

## Chapter 2

# Providing Mental Health Services in Local Detention/Correctional Facilities

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### NEED FOR MENTAL HEALTH SERVICES IN LOCKUPS AND JAILS

Throughout New York and across the country, local correctional facilities and detention centers have reported an increased number of detainees with a serious mental illness. In fact, on an average day, 9% of men and 18.5% of women entering local jails have a history of serious mental illness, rates two to three times higher than the general population. (Teplin, 1996) In addition, 75% of those with mental illness also have a co-occurring substance abuse disorder, and are likely to stay incarcerated 4–5 times longer than similarly charged persons without mental disorders. (APA, 2000)

Several factors have contributed to the increased numbers of people with mental illness in correctional facilities. First, over the past twenty-five years, de-institutionalization associated with the downsizing of state-run psychiatric centers has led to the discharge of patients into communities. Unfortunately, community-based mental health programs struggle to provide the comprehensive services necessary to support the special needs of this population.

Thus, an unintended result of de-institutionalization has been the involvement of people with mental illness with the criminal justice system, many who have only been charged with minor offenses. (Goldstrom, et al 1998) This also is compounded when new standards restricting the use of involuntary commitment prevents correctional personnel from transferring these individuals to a state hospital as readily as was once possible. In addition, new laws affecting mandatory sentencing and longer minimum sentences have increased the jail population. These laws resulted in the detention of an unprecedented number of criminal offenders, many of which had mental health related problems.

Though the local correctional population consists predominately of young males ranging from 18–30 years of age, an increasingly high number of adolescents are being adjudicated to adult correctional facilities. Specifically, in 1999, county jails in New York incarcerated over 15,000 inmates between the ages of 16–18. (SCOC, 1999). Due to limited

resources, facilities struggle to provide the special health needs of this population.

### INVOLVEMENT OF CRIMINAL JUSTICE AGENCIES IN LOCAL MENTAL HEALTH SERVICES PLANNING

Legislation (*Chapter 99 of the Laws of 1999*) requires local correctional facilities and other local criminal justice agencies to be part of the planning process for development of local services or unified service plans. The intent of the legislation is to improve coordination between local governmental units and local criminal justice agencies/correctional facilities in the delivery of services to persons with mental illness who come into contact with the criminal justice system. This coordination can be facilitated by involving representatives from local jails and other criminal justice agencies in the planning process. Some counties have also established mental health–criminal justice system/corrections committees to focus on planning in more detail for the delivery of mental health services to people with mental illness in the criminal justice system. These committees have produced outcomes such as interagency policies and procedures, new program designs, and applications for grant funding.

### TYPES OF MENTAL HEALTH SERVICES PROVIDED

**Suicide Prevention/Crisis Intervention:** The rate of suicide in jails and lock-ups is higher than that of the general population with the prevalence of mental illness frequently cited as one of the principle reasons. In fact, data collected between 1993–1997 by the [NYS Commission of Correction](#) indicate that of those inmates who committed suicide in a county jail, 50% had a psychiatric diagnosis and 71% had both substance abuse and alcohol histories.

However, clinicians have recognized that incarceration can be very stressful on inmates with or without mental illness. Inmates may experience the sudden shock of being separated from families and other sources of social support, and

have anxiety over trial or sentencing outcomes. There also may be doubt about one's ability to meet self or peer imposed standards of behavior that can induce feelings of intense helplessness or hopelessness. Thus, shame over one's past and despair for the future may cause inmates to view suicide as the only feasible way of ending their sense of anguish.

Beginning in 1984 and continuing across New York State at the present time, a [Forensic Suicide Prevention Crisis Service Project](#) is being implemented. This project has been successful in reducing the number of completed suicides. Clinicians should become familiar with this program, and may be asked to become trained to instruct the program to current staff or new recruits. An effective suicide prevention and risk management program consists of the following:

- | Screening for suicide risk using the *Suicide Prevention Screening Guidelines*
- | Supervision (1 to 1) only effective supervision for suicide prevention
- | Mental health observation
- | Scheduled mental health treatment
- | Crisis intervention
- | Forensic inpatient hospitalization
- | Use of effective communication skills
- | Investigation
- | Debriefing for staff
- | Training

**Mental Health Screening/Evaluation:** Policies and procedures for performing screenings and evaluations during and after intake vary with each facility. Guidelines and standards are available by nationally recognized organizations to assist facilities with developing a protocol for mental health screenings and evaluations. (See page 2-10 for more information.)

**Medication Management:** The prescription, monitoring and dispensing of psychotropic medication occurs under the supervision of the facility psychiatrist. Communication between the jail medical and mental health services should occur to ensure that each department has awareness of the name and dosage of all medications. Both corrections and mental/medical staff should be trained on the side-effects as well as signs of potential hoarding or "cheeking" of medication.

**Case Management:** Case management includes efforts

to coordinate and provide continuity of mental health care for detainees upon entry, and during jail sentence, and to provide linkages to community based services upon release. This may include individual counseling, meetings with family, referrals to appropriate resources and entitlements. In fact, it has been found that jail-based case management increases the probability that inmates will access mental health services upon release. (Finn-Will, 1996)

**Mental Health Observation Units:** These units provide special housing and services for inmates with mental illness who may not be appropriate to live in general population housing. Due to psychiatric symptoms, these inmates may pose a threat to the general population, or more commonly, may be more vulnerable. The length of stay varies, with the primary goal to triage symptoms for return to general population. The coordination and programming within these units requires collaboration between both correctional and mental health personnel; thus, staff should be dually trained.

**Access to Inpatient Psychiatric Care:** Often the mental health care needed by an inmate goes beyond the scope of the services available at the jail. Thus, clinicians should be aware of the policies and procedures for securing inpatient mental health care. For more specific information on the mental hygiene law and designation procedures, please refer to Chapters 6 and 7.

**Discharge Planning:** Case managers and clinicians should assist inmates with obtaining links to services upon release. This includes assisting the inmate with the following depending on the individual's needs:

- | Mental Health/Medical Services
- | Transportation
- | Housing Assistance
- | Emergency Services
- | Vocational and Educational services

To ensure that these services are being accessed, discharge planning should also include follow-up with the inmate or community service provider to make certain that the inmate is linked with the appropriate service/resource. In fact, the greater the intensity of these services after release, the lower the likelihood the person will return to jail. (Finn-Will, 1996)

ADVANCED DIRECTIVES

An advance directive is a document which indicates an individual's wishes for his or her own mental and/or physical health care. Advance directives enable individuals to participate in their own physical and mental health care, to ensure that their choices are honored if they are determined by a physician to be incapable of making treatment decisions. There are different types of advance directives, including a **health care proxy**, a **living will**, and a **do not resuscitate (DNR) order**.

With a **health care proxy**, an individual appoints a specific person to make mental and physical treatment decisions for them, should they no longer be able to make those decisions for themselves. A **living will** is a written statement which provides specific instructions on future healthcare treatment to be carried out if one loses capacity to make such decisions. **Do-Not-Resuscitate (DNR) Orders** are verbal or written requests made to medical personnel to not attempt emergency cardiopulmonary resuscitation (CPR) if one's breathing or heartbeat stops.

Individuals cannot make decisions regarding whether or not to undergo psychiatric hospitalization in an advance directive; New York State Mental Hygiene Law governs the admission of patients to a hospital for psychiatric care.

A properly executed advance directive must be properly signed, dated and witnessed. Any two people 18 years or older can be witnesses, but if an individual is an inpatient in a psychiatric hospital and wishes to complete an advance directive, one of the witnesses must be a psychiatrist, and the other may not be an employee of the hospital.

Although incarceration in a jail severely limits an inmate's ability to direct his/her mental health care, jail mental health and correctional staff may want to consider adopting a modified advanced directive approach. Staff may consider obtaining information from an inmate with mental illness about effective emergency management interventions at a time when the inmate is without acute symptoms. This may provide both mental health and corrections staff with valuable information about how to effectively respond to that inmate should he/she develop acute symptoms which threaten his safety and/or safety of the facility.

For more information on advance directives contact:

**NYS Office of Mental Health:**

Victor Pagano  
(518) 463-9242 or 1-800-222-9282

Ron Bassman  
(518) 473-6579 or [HYPERLINK](#)

E-mail: [corarxb@omh.state.ny.us](mailto:corarxb@omh.state.ny.us)

**The Advance Directive Training Program**

291 Hudson Avenue  
Albany, NY 12210  
(518) 463-9242

**OPERATIONAL CONSIDERATIONS:  
WORKING WITHIN THE CORRECTIONAL SETTING**

Providing mental health services within the correctional environment requires special considerations, and in some ways can be very different from providing services in the community. Below are tips for new clinicians to consider.

**Security is top priority.** The clinician should be aware that security will almost always have a higher priority than mental health treatment and other program activities. This responsibility rests with the chief jail or police lock-up administrator and is carried out by correction officers. This line staff provide supervision, enforce regulations and control for contraband such as guns and weapons. Because of their increased responsibility to supervise the safe operation of the facility, clinicians should refer to them as "officers" not as "guards."

**Follow facility's procedures when entering and exiting the jail.** Upon entering the jail, clinicians may have to check-in at the front door, obtain an appropriate pass, and sign the log in accordance with established procedures. At this time, proper identification must also be presented. Most sheriff's and police chiefs will not allow anyone entering the facility to carry sharp instruments, cameras, tape recorders, or other items that potentially threaten the security of the institution. While rare, correction officers may also insist that clinicians step through a metal detector or to remove all contents from their pockets, handbags or brief cases for inspection. When departing, clinicians should remember to sign out, return the visitors pass if one was issued, and follow all other required procedures.

**Utilize appropriate clinical space:** Many jails are old, and physical conditions of available interview rooms frequently leave much to be desired. Mental health staff should nevertheless object if the space reserved for their use is grossly inadequate. (e.g., it is unsafe, lacks privacy, etc.) For most interviews, a private room with see-through windows is ideal. The room should not be totally sound proof when the door is closed, because assistance may be needed if an inmate becomes violent or otherwise unman-

ageable. Mental health staff should request that an officer remain nearby if they are at all concerned about an inmate's behavior.

**Become familiar with jail activities and schedule appointments accordingly:** When scheduling appointments, the clinician should take the following activities into consideration:

- | **Inmate Counts:** [NYS Commission of Correction](#) requires that jail staff conduct a formal count of the entire inmate population at least once during every regularly scheduled shift. No movement is permitted in the jail during this time.
- | **Meals:** Meal times tend to fall much earlier than one might expect, and if an inmate receives mental health services while meals are being served he or she may lose the opportunity to eat.
- | **Shift Changes:** Officers change shifts three times a day. Most jails do not allow anyone to enter the facility until the shift change has been completed. At best, a clinician arriving at this time would almost certainly encounter a delay in getting an inmate escorted to a room while incoming officers receive their assignments. Day and evening shift changes are typically scheduled to take place between 7:00 and 8:00 a.m. and between 3:00 and 4:00 p.m. respectively.
- | **Court Appearances:** If your office is off-site, before going to the jail to see a particular inmate, clinicians should check to see if the inmate has a court appearance scheduled. A court appearance will obviously take priority over a mental health session.
- | **Visitation:** Inmate visits should not be interrupted if at all possible. If there is a regularly scheduled day for visitation, it is preferable to schedule mental health appointments for another time. Attorneys and probation officers, however, do not always go to the jail during normal visitation hours. Mental health personnel should not be offended if an inmate prefers to see an attorney if one happens to arrive at the same time as the clinician. From an inmate's point of view, legal services are typically more important than mental health appointments.
- | **Recreation:** [NYS Commission of Correction](#) states that an inmate is entitled to a recreation period of at least one hour each day. Though inmates can be removed from recreation, mental health staff should try avoiding this as much as possible. Inmates look forward to recreation, because it provides one of their few opportunities to leave their housing area, exercise, and

speaking freely with their peers.

- | **Part-time Mental Health Staff:** A deliberate effort should be made to be at the jail on the same days and times every week. A standard routine lets jail officials know when the clinician will be available and enables them to schedule inmate appointments and staff consultations accordingly.

**Become familiar with inmate rules and regulations:** Clinicians should familiarize themselves with the inmates' rules and regulations, and if uncertain about the propriety of a given activity or inmate request, should contact the shift commander. Clinicians should remember that even an innocent favor (such as mailing a letter for an inmate) could be illegal. State codes mandate that local correctional facilities give each incoming detainee a written copy of facility rules and information about such matters as rules of conduct, items they are allowed to have in their possession, and the nature of available health services.

**Understand your facility's classification system:** Both a management and assessment function, classification is a procedure that is done by corrections during intake to determine appropriate housing assignments. It includes identifying inmates overall level of security risk, as well as special service needs including medical and mental health needs. Some jails provide special housing units for inmates with mental illness. Corrections officers in these units are encouraged to receive special training in mental health.

**Clinicians should initiate informal inmate contacts via rounds onto the housing:** Mental health staff cannot assume that every inmate who needs treatment will be referred for a formal assessment. Correction officers refer those individuals who have the most difficulty adjusting, but many symptoms of mental illness that would be apparent to a clinician may be overlooked or misinterpreted by someone who has not had comparable training. Even if inmates are encouraged to request mental health appointments by themselves, many will be reluctant to do so because of peer pressure. Periodic visits to the tier can also help gain credibility in the eyes of both inmates and correctional personnel.

**Other things to consider:** Clinicians should wear attire that is business in nature rather than casual, and should not carry large sums of money or wear valuable jewelry when visiting the jail.

ESTABLISHING LIAISONS

## AND MAINTAINING EFFECTIVE RELATIONSHIPS WITHIN THE CRIMINAL JUSTICE SYSTEM

Before effective services can be delivered to the inmate population, mental health professionals must first establish a good working relationship with facility administrators and representatives from other criminal justice agencies. Below are officials that clinicians work with on a regular basis along with suggestions on establishing effective collaborative relationships.

! **Chief Facility Administrator/Shift Supervisor:**

The chief facility administrator is responsible for the facility, and should designate a liaison person who can regularly discuss operational needs and problems associated with mental health services.

! **Direct-line Correctional Staff:** Clinicians not only depend upon correctional staff to enter and exit the facility and to summon inmates, but they also are a resource to provide valuable information regarding an inmate's behavior or background. Training on mental health topics should be co-taught with a mental health and correctional instructor.

! **Medical Staff:** Jails are required by state codes to employ a physician at least on a part-time basis, and many employ full-time nurses or physician's assistants. Clinicians should communicate regularly with the jail medical staff to exchange information to avoid possible conflicts over issues involving treatment. (e.g., psychotropic medications), and to ensure continuity of care.

! **Community-Based Mental Health Programs:** Clinicians, case managers and discharge planners should have a knowledge of community resources in order to make appropriate referrals. Because of the reluctance for some programs to accept forensic clients, clinicians may also have to advocate for inmates to be accepted into these programs. Clinicians should seek out opportunities to network with service providers and should participate in collaborative meetings with other agencies.

! **Local Judges, the District Attorney's Office, Probation/Parole:** These relationships are necessary to facilitate certain types of inpatient admissions and to arrange alternatives to incarceration that seem appropriate for a particular inmate. Prior to establishing these relationships, however, clinicians should consult with their local mental health director or commissioner to determine the appropriate coordination process.

## COMMON CHALLENGES FOR CORRECTIONS AND MENTAL HEALTH

Many problems can be avoided if both jail officials and mental health clinicians support each other's goals and gain a greater understanding for the limitations of each other's function.

For example, clinicians should not convey the impression to corrections that mental health staff's primary role is to monitor the facility, report abuse, or to act solely as an inmate advocate. Though these are important factors to consider, a negative rapport with corrections will develop if a clinician sets out to "police" the facility.

In addition, misunderstandings commonly arise when corrections officers or police conclude that a certain inmate requires inpatient psychiatric care that is contrary to the clinician's assessment. If the clinician does not clearly communicate why the person cannot be hospitalized, detention officials may hold anger and frustration toward the evaluating clinician. All such cases should be discussed as they arise along with any problems that mental health staff encounter while providing inmate services.

Jail and mental health staff will not always agree, but it is better to bring the issue out in the open to explore possible solutions.

## MENTAL HEALTH INVOLVEMENT IN CAPITAL CASES

### **The following is the text of a Chairman's Memorandum (No. 24-98) issued by the New York State Commission of Correction in November, 1998.**

Several jail administrators and mental health providers have requested guidance from the State Commission of Correction (SCOC) and/or the Office of Mental Health (OMH) in providing services to capital defendants. Representatives of the SCOC and the OMH met with representatives of the Capital Defender Office (CDO) to discuss this matter. While the CDO represents defendants facing capital and potentially capital charges, it is not the sole provider of legal representation to capital defendants. The CDO does, however, have a statutory duty to consult on all capital cases in the State even when retained counsel provide representation. As a result, the SCOC and the OMH developed the following guidelines that, hopefully, will assist you in managing inmates facing the death penalty.

### **General Considerations**

Correctional administrators should not abdicate their obligation to safely keep inmates committed to their custody. Nor should administrators prevent mental health service providers from providing services to their inmates. In most cases, the CDO or a private attorney is present when a potential capital defendant is arraigned, and accompanies the defendant to the jail. This is a good opportunity for facility staff and/or mental health providers to meet with the attorney to discuss questions or issues, such as scheduling of services and confidentiality of information, for example.

The CDO has asked to be notified whenever mental health services providers seek to evaluate or treat the inmate so that the attorney may attend the evaluation or treatment with their client. The SCOC and the OMH have informed the CDO that without the inmate's consent any disclosure of information regarding evaluation or treatment would violate the confidentiality provisions of the Mental Hygiene Law §33.13. Furthermore, the CDO has been advised that, even with consent, its presence during the evaluating or treatment process can have an unproductive effect upon its clinical outcome. The CDO indicated that it will do all it can to minimize this effect.

The concerns raised by the CDO are serious ones and not to be taken lightly. The CDO considers all statements made by capital defendants to be protected and confidential and that by participating in clinical interviews, inmates do not waive their statutory rights to confidentiality or their constitutional rights to freedom from self-incrimination, assistance of counsel, or due process of law.

The SCOC and the OMH have assured the CDO that mental health service providers zealously protect the confidentiality of their interactions with inmates according to strict codes of ethics under which the various treatment professions practice. Moreover, the provisions of Mental Hygiene Law §33.13 adequately protect the constitutional and confidentiality rights of capital defendants since all clinical information is presumptively confidential and barred from disclosure unless expressly authorized under the statute. Since there is no statutory exception for the disclosure of otherwise confidential clinical information to prosecutors of capital cases, the only applicable exceptions would be inmate consent or a court order requiring disclosure upon a finding that the "interests of justice significantly outweigh the need for confidentiality" (i.e., a judicial subpoena **without this finding** would be **insufficient to release** the information.)

Finally, an on-call attorney from the CDO is available 24 hours a day, seven days a week at 800-473-8930. If private counsel represent a capital defendant, the CDO will always be able to identify such counsel.

### **Routine Interaction**

It is understood that correction officers will have routine casual interactions and conversations with their inmates as part of daily jail life. Correction officers are generally trained to detect subtle signs of mental illnesses or other problems based on an inmate's behavior. Should a correction officer believe that mental health intervention is needed in a particular case, and the situation is not believed to be an emergency, the inmate's attorney must be notified of the scheduled clinical encounter **if the inmate has consented to the release of this information to the attorney.** Upon the attorney's request and the approval of the mental health service provider, the encounter may be scheduled when the attorney can be present at the jail. An appropriate level of supervision may be required in the interim pursuant to the SCOC's security and supervision minimum standard, 9 NYCRR §7003.3 (h). Otherwise, mental health service providers must respond to correctional referrals or self-referrals from the inmate.

### **Confinement in a Designated Mental Health Unit**

An inmate may be placed in a designated mental health unit within the facility if the inmate's condition warrants such placement, and assuming such a unit is available. In this context, as well, attorneys representing capital defendants expect to be given advance notification of clinical encounters **if the inmate has consented to the release of this information to the attorney.**

### **Emergency Interventions**

There may be occasions when emergency intervention is necessary if an inmate is seriously decompensating and is believed to be a danger to himself or others. In such cases, **even where the inmate has consented to the release of this information to the attorney,** mental health service providers may meet with an inmate without having given prior notification to the attorney of the clinical encounter. Where authorized by the inmate, the attorney must be notified immediately.

### **Continuity of Care**

Services offered by jail mental health services providers and mental health professionals employed by the inmate's attorney should be coordinated to ensure that there is continuity of care. Such providers and professionals should interact to facilitate the continuity of care. The sharing of otherwise confidential clinical information maintained by the jail mental health service provider shall be in accordance with Mental Hygiene Law 33.13 (i.e., inmate consent or court order upon requisite finding (*See Routine Interactions, above*)).

### **Conclusion**

Capital cases are usually high profile and complex cases. Although the CDO and other attorneys representing capital defendants must zealously guard the rights of their clients, they also recognize the jail's duty to provide necessary mental health services. Hopefully, the guidelines set forth above will assist you in dealing with these situations. It should be clear, however that an inmate must not be denied timely access to a mental health provider.

## CURRENT OPINIONS OF THE COUNCIL ON ETHICAL

### AND JUDICIAL AFFAIRS

#### American Medical Association

#### E-2.06 Capital Punishment.

An individual's opinion on capital punishment is the personal moral decision of the individual. A physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a legally authorized execution. Physician participation in execution is defined generally as actions which would fall into one or more of the following categories: (1) an action which would directly cause the death of the condemned; (2) an action which would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned; (3) an action which could automatically cause an execution to be carried out on a condemned prisoner.

Physician participation in an execution includes, but is not limited to, the following actions: prescribing or administering tranquilizers and other psychotropic agents and medications that are part of the execution procedure; monitoring vital signs on site or remotely (including monitoring electrocardiograms); attending or observing an execution as a physician; and rendering of technical advice regarding execution.

In the case where the method of execution is lethal injection, the following actions by the physician would also constitute physician participation in execution: selecting injection sites; starting intravenous lines as a port for a lethal injection device; prescribing, preparing administering, or supervising injection drugs or their doses or types; inspecting, testing, or maintaining lethal injection devices; and consulting with or supervising lethal injection personnel.

The following actions do not constitute physician participation in execution: (1) testifying as to medical history diagnoses or mental state as they relate to competence to stand trial, testifying as to relevant medical evidence during trial, testifying as to medical aspects of aggravating or mitigating circumstances during the penalty phase of a capital case, or testifying as to medical diagnoses as they relate to the legal assessment of competence for execution; (2) certifying death, provided that the condemned has been declared dead by another person; (3) witnessing an execution in a totally nonprofessional capacity; (4) witnessing an execution at the specific voluntary request of the con-

demned person, provided that the physician observes the execution in a nonprofessional capacity; and (5) relieving the acute suffering of a condemned person while awaiting execution, including providing tranquilizers at the specific voluntary request of the condemned person to help relieve pain or anxiety in anticipation of the execution.

Physicians should not determine legal competence to be executed. A physician's medical opinion should be merely one aspect of the information taken into account by a legal decision maker such as a judge or hearing officer. When a condemned prisoner has been declared incompetent to be executed, physicians should not treat the prisoner for the purpose of restoring competence unless a commutation order is issued before treatment begins. The task of re-evaluating the prisoner should be performed by an independent physician examiner. If the incompetent prisoner is undergoing extreme suffering as a result of psychosis or any other illness, medical intervention intended to mitigate the level of suffering is ethically permissible. No physician should be compelled to participate in the process of establishing a prisoner's competence or be involved with treatment of an incompetent, condemned prisoner if such activity is contrary to the physician's personal beliefs. Under those circumstances, physicians should be permitted to transfer care of the prisoner to another physician.

Organ donation by condemned prisoners is permissible only if (1) the decision to donate was made before the prisoner's conviction, (2) the donated tissue is harvested after the prisoner has been pronounced dead and the body removed from the death chamber, and (3) physicians do not provide advice on modifying the method of execution for any individual to facilitate donation. (I) Issued July 1980. Updated June 1994 based on the report "Physician Participation in Capital Punishment," adopted December 1992, (*JAMA*. 1993; 270: 365-368); updated June 1996 based on the report "Physician Participation in Capital Punishment: Evaluations of Prisoner Competence to be Executed; Treatment to Restore Competence to be Executed," adopted in June 1995; Updated December 1999; and Updated June 2000 based on the report "Defining Physician Participation in State Executions," adopted June 1998.

**Note:** There is debate within the medical community regarding some aspects of physician participation in the process of capital punishment, particularly regarding physician involvement in death-row competency examinations. The Medical Society of the State of New York approved a policy statement

in May, 1990 indicating that participation in “the determination of mental and physical fitness for execution” should be included in the definition of prohibited participation in executions. (Physician’s involvement in capital punishment, *New York State Journal of Medicine*, 91:1, pp. 15-18). The World Psychiatric Association (1996) specifically prohibited its members from engaging in determinations of competency of death row inmates to be executed. Its ethical guidelines

state, “Under no circumstances should psychiatrists participate in legally authorized executions nor participate in assessments of competency to be executed.”

## FORENSIC MENTAL HEALTH STANDARDS AND GUIDELINES

Many nationally recognized standards and guideline have been developed to assist correctional and mental health professionals with organizing mental health services. Some offer accreditation as well as technical support. Below is a list of the organizations which offer such assistance.

### **American Association for Correctional Psychologists**

Standards for Psychological Services in Jails and Prisons (1980).

Published in "Criminal Justice and Behavior."

**Contact:** Robert Smith  
Marshall University Graduate College  
100 Angus E. Peyton Dr. South  
Charleston, WV 25303-1600  
(304) 746-1929

### **American Bar Association**

Criminal Justice Mental Health Standards 1984 & 1989

**Contact:** American Bar Association, Service Center  
514 N. Fairbanks Ct.  
Chicago, IL 60611  
(312) 988- 5522

### **American Correctional Association**

ACA and Commission on Accreditation for Corrections,  
Standards for Adult Correctional Institutions 3rd Ed. (1990);

ACA and Commission on Accreditation  
for Correction 3rd Ed.

Foundation/Core Standards  
for Adult Local Detention Facilities (1990).

**Contact:** American Correctional Association  
4380 Forbes Blvd.  
Lanham, MD 20706-4322  
(800) 222-5646

### **American Psychiatric Association**

Principles Governing the Delivery of Psychiatric Services in  
Lock-Ups, Jails and Prisons, in Psychiatric Services in  
Jails and Prisons, Task Force Report 29 (1989)

General Guidelines for Providers of  
Psychological Services

**Contact:** American Psychiatric Association  
1400 K Street N.W.  
Washington, D.C. 20005  
(888) 357-7924

### **American Psychological Association**

**Contact:** American Psychological Association  
750 First Street, N.E.  
Washington, D.C. 20002-4242  
(202) 336-5500

### **American Public Health Association**

APHA, Standards for Health Services in Correctional  
Institutions: Mental Health Care Services (1976);

APHA, Standards for Health Services in Correctional  
Institutions: Mental Health Care Services (1986)

**Contact:** American Public Health Association  
800 I. Street, N.W.  
Washington, D.C. 20001-3710  
(202) 777-2742

### **United States Department of Justice**

Federal Standards for Jails and Prisons (1980)

**Contact:** Office of Public Affairs  
(202) 616-2777

### **National Commission on Correctional Health Care**

Mental Health Services in Correctional  
Settings (1992)

NCCHC Standards for Health Services in Jails (1996)

NCCHC Standards for Health Services in Prisons (1997)

Correctional Mental Health Care:  
Standards and Guidelines for Delivering Services (1999)

### **New York City Board of Corrections**

Mental Health Minimum Standards  
for NYC Correctional Facilities (1984)

**Contact:** New York City Board of Corrections  
51 Chambers Street  
New York, NY  
(212) 964-6307

### New York State Commission of Correction

State-mandated minimum standards for health services.

**Contact:** New York State Commission of Correction  
4 Tower Place  
Albany, NY 12203-3702  
(518) 485-2346

### New York State Suicide Prevention Program

NYS Local Correctional Suicide Prevention Crisis Service Program

**Contact:** NYS OMH, Bureau of Forensic Services  
at the Ulster County Mental  
Health Department  
239 Golden Hill Lane  
Kingston, NY 12401  
(845) 340-4168

### **NYS Mental Health Services in Local Correctional Facilities: Staff and Core Services Guidelines**

Guidelines for Mental Health Staffing for Screening, Assessment and Crisis Intervention and Ongoing Treatment and Support (March 1994)

**Contact:** NYS Office of Mental Health  
44 Holland Avenue  
Albany, NY 12229  
(518) 474-2568  
NYS Conference of Local Mental  
Hygiene Directors  
99 Pine Street  
Albany, NY 12207  
(518) 462-9422

### JAIL MENTAL HEALTH SERVICES/REFERENCES

American Psychiatric Association. *Psychiatric Services in Jails and Prisons, a Task Force Report of the American Psychiatric Association*, Washington D.C.: American Psychiatric Association, 2000.

Finn-Will, H., Turner, P. and Ventura, L.A. Lucas County (Ohio) Sheriff's Office: an NIC Resource Center, Mental Health Case Management Services in a Correctional Setting. *Jail Suicide/Mental Health Update*, Spring 1998.

NYS Commission of Correction, 1999 Sheriff's Annual Report.

Goldstrom, M.Sc., Henderson, M., Male, A., and Manderscheid, R.W. Jail mental health services: a national survey. *Mental Health, United States, 1998*. Center for Mental Health Services, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 1998.

Teplin, L.A.; Abram, K.M.; and McClelland, G.M. Prevalence of psychiatric disorders among incarcerated women. I. Pretrial jail detainees. *Archives of General Psychiatry* 53:505-511, 1996.

