40%	55%	37%
Hays State Prison	1450	272	19%	29%	39%
Johnson State Prison	1091	276	25%	45%	50%
Lee Arrendale State Prison	1464	716	49%	68%	71%
Metro State Prison	992	459	46%	74%	60%
Phillips State Prison	1096	316	29%	41%	54%
Pulaski State Prison	1137	512	45%	65%	65%
Rogers State Prison	1347	154	11%	21%	100%
Rutledge State Prison	598	245	41%	68%	47%
Valdosta State Prison	872	413	47%	63%	60%
Total	**23,577**	**7,103**	**30%**	**46%**	**54%**

*Excluding Private Facilities and Probation Detention Centers.

MH Isolation as a Percentage of Total Isolation Placement



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PSYCHIATRIC CLINICS OF NORTH AMERICA

An Overview of Correctional Psychiatry

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The rapidly escalating rate of incarceration in the United States has been associated with an increasing number of imprisoned individuals who suffer from a mental illness [1–3]. Research indicates that as many as 20% of inmates in jail and prison are in need of psychiatric care for serious mental illness [4]. According to the US Bureau of Justice Statistics, an estimated 283,800 mentally ill offenders were incarcerated in US prisons and jails at midyear 1998 [5]. In response to the critical need for substantive discussion and policy development relevant to providing treatment for incarcerated persons with mental illnesses, the Council of State Governments established the Criminal Justice/Mental Health Consensus Project. A 432-page report was issued by the Consensus Project during June 2002 that included detailed recommendations for improving responses to incarcerated persons with mental illnesses [6,7].

There are numerous agencies and organizations that provide a wealth of information relevant to correctional health care systems, including the US Department of Justice's Bureau of Justice Statistics, The National Commission on Correctional Health Care (NCCHC), and the American Psychiatric Association. It is no longer difficult to find literature specific to correctional mental health care, which will assist administrators and clinicians in establishing adequate mental health services within jails or prisons [4,8–12].

This article focuses on several evolving issues in correctional mental health care that are especially controversial and often inadequately addressed within correctional facilities.

SERIOUSLY MENTALLY ILL INMATES IN SUPERMAX PRISONS

During the past decade, many prison systems have constructed facilities (often called supermax prisons) or units with the specific purpose of incarcerating inmates under highly isolated conditions with limited access to programs, exercise, staff, or other inmates. Characteristics of such units generally include being locked in a cell for 23 hours per day for many months to years at

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psych.theclinics.com

a time. Riveland [13] describes these facilities as representing a philosophical change in correctional management of troublesome inmates from a "dispersion" approach to a "concentration" approach. The underlying premise of the concentration approach is that general population prisons will be safer and more efficiently managed if the troublemakers are completely removed [13,14].

There are several different statuses that can result in segregation. Disciplinary segregation, typically ordered as punishment for an institutional infraction, is often of short duration. In contrast to this status, which is based on what the inmate has done, administrative segregation is typically imposed based on what the inmate might do. That is, administrative segregation is prospective in nature and designed to protect other inmates from a danger believed to be posed by the inmate. It is often administrative segregation, a classification status, which has now commonly led to the imposition of long-term segregation.

There are three situations that result in segregation status, and in our view they require different institutional responses. First are inmates who, either because they are unable or unwilling, fail to abide by institutional rules, thereby creating a danger to institutional order, security, or the safety of staff and inmates. For these segregation inmates, the purpose of segregation ought to be the creation of a safe learning environment in which an inmate can learn how to safely "do time." But today's long-term segregation environments not only fail to facilitate such learning; they virtually preclude it. Inmates are housed in conditions of such extreme control that they get to make few if any decisions, except perhaps whether to obey direct orders.

The second type of segregation inmate is one who knows well how to negotiate a correctional environment but whose wish for power and money lead him to join and even lead prison gangs in the perpetration of organized crime within the prison. These inmates, leaders or "shot-callers" of prison gangs, are believed to pose such an extreme danger to other prisoners that, so long as they remain gang affiliated, they can never return to the general population. This situation is especially common in California, where the gang problem is most severe.

Finally, in some states, inmates find their way into long-term segregation because their mental and intellectual limitations prevent them from following orders and successfully following prison rules. Placing such inmates, already mentally disabled and psychologically vulnerable, in segregation serves no useful purpose and should not occur. In other words, absent the most extraordinary circumstances, no one should ever be placed in long-term segregation because of their serious mental disability or its symptoms.

It is the authors' opinion that the use of supermax confinement is overused within correctional facilities in the United States [15]. Because of its extreme limitations on liberty and its potential for harm, use of this type of program should be reserved for cases in which there is no less restrictive way to remedy an unsafe situation. Further, with few exceptions, inmates should not be placed in long-term lockdown housing units for prolonged periods of time without at least some reasonable opportunity of being able to work their way out via a behaviorally oriented system with definable, measurable, and achievable

outcomes. Such a system should include some ability for each inmate to control, by displaying prosocial behaviors, the conditions of his confinement. These conditions include the ability to watch educational videos, recreation television, to have a radio or a fan in the room, or to have additional time out of cell. At higher levels, it may also include the ability to exercise with other inmates, so long as security concerns (eg, rival gang membership) are taken into account.

There are a small number of inmates whose violence has been so extreme as to preclude the opportunity to ever return to the general population. Examples would be inmates serving life sentences who have assaulted staff with a deadly weapon or attempted to perform contract murders for a prison gang. However, even for these inmates, having some control over their living conditions is desirable for the prison. Abiding by the rules of the segregation environment ought to result in some improvement in the inmate's living conditions; otherwise, inmates may lose any motivation at all to behave properly, thereby endangering the staff who must work with them.

In one state prison system, one of the authors (JD) helped staff to develop such a behavioral system. Before the system was even implemented, the inmate behavior changed so significantly that the incident rate on the segregation unit reportedly dropped by 80%.

There is only sparse literature on the impact of long-term segregation on psychological functioning. There are few, if any, adequate scientific studies concerning the impact of locking an inmate in an isolated cell for an average of 23 hours per day with limited human interaction, minimal or no programming, and in an environment that is designed to exert maximum control over the individual. There is general consensus among clinicians that placement of inmates with serious mental illnesses in these settings is contraindicated because many of these inmates' psychiatric conditions will clinically deteriorate or not improve [16]. In other words, many inmates with serious mental illnesses are harmed when placed in a supermax setting, especially if they are not given access to necessary psychological and psychiatric care. In addition to potential litigation, this is one of the main reasons that many states (eg, Ohio, California, Illinois, and Wisconsin) exclude inmates with serious mental illnesses from admission to supermax facilities [17].

The standard of care relevant to supermax prisons and inmates with serious mental illnesses is becoming clearer as the result of clinical experience and litigation. First, it is clear that, except in the most extraordinary and dangerous circumstances, no one should be housed in segregation while they are acutely psychotic, suicidal, or otherwise in the midst of a psychiatric crisis. Though the response to segregation varies from person to person, there are certain conditions that increase the likelihood that an inmate will have an extreme and negative psychological response to segregation. Foremost among these conditions are serious mental illnesses such as schizophrenia.

Though there may be exceptions, the standard of care appears to now require either exclusion of seriously mentally ill inmates by way of mental health

screening processes or transfer to a specialized mental health program within a supermax. For inmates with a serious mental illness who legitimately need an extremely high level of security, the specialized mental health program should offer at least 10 to 15 hours per week of out-of-cell structured therapeutic activities in addition to at least another 10 hours per week of unstructured exercise or recreation time. Because these inmates may still require supermax classification, the correctional officer staffing should be sufficient to comply with security regulations (eg, two correctional officers may be required to escort each inmate who is removed from their cell) [17–22].

Controversies surrounding these treatment guidelines include the use of metal enclosures that are designed to allow inmates to participate in group social or therapeutic activities while physically separated from other inmates and staff. These holding cells are variously known as "therapeutic modules," "programming cells," or, by their detractors, as "cages." These cells are similar in shape to an old-fashioned telephone booth, but when properly constructed are about twice the size, with ample lighting, a seat, a shelf, adequate ventilation, and good visibility for purposes of group therapeutic activities in a setting with adequate sound privacy. Well-constructed therapeutic cubicles in one large eastern prison system are 4.5 feet deep, 4 feet wide, and 7.5 feet tall, but are expensive (approximately $18,000 each). Typically, 6 to 10 cells are placed in a semicircular fashion to allow appropriate group interaction during scheduled therapeutic activities. Inmates are not cuffed while in these cells, which allows for active participation in various therapies, such as art, music, and journaling, as well as increased physical comfort (in contrast to being cuffed during 1 to 2 hours of continuous therapy). It has been the experience by one of these authors (JM) that these programming cells, when properly constructed and used, have been well accepted by most inmates using them.

Assuming that supermax inmates have been properly classified, the decision regarding the nature of the security required during treatment should be a collaborative one, involving attention to custody and therapeutic concerns. Unquestionably, the safety of staff and inmates is the highest priority, and the ultimate responsibility for institutional safety falls on the institutional warden or equivalent. It is the authors' experience, however, that when there is good interdisciplinary communication, it is easy to accommodate both interests. Ultimately, good treatment enhances institutional security, and vice versa.

For example, it would not be appropriate for custody staff to require the presence of a correctional officer in the room during therapy sessions if such sessions could be safely done without them present. If a traditional therapy setup is deemed to be too dangerous, the therapist and the correctional staff should collaboratively decide on an acceptable alternative, which might include the use of therapeutic modules as previously described, some type of restraint, or even the presence of correctional staff member that is trusted by the inmate.

The authors' recommendation of 10 to 15 hours of structured therapeutic activity in such units is based on experience with six large correctional systems involved in systemwide class-action litigation that focused on the adequacy of

the mental health system. Because of the variability in the conditions of confinement in supermax prisons across the county and the varying needs and capabilities of inmates with serious mental illness, it is meant as a guideline only. Institutional conditions include the nature of the physical plant, staffing, security practices, access to televisions and radios, group recreational yard, duration of confinement, allowable property, and educational and program opportunities. The intention is to provide enough healthy social interaction for treatment purposes as well as to prevent a person with a serious and disabling mental illness from potentially getting worse because of the absence of normal social interaction.

Less clear and more controversial is the psychological impact of long-term confinement on inmates who do not have preexisting mental illness. Despite claims to the contrary, it is not currently clear whether, how often, and under what circumstances such confinement causes persons to develop serious mental illness (eg, psychotic symptoms and disabling depressive or anxiety disorders). The literature, in addition to being sparse, provides conflicting perspectives on this question [23–28]. This question is also appropriately raised in housing units that are essentially lockdown units, even if they are not labeled supermax. Commonly known as administrative segregation, disciplinary segregation, or punitive segregation, it is not uncommon for inmates to be housed in such units for many months or even years at a time.

Mental health clinicians working in such facilities report that it is not uncommon to observe many inmates who do not have preexisting serious mental disorders develop irritability, anxiety, and other dysphoric symptoms when housed in these units for long periods of time. This is consistent with the finding that many non–mentally ill inmates in supermax settings respond favorably to weekly (or more frequent) rounds by mental health clinicians for monitoring purposes, especially when provided with copies of crossword puzzles, reading materials, or simply friendly conversation. Further, these rounds in segregation allow mental health professionals to detect psychological deterioration much earlier and prevent the more severe exacerbations of psychoses, depression, or anxiety that can cause the most severe discomfort to inmates and disruption to the correctional environment.

Claims that long-term segregation necessarily causes particular kinds of psychological harm, often described as being scientifically proven, have been published and presented in journals and educational meetings, and verbalized in legal testimony [24–26]. In the authors' opinion, most of these claims significantly overstate what is known about the psychological impact of long-term supermax confinement, especially on inmates who do not have preexisting mental illness. Though many of these advocates have made a significant contribution to improving mental health services in correctional facilities, in part by raising these issues, the long-term psychological effects of such environments are not known, and the basis for such claims lacks scientific support.

Grassian [25] observed that rigidly imposed solitary confinement may have substantial psychopathological effects, which may form a clinically

distinguishable syndrome. His observations were based on 30-minute interviews of 14 inmates housed in a segregation unit (Block 10) at Walpole Correctional Institution in Massachusetts around late 1979. These interviews were conducted by one of two plaintiffs' psychiatric experts in the context of a class-action suit challenging their conditions of confinement. There was no control group of any kind for this study. Dr. Grassian himself had been retained by counsel for the plaintiffs, a fact that was known to each inmate in the study. Finally, and most importantly, each of these inmates was a plaintiff in class-action litigation against the state of Massachusetts. That is, they had an obvious interest in presenting pathology to their own retained expert witness (Dr. Grassian). Despite the obvious limitations of these observations, Grassian's suggestion that the use of what he called "solitary confinement" carries major psychiatric risks was a significant contribution to the literature in that it raised an important though still unanswered question about the effects of these environments over time.

Despite these possible reasons for reporting symptoms, Grassian [25] noted that inmates denied having these symptoms, but after continued questioning by Dr. Grassian, eventually acknowledged that these symptoms existed.

In a 1986 article, Grassian and Friedman [29] proposed a solitary confinement syndrome based on "the Walpole observations, the recent literature, and the older German reports." The alleged symptoms of this syndrome included massive free-floating anxiety, perceptual distortions and hallucinations in multiple spheres, difficulty with concentration and memory, acute confusional states, persecutory ideation, and motor excitement. This syndrome has subsequently been named the SHU syndrome by Grassian in the context of the supermax Pelican Bay State Prison's security housing unit (SHU) [26]. Kupers [26] has expanded the constellation of symptoms that are consistent with this so-called syndrome, which has also been the theoretical basis for the so-called "Death Row syndrome" [14,30].

Haney [24] provides a review of the literature and cites his own research at the Pelican Bay State Prison's security housing unit to support the concept of a SHU syndrome. Haney's literature review, although useful, is significantly flawed. Specifically, he writes the following: "To summarize, there is not a single published study of solitary or supermax-like confinement in which nonvoluntary confinement lasting for longer than 10 days, where participants were unable to terminate their isolation at will, that failed to result in negative psychological effects. The damaging effects ranged in severity and included such clinically significant symptoms as hypertension, uncontrollable anger, hallucinations, emotional breakdowns, chronic depression, and suicidal thoughts and behavior . . ." [24].

Haney references an article by Suedfeld et al [27] as supporting adverse symptoms occurring in prisoners exposed to supermax confinement. However, closer reading of the article included the following conclusions: "Our data lend no support to the claim that solitary confinement, at least as practiced in this sample of North American prisons, is overwhelmingly aversive, stressful, or damaging to the inmates ... on the whole, this first attempt at an empirical

evaluation of the effects of solitary confinement indicates that the situation is tolerable and in some cases may even be perceived as beneficial, although it clearly has unpleasant features. Prisoners who have been in solitary confinement showed no deterioration in personality or intellect . . . " [27]. The authors do indicate that their study had some shortcomings that make its conclusions less than definitive. It appears, then, that Suedfeld et al [27] have not answered this question; this study is described as an example of the inaccuracy of Haney's claim about the research in this area. At this time, the question has yet to be answered; that is, no one knows the long-term psychological effects of segregation on inmates, especially those with no preexisting serious mental illness.

The January 2001 issue of *Canadian Journal of Criminology* included a 36-page article titled "The Psychological Effects of 60 Days in Administrative Segregation," which concluded that, overall, segregated prisoners had poorer mental health and psychological functioning as compared with nonsegregated prisoners, but "there was no evidence, however, that, over a period of 60 days, the mental health and psychological functioning of segregated prisoners significantly deteriorated" [28]. This issue of the journal also included three articles submitted in response to the study by Zinger, Wichmann, and Andrews [28] that challenged their findings. Admittedly, the 60-day time period is significantly less than in many supermax prisons. It is not clear that these conditions, over time, do not cause psychological harm. It may be that the effects are not yet known.

Whether one agrees with Zinger et al's findings [28], their article, like Haney's 2003 article [24], provides a useful literature review relevant to existing research on the mental health effects of segregation. They point out the literature in this area is conflicting, filled with speculations, and often based on far-fetched extrapolations and generalizations. Methodological shortcomings apparent from reviewing the literature include reliance on anecdotal evidence, wide variation regarding the conditions of confinement present in different prisons, and an overreliance on field and laboratory experiments pertinent to sensory deprivation.

Haney [24] cites his own research to estimate the extent to which prisoners confined in supermax-type conditions suffer resultant adverse effects. He reports that in his Pelican Bay study, a random sample of 100 SHU prisoners were assessed in face-to-face interviews. He asserts that the data was representative of and, within the appropriate margins of error, generalizable to the entire group of prisoners at the supermax facility. His findings were described as being consistent with Grassian's SHU syndrome (also known as reduced environmental stimulation (RES)) in addition to demonstrating adverse psychological effects of supermax confinement. At least two significant flaws in his methodology question the validity of his conclusions. First, this study was performed in the context of class-action litigation challenging the adequacy of the mental health system at the Pelican Bay State Prison (PBSP). Dr. Haney was one of the plaintiffs' experts in this case. Second, a significant percentage of

the SHU inmates had preexisting serious mental illnesses, which should have resulted in separate analyses of adverse psychological effects of supermax confinement for inmates without preexisting mental illnesses as compared with inmates with such illnesses. Haney [24] also cited evidence in his article that it was likely that inmates with serious mental illnesses were overrepresented in supermax housing units, which was likely at PBSP during the time of his study.

Despite the criticism of Haney's article, the authors agree strongly with his conclusion that "there are better and worse supermax prisons, and we should take steps to ensure that all such facilities implement the best and most humane of the available practices. In general, far more careful screening, monitoring, and removal policies should be implemented to ensure that psychologically vulnerable—not just mentally ill—prisoners do not end up in supermax in the first place, and that those who deteriorate once there are immediately identified and transferred to less psychologically stressful environments. In addition, prison disciplinary committees should ensure that no prisoner is sent to supermax for infractions that were the result of pre-existing psychiatric disorders or mental illness."

Another problem in the literature and expert testimony is the comparison between confinement in a supermax-like setting to experimental models related to sensory deprivation, prisoner-of-war (POW) experiences, polar habitation, or nineteenth-century German experience with solitary confinement in prisons [29,31]. Most supermax-like settings are more dissimilar than similar to such conditions. The use of the term "solitary confinement" is a misnomer because in these facilities inmates can see and communicate with correctional officers and fellow inmates. Many inmates in such circumstances are housed with roommates. It is not uncommon to have access to radios and televisions, which contrasts dramatically with sensory deprivation tank experiments and many POW experiences. This of course does not belie the obvious and severely stressful nature of such confinement. As Haney [24] and others have pointed out, the social interactions in such settings are anything but normal. In the authors' opinion, learning about the effects of these settings is important, and requires objective, even-handed, and accurate social science.

Zubek, Bayer, and Shephard [32] conceptualize segregation units to have three main characteristics: social isolation, sensory deprivation, and confinement. Each of these elements can vary significantly as do inmates' responses to the segregation experience. In general, the decreased/altered social interactions for inmates in supermax facilities appear to be more of a problem from a mental health perspective in contrast with sensory deprivation. Many of the milieus in such facilities are characterized by sensory overstimulation (eg, inmates yelling for communication purposes or for other reasons), which causes distress for inmates, especially during evening hours. The conditions of confinement, which include not only the physical plant and imposed property restrictions but also the nature of the inmate's interactions with correctional officers, are obviously important variables relevant to an inmate's adjustment.

NEEDED RESEARCH

The Colorado Department of Corrections [33] published a useful study that provided basic statistics relevant to the Colorado DOC's administrative segregation population. This study also sought to help shape the design for a subsequent prospective research project to determine if supermax-like confinement causes psychological harm to inmates, with and without preexisting mental illness. The authors recommend that such a study include the following components: (1) Repeated measures designed to determine whether inmates decompensate over long periods of lockdown status, (2) A control group to help assess whether any significant psychological changes are due to the lockdown environment specifically or simply associated with the general prison environment, (3) The repeated measures should cover a variety of psychological dimensions (eg, suicidal ideation, hopelessness, or psychotic symptoms), and (4) Assessments should be based on multiple sources (eg, inmate self-report, clinician, or correctional officer) [33].

MENTAL HEALTH INPUT INTO THE DISCIPLINARY PROCESS

Dvoskin et al [34] discuss the case of Powell v Coughlin (953 F2d 744 (2d Cir. 1991)) in which the court held that inmates had no right to formal evaluations by prison mental health staff before undergoing disciplinary hearings. Though formal evaluations are not required, however, these authors strongly recommend mental health input into disciplinary proceedings. This is important for three reasons. First, it allows consideration of an inmate's ability to stand hearing. Second, it allows for consideration of the inmate's culpability and thus the appropriateness of the punishment. Finally, mental health input allows identification of those inmates whose mental illness would make the same segregation punishment more unpleasant than it was intended to be.

Except for a useful article by Krelstein [35], little else has been written about mental health clinicians providing input into the disciplinary process, especially when inmates with serious mental illnesses have committed a rule infraction. It is useful for mental health staff to be notified when caseload inmates receive serious (ie, major) rule violations because their actions leading to the violations are often clinically significant. A procedure should be in place that results in timely notification to mental health staff of such occurrences, which should facilitate mental health input to the disciplinary process, when indicated, relevant to issues of competency to proceed with the disciplinary hearing, mitigating factors, and dispositional recommendations. Mental health staff should also be available to the disciplinary hearing officers for consultation purposes, when a non–caseload inmate appears to be demonstrating symptoms of a serious mental illness [36].

The authors recommend that the mental health input into the disciplinary process not address issues related to responsibility (eg, the equivalent of an insanity plea) [34]. Similar to the low rate of successful "not guilty by reason of insanity" pleas in the nonincarcerated population, it is rare that inmates would meet most nonresponsibility standards in prisons that have constitutionally

adequate mental health services if the assessment was made by a forensically experienced mental health clinician. In general, inmates meeting such criteria are usually diverted out of the disciplinary system process to a structured psychiatric setting. The use of valuable clinical resources for these forensic assessments is hard to justify in a correctional mental health system with limited clinical resources [34].

Clinicians providing mental health input into the disciplinary process need special training relevant to such assessments, and hearing officers need training on how to use such information obtained from the mental health clinicians. Though the ultimate issue of competence to stand hearing or culpability is up to the hearing officer, in the authors' experience, relevant, simple, and competent psychological consultation is helpful in reaching a just result. An ongoing training and quality improvement process should occur relevant to this area because of frequent changes in hearing officers and rotation of clinicians to other program areas.

SUMMARY

Supermax facilities may be an unfortunate and unpleasant necessity in modern corrections. Because of the serious dangers posed by prison gangs, they are unlikely to disappear completely from the correctional landscape any time soon. But such units should be carefully reserved for those inmates who pose the most serious danger to the prison environment. Further, the constitutional duty to provide medical and mental health care does not end at the supermax door.

There is a great deal of common ground between the opponents of such environments and those who view them as a necessity. No one should want these expensive beds to be used for people who could be more therapeutically and safely managed in mental health treatment environments. No one should want people with serious mental illnesses to be punished for their symptoms. Finally, no one wants these units to make people more, instead of less, dangerous. It is in everyone's interests to learn as much as possible about the potential of these units for good and for harm.

Corrections is a profession, and professions base their practices on data. If we are to avoid the most egregious and harmful effects of supermax confinement, we need to understand them far better than we currently do. Though there is a role for advocacy from those supporting or opposed to such environments, there is also a need for objective, scientifically rigorous study of these units and the people who live there.

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