MENTAL HEALTH SCREENING FOR PRISONERS UPON ENTRANCE TO STATE PRISONS

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ABSTRACT

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The prison system has left a penal system that strives to rehabilitate an offender, for one that simply punishes. This is detrimental for prisoners with mental disorders, as their condition may worsen exponentially with incarceration. This research examines the mental health screening processes for prisoners upon entrance to state prisons across the United States, by identifying the screening process via state policies.

State policies were identified by going onto the respective DOC websites for every state, and reading through the mental health/health policy in order to identify whether or not there were mental health screening processes in place. The resulting analysis reveals that most states do mandate an initial mental health screening for prisoners, although, they do use an array of screening tools to do so. An array of screening tools makes it difficult to assess the systems with best practices and systems in need of improvement, and a national standard of testing would benefit the data collection for future projects.

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DEDICATION

I dedicate this thesis to my mother and father for their unwavering love and strength that not only got me to be studying in the United States, but all your sacrifices have helped me to study what I love and making my dreams come true. I could not have done any of this without your support, your dedication to my education, and your words of wisdom.

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Introduction

In the state prison system, it is often posited that all of the prisoners are of sound mind and body as they have gone through the court system without any type of mental health diversion. It is often unclear whether or not prisoners who are sent to prison have received any sort of mental health treatment or assistance before they become incarcerated. Unfortunately, the reality of even being screened for a mental health disorder may be slight. Most prisons and jails have, by default, become mental health facilities for prisoners, due to the lack of mental health facilities within the United States that should be caring for patients and as a result have criminalized the mentally ill (Fisher, Tower, Silver, & Wolff, 2006).

Many studies across the world focus mainly on the mental health of prisoners that are already incarcerated, and also the types of care for these patients (Davies, 2003; Romilly & Bartlett, 2009; Filho & Bueno, 2016). Studies generally confirm what researchers, policy makers, practitioners, and advocates have long understood: the current and lifetime prevalence of mental illnesses is higher among incarcerated populations than in nonincarcerated populations (Prins, 2014; Holton, 2003). It is often recognized that offenders' poor mental health can be exacerbated by the conditions of incarceration, little comprehensive effort has been made to address this problem as the balance between public safety and human rights has left corrections services with challenges in providing appropriate care for inmates (Al-Rousan et al., 2017). Researchers have noted that a holistic screening and training approach would benefit both the offender and the institution (Smith, 2012). However, there is a dearth of research regarding the current state of mental health service delivery in state prisons.

Mental health screening in prisons are important for the safety and quality of life of the mentally ill prisoner, their fellow prisoners, the prison staff, and the general population once the incarcerated are released after their sentence is completed. Mental health screening should also assist in re-entry efforts improving the likelihood that released offenders will continue outpatient treatment, and by doing this, the rate of re-offending could decrease.

Literature Review

Mental health screening tools vary worldwide as legal systems and policies to care for prisoners differ. In the United States, the National Commission on Correctional Health Care (NCCHC) and the American Correctional Association (ACA) have set standards for the health and mental health care within prisons. Accreditation with the NCCHC and the ACA occur on a facility to facility basis and not necessarily on a statewide basis. In order to be accredited with either the NCCHC or the ACA, each facility that wants to be accredited has to meet certain standards, which are outlined in their manuals once the facility wants to move forward with accreditation. For the NCCHC accreditation purposes, 100% of applicable essential standards must be met, and at least 85% of applicable important standards ("NCCHC Accreditation Survey," 2018). Facilities that are accredited with NCCHC receive training and assistance with mental health issues that may arise, and how to keep the facility at the highest standards following the NCCHC standards set in place since 2008. ACA standards are stricter, in that all the accredited facilities must comply with all the standards set forth by the ACA Standards Committee. The Standards Committee write updated standards of operation every year and gets approved by majority vote through the Committee. ACA publishes 22 manuals every year to cover all areas of correctional operation, including; adult, juvenile, and community corrections as well as correctional training academies, industry programs, and central administration offices ("ACA Standards", 2018).

According to NCCHC and ACA, the benefits of accreditation help to improve the value of the facility in terms of efficiency of the health care system. Such benefits include; increases prestige for the facility, creates an increase in community support, increase in staff morale, and better outcomes with budgetary requests. Those that are not accredited, quite often, do not have any mental health screening processes in place (Curtis, 2012) which decrease the value of the prison and the effects it has on the prisoners and the community at large, however, these claims have not been verified by independent research or the literature reviewed.

Mental Institutions and Deinstitutionalization. Mental health institutes had a brief stint in American history, although it lasted for a few decades and very few exist today, it was part of a very small blip on the American history timeline. Mentally ill people were treated differently depending on which century is examined. As early as the 1600s mental illness can be traced to how people were treated and the lack of understanding that was prevalent. Such is evident in the Salem witch trials which were turbulent times led by churches and religion. But, at the end of the 17th century and continuing into the18th century, secularism grew and the churches' power waned, so did the view that disturbed behavior was a symptom of demonological possession, to be dealt with exorcism or death (Bassuk & Gerson, 1978). Once this view of possession was over, the mentally ill were more likely to be housed in either prisons or psychiatric institutions. Negative attitudes and stigmatization led to unhygienic (and often degrading) confinement of mentally ill individuals ("A Brief History of Mental Health", n.d). These institutions often had terrible living conditions and inhumane treatment options such as blood-letting, gyrators, and tranquilizer chairs (Farreras, 2018). Degrading conditions and experimental treatments brought out advocates in search of improving the institutionalization settings and to decrease the incarceration rates of the mentally ill.

Such an advocate for the mentally ill was Dorothea Lynde Dix. She gathered evidence of how insane men and women were housed and treated. In state after state, Dix then submitted memorials that publicized her findings and lobbied members of the state legislatures to vote for bills that would either create new mental hospitals or improve old ones (Norbury, 1999). These hospitals seemed to be running well, until the late 1880s where exposés of appalling conditions in these institutions led to investigations and reforms. These reforms, however, did not improve the treatment or prescribed conditions. Patients were castrated, lobotomized, received electroshock therapy, and new drugs that catapulted these patients into subversive behaviors (Joseph, 2016; Morrison, 1991; Reilly, 2015). With these new medical procedures not necessarily being seen by the outside community, there was an influx of patients due to favorable societal views, as they thought these patients were being 'cured' of their mental ailments. Those individuals who were unable to engage in productive labor were confined in special institutions where they would no longer threaten the social order (Grob, 1980).

Mental health facilities were overflowing, custodial care decreased and governmental assistance became obsolete. Conditions within these asylums were so horrendous that what little staff was left would simply just walk away. Asylums slowly shut down and as a result the patients were left to fend for themselves if their family would not care for them. On the streets many of these former patients now had repeat encounters with police and the criminal justice system (Raphael, 2000; Paulson, 2012; Raphael & Stoll, 2013). Transinstitutionalization of mental health care to incarceration was a theory that in 1939, Lionel Penrose published. He claimed that two populations [are] inversely correlated: as one decreases, the other increases, in terms of the relationship between populations of psychiatric hospitals and that of prisons (Torrey, Kennard, Eslinger, Lamb, & Pavle, 2010). Unknowingly, his interdependent hypothesis

publication catapulted the United States into embarking in a social experiment in the late 1950's known as deinstitutionalization, due to the debating of procedural, statutory, and ideological changes taking place at the time. Deinstitutionalization was a product of the overcrowding and deteriorating hospitals; new medications that significantly improved the symptoms of about half of patients; and as Torrey (1995) pointed out that there was a failure to understand that many of the sickest patients were not able to make informed decisions about their own need for medication; as well as the introduction of the Medicaid and Medicare programs, which cut the funding for state run mental hospitals and shifted the funding towards community care facilities. This fund shift created an incentive for states to transfer all eligible residents of mental hospitals to nursing homes and other facilities (Raphael & Stoll, 2013).

Deinstitutionalization taking effect and mental hospitals shutting down, transinstitutionalization was now the shift that many patients experienced. Transinstitutionalization is the process whereby individuals, supposedly deinstitutionalized as a result of community care policies, in practice end up in different institutions, rather than their own homes (Scott & Marshall, 2009). The shift from psychiatric institutions put patients in general hospitals, nursing homes, or prisons.

Research related to the transinstitutional shift has emphasized mental health care within the prison system instead of the effects upon prison admission and impact for incoming prisoners who have any mental instability. However, focusing on mental health screening at the intake process, could assist staff in meeting or maintaining the healthcare needs of prisoners while they serve their terms (Hayes, Senior, Fahy, & Shaw, 2014), and could assist prisoners of minor offenses; such as lower level drug offences or outbursts due to mental health issues, get care in the prisons' health care facilities for mental health services or rehabilitation services. Screening

for its sake, though, is inadequate without appropriate training. Prisons with a screening process in place, past studies have found poor identification of offenders with mental illness for treatment services (Martin, Colman, Simpson, & McKenzie, 2013a). This poor identification can happen when the offender has no previous record of psychiatric treatment, the test being administered does not include certain disorders (such as drug disorders, or major depression) screening can result in false positives for offenders who do not have any mental disorders, thus creating a lack of resources for people who severely need mental health care (Martin, Wamboldt, O’Connor, Fortier, & Simpson, 2013). Mental health disorders follow a guideline as emphasized in the Diagnostic and Statistical Manual of Mental Disorders fifth edition (DSM 5) and is intended to aid in the accurate diagnosis and treatment of mental disorders (American Psychiatric Association, 2013). A proper screening of the prisoner upon intake could reduce negative effects while incarcerated. Before incarceration, steps could be taken to divert a person from prison. A diversion could take place in the initial steps of the criminal justice system such as the courts.

Mental Health Courts. For low level crimes or for severe crimes, a person could be diverted to the mental health court (MHC), which is a promising step for arraignment due to the fact that they could be diverted to mental health facilities instead of prisons. MHC’s have received praise in many articles (Almquist & Dodds, 2009; Mazar, 2017; Canada & Ray, 2016; Bullard & Thrasher, 2016; Snedker, Beach, & Corcoran, 2017) for their ability to reduce recidivism among mentally ill patients. Gottfried and Christopher (2017) pointed out the implementation needs of successfully transitioning mentally ill offenders from the justice system to community-based mental health treatment services by using MHC’s as a foundation.

Incarcerated individuals with mental health issues present various challenges. Such challenges include; lack of mental health care throughout their term, stigmatization,

discrimination, isolation from social networks, increased amount of infractions, various forms of violence, and even an increased risk of suicide (Haney, 2017; Morrison, 1991; Melnikov et al., 2016; Matejkowski, 2017; Winters, Greene-Colozzi, & Jeglic, 2017). The detection, prevention and proper treatment of mental disorders, together with the promotion of good mental health, should be both a part of the public health goals within prison, and central to good prison management (WHO, 2005). By failing to detect symptomatic prisoners, it could potentially lead to victimization from other inmates. Serious disorders such as schizophrenia or bipolar disorder become high risk factors for the patient, other prisoners, and also the staff. Violent psychosis can increase the chances of being violent towards others and also to self-harm. Daquin and Daigle (2017) looked at the types of mental health issues that created an environment for the person to be victimized inside of prisons. They found that inmates with mental disorders are acutely vulnerable to being targets because they deviate from the norm and can easily be manipulated.

Victimization. Prison itself presents many challenges to those incarcerated, regardless of their types of crimes, they have to adjust to confinement and as research has shown that confinement has negative effects on prisoners who have no mental disabilities (Jordan, 2011; Yang et al., 2009; Fazel et al., 2016). Violence in general is a byproduct of prison life, as these individuals are already antisocial in nature (in comparison to the general public) and confined in an overcrowded and often deteriorating and underfunded setting that creates hostile feelings (Schenk & Fremouw, 2012; Duran et al., 2018; Morris et al., 2012). Combining all of that hostility with the fact that a person has a mental illness can create an environment that has the potential to not only make the person lapse into further mental declination and degradation, but it allows for other prisoners to victimize those who cannot defend themselves. Verbal abuse and physical assaults are common experiences for seriously mentally ill inmates, and rapes are not

rare (Torrey, 1995). Victimization occurs mainly in the prisons' general population without special protections from the guards or other prison staff. Much of the research shows that victimization across all types are highest amongst the mentally ill (Blitz, Wolff, & Shi, 2008; Wolff, Blitz, & Shi, 2007; Goode, Hassine, Kupers et al., 2015) and people who have mental illnesses are often physically or cognitively unable to protect themselves from harm. Besides external reasons for victimization, the mentally ill person could provoke another inmate unintentionally. Daquin & Daigle (2017) found that prisoners with depression and/or personality disorder were more vulnerable, but those with psychotic disorders less so; those who reported depressive cognitions, paranoia, and/or hallucinations were more vulnerable.

Lack of medication from doctors, or the incorrect prescriptions may cause severe side effects physically and mentally. These effects could manifest into physical portrayals of hallucinations or could alter their personality into a violent one if their personality disorders and mood swings are not kept balanced (Niveau, 2007; Hassan, Edge, Senior, & Shaw, 2014; Rice & Harris, 1997). They could physically attack another inmate in a delusional state, or as they often do, seek extra attention from the guards and are often seen negatively by the other inmates. Some prisons do not have the funding to supply the mentally ill with the correct medications, and often times if the prisoner has not had any professional mental health assistance in the past, it can take a long time for the prison health staff to diagnose, prescribe the correct medication, and see an improvement in the patient (Bowen, Rogers, & Shaw, 2009; Exworthy et al., 2012; Adams & Ferrandino, 2008). The screening process at intake is where the assistance to staff would come in to better diagnose and treat these incoming prisoners/patients.

Mental Health Screening. Screening at reception into custody has been both criticized and praised. Criticisms include the lack of understanding the effects of helping the mentally ill, also a

monetary perspective (as screening tools and tests are reasonably expensive), and the value of screening along with the variation between positive and falsely positive results that have been reported (Martin et al., 2016; Steadman & Veysey, 1997).

Proper understanding of the effects of mental illness could assist staff to provide the necessary mental health treatment options that are needed for the incarcerated to be healthy and stable. Lack of understanding could result in lack of medications, incorrect medications, or incorrect diagnosis (Martin, Hynes, Hatcher, & Coleman, 2016), which could have adverse effects not only on the prisoner with the mental illness, but their fellow prisoners, as well as the staff who are looking after them on a daily basis. Correct procedures for a healthy and stable prisoner would be upon admittance into the facility; to check whether they are well enough to be a part of the prisons' general population or if they need to be admitted to an on-site treatment facility; their prolonged stay in the prison or facility in terms of medications and behavioral treatment options; and the protection that those with mental illness need while serving out their terms (protection from other inmates, guards, or themselves).

Cost of administering the screening tests is another criticism. Reasons for screening costs vary between payment to employees, re-testing, as well as any validation costs needed. Registered nurses, correctional facility staff as well as behavioral clinicians are amongst those who administer the initial screening as well as the re-assessment screening. All these employees administer the screening tests and if a prisoner tries to hide their illness or there is a false positive on the initial screening test, additional testing is administered at the cost to the state (Martin, Colman, & Wells, 2017; Lurigio, & Swartz, 2006) in terms of additional hours paid to the test administrator and the actual cost of the test itself. False positive testing can occur when the prisoner has been through the system before and knows essentially how to 'cheat the system' as

they do not want to be on any sort of medication, or the prisoner has a comorbid diagnosis upon entry (such as a drug dependency and a mental health issue), or they do not know how to convey their illness as they have not been diagnosed and treated before (Hills, Siegfried, & Ickowitz, 2004). Paying employees as well as extra screening testing is costly, but not as much as validating a screening test.

Validation of screening tests are costly, as there are multiple standards and guidelines that need to reached in order for research to take place to ensure the validity of the test. After gaining evidence of a strong and valid screening test, it then has to go through a federal agency (in this case, the DOC) to be approved. Every level of validity for a screening test involves payment, which could hamper some prisons if they do not have proper funding. By using already validated screening tools, it decreases the costs for prison facilities.

Even with the criticism, the praise lies in the fact that when prisoners do indeed get screened and test positively, actions should be taken as effective management can only be provided when there are clear pathways based on a need identified early in custody (Hayes et al., 2014). Without this screening process, many mentally ill patients may become violent, may be abused, they may even self-harm or commit suicide (Hautala, 2015). Screening is a critical component to a correctional mental health strategy (Martin, Colman, Simpson, & McKenzie, 2013b) and has the potential to give people the medical attention they need. By screening properly with the tests that are available to staff at the time of entry, they may also be able to send the prisoner to be evaluated even further and to get medication, therapy, or substance abuse assistance.

By introducing proper procedures in terms of mental health screening upon intake, there could be a shift in criminal statistics as most mentally ill prisoners upon release do not seek

outpatient care as they fear being sent back to prison instead of mental health facilities that could help them, and they tend to end up having a higher recidivism rate than the general population (Rotter & Carr, 2011; James & Glaze, 2005; Wilson, A.B., Draine, Hadley, Metraux, & Evans, 2011). Individuals with mental illness are at greater risk of recidivating due to criminogenic risk factors other than mental illness, but that are highly correlated with mental illness (Wilson J.A., & Wood, 2014). Screening processes should be an important step in assessing and assisting mentally ill prisoners, and in doing so has the ability to reduce further recidivism due to therapeutic and medication assistance.

Little is known, however, about the extent to which states implement screening processes, the types of screening, when screening occurs, or states' alignment with recommendations as set forth by the National Commission on Correctional Health Care or the American Correctional Association. This study examines mental health screening processes across the United States and compares the usage of these screening processes as per state policy.

Methods

The current research is a content analysis of state prison policies related to identifying mentally ill inmates specifically examining the admission screening processes. This examination used a probability sample of all 50 states' policies, the policies analyzed for each state is representative of the institutions within those states. The sample analyzed included all 50 state department of corrections (DOC) systems. Electronic searches using Google included using a combination of relevant search terms: '[state name] mental health policy', [state name] mental health screening', and '[state name] department of corrections'. Relevant qualitative policy material was identified

via state prison websites or direct contact via telephone and email. Once on the appropriate states' DOC website, the policy section was identified and the appropriate health/mental health policy document was downloaded in PDF format to be read in its entirety, to identify whether or not the mental health screening process was addressed in the policy. If the mental health screening process could not be found, the contact information for either email or phone numbers were looked at on the 'contact us' page of the appropriate DOC websites. An email was first sent out and then a call was placed a few days later. Those states that did not reply to emails or answer calls were contacted repeatedly until the appropriate person was able to answer all of the questions asked. Policies related to mental health screening for new inmates were compared to identify systems with best practices and systems in need of improvement.

A coding schema was developed consisting of various questions that assisted in evaluating whether or not state prisons screen for mental health. These questions included:

a. Who is responsible for screening the inmates?
b. Which questionnaire(s) is used?
c. When do they screen the inmate?
d. Do they re-asses the inmate to determine whether further treatment is needed?

The initial pre-assessment of data revealed that the re-assessment question being open ended did not give a well-rounded range of questions and answers. More information was needed to be clarified in order to gain insight into the testing done beyond only the initial mental health screening. The coding schema was then expanded to include the following questions:

e. Who do the initial test screeners refer the inmate to?
f. Who is responsible for administering the re-assessment?

g. Which questionnaire(s) is used for the re-assessment?

h. How long is the re-assessment test?

Addition of the new questions created a clear distinction between the initial mental health screening process and the re-assessment screening process. Both portions of questions now being asked, the full scope of mental health screening could be looked at, even though the information gathered from the online policies had varying levels of information. Any missing information was gained by calling the Mental Health or Health departments of the Departments of Corrections (DOCs) for each state, or by contacting them via email.

Analysis of data

The qualitative data was collected in an excel spreadsheet and then recoded into nominal variables (where qualitative answers were given a corresponding number) and entered into the Statistical Package for the Social Sciences (SPSS) program. Minor coding was needed for the states, which were placed in alphabetical order and numbered from 1-50. The data was converted into appropriate variables to process descriptive statistics regarding responses to each question asked of the states. The question of 'how long the re-assessment test was' was compared to the question of 'which kind of test was used for the re-assessment' in the crosstabulation form. Very little other analysis was able to be done with this nominal level of data.

Results

The data collected was from all 50 state's policies regarding the mental health screening process for incoming inmates (see Appendix A). Thirty-two states provided all information requested (either via online policies, telephone calls, or emails). Ten states provided partial information,

and eight states had no information available and did not respond to emails or phone calls. With the information gathered it was evident that most states (84%) have a mandated policy to do a mental health screening for prisoners upon entry.

Administrator of the initial screening varied by state. Table 1 offers a division of administrators of initial screening. The most common administrator was mental health staff (24%) which consisted of Masters or Doctoral Psychology students, while being overseen by a Behavior Specialist (Psychologist or Psychiatrist). The Behavior Specialist themselves screened 20% of the time as seen in Table 1.

Table 1

Person(s) administering the initial mental health screening upon prison entry

Who Administers Screening	Frequency	Percent
Registered Nurse	7	14.0
Health Care Staff	9	18.0
Mental Health Staff	12	24.0
Behavioral Specialist	10	20.0
Other	4	8.0
Total	42	84.0

Missing	8	16.0
Total	50	100.0

The types of screening tests that were administered were divided into the types of tests that were the most common in the correctional setting. The Brief Jail Mental Health screen (BJMH) consists of six questions that ask the prisoner about their current mental health status (whether they have intrusive voices or thoughts), as well as two questions about their history of hospital for emotional or mental health problems. The BJMH was validated by the Department of Justice (DOJ) in 2006 through a federally grant research project done by Osher et al. (2006) in which they state that the BJMH successfully classifies 73.5% of males, but only 61.6% of females with mental instabilities.

The Prison Rape Elimination Act (PREA) screen is used to determine whether or not a prisoner is at risk of sexual assault or whether they have the potential to be sexually aggressive towards other prisoners while in custody, which has a mental health aspect due to the nature of a sexual predator or the victim needing therapeutic intervention. States may use PREA as the primary mental health screening, due to the risk factor scores for PREA can be a determinate factor in housing, cell, work, education, and program assignments for inmates (South Dakota Department of Corrections, 2016, p.5). The DOJ did not validate PREA, because validation can be costly to smaller agencies. They stated that objectivity is most important for risk assessment, and with proper training the staff can do the assessments properly (“Is There a Validated and Objective”, 2013).

St Louis University Mental Status Exam (SLUMS) consists of 11 questions to determine the cognitive ability as well as the recollection ability of prisoners. SLUMS was initially created as an Alzheimer's test to determine any type of dementia (it also categorizes the prisoner's education level which can be a determent factor with recollection and recognition of words and shapes). The NCCHC and ACA questions that are in their manuals, consist of various questions to determine cognitive ability as well as covering the basis of the DSM5 symptomology. These tests all vary in what they are seeking to determine from the prisoner, but the common factor is the mental stability (whether they are hallucinating or having intrusive thoughts) or their cognitive abilities.

Figure 1 shows that the screening test most common in prisons is the state's own assessment (50%) which consists of various testing elements that the different states developed from NCCHC or ACA standards, or by adapting screening tests done by other states and validated for their accuracy by the DOCs own health department boards who approve changes and corrections to policy changes.

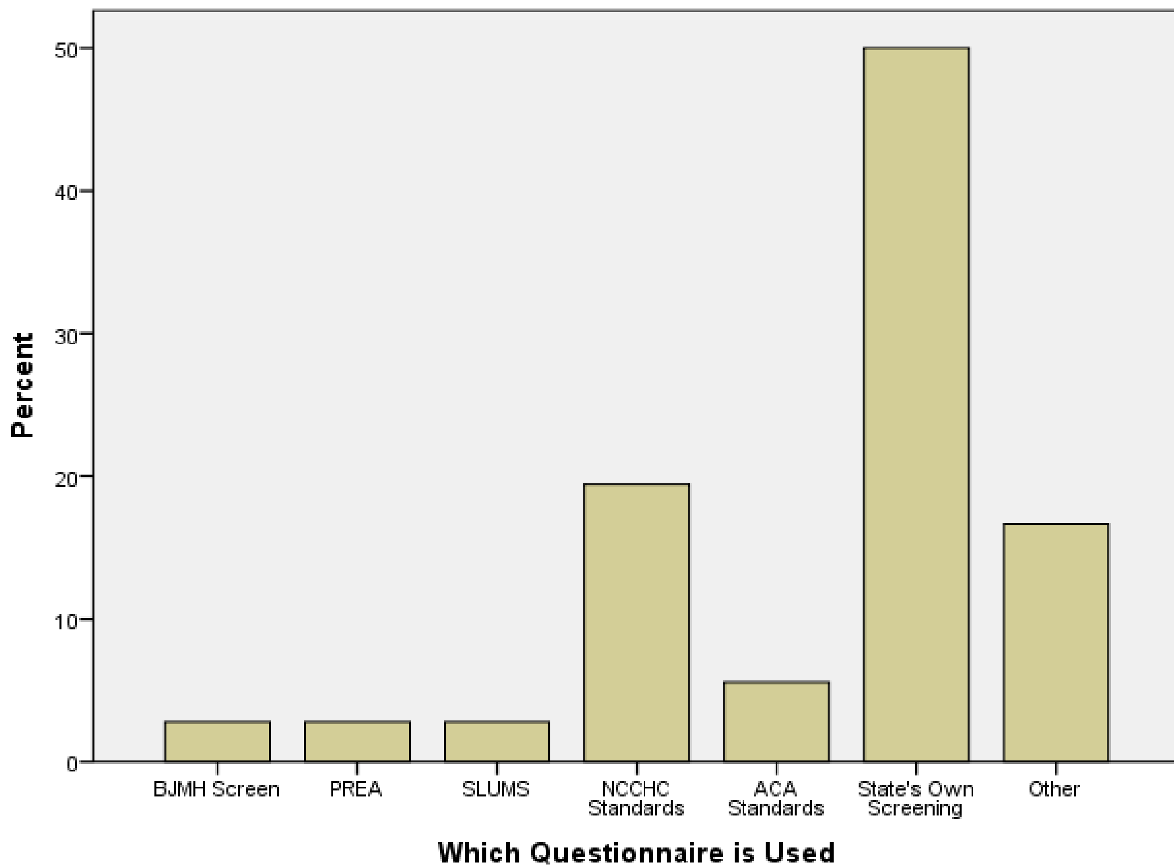

Figure. 1. Which questionnaire is used in the initial mental health screening process compared by percentages.

When looking at the amount of time that it takes to administer the initial screening, it is very important to screen as quickly as possible. The reason for a quick screening process is due to the negative effects that could occur if there is a delay in screening, such as; suicide risk, medication that needs to be administered, a treatment plan that needs to be created, and victimization in the prisons' general population (Hautala, 2015; Hayes et al., 2014; Haney, 2017; Morrison, 1991; Melnikov et al., 2016; Matejkowski, 2017; Winters, Greene- Colozzi, & Jeglic, 2017; Daquin & Daigle, 2017). As can be seen in Figure 2, most states (51%) screen within a 24-hour period, and 12% screen in less than a 12-hour period. Only 10% screen within 24-48 hours,

7% screen anywhere from 3-7 days, 14% screen in 8-14 days, and almost 5% screen in 30-45 days. The longer a prisoner waits to get a screening, the more adverse the effects are if they have a mental health need (Fazel et al., 2016; Blitz, Wolff, & Shi, 2008; Goode, Hassine, Kupers et al., 2015.

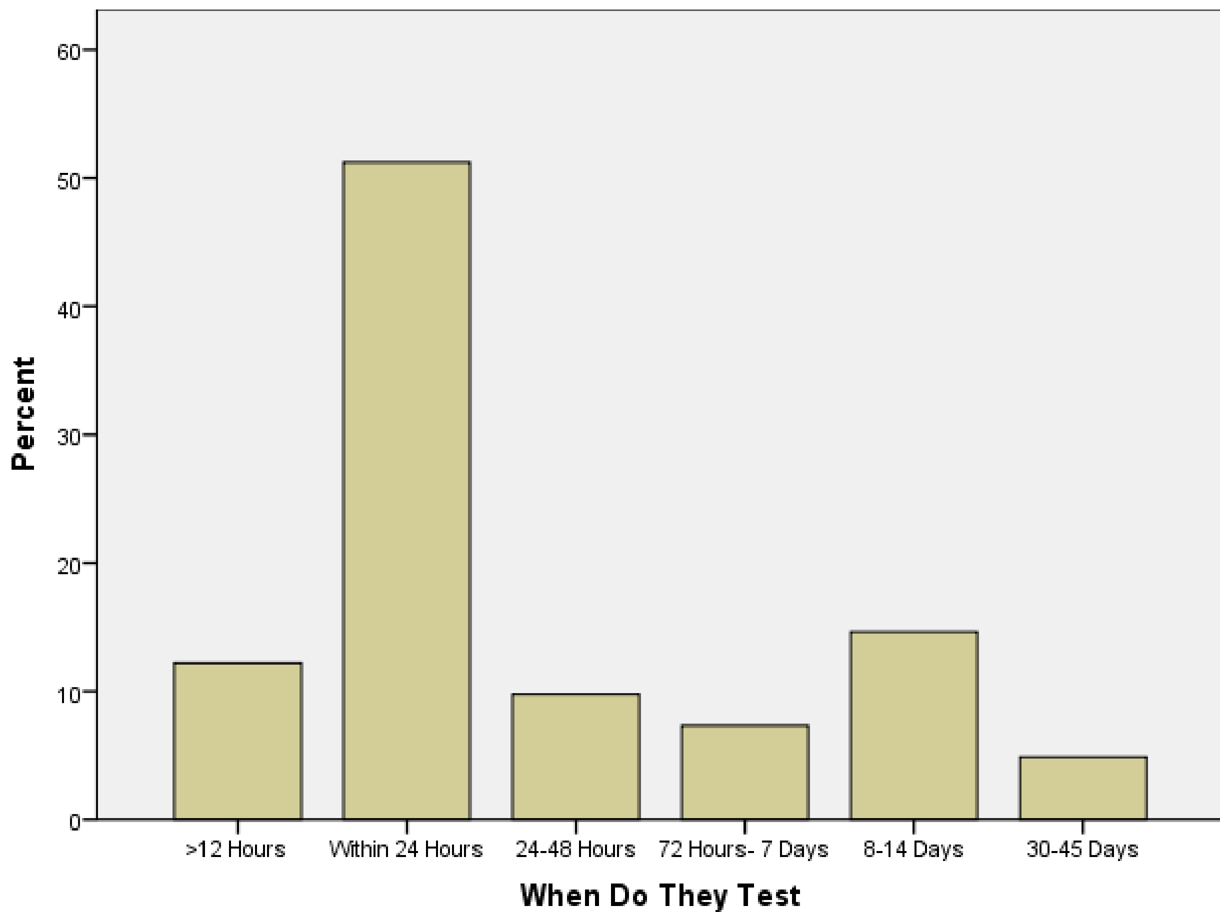

Figure 2. Time to initial screening.

After the initial mental health screening (either as a screening by itself, or as part of the general health screening process) a prisoner may be flagged as needing additional mental health assistance (see Appendix B). If they are flagged, they are then sent for a re-assessment to either mental health staff (43.9%) or a Behavior Specialist (43.9%), the Behavioral Specialist in the re-assessment portion is usually a Psychiatrist so that they have the ability to prescribe medication

and create a treatment plan that is needed depending on the inmates' mental health needs level. Table 2 shows the types of testing done in the re-assessment and compares how long each of these tests take. The mental staff or behavior specialist takes 30 minutes to 1 hour to do a clinical assessment (91.7%) that covers basic elements of the DSM 5 diagnostic tools to diagnose and recommend treatment options in either inpatient (within the prison) or outpatient (in a state hospital/mental health hospital) facilities, depending on the severity of the mental illness.

As is the case with timing of the initial screening, the time it takes for a re-assessment to be done is crucial to assist the medication, transfer to the mental health ward, if the prison has one (intra-system transfer), or a transfer to an outside facility (inter-system transfer). Re-assessments typically occur within 14 days (43.2%) after the prisoner is referred by being flagged in the initial screening, by a concerned employee, or by the prisoner themselves.

Table 2

Crosstabulation comparison of tests used and how long they took in the re-assessment

		What Test is Used						
How long is the test		Clinical Assessment	DSM 5	CMHE	SLUMS	State's Own Assessment	Other	Total
30 min – 1 Hour	Count	11	0	0	1	2	1	15
	Percentage	91.7%	0.0%	0.0%	100.0%	33.3%	9.1%	100.0%
1 -2 Hours	Count	1	0	1	0	2	7	11
	Percentage	8.3%	0.0%	100.0%	0.0%	33.3%	63.6%	34.4%
2 – 3 Hours	Count	0	1	0	0	2	3	6
	Percentage	0.0%	100.0%	0.0%	0.0%	33.3%	27.3%	18.8%
Total	Count	12	1	1	1	6	11	32
	Percentage	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Discussion

Mental health is an ongoing issue in the state prison system that continues to be a part of the criminal justice system. By looking at the types of situations that the mentally ill find themselves in when incarcerated (such as victimization), certain procedures should be put in place for protection and assistance for these prisoners. The purpose of mental health screening is to refer inmates with mental health issues to receive a more extensive re-assessment in order to assist with therapies or medications, even though Martin et al. (2013a) points out in their research that poor identification of mental illness can still occur with a screening process in place.

The current content analysis observed all 50 states' policies on their mental health screening assessments for incoming prisoners. Most states (42) provided information regarding mental health care for inmates on their public websites, while a few (8) did not have any mental health care information available online. The online information had a generalized scope of medical and mental health that should be provided for prisoners when they are initially assessed and also when flagged for a re-assessment. The health and mental health standards set forth by the NCCHC were not common practice for all the states contacted (either by phone or email); some claimed that they follow the NCCHC mental health guidelines (4).

Most state policies indicated that there should be NCCHC or ACA guidelines that needed to be followed, but due to the fact that these guidelines are facility to facility specific, those prisons that are not accredited with the NCCHC or ACA do not need to follow these guidelines shown in the statewide policies. The NCCHC and the ACA both require certain standards to be met for accreditation, even though there is little evidence indicating that the standards are met year round by the facilities. Criticisms of the accreditation efforts for these organizations is that

the money used for the process comes from public taxes and there is very little transparency or public accountability; as private organizations, the ACA and NCCHC are not required to disclose their internal records to the public (Hunter, 2016). By not disclosing their paperwork, there is no way to know whether the guidelines put forth by these organizations are merely for policy purposes, or whether they are actually put into practice by the facilities who are accredited by them.

Regardless of those facilities accredited with the NCCHC and ACA; almost all state policies mandated an initial mental health screening which was either included in the initial health screening, or was a separate screening from the medical portion of their screening process. Only 3 states, out of the 42 with information, did not have a separate mental health screening process.

Previous researchers failed to use statistical analysis for their studies, as most were reviews of the mental health screening process, such as Hautala (2015) and Martin et al. (2013), who used a qualitative method of analysis instead of a quantitative approach. In addition, most content analysis for initial mental health screenings looked at previous research instead of conducting their own examinations, with the exception of relatively few studies that conducted their own qualitative and quantitative examinations.

Previous studies such as Martin et al., 2016 and Steadman and Veysey, 1997 have shown that false positive results in mental health screening occur more often than not. False positive results can be eliminated or even lessened by the re-assessment opportunities available, and with the mental health systems in place, anyone, from the prison guards, fellow inmates, to the prisoners themselves, is able to refer prisoners to mental health checks at any point in time. The

results from the current research indicate that there are numerous opportunities for reassessment. These findings reduce the likelihood of false positives as was the concern of previous researchers (Martin et al., 2016) and (Steadman & Veysey, 1997).

The high numbers of staff assisting prisoners, assessing prisoners, and diagnosing prisoners help prevent the many mentally ill from violence and other negative effects, which is an important health prospect for the prisoner and the prison facility as (Martin, Colman, Simpson, & McKenzie 2013b) point out in their study. Hayes et al., (2014) praised the effectiveness of the mental health screening process and the actions that can be taken, which aligns with the findings of the current study that most states do indeed screen for an array of mental illnesses and prescribe medication as well as therapeutic assistance for those who need it.

Policies on public websites for the state DOC's often may be updated within their own systems, but not on the public websites where they are available for viewing. The lack of updating can result in an incomplete data set as well as non-current policies for states. The benefits of adhering to an updated policy system could be that it can increase mental health awareness for other parts of the criminal justice system. These branches of the criminal justice system could then assist in diversion before incarceration, such as Gottfried and Christopher (2017) suggest, and the mental health screening process could also help reduce the recidivism rates for the mentally ill that tend to have higher recidivism rates than the general prison population (Rotter & Carr, 2011).

Limitations

It is important to note the limitations of the current content analysis project. First, very few state policies clearly defined which tests needed to be used in order for the state to do their initial screening assessment. Most do, however, rely on published standards; such as the ACA (American Correctional Association) or the NCCHC (National Commission on Correctional Health Care) standards. Due to the limited policy information on DOC websites, direct contact via telephone phone calls aspect became the primary method to gather information.

However, states were reluctant to give out information considering the sensitive nature of mental health screening. State policies, though, should be publicly available. Some state employees were uncomfortable offering information without prior approval when a higher authority was unavailable. Finally, some were reluctant due to ongoing legal sanctions (as was the case for Arizona).

Third, the lack of fully collecting data from all 50 states, either via their website or phone calls, hampered the completion of the study to fully understand the scope of mental health screening tools being used to diagnose and treat prisoners with mental illnesses.

Conclusion

With those limitations in mind, the evidence gathered showed that states do indeed use an array of screening tools to do the initial mental health screening as well as the re-assessment. A lack of consistency in types of screening tools across the United States made it difficult to assess which systems had the best practices and the ones which needed improvement. A number of states (18) created their own initial screening questionnaire based off of the ACA or NCCHC standards, or

they adapted them from screening tools used in other states after validating their usefulness. To better assess the failures or accomplishments of screening tools, there should be a national standard of tests used across the United States, as well as certified personnel (in the mental health field) should be mandatory for initial assessments, to be able to better assess nonverbal cues that non trained personnel would not be able to pick up on.

By having a standardized screening tool and the correct personnel, it could reduce the number of re-assessments needed as well as the correct diversion to behavioral therapies as well as medications, before the prisoner enters the prisons' general population. By assigning a level of need to a prisoner (mental health needs), the prisoner could be sent to outpatient services and by receiving care it has the potential to reduce the recidivism rates that are experienced by the mentally ill.

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Appendix A

State	Do they initially screen?	Who Does the Initial Screening?					When Do They Test?						
		RN	Health Care Staff	Mental Health Staff	Behavior Specialist	Other	>12 Hours	Within 24 Hours	24 - 48 Hours	72 Hours- 7 Days	8-14 Days	15 - 29 Days	30 – 45 Days
Alabama	X			X				X					
Alaska	X	X						X					
Arizona	X					X		X					
Arkansas	X				X				X				
California	X		X					X					
Colorado	X			X									X
Connecticut	X		X					X					
Delaware	X	X					X						
Florida	X		X								X		
Georgia	X				X			X					

Hawaii	X					X	X						
Idaho	X		X					X					
Illinois													
Indiana	X				X								
Iowa	X				X						X		
Kansas	X		X				X						
Kentucky	X			X				X					
Louisiana	X		X							X			
Maine	X		X				X						
Maryland	X			X				X					
Massachusetts	X				X					X			
Michigan	X				X								X
Minnesota	X			X				X					
Mississippi	X		X						X				
Missouri	X	X						X					

Montana													
Nebraska	X				X						X		
Nevada	X				X			X					
New Hampshire	X			X							X		
New Jersey													
New Mexico	X				X			X					
New York	X			X				X					
North Carolina	X	X							X				
North Dakota	X					X		X					
Ohio	X	X								X			
Oklahoma	X	X						X					
Oregon	X	X						X					
Pennsylvania	X			X				X					
Rhode Island													
South Carolina	X					X		X					

South Dakota													
Tennessee													
Texas													
Utah	X			X					X				
Vermont	X		X					X					
Virginia	X			X				X					
Washington	X			X			X						
West Virginia													
Wisconsin	X			X							X		
Wyoming	X				X						X		

Appendix B

State	Do They Re-assess?	Who Does the Re-assessment?					When Do they Re-assess?							
		Mental Health Staff	Health Care Staff	Health Clinician	Behavior Professional	Multi-Tasked Team	12 – 47 Hours	48 – 72 Hours	Within 72 Hours	1 – 7 Days	5 – 7 Days	7 – 14 Days	Within 14 Days	15 – 30 Days
Alabama	X				X			X						
Alaska	X	X						X						
Arizona	X		X											
Arkansas	X	X						X						
California	X			X								X		
Colorado	X			X									X	
Connecticut	X	X							X					
Delaware	X	X							X					
Florida	X	X							X					
Georgia	X				X			X						

Hawaii	X		X										X	
Idaho	X	X											X	
Illinois														
Indiana	X				X									
Iowa	X	X												
Kansas	X					X							X	
Kentucky	X	X											X	
Louisiana														
Maine	X	X											X	
Maryland	X				X								X	
Massachusetts	X				X								X	
Michigan	X	X												
Minnesota	X	X						X						
Mississippi	X				X					X				
Missouri	X				X								X	

Montana														
Nebraska	X	X											X	
Nevada	X				X			X						
New Hampshire	X	X											X	
New Jersey														
New Mexico	X				X				X					
New York	X	X						X						
North Carolina	X	X									X			
North Dakota	X	X									X			
Ohio	X	X										X		
Oklahoma	X	X								X				
Oregon	X				X								X	
Pennsylvania	X				X									X
Rhode Island														

South Carolina	X				X								X	
South Dakota														
Tennessee														
Texas														
Utah	X				X				X					
Vermont	X				X								X	
Virginia	X				X								X	
Washington	X				X					X				
West Virginia														
Wisconsin	X				X					X				
Wyoming	X				X								X	

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