Nebraska Department of Correctional Services
Behavioral Health Needs Assessment
December 2015

Scope and Introduction

The management and treatment of the behavioral and mental health needs of the inmates under its jurisdiction is one of the primary missions and challenges for any correctional department. The Nebraska Department of Correctional Services (NDCS) shares this perspective and since his arrival in February, Director Frakes has identified new leadership for behavioral health and brought in outside consultants to conduct an independent review of the system. Dr. Lisa Jones (Behavioral Health Administrator) and Dr. Martin Wetzel (Director of Psychiatry) were appointed in July of this year and are already implementing a number of new initiatives. The Department brought in Dr. Bruce Gage to conduct an assessment of the Department's mental health services and resources which forms the basis for this report. Lastly, the Department requested technical assistance from the Council of State Government's(CSG) Justice Center in the form of a Justice Program Assessment to evaluate the Department's substance abuse, sex offender, violent offender and other programming options. This assessment began in November 2015 and is expected to be completed in the spring of 2016.

In addition to Dr. Gage's report, this document summarizes the work that NDCS has done over the last nine months to assess where we are currently and where we want to be in terms of the provision of behavioral and mental health services. The scope for this report was set forth by the legislature in LB 657 (2015):

> "It is the intent of the Legislature that the Department of Correctional Services implement a needs assessment regarding behavioral and mental health treatment and staffing. The needs assessment shall be completed by appropriately trained mental health professionals. The assessment shall include:
>
> (1) Review and summary of relevant existing data sources;
>
> (2) A detailed review of need factors in the Department of Correctional Services population including risk behaviors, mental health needs, behavioral health needs, and diagnosis;
>
> (3) A detailed review of existing treatment and analysis of the adequacy of that treatment based on:

(a) Professional standards of care;

(b) Best practices;

(c) Availability of programming aligned with mental health needs and diagnosis (using valid instrumentation); and

(d) Availability in different facilities and levels of custody; and

(4) Analysis of needs, based on data gathered regarding:

(a) Staffing needs to meet professional standards of care;

(b) Needs related to developing new or different treatment based on needs analysis; and

(c) Needs related to achieving an appropriate level of service that meets the goals of institutional and community safety and community integration.

The department shall issue a report to the Appropriations Committee of the Legislature electronically on this subject by January 1, 2016."

Dr. Gage Report

The Department requested the services of Dr. Bruce Gage, Chief of Psychiatry for the Washington Department of Corrections, to assess the Department's behavioral health services and make recommendations for improvements. Dr. Gage made site visits, conducted a review of mental health policies and procedures, reviewed available programming, and analyzed data on mental health contacts, mental health diagnosis, psychiatric medications, and average length of stay. Dr. Gage's report, which is included as Appendix 1 to this report, provides a comprehensive look at the NDCS system and directly addresses the issues requested by the legislature in LB 657. The report makes a number of recommendations which are listed below, many of which are in the process of being implemented.

- Develop vision statement for behavioral health
- Information technology – more robust informatics
- Shorten initial MH screening at DEC, only do full assessment on those who screen positive
- Improve detection and referral mechanisms
- Outpatient services: Distinguish treatment from programming and focus clinical staff on treatment;
- Develop more diverse residential mental health based on type of disorder

- Develop residential mental health at various custody levels
- Expand levels system for residential MH units
- Structured approach for psychotropic prescribing and bed control
- Improve medication administration, eliminate delivery by custody staff
- Support Discharge Review Team
- Improve and expand peer review and quality processes
- Revise suicide monitoring policy
- Address staffing vacancies, increase # of psychiatrists on staff
- Identify option for licensed mental health care for the most seriously ill

While the Gage report contains the vast majority of the information requested by the legislature, there is other work being done to address these issues. Below is a brief overview of changes underway from the Department's new behavioral health leadership, a discussion of staffing issues and a summary of the Justice Program Assessment currently being conducted by CSG.

New Behavioral Health Leadership

Since Director Frakes appointment in February 2015, significant changes have been made to the behavioral health leadership within the Department. Dr. Lisa Jones was appointed as the new behavioral health administrator and a new chief of psychiatry position was created and filled by Dr. Martin Wetzel. Dr. Jones and Dr. Wetzel have been tasked by Director Frakes with helping to establish a vision for behavioral health within the Department and to ensure that we are providing care which meets the needs of our mentally ill inmates. Since taking office Dr, Jones and Dr. Wetzel have been busy reviewing the programs, staff and treatment resources within the Department and have already initiated a number of reforms, which are outlined below:

1. Development of information sharing between Substance Abuse, Mental Health, Social Work, Reentry, Parole, and Probation, to ensure seamless transitioning for our inmates.
2. Development of formal policy (in progress) and a referral form for the Discharge Review Team.
3. Substance abuse treatment offered to Protective Management inmates
4. Domestic Violence programming offered at WEC, OCC, NSP, and Community Custody – This program is co-facilitated by clinical and non-clinical as recommended in the Gage report.

5. Review by the Mental Illness Review team (MIRT) of all inmates with major mental illness housed in the special management unit at TSCI with the following results:
    a. 6 were transferred to LCC/SMHU
    b. Several had diagnoses updated (e.g. due to not experiencing any symptoms for an extended period of time, being initially diagnosed due to symptoms caused by drug/alcohol withdrawal, not a mental illness, ect.).
    c. Behavioral Plans were developed for those who remained in SMU with a MI diagnosis
6. Clinical Program Manager assigned to the substance abuse residential treatment community
7. Policy Directive changing MH Diagnoses to be consistent with DSM 5.
8. Policy Directive changing diagnosis form for involuntary medication referrals to be consistent with DSM 5.
9. Proposed a new Mental Health coding system based upon mental illness diagnosis and current level of functioning, as a more effective manner of identifying those with the highest acuity of need and the most appropriate level of care.
10. Incorporated a functional analysis into mental status investigation.
11. Proposed streamlining mental health assessments at the Diagnostic and Evaluation Center.
12. Proposed streamlining substance abuse assessments at Diagnostic and Evaluation Center.
13. Referral to and collaboration with the Lincoln Regional Center for highest need inmates.
14. Conducted a mental health all staff training.
15. Installation of therapeutic restraint chairs in the secure mental health unit allowing inmates in restraints an opportunity to participate in out of cell programming.
16. Collaboration with reentry services in reviewing and selecting a risk-needs-responsivity assessment tool.

<u>Risk-Needs Responsivity Tool and Functionality Assessment</u>

The Department is also in the process of obtaining a new risk-needs-responsivity tool which will improve the ability to identify high risk and high needs individuals and also target interventions to those patients who are at a stage where they will be responsive to treatment. The RFP for the tool was issued this fall and the vendor selection process was recently completed. A contract with the selected vendor will be completed in the near future and training and use of the tool is expected to begin this spring. Once the tool is in place, it will improve the ability to focus behavioral health resources on those with the greatest need and who will benefit most from treatment at a particular point in time. Tracking the current

acuity of MH diagnosis is another area where significant changes are underway. Dr. Wetzel and Dr. Jones implementation of the new MH coding system which includes a current functionality assessment will assist in identifying those inmates who diagnosis is currently being managed well from those who may be in an acute phase and need a higher level of care.

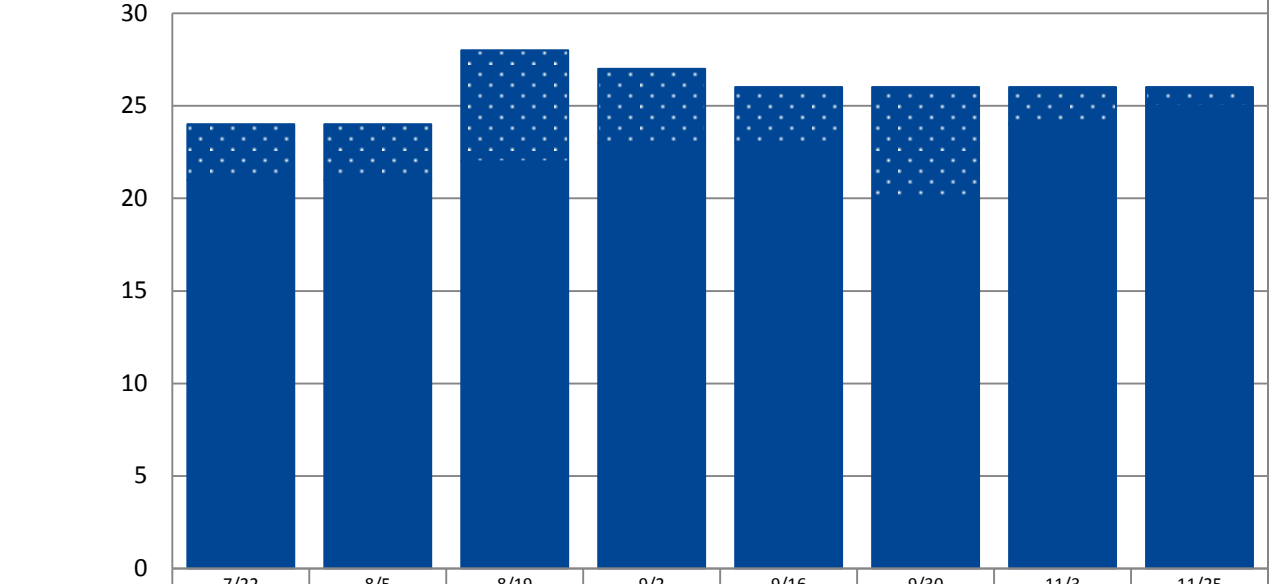
Diagnosis Breakdown

While the Gage report does identify the prevalence of mental illness within the NDCS population, Dr. Gage was not able to provide a detailed breakdown of the behavioral health needs of the system within the timeframe he had to conduct his assessment. Appendix 3 provides a list of behavioral health diagnosis of activing inmates within the system and the prevalence of such diagnosis. This list represents 4,419 inmates out of 5,336 active inmates and a total of 9,862 diagnosis. The number of diagnosis averages over 2 per inmate and represents multiple diagnosis over the course of their incarceration. It is also important to note that not all individuals with a behavioral health diagnosis require programming to address their behavioral health needs. Many inmates with behavioral health diagnosis are able to function in general population with medication management or periodic visits with mental health staff. Consistent with Dr. Gage's report, the number of substance abuse related diagnosis total 4,497, close to 46% of the total behavioral health diagnosis in the system. This document will continue to be refined as the risk-needs assessment rolls out and the mental health coding system is fully implemented and regular updates will be provided to the committee moving forward.

Staffing

An issue identified by Dr. Gage which has an impact on the ability to address other issues is mental and behavioral health staff vacancies. Dr. Gage indicated in his report that while he felt that the total number of staff dedicated to mental health is slightly on the low side, this assumes that the existing vacant positions are filled. Staff vacancies for behavioral health positions are an ongoing issue that the Department continues to work to address. A combination of low unemployment and competition for licensed mental health practitioners from both the private sector and other state and local behavioral health providers has made it challenging to keep these positions filled. Below is an updated chart indicating clinical vacancies agency wide since July. This chart reflects 25 total vacancies out of 167 authorized behavioral health positions as of November 25, 2015. NDCS has hired a full time recruiter and diversified its recruitment efforts to try and recruit staff and is also looking at contracting as an option to fill these positions. We will continue to update the legislature on the progress in addressing

these vacancies and are examining additional options to address this issue during the next biennium budget in the fall of 2016.



	7/22	8/5	8/19	9/2	9/16	9/30	11/3	11/25
Newly Authorized	0	0	0	0	0	0	0	0
Pre-Service	0	0	0	0	0	0	0	0
Future Pre-Service	3	3	6	4	3	6	2	1
Vacant	21	21	22	23	23	20	24	25

Behavioral Health clinical positions include: Clinical Psychicatrist, Licensed Psychologist, Mental Health Practitioner II, Mental Health Practitioner Supervisor, Certified Master Social Worker, CMSW Supervisor, Chemical Dependency COunselor, Chemical Dependency Supervisor, Registered Nurse, Nurse Practitioner, and Nurse Supervisor.

Another area the report is to address is staffing levels needed to meet the professional standards of care. Unfortunately, professional standards for care for medical professionals do not set specific standards relating to staffing ratios. The National Commission on Correctional Health Care noted the following with regard to staffing level standards:

> "The number and types of qualified health care professionals required depend on the size of the facility, the types and scope of health services delivered, the needs of the inmate population and the organizational structure. It is not possible to specify exact ratios, but the number of staff

must be sufficient to ensure that there are no unreasonable delays in patients receiving necessary care." (*CorrectCare Volume 28, Issue 2, Spring 2014)*

The Department continues to investigate options to best meet the needs of the mentally ill population with available staff resources while also aggressively addressing vacancies. Strategies such as mission based housing and focusing available resources on the highest needs populations will continue to be utilized to ensure that inmates receive needed care without unreasonable delays. Dr. Jones is working with her staff to create mechanisms to better assess acuity and functionality of those with mental illness. This work will improve the use of targeted interventions and ensure the best use of available resources.

Justice Program Assessment & Ongoing program evaluation

One area that Dr. Gage's report does not focus upon in detail is the adequacy of existing treatment programs within the Department. The primary reason for this is that evaluating the adequacy of behavioral health programming is a complicated process that requires time and resources that were not available in the time frame provided for this report. To address this issue, Director Frakes requested technical assistance from the Council of State Governments in September of 2015 in the form of a justice program assessment. This request was approved in November and the JPA team has been on site several times conducting observations of programming and gathering information. A copy of the letter approving the request is attached to this report.

The JPA process will provide a description and analysis of the programming options offered by the Department at various facilities and custody levels, determine whether it is based in evidence based practice shown to reduce recidivism and assess the fidelity of the programming being delivered to established models. This process is being expedited as quickly as possible and is expected to be competed in the spring of 2016.

In addition to the JPA, the Department will also begin engaging in regular ongoing program evaluation as part of the reforms included in LB 605. A full time program evaluator position has been created and is in the process of being filled. This position will allow the Department to conduct the types of long-term analysis necessary to document the success of behavioral health treatment services over time and to make changes and improvements to programming based upon outcomes. While this is a long-term

project for the Department, NDCS is excited to have the resources available to measure and improve the quality of services provided to inmates.

Conclusion

Meeting the behavioral and mental health needs of the inmate population is one of the primary goals of NDCS and an area where we acknowledge that there is room for improvement. Dr. Gage's report serves as an excellent initial roadmap for reform that will be built upon and expanded by our new behavioral health leadership in the Department and the Justice Program Assessment being conducted by CSG. Fortunately, as noted by Dr, Gage in the conclusion of his report "You also have high quality, professional, and dedicated staff. It is important for them to experience positive change and to know their work is valued." NDCS will continue to be diligent in recruiting, retaining and engaging staff and making improvements to existing programs in line with best practices. We look forward to working with the legislature and the appropriations committee to accomplish these goals.

Director Scott Frakes
Nebraska Department of Correctional Services

APPENDIX 1 – Dr. Bruce Gage's Assessment of the NDCS Behavioral Health System

Mental Health System Consultation

July 6, 2015

Bruce C. Gage, M.D.

I have completed this consultation regarding the mental health services in the Nebraska Department of Correctional Services (NDCS) at the request of Director Scott Frakes. While behavioral health encompasses mental health, sex offender, and chemical dependency services, the charge was to focus on the mental health component. In the interest of full disclosure, Mr. Frakes and I worked together during his tenure with the Washington Department of Corrections (WA DOC) and WA DOC has kindly afforded me the time to provide this consultation. I am not being compensated for this consultation other than receiving my normal salary.

NCDS leadership, notably Dr. Cameron White, was very helpful and accommodating, providing open access to facility staff, facilities, and inmates as well as a great deal of background information. Staff were uniformly professional and courteous, answered questions readily, and openly offered their thoughts and opinions.

I am aware that this consultation occurs in the context of concerns about the quality of mental health services in NDCS, among other concerns about the agency. I am further aware that some of this concern, especially with regard to mental health, was magnified by a released offender who committed several murders shortly after leaving NDCS.

At the time of my visit, the NDCS census is about 5225 and the system is running over capacity, specifically at 160% of designed capacity and 117% of official capacity.

My charge in conducting this consultation was to provide an objective and impartial opinion about mental health services in NDCS and to make recommendations for improvement.

ASSUMPTIONS AND BACKGROUND DATA

It is important to convey some assumptions underlying this report that are based on general research in the correctional arena. Specifically, the most reliable studies of prisons find that about 20-25% of male prisoners and 30-50% of female prisoners receive or need some form of mental health treatment. Most

of these individuals do not require hospital or even residential level services; only 2-4% are so ill that they need this level of robust service. This excludes most personality disorders, intellectual disability, and dementia. These special populations are generally not served in residential mental health units as they require very different types of service.

DATABASE

The database for this evaluation consists of the following:

1. Three day site visit including LCC, DEC, NSP, and NCCW including:
    a. Interview of numerous staff and patients
    b. Review of patient records
    c. Visits to the male and female mental health residential units, restricted and secure housing units (mental health included), general population settings (various custody levels), medical facilities, and recreational facilities
2. NDCS policies
    a. AR 115.09
    b. AR 115.12
    c. AR 115.23
    d. AR 115.24
    e. AR 115.25
    f. AR 115.30
    g. AR 116.02
3. NCDS behavioral health positions (authorized and filled/vacant)
4. NCDS behavioral health organizational chart
5. 2013 NCDS statistics
6. Department of Correctional Services Special Investigative Committee (LR 424-2014) Report to the Legislature dated 12/15/14
7. Nebraska Department of Correctional Services: Disciplinary Process, Programs, and Commitment Processes by the Performance Audit Committee of the Nebraska Legislature dated 11/14
8. A list of all mental health contacts from the Nebraska Inmate Case Management System (NICaMS) from 2013-2014 (this does not include some contacts by psychiatric prescribers that are placed in the hard copy medical record)
9. Numbers of inmates on psychotropic medication
10. Average length of stay in residential mental health units
11. A list of all suicide attempts from 2013-2014
12. A summary of all mental health diagnoses in NDCS
13. Mental Illness Review Team (MIRT) procedures
14. Clinical Violent Offender Review Team (CVORT) procedures
15. LB1199 (civil commitment of sex offenders) assessment procedures
16. Manuals and program descriptions of the male (LCC) and female (NCCW) mental health residential programs in NDCS
17. Healthy Lives (sex offender treatment) program description
18. Violence Reduction Program (VRP) program description

19. The NDCS formulary
20. Medical Protocol 29 detailing the Peer Review Process
21. Medical Protocol 36 detailing the Audit Plan
22. Consultation reports by Dr. Thomas White dated 6/19/06 and 5/13/13
23. A compendium of groups and services provided by behavioral health staff
24. A listing of current groups and numbers of participants
25. A summary of social work contacts for 2014
26. Documents summarizing the peer review process
27. Various forms
    a. Special Needs Contact Documentation
    b. Mental Health Programming Involvement
    c. Mental Health Psychological Evaluation Request
    d. Release of information

The following are salient observations and reviews of data. In the interest of readability, the notes and databases underlying these findings will not be recapitulated in detail but summarized. Interested parties are welcome to review all of the underlying information collected.

POPULATION

NDCS provided its population including total census, demographic information, mental illness diagnoses, the number of patients defined as having major mental illness (essentially those with psychotic disorders or other disorders with severe functional deficits), and numbers of patients on psychotropic medications. NDCS has a designed institutional capacity of 3275 and a census of 5225 (4/30/15). 2013 demographics reveal an average age of ca. 36, 7% female, and a racial mix that shows greater proportions of minority populations than in the general Nebraska population.

As in other correctional settings, NDCS has seen growth in the numbers of mentally ill and, along with that, serve more severely ill. The number of inmates with diagnosed mental illness is 4462 (82%) with the percentage of women having a diagnosis at 85% and males at 82%. The number of inmates with only a substance abuse diagnosis is 1621, leaving 2841 (52%) with some other mental illness diagnosis. About 25% of the male and 50% of the female population is on one or more psychotropic medications; these numbers are typical for prison settings.

In part following recommendations by Dr. Thomas White, NCDS has undertaken to identify and focus treatment on its most seriously mentally ill, designated as major mental illness (MMI). This includes patients with diagnoses of a psychotic disorder, bipolar disorder, and major depression. The prevalence of MMI in the system is reportedly 2-3% (100-150). This is lower than would be expected; most prevalence studies show rates of psychotic disorders alone in state prisons of 4-15% and depression is on the order of 10%. A conservative estimate is that 3-6% have a psychotic or schizophrenia-spectrum disorder and about 10% have significant depression or bipolar disorder. The remainder have less severe conditions, likely comprising the vast majority of those 25% of men and 50% of women on psychotropic medications.

LCC typically has about 85-90 in residential mental health and 350 being followed for mental health needs in general population.

NSP reports that 377 of their 1321 inmates are on psychotropic medications (28.5%). But they report only 12 identified as MMI.

NCCW report that they have 150 MMI by official tally but NCCW clinical staff believe the number is closer to 50. With a total census of about 325 and given that the agency wide estimate is only 100-150 MMI total, it is unclear what these numbers mean. Based on national figures, it is likely that at least 15% of the female population (50) have a major mental illness. Though typical of many correctional settings, the figure of 50% of the female population receiving psychotropic medication deserves careful review.

INITIAL ASSESSMENT

Initial assessment for males is conducted at the Diagnostic and Evaluation Center (DEC). Masters psychology associates (three) and doctoral psychologists (one, about .75 time) conduct thorough assessments on all inmates admitted to NDCS, about 2500 per year, or about 50 per week (about 13 per clinician per week). The month prior to my visit, there were 275, which is higher than normal. Assessments reviewed were fairly thorough and diagnoses consistent with the findings of the assessment. It is estimated that it takes up to two hours to complete an initial assessment, which is reasonable for a complete assessment. The expectation is that routine assessments are completed within 14 days; this has generally been possible but sometimes cannot be met when caseloads are high or any staff are out.

There is a psychiatric APRN stationed at DEC who sees all inmates on psychotropic medications and any others who ask to be seen. At the time of my visit, there were 160 patients on the APRNs case list, about 50 of whom had not yet been seen.

There is no defined benefit for treatment and no utilization review or utilization management mechanisms so the only determinants of who gets treated are inmate request and provider willingness to treat.

The DEC also houses a skilled nursing facility, which generally houses all those on suicide watches. There is some limited provision for watches elsewhere but this is not systematized. Sometimes those who are seriously decompensated are housed at DEC and, for a variety of reasons including lack of beds and denial of transfer due to concerns about dangerousness, may remain for extended periods of times. This also includes females having serious mental health conditions.

Two LMHP2 provide treatment services in DEC and also manage violators and county safe-keepers. There is also a limited amount of telepsychiatry time that is used to manage these patients; it has been difficult to get this operating in an organized fashion. The county safe-keepers are a challenge as they are high needs and reportedly cannot be place elsewhere, even on the mental health unit when their needs could be better managed there.

Female intake services are generally done at NCCW where they conduct about 40 intakes per month; these are done by the psychologist. They may sometime be done at DEC if the patient requires infirmary services or is on an extended watch.

The assessment includes a “level of care” determination with patients being identified as needing to be seen weekly, every two weeks, monthly, or every two months. This designation can be modified by clinicians at the receiving facility.

MENTAL HEALTH SERVICES

NDCS provides outpatient and residential services. It does not have access to licensed mental health beds; it neither has its own nor will any community hospitals take patients from the prisons. The sickest mentally ill are usually treated in the residential units or might occasionally be admitted to infirmary

(skilled nursing level at NDCS) settings. This is almost always the case for those placed on suicide watch except for short duration or special cases where the decision has been made to retain those who are engaging in self-injurious behavior for secondary gain.

One issue that deserves sharp clarification has to do with a Nebraska law governing the standard of care in the prison system. The law reportedly speaks to the standard of care being the same as in the community. At this point, it is being interpreted very broadly. Many inmates are receiving mental health services for conditions that most systems would not treat unless compelled by law.

Crisis Response

Crisis response is a substantial element of the mental health workload and the predominant task for non-prescribers working outside of residential mental health settings. During normal working hours, local mental health staff cover crisis response. This is typically initiated by a custody telephone call to local mental health; there is an informal call network rather than a structured approach. The nature of the approach to crisis response varies from setting to setting. At NSP, one MHP is assigned to crisis response for a week at a time on a rotating basis. The psychologist on staff at NCCW provides crisis coverage during working hours.

After hours, when no mental health staff are on site, crisis calls go to nursing staff who conduct an evaluation and then call the Mental Health Officer of the Day (MHOD) for the facility. Management decisions are made in conjunction with medical and correctional staff when needed. There is no psychiatric prescriber on call but the one full time psychiatrist in NDCS is often available for consultation.

Referral

Any staff can make a routine referral through a standardized form. Mental health staff are expected to see routine referrals within 14 days. The clinician then determines whether or not additional services are needed but there is no formal guidance about who should receive services and of what type.

Inmates can complete kites to request. Kites are answered within three days (this was not formally evaluated) and prioritized. In general, staff are obligated to see those who submit kites.

Outpatient (General Population) Services

NDCS mental health treatment staff (again, largely excluding those providing sex offender and chemical dependency treatment) are conducting about 1500 individual sessions per month (this includes residential settings). The nature or model of treatment is not indicated and individual outpatient treatment is not done under the guidance of a treatment plan. Much of the individual contact time is response to crises and other unstructured interventions in response to staff and offender requests; this primarily serves the cause of institutional management rather than a directed course of treatment. Those identified as MMI are assigned a MHP who sees them at least every two months.

NSP assigns mental health clinicians to residential settings in PC, restrictive housing, and the Violence Reduction Program. Others are assigned institution-wide and serve the general population; cases are assigned on a rotating basis.

I interviewed an MHP providing services to GP at LCC. There, a GP population of 400-500 yields a case load of up to 220-240 on medications and another 25 getting services but no medications. In addition, the position is responsible for conducting a mental status examination on 120 plus in Protective Custody every 3 months (some help has been provided recently). Until recently, about 20 hours were left for providing direct treatment and case management but this had been eroded because of having to spend 1 day each week supporting telepsychiatry visits and another half-day each week scheduling and assisting contract psychiatrists (setting up the calendar, getting patient passes, processing kites, and prioritizing follow-ups). This has left about 15 hours per week for structured treatment and about 5 hours per week responding to crises in GP; groups had to be cancelled in response to this work addition. No groups are being run in GP. This MHP noted that there is no formal guidance or plan that designates who should receive what types of services. Services vary from short term treatment for anxiety and acute (usually situational) problems (3-5 sessions) to monthly check-ins primarily for those with MMI and trauma. Others get little or no service.

There is more individual outpatient work being done at NCCW, though the amount is not tracked. An informal survey of staff at NCCW indicated that one Mental Health Professional was seeing about 20 patients weekly, another was seeing 5 weekly, and a psychologist (with a limited 8 person case load owing to other duties) was seeing one person weekly. Again, treatment is not guided by a treatment plan. Most treatment is CBT in orientation; DBT is not available. The staff note a good deal of unmet need in the GP, primarily related to issues associated with childhood trauma.

Mental health group work is dominated not by provision of mental health treatment groups but by what I will refer to as correctional programming. Correctional programming includes groups that may be run by non-clinicians and primarily serve the correctional mission, such as addressing criminogenic attitudes and anger dyscontrol. Most of these inmates do not require mental health treatment services. At the time of my visit, this included the following violent offender groups:

- NSP
    - Violence Reduction Program group – 12 participants
        - Four groups per week
    - Anger Management groups (2) – 20 participants
        - Two groups per week
    - Domestic Violence (unknown participation)
- CCCL
    - Anger Management groups (2) – 20 participants
- OCC
    - Anger Management groups (2) – 16 participants
- NCYF
    - Aggression Reduction Therapy groups (2) – 16 participants
    - Anger Management group – 6 participants

- TSCI
    - Anger Management groups (2) – 11 participants
- LCC, NCCW, WEC – none
    - Moral Reconation Therapy (MRT) is offered as "elective"

Restricted Housing Services

In most facilities, mental health staff are not specifically assigned to restricted housing though at NSP, 0.6 FTE of a MHP is assigned.

On restricted housing units, mental health does monthly mental status examinations of all inmates identified as mental health and every 90 days for others but does not do an assessment at the time of admission. A nurse reviews the chart of those newly admitted; if there is a medical problem at admission a nurse does an evaluation and if there is a question of mental health concerns, the nurse contacts mental health. Nursing also does daily health check rounds.

Those placed in restricted housing have all medications converted to staff administration except for rescue medications. The number of rescue medications the inmate may possess can be limited if necessary.

Custody staff does suicide screening on all entering restricted housing using a standard set of questions to which any yes answers necessitates a call to mental health and initiation of 15 minute checks in a camera room or if unavailable, placement in a suicide room in a skilled nursing facility. They remain on checks until seen by mental health, which may be the next working day.

Mental health also works in conjunction with custody in Multi-Disciplinary Teams where behavioral plans, usually drafted by mental health, are forged. These plans are generally not posted at inmate doors and fidelity to these plans has been mixed. Plans are rarely carried through to GP. According to mental health staff, these are used primarily at TSCI.

The restricted units at NSP, TSCI, and LCC are using the METEOR and ExPLORE programs to address behavioral problems. Mental health is running these groups.

At LCC, some mentally ill are housed in the 16-bed control unit, unit A. There is no programming here except for some in-cell, self-paced, workbook-based modules. They have some access to educational services.

Residential Mental Health Units

<u>LCC</u>

LCC D unit has a maximum capacity of 77, with a census of 72 during my visit. The average length of stay is about 80 days. The unit is run at a lower custody level than the physical plant provides for. Patients are allowed out after breakfast other than being locked down at lunch and at 1600, and then go down for the night at 2030. They are out of cell close to 10 hours per day. They get about one group per day and variable individual contacts. There is no transitional program from D unit and no "step-down"

residential setting available. A GP MHP provides follow-up, generally regular initial visits but quickly transitioning to monthly check-ins.

Those who leave to GP, which is usually locally to LCC (which does not have minimum custody), generally have a dramatic reduction in their privileges owing to the unit being run at an effectively lower custody level, for example they generally do not have the same degree of access to courtyards and/or dayrooms. Staffing shortages also interfere more with GP units than the residential mental health unit, which LCC tries to maintain full staffing for custody.

Treatment consists in groups, individual sessions, and medications. Treatment groups include "Core Groups" (which are described as on-going process groups), social skills, Dialectical Behavior Therapy (DBT) – both basic and advanced, some psychoeducational groups, and socialization groups such as Current Events.

There are 14 beds of restricted housing on LCC C unit, run at a higher custody level. The average length of stay is about 30 days. Patients get up to 12 hours out of cell per week (policy mandates 10 hours per week) and may take meals, showers, and yard time on D unit as a transition step. They receive a minimum of 2 hours and up to 3 hours of structured programming per week. This consists primarily of "Core Groups". There is a list of other more structured groups, similar to those on C, that is expanding but few are being run.

On both D and C units, staff monitor patient behavior daily using a tool referred to as a "Baseline" that tracks basic behaviors including acting out, program participation, and medication taking. On the basis of patient performance, they receive privileges. The privilege system is limited to essentially two levels with no clearly structured criteria and minimal privileges can be earned outside of additional commissary.

Privileges are limited. Patients either receive "A-Card" of "B-Card" privileges. The former provides for full canteen access and full access to the communal day areas whereas the form restricts canteen access and during day area privileges, they have to stay in the local day area. Their privileges for meals, showers, and yard are otherwise the same.

The population is very diverse with serious mentally ill, intellectual disabled, demented, and personality disordered patients mixed on these units (consistent with my observations and reviews). This has made development of a coherent program difficult. There has been a recent increase in the number of personality disordered patients referred by MIRT.

The Multi-Disciplinary Team (MDT), consisting of mental health and custody staff, meets every morning to review the behavior of each patient and to reinforce plans. The clinical treatment team also meets weekly to discuss the clinical treatment planning. Treatment plans are updated at least every three months. Treatment plans are very basic. I attended a team meeting where the plans for three patients were reviewed. The team reviewed progress, medications, behavior, program participation, and plans (treatment and/or release).

Chemical dependency, anger management, and social work services and groups are also provided on the units. Sex offender services not available on the residential mental health units.

There are a limited number of jobs available to the mentally ill ($1.21/hour). Those that cannot get jobs get paid $0.60/hour for treatment participation. They are paid monthly.

The mental health program utilizes special porters who are licensed as CNAs and provide assistance to particularly limited, often cognitively impaired, patients. They are generally made cellmates and assist in activities of daily living and helping their charges meet their programmatic obligations.

NCCW

NCCW has female residential beds, referred to as the Strategic Treatment and Reintegration (STAR) Unit, that are co-housed with protective custody. The two populations are not permitted to mix, which has limited out of cell time and programming opportunities for the STAR Unit women to some degree. The unit is run at essentially a medium custody level. Patients receive one hour of individual therapy per week, one group per working day (1-1.5 hours) and 3-4 hours of unstructured out of cell time per day (less lately due to problems coordinating the PC inmates' time out). They also get about 3.5 hours at the gym each week and take meals off the unit. Thus there is a total of about 40 hours out of cell time each week. The STAR program incorporates a phase system, which is a rudimentary level system with advancing privileges but with no formal criteria for advancement – individual therapists decide who advances. There is no formal transitional program but patients typically engage in off-unit activities such as a job prior to moving to GP.

The average length of stay is about 10 days and there were 9 patients at the time of my visit. The patients have varied diagnoses including schizophrenia, mood disorders, traumatic brain injury, and personality disorders.

There are two mental health professionals assigned to this unit. They are sometimes called to do other duties.

DEC

There are 31 beds licensed as skilled nursing beds in the DEC infirmary. Sometimes those with severe mental health problems are housed in the infirmary, though there is no formal mental health program here. It is primarily for those patients who need restraint and active medication management.

Mental health staff report that patients can get "stuck" in the DEC skilled nursing beds owing to limited opportunities for placement elsewhere.

This area is also where the suicide monitoring cells are located. If they are filled, those needing a watch may be transferred to another facility, e.g. NSP.

TSCI

There is a long-term plan to open residential mental health beds in a high level custody setting at TSCI but difficulty covering current staffing needs has slowed this plan.

Medication Management

NDCS has a formulary, which is the only real restriction placed on prescribing. The formulary is moderately restrictive with regard to psychotropics but non-formulary medications are obtained fairly readily and regularly, often for good reasons (such as clozapine).

Psychiatric prescribers spend virtually all of their time conducting assessments and follow-ups for the purpose of prescribing psychotropic medications. Psychiatric prescribers are following about 1300 patients on psychotropic medications (about 100 in residential beds).

The psychiatric APRN stationed at DEC is doing the vast majority of initial psychiatric assessments. These are done for all patients on psychotropics at admission, any patient referred by mental health (emergently or routinely), and any patient who requests to be seen for medication.

Patients who come in on psychotropic medications have initial orders written either by medical staff (for up to 30 days) or a psychiatric prescriber, usually the psychiatric APRN.

A weekly report of expiring medications is generated from the pharmacy software. Mental health receives a copy. Medical will sometimes write bridging orders for up to one month if a psychiatric prescriber is unavailable.

Long-term use of benzodiazepines is fairly common in NDCS. I also saw some examples of polypharmacy, such as three or more antipsychotics or antidepressants ordered for a patient (there is no good evidence for use of three agents like this but occasionally in refractory patients it is reasonable to try such combinations). Virtually no stimulants or atomoxetine are used for ADD/ADHD but some receive clonidine or guanfacine. But in general, other than the substantial benzodiazepine use, prescribing practices are conventional and appropriate for the correctional setting. Laboratory (e.g., drug levels, metabolic studies) and AIMS monitoring was present in a number of charts though I did not do a systematic review of medication monitoring.

The rate of provision of involuntary medications is reasonable for the population. I did not see evidence of over- or under-use. All those on involuntary medications are on a residential mental health unit. While appropriate in most cases, it is reasonable to house those who are stable on involuntary medications in general population, assuming they can be well-monitored. Currently, NDCS mental health staff estimate that 15 patients in the residential units are on involuntary medications, many of whom are stable enough for general population but remain because of their involuntary order.

During normal work hours, emergency medications are obtained by whatever psychiatric prescriber can be located. This may not be a prescriber assigned to the institution. For instance, NCCW first calls the APRN at DEC to get emergency order and if that fails will usually try to contact a medical provider.

There is no formal on-call provision for psychiatry. Emergent medication orders after hours are generally given by medical providers in consultation with the MHOD and nursing staff. The one full time NDCS psychiatrist is often available informally after hours and will sometimes provide orders.

Facility Transfer

Mental health does a 5-10 minute intake screening when inmates transfer from other facilities. Nursing and custody also screen incoming transfers. This is sufficient.

Staff report that medications occasionally do not accompany inmates when they transfer, causing disruption in treatment as it can take several days to get a new supply from the pharmacy. The magnitude of this problems is unclear.

Re-Entry

Social workers focus on re-entry planning, including some limited transition group work. Each tends to specialize on different populations because of the different needs and community services they require. They provided services to 612 inmates during 2014. This is about 25% of those releasing. The social worker creates a 2-4 page release plan specifying aftercare details.

Staff and patients both report that the two week supply of medications NDCS provides at release is rarely enough to bridge the gap until their first appointment with a community psychiatric prescriber.

Social workers are assigned to residential mental health units and to serve those in GP with high needs. Homeless releases for those receiving social work services are uncommon (except for those with sex offenses). Most mentally ill are placed in group homes, halfway houses, clean and sober housing, or occasionally with family.

As noted below, offenders get two weeks of medications at release. The social worker on LCC reported that the majority of patients can get new medication orders within that time but a substantial number cannot.

SUICIDE AND SELF-HARM

Custody staff can place any inmate on 15 minute checks in a camera cell or, if such a cell is unavailable, can place the inmate directly into a suicide cell in the Skilled Nursing Facility (SNF). The SNF at DEC has safety cells that are suicide proof and have cameras that provide good coverage.

Custody does routine suicide checklists for those brought into restricted housing and if positive any of the items are positive, the inmate is similarly placed and the mental health must be contacted (the form is also routinely forwarded to mental health for review and follow-up as necessary). The inmate stays on this level of watch until seen by mental health, which may be the next working day. Mental health then determines whether to be placed on Plan A (full suicide precautions with smock, safety trays, and constant monitoring) or Plan B (step-down precautions). While these involve standard conditions,

mental health can modify these as needed. Mental health staff of course can also place inmates on watch themselves.

I noted that some of the suicide smocks are deteriorating. And they are of a type that can be taken apart and used to create ligatures, especially as they age and are repeatedly washed.

NCCW estimates that 1-2 females are placed on watch each week (primarily for suicidality and mostly from intake). Most stay at NCCW in the suicide cells located in the secure unit of NCCW. They report few who engage in self-injurious behavior such as cutting, but mental health staff wonder whether this is under-reported. There has not been a suicide at NCCW for about 20 years.

RESTRAINT

Restraint decisions are made, as specified by policy, by a triumvirate of custody, medical, and mental health staff. If there is no agreement, the final decision falls to the medical director. Staff report that mental health recommendations are generally followed and none saw the process as problematic, though somewhat cumbersome.

While behavioral restraint of males occurs regularly, it is rare for females, the last being in 11/13.

Mental health staff see all patients in behavioral restraint every 12 hours, including on weekends. Cursory review of charts indicated that this was being adhered to.

I saw one inmate restrained on a hard bed with no mattress. This is reasonable only for very short term placement.

FACILITIES

Facilities are highly variable. There is limited programming space on both the male and female residential mental health units. Minor physical plant modifications could improve the usability of some spaces.

LCC

The mental health residential units have been spared the degree of double-bunking and other measures necessary in general population to house the committed population. The D unit LCC residential mental health unit can house up to 77 in 53 cells. The C unit restricted mental health housing is currently 14 beds with 16 to be added. This is an older facility and is not suicide-proof, having second floor tiers from which jumping is possible. There have been attempts to jump and hang, but none successful in the memories of staff or in provided data sets. The cells themselves are reasonably suicide-proof for this setting but still provide anchor points for hanging. Yard space is adequate but with limited facilities. There is a plan to post video monitors in D unit hallways so that patients in cells can have passive access to some programming and entertainment.

There is no provision for those in residential mental health to eat separately from GP though staff monitor them and they are somewhat physically separated from GP.

The secure mental health unit (A unit) in LCC is archaic and austere. The 16 cells are marginally suicide-proof for this setting with breakable fixtures accessible; there are only low anchor points. There are four cells with cameras, though they are easily covered. There is no programming space on this unit. This setting is not adequate for the delivery of mental health services and provides only a secure setting. Many mentally ill transition through this unit into the residential mental health housing. Yard space is limited and there are no facilities.

There are four ADA cells in the medical area (two with cameras and two being used for storage) but they are not set up in an easily monitored fashion and are in disuse. But the facility in general (including the mental health residential settings) is not ADA compliant.

NCCW

The NCCW residential housing or Strategic Treatment and Reintegration (STAR) unit is co-housed with Protective Custody and does not have a fixed number of beds but is generally considered to be 19 rooms with a maximum census of 30; the census at the time of my visit was 9. NCCW is more modern but the STAR unit is also not suicide proof, again having second floor tiers from which jumping is possible. The cells are reasonably suicide-proof for this level of care.

There is one small group room on the unit.

NCCW has two cells in their secure housing area that are reasonably suicide proof and provide adequate video-monitoring capability. The low anchor points seen at LCC have been mitigated to some degree at NCCW (e.g., the desks have been modified). Those needing more extended suicide watch are transferred to DEC.

TCSI

While facilities at Tecumseh are reportedly much better (I did not visit), as noted above it has been possible to maintain only enough mental health staff to provide basic mental health surveillance and limited service.

There is a mental health secure placement and suicide watch cells but, owing to the staffing shortages, they are generally only used temporarily prior to transfer to LCC.

DEC

There is a skilled nursing facility in the DEC that includes four cells set up for suicide watches. In general, any patients requiring suicide watch are moved to this facility though there are two similar watch cells in the skilled nursing facility at NSP. The DEC suicide watch cells are highly suicide proof and have good quality video-monitoring capability.

NSP

NSP is an older facility. It does not have residential mental health. The mental health building houses only offices but no patients can be there as it is in an area not monitored by custody. This means that

mental health has had to find and share spaces for running groups and seeing patients, which interferes to some degree with scheduling and productivity.

The control unit here is archaic with linear cell blocks having barred cells. The cells are minimally suicide proof; they have breakable fixtures, available anchor points, and cameras that are easily covered. There is a marginally adequate programming space with eyelets in the floor to restrain a small number of prisoners while they participate in groups. There are eight individual yards which are adequate size but without any facilities.

NSP has 12 Skilled Nursing Facility beds almost exclusively used for medical treatment. There are 26 ADA beds (primarily for those with mobility problems but occasionally manages the demented) that is full; there is no special program here and no additional staff – use of this is determined by medical staff. There is also a 100 bed substance abuse program at NSP with 15 dedicated clinical staff.

The two suicide cells in the Skilled Nursing Facility area at NSP are reasonably suicide proof and provide adequate video-monitoring capability.

STAFFING AND ORGANIZATION

Organizational Structure

In 2004, mental health was consolidated under NDCS health services, which itself had been created to provide general oversight for health care in 2001. The Behavioral Health Administrator reports to the Medical Director and Chief Operating Officer. The Behavioral Health Administrator oversees psychiatric prescribers directly as well as the Behavioral Health Assistant Administrators for Substance Abuse, Sex Offender Services, and Mental Health and the Director of Social Work.

Mental Health Staffing

I found the mental health staff to be professional and knowledgeable. They knew their patients and most demonstrated sound understanding of the functioning of the system. They reported generally collegial relationships with custody and other health services staff.

The numbers below are not crystal clear to me but reflect the information provided. I note that in many instances, positions are reported full but there are spreadsheets that indicate that positions are marked "leave vacant for cost savings" but are then not marked as vacant (e.g. at NCCW). There are also position numbers rendered but with no information about what types of positions though may indicate they are designated for "MH", "SOS", "SW", or "SA".

Of the 181 positions in all of behavioral health, the positions are assigned as follows

- Designated "907" – 18
    - 2 vacant (one NSP, one OCC)
    - This includes MHP II, mental health security specialists, master social worker, and nurse practitioner positions, many (or all) of which are assigned to MH
- Designated "Dual" (meaning work for more than one section of behavioral health) – 2

    - None vacant
- Designated "MH" – 53
    - 8 vacant (one DEC [administrative], two LCC [clinical], two NSP [administrative], three TSCI [clinical])
- Designated "Psychiatry" – 4
    - Two vacant (but note that one of them is actually filled by a medical mid-level)
- Designated "SA" – 65
    - 12 vacant
- Designated "SOS" – 11
    - 2 vacant
- Designated "SW" – 9
    - One vacant
- Undesignated – 19
    - Most are marked as "leave vacant for cost savings", "gone from budget 2010", or have been reclassified.

Central Office

Dr. Cameron White (1.0 FTE) and 0.5 administrative time (it is designated as full time but only filled part time) constitute the mental health presence at the Central Office. Dr. White is functioning as the Behavioral Health Administrator. The 0.5 FTE Mental Health Director position is vacant. In addition to mental health, Dr. White also oversees the sex offender and substance abuse programs.

Psychiatric Prescribers

The information provided gives different information regarding psychiatric positions. The organization chart indicates 5 FTE whereas the position listings show different numbers of mid-levels and psychiatrists, some of which are medical providers. Regardless, the actual psychiatric presence consists of one psychiatrist, one psychiatric APRN, and there has been a recent addition of contract psychiatric services. The contract services consist of telepsychiatry and on-site visits totaling about 0.7 FTE at NCCW, 0.6 FTE at NSP, and 0.2 FTE at LCC.

There is no provision for psychiatric on-call services but the psychiatrist is informally available most of the time. Medical providers do order emergent medications after hours in consultation with the MHOD and on site nursing staff.

Mental Health Service Providers

There are 82 FTE facility clinicians assigned to mental health, 12 of which are vacant:

- 17 Clinical Program Managers and Clinical Psychologists (the clinical leadership for mental health, 4 vacant
- Three Mental Health Security Specialists (a hybrid custody and mental health position), one of which is vacant

    - Three additional positions are reportedly being added to add the additional C unit residential mental health beds at LCC
- One Mental Health Practitioner II
- Two Mental Health Nurses, one vacant
- Two Mental Health Professional I, one vacant
- 34 Mental Health Professional II, two vacant
- 6 Mental Health Professional Supervisors, one vacant
- 12 Social Workers (including the Director), two vacant
- 5 Psychologist I

Staffing has been a substantial problem at TCSI. DEC, NCCW and NSP clinical positions are filled (other than psychiatry). LCC is intermediate.

Psychiatric coverage at LCC consists of the one full time psychiatrist and additional contract hours that amount to about one position.

LCC general population is served by two MHP. One MHP is also assigned to restricted housing.

LCC residential is staffed by one Clinical Program Manager, one psychologist, one psychiatric nurse, 4 MHP, and one social worker.

Custody staffing on LCC D Unit consists of one Mental Health Security Specialist (an additional is being added – they work 1200-2000), who serve the custody officer function but also have training in mental health, though they are paid less than officers. They run some groups (1-2 per day) in addition to managing the floor along with two Case Workers, one Case Manager, and a 0.5 FTE Unit Manager.

Mental health staffing on LCC C Unit consists of one MHP and one Mental Health Security Specialist II (MHSS-II). The custody staffing on C Unit is similar to D Unit; there is a plan to add 3 MHSS-II and one MHP when the beds are increased from 14 to 30 in the near future. Officers cover the remaining security functions, primarily external security.

NSP has one psychologist, one MHP Supervisor, 5.5 MHP, and three days of contract psychiatric time per week. All mental health positions are filled.

NCCW has one Mental Health Services Supervisor (15% clinical), 2 MHP on the STAR Unit, one psychologist who conducts intake and does crisis response (and a small treatment load), one MHP who responds to kites and does routine appraisals (other than intake) and some treatment, and one secretary. All mental health positions are filled. Psychiatric coverage is fragmented with one psychiatrist providing a day per week on site and another 2.5 days per week is provided by various telepsychiatry practitioners.

There is a mental health officer of the day (MHOD) available by telephone at off hours. Nursing staff conduct evaluations and consult with the MHOD on crises and other concerns.

<u>Other Behavioral Health Staffing</u>

I also note that there are about 70 positions assigned to chemical dependency treatment and 11 to sex offender treatment.

Trainees

NDCS provides training for medical students and trainees in psychiatry residencies, physician assistant programs, and APRN programs. Trainees had positive reports about their experience and the quality of supervision.

POLICIES AND PROCEDURES, INFRASTRUCTURE AND SUPPORT

Policies and Procedures

In general, policies and procedures are in place for important mental health functions. Some salient policies deserve mention here but I will not comment on their general content and instead address issues in my opinions and recommendations.

Placement

The Mental Illness Review Team (MIRT) is the body that determines whether an inmate is designated as having a Major Mental Illness (MMI). MIRT also makes decisions about who utilizes residential beds and whether those with MMI are placed in designated Secure Mental Health Unit (SMHU) beds in restricted settings, though the warden may overrule MIRT placement decisions (and sometimes does).

MIRT meets monthly but there is provision for handling emergent cases electronically. Movement out of the residential units can be difficult to effect owing to overcrowding in general population. One patient on the unit had been cleared for GP placement 3 weeks previously and staff report it typically takes a month. As a result, the unit is almost always full (especially given limits on those who can have cellmates) also making it difficult to get people into the unit when needed. While MIRT makes decisions about who can use the beds, custody will sometimes block placement if there is a concern about safety/security, including when staff have a history of being assaulted or threatened by a mentally ill inmate; there is no alternative placement in such situations.

The Clinical Violent Offender Review Team (CVORT) similarly assesses inmates but in this case not for treatment but for the need for correctional programming directed at violence reduction. The Violence Reduction Program (VRP) at NSP, to which CVORT can refer, was developed as part of a PREA grant in 2007 and has continued on after the grant, staffed by mental health.

The Sexually Violent Offender Review Team (SVORT) serves the same function for inmates with sex offenses. Note that while Nebraska has a civil commitment law for sexually violent predators, it does not have mandatory prison sex offender treatment related to particular crimes.

The Clinical Substance Abuse Review Team (CSART) serves this function for those with substance abuse disorders. There are 313 substance abuse beds in the system as well as some outpatient level treatment

in GP and out of custody. Nebraska law does not have statutorily mandated substance abuse treatment as a sentencing alternative.

It is important to note that there is presently no centralized bed control for the whole NDCS system.

Discharge Review Team

This team reviews inmates who might represent a danger to the community when released. The primary charge of this team is to review cases for whether or not civil commitment is indicated.

Peer Review Process

The internal and external peer review process is not intended to be a robust peer review process for the purposes of monitoring the general practice of clinicians. It is more consistent with morbidity and mortality committee function in that it is driven by events or complaints rather than routine assessment of practice by their peers. It appears that this function is done through the supervisory function rather than peer review. This is reasonable and typical in correctional settings.

Audit Plan

The Audit Plan (MP36) is generic but sufficient. However, review of the audit forms shows them to be very rudimentary and to consist primarily in a chart review to determine whether the correct elements are present. I did not review any audit results.

Medication Administration

It is my understanding that nursing staff administer medications at OCC, NCYF, TSCI, and in Skilled Nursing Facilities while custody gives medications to patients in other settings from a tackle box that is charged by the pharmacy. While policy provides that the staff member will write down the number of pills that the patient took, in fact the patient wrote this themselves. During my visit, tackle boxes were stolen by a porter when a door was not properly secured. The medications were replaced from the local pharmacy and there were reports of GP inmates exchanging pills; the medications were not recovered.

Diversion of medications is identified as a growing problem at NCCW with Wellbutrin and opiates leading the way. The magnitude of the problem is unknown and staff do not know how big the issue is in the male prisons.

Information Technology

Information technology systems at NDCS are limited and outdated. The mental health data system (NICaMS) was created by NDCS in order to track mental health information and provide a limited records function. Its functionality is limited to free text entry and a few drop-down boxes to characterize the nature of patient encounters and enter diagnoses. It does provide the ability to search and aggregate the data. Mental health is the only clinical group that uses this system. Medical providers use a paper record. Psychiatric providers use both systems. The pharmacy uses the CIPS system.

Routine reports for mental health are limited. There are reports for some clinical purposes such as detecting those whose prescriptions are expiring. In general, this functionality is not readily available. The existing systems are fragmented, archaic, and the data is not aggregated in a data system capable of providing real reporting functionality.

The most notable feature of medication management is that there are no nurse-administered medications except in the skilled nursing areas. Some offenders keep and administer their own medications, typically delivered on a standard pill card. The rest have their medications delivered from pharmacy in unit doses to custody staff (no nursing staff involved) in a tackle box who then give the medications to the inmates. It was said that the custody staff write down the number of pills given to the inmate who then writes down the number taken. What I saw was that the inmates wrote down the number they were ordered and also wrote down the number taken. The custody staff generally required that the inmate show their identification and then got the medications out of the packages and gave them to the inmate. The custody staff floated some medications (they came crushed); they did not use gloves or wash hands. Sometimes a cursory mouth check was done. While I was visiting, a tackle box being delivered by an inmate went missing and medications were reportedly being given or sold to other inmates. There was reportedly a breakdown in the procedure for obtaining and checking in the tackle boxes of medications. These boxes were seen unsecured several times throughout the visit.

There has been a substantial problem with diversion and overdose (some requiring hospitalization) at NCCW, primarily Wellbutrin and opiates.

Laboratory and Ancillary Services

Laboratory studies and specialized studies such as MRI are available though access to specialized studies is limited and may take a long period of time to obtain other than in emergencies.

Training

There is no regular gathering of mental health staff. There are periodic –in-service offerings, including from outside experts brought in by NDCS.

RECOMMENDATIONS

Before going into detail, I enumerate my primary recommendations. They are put in the general order in which they should be addressed; this is especially true for the first few.

- Develop a clear sense of vision for the mental health system
- Establish a “mental health benefit” for the system
    - Develop utilization review and utilization management processes over time
- Develop more robust informatics
    - This will be necessary to provide the QI, audit, and utilization processes with the information needed to implement, manage, and monitor the system – without sufficient informatics, an effective system cannot be created or maintained
- Review organizational structure in light of vision

- Focus initial assessment
    - Not every admission needs a complete mental health assessment
        - Admission is not a good time for comprehensive assessment owing to the distorting effects of the early period of incarceration
        - A brief face-to face assessment by mental health ASAP following admission is optimal
            - 5-10 minute screening to detect suicidality, risk of self-harm, acute mental illness and the potential for mental health needs
                - Prioritize based on screening
                    - Emergent – see immediately
                    - Urgent – see next working day
                    - Routine – assess within two weeks
                    - No further assessment required at this time
            - In my view, this meets NCCHC standards (which are not clear on what such an assessment consists of)
    - Full assessment for those entering on psychotropic medication or who are detected on the initial screening
        - Only refer those on psychotropic medications or who meet medical necessity criteria for treatment to a psychiatric prescriber
- Assure robust detection and referral mechanisms
    - Staff referral (custody or medical)
        - Emergency – staff must be able to declare emergencies
        - Routine requests
            - Must include a reason for referral
            - Triaged within one working day
                - Emergent – see immediately
                - Urgent – see next working day
                - Routine – see within two weeks
    - Inmate self-referral
        - Emergency – inmates must be able to declare emergencies and be appropriately evaluated, which may initially be by nursing staff
        - Routine (“kite”) requests
            - Must be confidential or done through clinical staff
            - Triaged within one working day
                - Emergent – see immediately
                - Urgent – see next working day
                - Routine – see within two weeks
- Structure mental health outpatient mental health services
    - Distinguish treatment and programming
        - “Treatment” is done for the purpose of benefitting a patient; “programming” is done with the correctional mission in mind, primarily reduction of recidivism
            - Mental health staff should focus on treatment
    - Provide for dedicated crisis response (rather than asking primary therapist to respond
    - Clarify and sharpen the mental health role in restrictive housing

        - Effective mechanisms for diversion from restrictive housing are necessary for this function to achieve its full value
    - Develop/endorse treatment protocols, modules, and/or manualized treatment for common conditions treated in GP
        - Emphasize group over individual to the extent possible
- Develop a more diverse residential mental health service and special housing settings
    - Differentiate housing settings by type of disorder to the maximum extent possible (owing to the variability of the symptoms and behaviors some patients with disorders of another category may fit better with a different group of patients, for example some TBI patients will be better treated in residential mental health than with other cognitively impaired)
        - Major mental illness (psychotic disorders, bipolar disorder, major depression – moderate or more severe, other mental illnesses with severe functional deficits)
        - The cognitively impaired
            - Traumatic brain injury (TBI)
            - Dementia
            - Intellectually disabled (best if have their own special housing unit)
        - Personality disordered, behaviorally disruptive
            - Including most self-injurious behavior
    - Develop mental health residential at various levels of custody
        - Restrictive (the following are emerging standards or recommendations being promulgated by experts in the field)
            - 10 hours of structured out of cell programming per week
                - Treatment
                    - Structured recreation
                    - Formal groups
                - Education
                - Work
                - Correctional programs
            - 10 hours of unstructured out of cell programming per week
                - Free recreation
                - Meals
                - Showers
                - Yard
        - Intermediate
            - 12-20 hours of structured out of cell programming per week
            - 10 hours of unstructured out of cell programming per week
        - Minimum
            - Highly variable needs. Typically need less structured treatment and more work/education/correctional programming and more unstructured time.
- Strengthen systems for bed control
    - Nobody placed in a residential mental health unit without mental health assent
    - Nobody removed from a residential mental health unit without mental health assent

    - Safety/security needs may trump a particular placement but some placement must be found
- Develop structured approaches to psychotropic prescribing
- Do away with tackle boxes for medication administration
- Support Discharge Review Team
- Sharpen peer review
- Expand quality processes
    - Build out audits
    - Develop QI processes
- Simplify restraint process
- Expand options for suicide monitoring and put decision-making in hands of mental health
- Develop staffing to serve the preceding
- Improve facilities
- Provide access to licensed level of care

Vision

Vision statements can be worthless or enlivening and guiding. What I suggest here is not a simple statement of purpose or mission such as taking care of the mentally ill but rather a guiding vision of what values and principles are to govern the mental health system.

A caveat emptor is in order here. In many of the recommendations that follow this "vision" section, the reader will be aware that they imply particular answers to some of these questions. I will try to point out different directions where reasonable but doubtless my personal bias will creep in.

Questions that you can use to develop the vision might include:

- How are we to prioritize our resources for mental health, substance abuse, and sex offender treatment?
    - Most of the below questions should be posed regarding all three services but I posit them for mental health
- How and to what degree does mental health participate in institutional management and control and how is this balanced with patient care?
- Should mental health have a role in offender programs and if so, what is it?
- Do we want to do the constitutional or statutory minimum and if not, how much more?
- Do we focus on doing a good job of treating the sickest or do we try to expand and stretch our resources to serve as many as possible?
- Is our primary treatment goal symptom reduction or functional improvement?
- What correctional interests do we serve?
    - Reduced recidivism
    - Reduced infractions and behavioral disruption within the prisons
    - Restoring function sufficiently to allow prison program participation
- Do we want to emphasize crisis management or structured treatment?
- Should the focus of treatment be on psychotropic medications or are other forms of treatment important to establish and develop?

- If so, what kinds of treatment?

Mental Health Benefit

Answers to the above questions will guide you to establishing what I am calling your mental health benefit. But it is essential for NDCS to have a clear understanding of the Nebraska law that is said to mandate that NDCS provides the same standard of care as the community. NRS 83-4, 154 states that NDCS must provide "…the type, quality, and amount" of medical care that a person in the community "…could expect to receive in that community." But it also speaks to the "community in question", raising the possibility that it is a local (not state) standard. It cannot be the case that NDCS is required to treat anyone who asks to be treated. Any health care system or insurer will have defined benefits.

NDCS should establish a defined benefit for mental health care. As it is difficult to do this purely on the basis of diagnosis for mental illness, it will almost certainly be necessary to include a functional component to determinations of medical necessity unless barred by law.

In order to implement a defined benefit, some form of utilization review and utilization management is necessary. It need not start as a robust system and can even begin simply by publishing the benefit with the expectation that individual practitioners will adhere to the benefit under ordinary supervision. You will find this a relatively ineffective system but it introduces the concept and can help you refine the benefit (an on-going process). Staying within this approach, the role of the supervisor can be strengthened and expanded to allow for formal authorization for treatment (in at least some cases) to be required for treatment to begin. This changes the role and workload of supervisors but this is not a real barrier. They do less direct care but structure services in general so that it is more effective and the overall efficiency of your system improves.

A more robust system that provides for independent utilization determinations can also be developed but may not be necessary. This could be done by committees (including of practitioners themselves), a utilization office, or any of a number of models.

Note that utilization mechanisms demand accurate assessment and thereby indirectly feeds back on your peer review, audit, and QA/QI processes.

But most importantly, you will need mechanisms for tracking utilization.

Informatics

It is not possible to create and maintain utilization processes without a better system of information management. Reliable data and the capacity for robust analysis of that data are essential for a variety of other functions (notably QA/QI, budgeting, and resource allocation).

NDCS has serious shortcomings with regard to informatics in mental health and health services in general. While a number of staff have, out of necessity, created workarounds to try to address these limitations, they are poorly integrated and inflexible. It is not currently possible to get a clear picture of the services delivered to an individual, by a staff member, or in the aggregate. A tremendous amount of

work had to be done by hand in preparation for my visit; much of this was information that should be considered "dashboard" level information available at any time, such as the ability to characterize the current mental health population, to track service delivery and service utilization, to monitor medication trends and costs, to manage bed utilization, to track critical incidents, etc.

This is an area for substantial development with large potential pay-offs in terms of developing real systems for utilization review and management, ability to report efficiently both inside and outside the organization, and audits and quality improvement. In short, without better informatics, it will be very difficult to maximize the efficiency and effectiveness of services.

Organizational Structure

In general, the administrative organizational structure is typical of correctional mental health systems. The system has chosen to break behavioral health up into mental health, substance abuse, sex offender, and social work services. The only unusual structure is that facility psychiatrists report directly to the behavioral health administrator; they would typically report to the local mental health administrator but I do not see this as problematic as long as there is sufficient clinical oversight through peer review or other structured clinical oversight. At this point, the Medical Director provides clinical oversight to the psychiatric prescribers. It would be preferable for psychiatric prescribers have clinical oversight by a psychiatrist, which could be done by a chief psychiatrist (discussed below under **Staffing**) or by peer review (which would need to be restructured if it were to serve this purpose, also as noted below under **Peer Review**).

The decision to split behavioral health up is reasonable and allows clarity and division of mission. It can create problems of silos and challenges to fluid restructuring of clinical services but I do not see it as a fundamental barrier. In some ways, it forces a careful evaluation of how your services are arrayed in light of the priorities that are established by your vision. In my view such a careful analysis is critical. For instance it is noteworthy that your staffing for substance abuse treatment is more robust than for mental health. Is this in line with the department's vision and meeting its legal obligations?

These sorts of questions must be answered not in the sense of winners and losers but from the perspective of achieving the goals of behavioral health in the context of the NDCS prison system and its larger mission and vision.

Behavioral health cannot function in a vacuum and has some responsibility to the overall correctional system. It is for this reason that I support your system's approach of not privatizing mental health. When the focus is on profits and the delivery of contracted clinical services, the system loses the sometimes unrecognized benefits of an embedded mental health system. An embedded system can add a great deal of value by providing forensic functions, training, program development (not just for mental health), risk assessment, risk reduction, connections to training programs, leadership, and so on. A privatized system can provide sound clinical care (with a properly crafted and monitored contract) but in my opinion a degree of flexibility and ineffable added value is likely to be lost.

Initial Assessment

The nature of the initial assessment must be driven by a variety of factors including: standards, volume, resource management, and the mental health benefit. In general, there must be some form of mental health screening of every inmate. But what NDCS is currently doing is more than is necessary. The primary goal at this point is to not miss high risk problems: suicide risk, psychosis, severe mood disorders, and significant cognitive deficits.

A reception screening can be conducted by a trained officer or nursing staff (in prisons, this is almost always done by nursing staff and is the most prudent approach). This should include a mental health component (typically a checklist) that addresses: suicide (current ideation and past attempts and ideation), psychotropic medications (whether currently ordered, currently taking, any past use), past psychiatric hospitalizations, current and past outpatient treatment, past correctional treatment, any mental health complaints, history of special education, and observations of unusual behavior, orientation, and general demeanor (agitation, tearful, etc.).

Currently, a full assessment is being done on all admissions to NDCS; this is unnecessary. An intake mental health screen should be done on all admissions by mental health staff ASAP (but within two weeks in all instances). But this need only be a 5-15 minute, semi-structured interview that covers most of the elements of the reception screening and adds additional information such as what specific medications are being taken or have been taken, reasons for past hospitalizations, details of current complaints, and more robust inquiry into suicide risk and significant signs and symptoms of major mental illness.

An assessment need be done only on those for which either screening is positive. And even at this stage, it need not be a full assessment but a brief assessment sufficient to make a determination about whether the inmate is likely to meet medical necessity criteria for treatment (the exception to this is that a full assessment will be necessary for anybody admitted on psychotropic medication). One way to handle this is by designing a progressive assessment that can be halted at several points along the way to a complete assessment.

Referral

Initial screening will always miss some cases and of course many inmates will decompensate after admission. There must be robust detection mechanisms. This requires that both staff and offenders can initiate an emergency to which there will be an immediate response either by mental health staff or by nursing (who then consults with mental health). Note that mechanisms to curb inmate abuse may be necessary, which may include infraction for misuse of emergency declarations, co-pays for emergencies, or other behavioral approaches.

Both inmates and staff (custody and medical) must also be able to generate a routine referral. It must include a reason for the referral. The inmate must be able to submit the referral confidentially (NDCS has taken officers out of this process to insure confidentiality).

Referrals then have to be triaged, usually by the next working day is sufficient (since there are other mechanisms for emergencies). The referrals are categorized into emergent (to be seen ASAP), urgent (to be seen by the next working day), and routine (to be seen within two weeks).

Urgent and emergent responses should not entail a full assessment but crisis management and a referral for full assessment if indicated. Routine referrals also need not entail a full assessment but a brief assessment to determine whether a condition meeting medical necessity is likely present.

It is important to track referrals as this is an essential detection function and a place where systems often struggle to meet their own internal standards.

Outpatient Services

Another area where substantial clarification and some potential savings can be accrued is in minimizing the use of mental health staff for correctional programming. Licensed mental health staff should generally be reserved for treating those whose conditions meet medical necessity criteria. This not only brings structure and savings but also prevents NDCS from running afoul of informed consent. One way to look at the distinction between treatment and programming is that treatment can be refused without fear of sanction (inmates have a right to refuse all but legally mandated involuntary treatment) while inmates who refuse programming may be sanctioned.

But it is also reasonable to ask mental health to assist in establishing some of these programs both in terms of using their expertise in identifying evidence-based programs but also in terms of providing training and initial direct service while non-licensed staff develop the expertise to conduct the program with fidelity.

With regard to general outpatient services, it is important to move from a crisis-driven system to a proactive and preventive system to the maximum possible. When crises are the only way to assure contact with mental health, crises are reinforced and it creates a negative spiral. Delivery of structured services to those in need is the best antidote for this. Other than medications, this should primarily focus on short courses of treatment (8-12 weeks) in groups and limited individual therapy using evidence-based approaches to the most common serious problems faced in GP: PTSD, depression, and severe anxiety disorders. Most of this will be CBT-based treatment but the most important initiative is to bring structured courses of evidence-based (often manualized) treatment to GP.

Those with major mental illness in GP will primarily need medications and case management services (assistance in developing programs and navigating the system, supportive contact, and psychoeducation). This too needs to be structured with scheduled contacts and formal expectations.

The most effective structure for providing this is to assign primary therapist to active patients, i.e. those receiving case management services or more. This provides continuity of care, confers clear clinical responsibility, and simplifies coordination with custody, medical, and other behavioral health services. They become the point of contact and coordinator for their patient much like a primary care doctor.

It is also important to strengthen the mental health presence in restrictive housing. Placement in restrictive housing is a high risk time. I recommend that mental health be assigned to all restrictive housing units in sufficient number to allow initial screening of all new entries by the next working day. The custody and nursing screenings are adequate to detect emergent problems but more careful assessment is prudent. Weekly rounds are also a sound practice being adopted in many systems and I recommend this occur as well. While rounds can be conducted at cell front, screenings and assessments should be done in private, even if that is with a restrained patient or in a non-contact booth.

Unless these initiatives are accompanied by real mechanisms for transferring those with serious mental health conditions out of restricted to a residential setting with meaningful access to care (even if high security), this function is almost useless. The mental health treatment that can be offered in traditional restrictive housing units is extremely minimal and limited in efficacy.

Residential Mental Health Services

It can be expected that about 2-4% of the correctional population will need residential or hospital level mental health services, depending on the efficiency and effectiveness of outpatient services and the conditions in general population. The worse these are, the more it can be expected that those with mental illness will fare poorly. Conditions such as crowding, violence, and limited direct oversight by correctional staff are particularly notable in terms of the likelihood of leading to mental health decompensation. Lack of structured outpatient services and access to psychiatric services are of course contributory as well.

The array of residential services in NDCS is limited. At the present time, the residential mental health units house patients with very diverse disorders including dementia, traumatic brain injury, intellectual disability, personality disorder, and major mental illness. It is not possible to run an effective program with such diversity both because the services they require are so disparate and because these populations often do not mix well together.

This problem is not easily remedied at NCCW as the numbers are too low to efficiently create special housing settings for the different populations. This means that mental health staff in the STAR program must be able to provide flexible programming targeted at the different populations. The one point I will mention is that NDCS would do well not to mix the PC and mentally ill as this is resulting in a situation in which, by virtue of being mentally ill, these inmates get reduced access programs and out of cell time, which is likely an ADA issue. If there are logistical strategies that can remedy this issue, that is sufficient as there is no inherent reason the populations cannot be in the same living area. Beyond this, I have no helpful recommendations for the STAR program (except see my comments below on a level system) other than to develop diverse interventions to match the diverse population. The small numbers and diversity make group treatments less attractive though they should be used to the maximum extent possible.

The male prisons have the numbers to make some progress on these issues. In order to frame the issue better, I will offer some prevalence information as background. The prevalence of dementia in those over age 70 is 14% (and very low below age 65), higher in correctional settings. The prevalence of

intellectual disability in correctional settings is 4-10%. The prevalence of TBI has been estimated as high as 60% in corrections. In the general population, the prevalence of disability following hospitalization for TBI is 1%. Thus at a minimum, about 6% of the NDCS population (over 300 inmates) likely has a readily demonstrable cognitive deficit. This population should not be admixed with the mentally ill, though some with these conditions may have concomitant mental illness that necessitates their placement in mental health residential settings. They have very different service needs, often have physical limitations (requiring appropriate physical plants), and need a different living unit structure (privilege system, activities, incentives, etc.).

There is currently no good option for any of those with cognitive impairment and this is clearly an area that will need to be developed. Unfortunately, those with dementia, traumatic brain injury, and intellectual disability can also have very different needs. Typically, systems address this by having special housing for the demented and the intellectually disabled and those with traumatic brain injury may be housed in either of those units or on a mental health unit, depending on the nature of their symptoms and behavior. Those with dementia should be preferentially directed to the ADA beds at NSP, as long as reasonable separation can be maintained between this population and those with mobility problems. The most essential intervention is to keep them busy with structured, non-stressful activities. This leaves the intellectually disabled and TBI; many with TBI can be treated successfully in habilitative programs alongside the intellectually disabled. Those TBI patients with profound deficits can also be directed at the ADA beds at NSP and those with symptoms more consistent with mental illness can be in residential mental health. Those with significant behavioral disorders will remain a challenge and various placements may be tried.

The needs of the personality disordered population (the majority of inmates have a personality disorder of varying severity) are also quite distinct from the mentally ill and the cognitively impaired. In general, they should not be placed in the same units, though again sometimes must be placed (preferably for short periods) in mental health settings. This population is especially challenging to treat. The VRP provides the right kinds of services for some of this population but does not address the needs of those who engage in self-harm and non-violent behavioral problems such as feces smearing, throwing, spitting, name calling, and other distasteful but non-dangerous actions.

Further, the VRP is set up as a voluntary program so some of the most behaviorally disruptive with severe personality disorders will not qualify. Note that were the VRP run as a program rather than as treatment, offenders could be assigned rather than render consent. While it is a good idea to have a voluntary program like the VRP, it may also be prudent to consider developing a residential program (likely in restricted housing) that uses the same basic principles as the VRP but does not require voluntary placement. The primary target population would be those with behavioral problems not due to a major mental illness or cognitive impairment, most of whom would have primary diagnoses of personality disorders. Some would have mental health treatment needs, but they would be secondary issues.

Recall that 2-4% of the population is likely to need residential or licensed care (about 100-200 in NDCS). Were special populations such as the cognitively impaired and behaviorally challenging personality

disorders to be removed from the residential setting, the current number of beds (77 D, 30 C [including 16 planned beds], 10 NCCW, limited DEC beds) is marginally adequate for those with major mental illness such as schizophrenia and severe mood disorders.

The major question is how to move from the current situation of having a broad range of disorders placed in a limited program to a more differentiated program with varied services targeted at different populations. In the simplest terms, the question amounts to what type of special housing unit to develop first. The two obvious choices are a unit for the cognitively impaired (likely emphasizing the intellectually disabled) or a step-down unit for the mentally ill. In order to answer this question, the first task is to determine how many cognitively impaired that could be housed together are in the existing male residential mental health beds and in restricted housing (recognizing that the system may not be well identifying this population, an initiative to identify this population may be necessary). If the number identified is sufficient to create a housing unit, this would be a reasonable first step that would also open beds for the mentally ill.

But the NDCS mental health team has identified a need for a "step-down unit", essentially a lower custody and less acute setting to transition patients towards general population. It also allows separation of those who must be kept apart. This type of unit will likely be necessary at some point but if sufficient beds can be opened by removing those with cognitive deficits, it may not be necessary to open such a unit immediately. The expansion of C unit beds will assist in this. And since the D unit is being run at an effectively lower custody level than the physical plant provides, NCDS would at least have residential beds at restrictive and medium custody levels. This allows some capacity to manage separtees. But in order to do this, the mental health programs at both C and D will need to be strengthened, especially C unit. D unit is likely just meeting the recommended hours of structured and unstructured time out of cell. The types of groups should be expanded to allow flexibility in offerings to meet the needs of a varying population. In general, D unit is providing sound care but will be aided tremendously by placing only those with major mental illness on the unit.

It will take substantial expansion of services on C unit to meet the 10 hours of unstructured and 10 hours of structured out of cell time. Assuming NDCS is able to preferentially house those with major mental illness on this unit, groups should be targeted primarily at low-demand, highly structured groups focusing more on rehabilitation (or habilitation) and recovery. Unstructured, on-going groups are generally of limited value with those having major mental illness.

In addition to the above comments on the content of treatment in the residential units, I recommend that NDCS develop a more robust level or privilege system on its units. The current systems are very minimal and are not altogether behaviorally sound.

This will be most effective once the populations have been separated as each will be different. What I am recommending is a progressive system of 3-5 levels that starts (for all those admitted) with minimal privileges and provides for progressive privileges that are explicit and largely invariant. To promote to the next level, patients must achieve specific behavioral criteria for specified periods of time. The criteria should be developed in conjunction with the privilege to be earned. As a simple example, access

to groups (unrestrained) might be made contingent on no staff assaults, not making threats to others, and being able to participate in the give and take of conversation for, say, two weeks. Domains of criteria might include: aggression/violence, treatment participation, medication taking behavior, social interaction, anger management, and self-care. These domains and the specific expectations within them would vary depending on the population of the unit.

Bed Control

The mechanisms put in place to identify specialty population (MIRT, CVORT, SVORT) are reasonable for identifying and prioritizing use of beds. However, it has proven challenging to move inmates to make space for those who have greater need services. It is often not possible to readily find a bed in general population for a lower acuity inmate. This has not been as big a problem for those who need a more secure setting and the female population as there are generally openings available for these populations. But it is a substantial problem for the D unit residential setting. Being able to promptly open space for those with more acute needs, without having to place them in highly secure settings when unneeded, is a critical need.

There are two obvious drivers for this problem: overcrowding in general population and the lack of centralized bed control for NDCS as a whole. Overcrowding makes it very difficult to have the flexibility that is needed to move inmates promptly, preventing efficient use of beds. Lack of centralized bed control precludes the use of automated processes in bed assignment which both improves accuracy and speeds the process. It also makes the operation of a mental health system within a correctional system very difficult as dynamic placement is important to efficient utilization.

Another issue that needs to be addressed is what to do when an inmate needing residential services is denied placement because of security concerns or other issues that a warden may identify. Right now, these inmates simply do not get the level of service needed. The problem is that there is only one location where certain services are available (e.g. LCC D unit) and if there is a keep separate situation, no alternatives exist. A formal solution needs to be developed for these situations. This could include developing special conditions for mentally individuals in a GP setting (probably on a case-by-case basis) or developing residential services at other locations.

Psychotropic Medications

My main recommendations with regard to psychotropic medications are to develop protocols and guidelines directed at common disorders where such guidelines are reliable and fairly prevalent in corrections, e.g. PTSD, ADHD, OCD, Panic, and Generalized Anxiety Disorder. For other conditions where guidelines have been less successful, such as mood disorders and to some extent schizophrenia-spectrum disorders, general formulary limitations such as allowing no more than two antipsychotics or two antidepressants absent review by the chief psychiatrist or other body are prudent.

Though non-formulary medications can be obtained, consider opening up the formulary. One way to do this without incurring undue cost is to provide for formulary and restricted formulary designations.

Most often, generics are formulary and brand name drugs, high risk drugs, and other expensive drugs are made restricted, only to be accessed after demonstrated failure of formulary drugs.

These sorts of guidelines and formulary limitations should be done so as to dovetail with the mental health benefit. The benefit determines who gets treated and the guidelines determine how they get treated.

By developing such guidelines and a structured formulary, it provides the agency with a way to demonstrate diligence to outside interests both in terms of attention to appropriate clinical standards and in terms of fiscal accountability. It is important the NDCS be able to present a rational and consistent approach to all patients. The agency is not required to provide all treatments or even the best treatments but adequate treatment. It is entirely reasonable, and in fact necessary, for the agency to place limits on the scope of practice of individual practitioners. But it must be done in a manner consistent with the clinical and scientific literature.

Medication Administration

The use of tackle boxes as is being done in NDCS is highly problematic. Even if it is totally legal, it is very unwise. In my opinion, the current practice of custody delivering medications from a tackle box must be stopped. While it is possible for custody to provide this function, there are many problems in allowing this and in how it is being done presently. There is a lack of security around the tackle boxes, a lack of attention to cleanliness (gloves not used; no hand-washing), poor tracking of medications from pharmacy to patient (identification was not uniformly checked), inability to closely monitor for adverse effects, lack of privacy, and a lost opportunity to provide teaching and coaching about mental illness and medications by clinical staff.

As I noted above, medications are not being properly handled in terms of cleanliness and proper tracking and security. Custody should also not be permitted to directly handle medication, such as taking out pills or floating crushed medications, which they do. Further, custody is not following the policy as it is written, including not tracking the medications as specified and not properly identifying patients. But even if it were done well (which would entail custody providing unopened, packaged medication from a secure container to patients who take them and then return the package to custody, documenting what they took) this system presumes that the patients are capable of medication self-administration because that is truly what this is or should be; custody is, in essence, just storing medication that patients are taking on their own. It is unreasonable for NDCS to assume all patients are capable of serving this function competently.

By having nursing staff provide medications for the most ill, it also provides a chance for monitoring efficacy, identifying adverse reactions and side effects promptly, and patient education. It also takes custody staff out of a precarious position.

Conversely, it is also important to have a clear pathway to self-administered medications. Self-management of mental illness is both an important skill and, if beyond the capacity of the patient, an important consideration with regard to re-entry planning. A structured approach to self-medication, at

least in the residential mental health units, is prudent, especially if transferring to general population where self-management is essential. But this should be reserved for those who have demonstrated the ability to properly take and self-monitor their medications. For the mentally ill, a self-medication program could readily be developed where patients would demonstrate their readiness in a system that progresses to full self-administration.

I recognize that there are safety and security concerns with self-medication. These are valid and must be carefully considered. If properly managed, self-medications can be done safely. It cannot be seen primarily as a cost-cutting measure, though it will reduce costs compared to staff-administered medications. The risks of diversion and overdose must be weighed against reasonable cost savings and the development of patient self-management skills. But in no cases should patients on suicide watch or, in my opinion, in restricted housing be self-administering medications (except necessary rescue medications).

Discharge Review Team

The Discharge Review Team is charged with providing risk assessments and civil commitment recommendations regarding pending releases who may be at high risk of violence. This team needs to be supported in conducting its work and assured that it is not the outcome that determines their effectiveness and value but the quality of their work.

It is important to be very clear in policy about how referrals to this team are made and for what purpose. Formal criteria are preferable though must allow for some clinical judgment. If the primary task is to assure that those who might qualify for civil commitment are detected and carefully evaluated, it makes sense for mental health (in conjunction with your legal team) to set the criteria for who should be referred and how they should be evaluated. In general, a formal actuarial risk assessment is not indicated for this purpose. In fact, testing is of little value as the question is whether they have a qualifying condition (mental illness as defined in statute and/or case law) and whether they meet the dangerousness criteria, which in do not map onto formal actuarial risk assessments. Dynamic risk assessment is pertinent and can be done using semi-structured tools but there is no formal test that can be used to determine whether someone is committable.

If a more general risk assessment is desired, then broader criteria for inclusion is indicated. But the product needs to be clearly specified. If it is to conduct an actuarial risk assessment, that leads in one direction – but it only gives a sense of who to be concerned about and does nothing to manage the risk. A risk reduction approach leads in yet a different direction, likely an actuarial risk assessment that determines who needs to have a risk reduction plan. The risk reduction plan would then need to be based on a dynamic risk assessment.

The team could serve both functions, but each would need to be spelled out explicitly.

Peer Review

It is important to have the function that this process serves, that is, a systematic review of sentinel events and other occurrences that the health care team wants to track for the purposes of risk reduction and quality control and improvement. It is appropriately viewed as coming under laws that provide some protection from public disclosure.

But this is not a typical peer review process, which contemplates review of routine clinical practice by peers. As long as regular evaluation of the practice of clinicians by clinicians is undertaken in some fashion, such as annually by a supervisor with the clinical credentials to evaluate the practice of the supervisee, then all is well. If this is not provided for, it is essential that some form of clinical supervision or clinical oversight (as distinguished from administrative supervision) be put in place.

Quality Processes

Quality improvement is of course essential. One way of distinguishing quality assurance from quality improvement is that the former focuses on "counting widgets" whereas the later focuses on making the widgets better. Quality assurance is thus a first step in QI as you thereby "assure" that you are doing what you say you intend to do. The next step is to improve the processes and the content. In the world of mental health, this means first being able to assure that you are rendering the services that your policies and your mental health benefit demand. Essential elements include:

- Diagnostic distribution of the patient population
    - In general population
    - In each residential unit
- Encounter tracking
    - Number of each type of encounter, at a minimum
        - Initial screening
        - Mental health assessment
        - Crisis response
        - Group treatment sessions (with growing sophistication, you can track type of group – e.g. CBT, psychoeducational, rehabilitative)
        - Individual treatment sessions (also can track type of treatment)
        - Psychiatric assessment
        - Medication management
        - Consider: re-entry planning, evaluation of those in restraints or on suicide watch, rounds, required periodic assessments such as PC or maximum custody)
    - Types of encounters by clinician and location
- Numbers on suicide watch
- Numbers in restraint
- Suicide and suicide attempts
    - Also requires formal assessment, usually in line with sentinel event policies and procedures and/or morbidity and mortality committee (or similar function
- Referrals and outcomes for civil commitment
    - Mental health
    - Sex offender

- Psychotropic medication monitoring
    - Numbers and percentages of patients on psychotropic medications
        - At admission
        - In the population
            - Preferably by GP and residential settings as well
        - By different categories of medication: antipsychotics, antidepressants, antianxiety agents, mood stabilizers (as a starting point)
    - Tracking those on involuntary medications
    - Medication costs
    - Important patterns (may vary with time)
        - Polypharmacy
        - Use of particular medications (e.g. controlled substances)
- Response to referrals
- Response to kites

These elements will allow you to both respond to common requests for information and will also give you a pretty clear picture of how your resources are actually being used and what kind of service the patients are receiving. In addition, it can give a clear sense of access both by giving raw numbers of those being treated and the timeliness of response.

The audit function, a quality assurance function, is essential and should be carefully tied to reports and informatics. Put differently, findings of audits should drive the creation of reports or "dashboards" that track problems identified during audits, especially those that are systematic in nature and represent either recurrent problems of systems changes.

As noted previously, the current audit forms ask for very rudimentary information. While a reasonable place to start, the intention must be to move from only looking at the content of an individual medical record (which is certainly important) to provision of services at a system level. Tracking things like timeliness of assessments, access to care, response to kites, and provision of services on a system level is essential to running a system. While not all of these would necessarily be part of an audit process, certainly many can (and should) be included; others can be addressed through the QI process.

As mentioned in the section on informatics, NDCS also needs more robust report capacity, which can supplant staff-intensive audits in many instances. High level dashboards, detailed standing reports, and ad hoc reports targeted at specific problems or initiatives are all essential to quality improvement and quality assurance. But they require infrastructure and carefully designed data systems and data calls.

Measurement is often a missing piece in correctional health systems due to challenges with informatics and staffing limitations. But without measurement, audits, corrective action plans, and quality improvement initiatives have very limited value.

Restraint

I did not see any major problems with restraint usage or over-usage. I would raise caution about restraining on a hard bed, which should not occur for any more than a few hours.

The main question I have is around the ordering of restraint. Presently, you provide for a triumvirate of custody, mental health, and medical to use behavioral restraint. Final authority for behavioral restraint resides with the Medical Director. This is consistent with the emerging trend for any medical and mental (behavioral) health restraint to be ordered by clinicians. But to demand this triumvirate make a joint decision in all cases is unduly cumbersome and does not put the person with the expertise in the position of making the decision. In short, for behavioral restraint mental health staff should have the ultimate authority, for medical restraint medical staff should have the ultimate authority, and for safety and security custody staff should have the ultimate authority.

I should add that, in my view, custody should have the authority to initiate behavioral restraint but evaluation and a formal order by a clinician should directly ensue.

I would also note (though did not have a chance to review this so it may not be a problem) that monitoring in restraint should consist of:

- Appropriate clinical restraints (restraint chair OK for up to four hours)
- Constant, direct observation
- Initial assessment by nursing
- Every 15 minute circulation checks by nursing for the first hour and then every two hours
- Nursing assessment every 4-8 hours
- Range of motion of all extremities every two hours (if safe to do)
- Ambulation daily (if safe to do)
- Offer water every two hours – track intake to the extent possible
- Offer food at usual times
- Initial order by clinician to initiate restraint or to continue custody-initiated restraint
    - Ordering clinician to see within 4 hours to evaluate need to continue
- New order for restraint every 4 hours for the first 24 hours, then every 12 hours (varying standards exist, including on-going every 4 hours in line with CMS standards, but this is reasonable in my view)
    - Ordering clinician sees patient and/or formal mental health assessment and consultation with ordering clinician daily
- Formal mental health assessment within 24 hours if not done in previous step
- Consider measures to reduce deep venous thrombosis if restraint continues past 48 hours
    - Heparin
    - Compression stockings

Suicide Monitoring

I did not find major problems with suicide monitoring practices, though I think it could be structured somewhat more clearly and, at the same time, provide for more flexibility. But I think the policy itself has some problems.

One thing I recommend be changed is the provision for custody, medical, and mental health to make joint decisions about degree and nature of suicide monitoring and conditions of confinement. Mental

health staff are the experts in this area and are the ones that should have the responsibility and authority to make these decisions. This is the same point made with regard to restraint.

Similarly, policy provides that "The discharge of the suicidal inmate from the hospital or other segregated areas will be a joint decision among Medical, Security, and Mental Health Staff." If the purpose of this is to provide for placing suicidal inmates who are also dangerous in more secure settings, that is reasonable, assuming that full suicide precautions can be applied. But in general, if this effectively allows staff other than mental health to limit suicide precautions, this is unreasonable. A comparison with a medical condition can be instructive. It is legitimate for custody to remove a patient with chest pain and possible heart attack from a hospital emergency room if the safety and security conditions warrant – but the agency and the officer must be prepared to defend their decision in the face of a death from heart attack. It is no different for the suicidal. Put differently, custody considerations can trump medical and mental health considerations and medical and mental health are obligated to do the best they can under whatever circumstances emerge, but this should be viewed as trumping the recommendation of the experts in their field rather than a joint decision. Where the body is placed is ultimately a decision custody must make and all will need to coordinate their efforts and do their best to render services regardless of setting. But the decision should lie with the expert, subject to being overruled on other grounds, which is not the same as making the decision jointly.

While policy provides for "constant or intermittent supervision (15 minute staggered checks)", it is not crystal clear that this provides for constant, unbroken, direct monitoring. It is necessary to have explicit provision for such monitoring unless that is to be provided in a licensed setting (see below), though even then it is necessary to have this provision while awaiting and during transport. Camera observation is not a substitute for constant, unbroken, direct monitoring. This is typically one-to-one. While opinions vary on this, I believe that one staff can monitor more than one person, depending on the physical layout. The staff needs to be able to see all those being monitored at any time; this can typically be done for no more than 2 or 3 at a time.

The next step is usually 15 minute staggered checks, with or without camera monitoring (without sometimes considered an additional step). After this, some systems provide for 30 minute checks, depending on what the routine monitoring is on the unit where the inmate is housed. Many systems are also moving to a formal step of housing with a cellmate, as appropriate on a case-by-case basis.

Mental health staff should also determine the conditions of confinement, that is, what items the patient may possess. As noted, it is reasonable to have standard conditions (such as Plan A and Plan B) as long as they can be modified as needed. They also should not be tied to the degree of monitoring, which contemplates different aspects of risk.

Lastly, the location of monitoring should be considered. Policy provides for this to occur in an infirmary or a segregation observation room. If these are the only locations with suicide-resistant cells, then this may be your only choice for the highest levels of suicide monitoring. It is preferable to have cells outside of segregation, usually near or in a clinic or infirmary; being placed on suicide monitoring should not be seen in any way as similar to or a form of punishment – it is already restrictive enough. Absent

the need for placement in licensed care or residential housing, those on monitoring should remain at the institution if at all possible, in part to reduce incentives to claim suicidal ideation and, more importantly, because that is where the clinicians familiar with the case are. So providing flexibility of location, assuming other suicide-resistant cells are available, would be a benefit. Note that suicide-resistant does not mean no toilet, no shower and no bed. It only means that there are no ready anchor points. Here I note that the suicide cells at NCCW are adequate but not as good as DEC. Expanding suicide-resistant cells may be a benefit to the system by reducing transport and not overburdening DEC with high acuity patients that they do not know.

Staffing

For a system this size, the minimal mental health staffing in the central office is likely only to be able to provide for basic oversight and monitoring of staff and mental health operations. In order to do the staff work necessary for real system construction, Quality Improvement, and utilization management, at least an additional FTE would be necessary, preferably a person with both clinical and administrative experience. It is also important to have at least a small amount of a psychiatrist's time to oversee psychotropic prescribing and provide clinical oversight of psychiatric prescribers as discussed above (one day a week would be sufficient).

The most notable issue with regard to staffing is the number of vacant positions.

It is beyond the scope of this report to recommend any formal staffing model. But a few points can be made. First, a comment about staff productivity is in order. In general, clinical hourly production (that is, the amount of time delivering direct care or documenting direct care) rarely surpasses 70%.

I offer the following assumptions to use when evaluating your own staffing and then offer an analysis of psychiatric positions to give a sense of how to think through your staffing needs.

In terms of staffing, positions are reported as full time equivalents (FTE). In general, it is prudent to have a staffing model based on patient population and general expectations of productivity in light of the types of services intended to be rendered by the mental health system. As the service model is not yet well-defined at NCDS, it may be difficult to have clarity about this, but I provide some rough estimates. This project is also made more difficult by virtue of inherent inefficiencies in delivering healthcare in correctional settings caused by limited movement in general (patients and staff), periodic curtailment of movement, escort requirements, and a variety of other conditions intrinsic to corrections. As such, it is unreasonable to expect clinical productivity much higher than 60% (60% of clinicians' time providing direct care). When custody staffing is limited or there are high levels of security restriction, productivity is further reduced. It is important to emphasize that what follows does not represent rich staffing, but minimally adequate staffing.

For psychiatric prescribers, it is reasonable for one FTE to have a case load of about 100 in a residential (non-licensed) mental health setting such as D unit at LCC or STAR at NCCW. As above, NDCS needs 100-200 residential beds. At a minimum, this calls for one FTE psychiatrist.

For outpatient services, covering a caseload of 400 is reasonable and 500 is generally a maximum in this setting. This allows outpatients to be seen at least every 90 days. In part, this depends on how often patients move between facilities, which requires additional time to review new patients. If we assume a stable load of 500 outpatients, this requires 250 clinician services hours (patient visit, charting, orders, etc.) every 90 days or 1000 hours/year. At 60% efficiency, one FTE provides 1200 hours/year; the additional time is necessary for new patients. Since about 25% of GP inmates are on medications in male prisons, there should be about 0.25 X 4900 = 1225 patients on medications, requiring about 2.5 FTE psychiatrist.

At NCCW, with a population of 325 and 50% on medications, about 160 are on medications. There are 10 in the residential setting. This amounts to just short of 0.5 FTE.

Given that about 25% of entering inmates will be on or need psychotropic medications and there are about 50 intakes per week, this means there are at least 12 new cases each week for the psychiatric prescriber at DEC. This is about 0.5 FTE. As this is also a population that is likely to need frequent visits initially, the remaining 0.5 FTE will only be adequate if stays at DEC are short, on the order of 2 months. Further, coverage of the suicide rooms and SNF are also potentially substantial work drivers, though variable. It should be expected that management of these cases is about 0.25 FTE. The APRN has a current case load of 160. Assuming this is typical and assuming a monthly average follow-up, this represents an additional 80 hours per month or 0.5 FTE. This results in an estimated need of 1.25 FTE at DEC.

This totals up to 5.25 FTE of psychiatric time at a bare minimum. In my opinion, the residential need is more likely to be closer to 200 than 100. I recommend that NDCS provide a minimum of 6 FTE psychiatrist. In addition, at least 0.2 FTE should be dedicated to central office functions such as monitoring prescribing practices, committees (e.g. pharmacy and therapeutics), developing protocols, and assisting in program development.

It is more difficult to assess the need for primary therapists as it depends entirely on the type of services they are expected to provide. A rough estimate is that a residential case load of 30 is a maximum which allows for individual meetings about every other week, one daily group (10 hours with preparation and charting), and administrative duties. The addition of a recreation and/or occupational therapist would allow more individual meetings by primary therapists and provide a type of service that psychologists are not trained in but is needed for those with major mental illness.

For outpatients, it is more highly variable but a case load of about 100, the majority of whom are getting only case management services, is a minimal starting point.

In addition, the following mental health services need to be accounted for:

- Clinical oversight and supervision
- Quality improvement
- Transfer and placement (e.g. MIRT)
- Intake screening

- Intake assessment
- Transfer screening
- Crisis response
- Restrictive housing
- Forensic functions
- Re-entry planning
- Any offender change groups being run by mental health

Nursing must also be provided around the clock. While it is preferable to have a psychiatric nurse around the clock, this is probably not feasible. Nursing coverage for the residential beds at LCC can be provided by a dedicated nurse (preferably psychiatric) who can provide day shift coverage five days per week and facility nurses would then have to provide off hours coverage. But see below my recommendations regarding medication administration, which would have a more substantial impact on nursing staffing. Given the size of the STAR program, nursing coverage would have to be shared with other services but it is important that there be a dedicated nursing function to check vitals, monitor side effects, respond to and screen medical complaints, and provide basic medication psychoeducation.

Social work services for re-entry are also essential. The current staffing seems sufficient.

Given the extent of reorganization I recommend, it will be very challenging to make a clear recommendation about staffing as it depends a good deal on what recommendations are undertaken. For instance, if mental health will continue to run offender change groups, this is a large amount of mental health staff time that is not directed at the mentally ill and their numbers should not be considered part of the mental health treatment numbers.

My general sense is that were NDCS positions filled and a more structured system developed, that the front line resources would be only slightly on the low side, assuming mental health staff are focused on mental health treatment rather than correctional programming per my discussion above. Where more resources are needed is oversight and, as noted above, central office as these functions are necessary to bring the kind of structure to the system that allows the frontline staff to function more efficiently and stretch their resources further. But I do recommend that each of the five major facilities have a general population supervising clinician with substantial training and experience, typically a doctoral psychologist, whose primary responsibilities are overseeing the clinical work of supervisees and assuring implementation of the system structure, including serving the frontline utilization review function. In short, this position is charged with making determinations (at least in marginal or unclear cases) about who gets treatment, providing clinical oversight of practitioners, and participating in system functions such as MIRT. They provide some direct service, but probably no more than half time in prisons of around 1000 (as they will not have large numbers to oversee).

I also recommend that you have a residential director for each residential unit. Given the current array, one for LCC D and a 0.5 position for LCC C would be sufficient. Given the limited residential beds at NCCW, the STAR program can be overseen by the NCCS mental health director.

Facilities

Other than my comments above about suicide cells, I will withhold any recommendations about physical plant modifications as that is beyond the scope of this report. The one exception is that it is my understanding that the LCC mental health residential setting is not ADA compliant; a solution needs to be found as the physically disabled must have access to these services.

But I will recommend that NDCS continue to explore using monitors in various settings to provide passive programming and also that the environment be generally enriched, especially in control units and special housing units. Lack of varied sensory stimulation is neurologically damaging.

Licensed Level of Care

All systems need to have access to licensed services for the most seriously ill. Systems can either create these themselves (usually only realistic in very large systems), coordinate with public sector hospitals, or enter into contracts with private hospitals. While the need for these beds should be sporadic when the prison mental health system is well-designed and fully implemented, there are always cases beyond the reach of the level of services that prisons should reasonably be expected to provide.

DEC is not a reasonable substitute for licensed level of care. It is a poor facility for providing mental health treatment as it has no programming space, limited access to meaningful privileges, and is not staffed to serve this function. As it will continue to need to serve medical purposes, modifications are not feasible. Most importantly, it is highly unlikely that any reasonably possible set of modifications and staffing increases would bring it into licensure.

This concludes my report. But before closing, I wanted to say that while the NDCS mental health system has room for growth, there is a lot of good work going on. Again, the focus on those with major mental illness and the services provided at LCC D unit are moving in the right direction and were the correct places to start. You also have high quality, professional, and dedicated staff. It is important for them to experience positive change and to know that their work is valued.

Respectfully submitted,

Bruce C. Gage, M.D.

Chief of Psychiatry, Washington Department of Corrections
Clinical Associate Professor, University of Washington

APPENDIX 2 – JPA Approval Letter

JUSTICE CENTER
THE COUNCIL OF STATE GOVERNMENTS
Collaborative Approaches to Public Safety

November 2, 2015

Scott R. Frakes, Director
Department of Correctional Services
State of Nebraska
P.O. Box 94661
Lincoln, NE 68509

Dear Director Frakes and the Nebraska Justice Reinvestment Steering Committee,

The Council of State Governments Justice Center (CSG Justice Center) is excited to receive your request to engage in a comprehensive assessment of Nebraska's correctional programs. Your leadership in undertaking this work is commendable and we are happy to target a portion of our justice reinvestment implementation technical assistance to evaluate current programming allocations and ensure that correctional programming is being targeted to maximize the likelihood of reducing recidivism. The U.S. Department of Justice's Bureau of Justice Assistance supports this request, at no charge to the state.

The assessment of Nebraska's correctional programs (referred to as the Justice Program Assessment or JPA), will evaluate the extent to which the state is making investments in programs for prisoners and parolees that will likely be able to reduce recidivism by adhering to evidence-based principles, specifically 1) targeting people who are most likely to reoffend (who), 2) using practices rooted in the latest research on what works to reduce recidivism (what), and 3) regularly reviewing program quality and evaluating how closely the program adheres to its established model. As identified in your request, the CSG Justice Center will require access to Department of Correctional Services' staff, programs, and data systems so that the CSG Justice Center may observe existing assessment practices, program assignment, program delivery activities, and data collection. Thank you for granting us this access to facilitate a successful JPA process.

We expect that this assessment will take approximately six months to complete and will culminate with a final report to the Steering Committee including the assessment findings and recommendations from the CSG Justice Center. This final report may be presented to a wider audience as determined by the Steering Committee during the JPA process.

We look forward to working with you on this endeavor. If you have any further questions about the JPA process, please contact Bree Derrick at bderrick@csg.org or 206-454-8285. Bree will be in touch to begin coordinating this work.

Sincerely,

Marshall Clement
Division Director, State Initiatives
Council of State Governments Justice Center

Appendix 3: Diagnosis Distribution among Incarcerated NDCS Population

On December 30, 2015, 5,336 sentenced inmates were housed in an NDCS facility, and 4,419 had a behavioral health diagnosis. The table above provides the distribution of diagnoses among the incarcerated population and includes inmates have multiple diagnoses. In addition, 246 inmates had only "V-code" diagnoses, which identify temporary conditions and/or factors that may influence present or future care. A NOS diagnosis represent the presence of meaningful psychiatric symptoms but the patient does not meet the criteria for a full diagnosis due to a variety of situations (ie. symptoms due to situational stress, withdrawal or intoxication).

Diagnosis Code	Diagnosis	# of Inmates with Diagnosis
304.3	Cannabis Dependence	963
304.4	Amphetamine Dependence	890
303.9	Alcohol Dependence	803
305.2	Cannabis Abuse	599
305	Alcohol Abuse	504
296.9	Mood Disorder NOS*	453
300.02	Generalized Anxiety Disorder	422
300	Anxiety Disorder NOS*	414
301.7	Antisocial Personality Disorder	347
309.81	Posttraumatic Stress Disorder	326
V61.21	Sexual Abuse of Child	311
309.9	Adjustment Disorder Unspecified	299
305.7	Amphetamine Abuse	264
304.8	Polysubstance Dependence	226
311	Depressive Disorder NOS*	208
296.3	Major Depressive Disorder, Recurrent	204
304.2	Cocaine Dependence	199
309.28	Adjustment Disorder w/ Mixed Anxiety and Depressed Mood	178
305.6	Cocaine Abuse	147
296.8	Bipolar Disorder NOS*	145
V61.12	Physical Abuse of Adult	111
304	Opioid Dependence	99
298.9	Psychotic Disorder NOS*	88
296	Major Depressive Disorder	87
295.9	Schizophrenia, Undifferentiated Type	63
295.7	Schizoaffective Disorder	61
305.5	Opioid Abuse	60
309	Adjustment Disorder w/ Depressed Mood	58
300.23	Social Phobia	54
V62.82	Bereavement	50
305.3	Hallucinogen Abuse	47
301.83	Borderline Personality Disorder	47
300.01	Panic Disorder without Agoraphobia	47
302.2	Pedophilia	45
296.89	Bipolar II Disorder	44
V71.01	Adult Antisocial Behavior	39
314.01	Attention-Deficit/Hyperactivity Disorder, Combined Type	39
301.9	Personality Disorder NOS*	38
292.9	Cannabis-Related Disorder NOS*	38

Diagnosis Code	Diagnosis	# of Inmates with Diagnosis
309.4	Adjustment Disorder w/ Mixed Disturbance of Emotions & Conduct	36
300.3	Obessive-Compulsive Disorder	36
312.3	Impulse-Control Disorder NOS	35
314.9	Attention-Deficit/Hyperactivity Disorder NOS*	34
296.6	Bipolar I Disorder - Most Recent Episode Mixed	33
309.24	Adjustment Disorder w/ Anxiety	32
291.9	Alcohol-Related Disorder NOS*	32
300.4	Dysthymic Disorder	31
292.9	Amphetamine-Related Disorder NOS*	30
V62.81	Relational Problem NOS	28
V61.21	Physical Abuse of Child	28
V61.12	Sexual Abuse of Adult	28
307.42	Insomnia	27
304.9	Other Substance Dependence	25
304.5	Hallucinogen Dependence	21
296.7	Bipolar I Disorder - Most Recent Episode Unspecified	21
V62.89	Borderline Intellectual Functioning	18
296.4	Bipolar I Disorder - Most Recent Episode Manic	16
305.9	Other Substance Abuse	15
296.5	Bipolar I Disorder - Most Recent Episode Depressed	15
312.34	Intermittent Explosive Disorder	14
302.9	Paraphilia NOS*	14
295.3	Schizophrenia, Paranoid Type	14
296.2	Major Depressive Disorder, Single Episode	13
300.21	Panic Disorder with Agoraphobia	11
312.31	Pathological Gambling	10
309.3	Adjustment Disorder w/ Disturbance of Conduct	10
292.9	Cocaine-Related Disorder NOS	10
301.81	Narcissistic Personality Disorder	9
296.4	Bipolar I Disorder - Most Recent Episode Hypomanic	9
294.9	Cognitive Disorder NOS*	9
317	Mild Mental Retardation	8
312.82	Conduct Disorder, Adolescent-Onset Type	8
305.9	Phencyclidine Abuse	7
305.4	Anxiolytic Abuse	7
301.22	Schizotypal Personality Disorder	7
V61.1	Partner Relational Problem	6
301.6	Dependent Personality Disorder	6
292.9	Other Substance-Related Disorder NOS*	6
292.84	Other Substance-Induced Mood Disorder	6
314	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type	5
313.81	Oppositional Defiant Disorder	5
307.5	Eating Disorder NOS	5
305.1	Nicotine Dependence	5
301.2	Schizoid Personality Disorder	5
301	Paranoid Personality Disorder	5
297.1	Delusional Disorder	5
301.13	Cyclothymic Disorder	4

Diagnosis Code	Diagnosis	# of Inmates with Diagnosis
292.9	Hallucinogen-Related Disorder NOS*	4
318	Moderate Mental Retardation	3
307.47	Dyssomnia NOS*	3
305.9	Inhalant Abuse	3
302.6	Gender Identity Disorder NOS*	3
292.9	Opioid-Related Disorder NOS*	3
V62.4	Acculturation Problem	2
780.52	Sleep Disorder Due to General Medical Condition, Insomnia Type	2
314.01	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Implusive Type	2
312.81	Conduct Disorder, Childhood-Onset Type	2
308.3	Acute Stress Disorder	2
307.1	Anorexia Nervosa	2
304.6	Phencyclidine Dependence	2
301.5	Histrionic Personality Disorder	2
300.81	Somatization Disorder	2
295.4	Schizophreniform Disorder	2
294.8	Dementia NOS*	2
293.84	Anxiety Disorder Due to General Medical Condition	2
293.83	Mood Disorder Due to General Medical Condition	2
292.12	Amphetamine-Induced Psychotic Disorder w/ Hallucinations	2
V65.2	Malingering	1
780.9	Age Related Cognitive Decline	1
313.82	Identity Problem	1
312.33	Pyromania	1
310.1	Personality Change Due to - General Medical Condition	1
307.89	Pain Disorder Associated w/ Both Psychological Factors & General Medical Condition	1
307.8	Pain Disorder Associated with Psychological Factors	1
307.51	Bulimia Nervosa	1
307.47	Nightmare Disorder	1
307.23	Tourette's Disorder	1
304.6	Inhalant Dependence	1
304.1	Anxiolytic Dependence	1
302.83	Sexual Masochism	1
302.82	Voyeurism	1
302.81	Fetishism	1
301.82	Avoidant Personality Disorder	1
301.4	Obsessive-Compulsive Personality Disorder	1
300.6	Depersonalization Disorder	1
300.22	Agoraphobia without History of Panic Disorder	1
300.19	Factitious Disorder NOS*	1
300.15	Dissociative Disorder NOS*	1
296.24	Major Depressive Disorder, Single Episode, Severe w/ Psychotic Features	1
296	Bipolar I Disorder - Single Manic Episode	1
294.1	Dementia Due to Head Trauma	1
293.82	Psychotic Disorder Due to - w/ Hallucinations	1
293.81	Psychotic Disorder Due to - w/ Delusions	1
292.9	Anxiolytic-Related Disorder NOS*	1
292.89	Amphetamine-Induced Anxiety Disorder	1
292.84	Amphetamine-Induced Mood Disorder	1
292.11	Amphetamine-Induced Psychotic Disorder w/ Delusions	1
292.11	Other Substance-Induced Psychotic Disorder w/ Delusions	1