

The Mental Health Services Delivery System (MHSDS)

THE “WHY, WHERE, TO WHOM, WHAT AND HOW” CDCR PROVIDES MENTAL HEALTH SERVICES TO INCARCERATED INDIVIDUALS: A TRAINING FOR BOARD OF PAROLE HEARING COMMISSIONERS

Purpose of Today's Training

The purpose of today's training is to provide an overview of the Mental Health Services Delivery System (MHSDS), its functions in treating incarcerated individuals with mental health problems at CDCR, and how patient safety is enhanced by the programs provided, so that individuals may continue with healthy practices and use of health care resources post-release.

The Goal of Mental Health Services Delivery System (MHSDS)

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The goal is to provide constitutionally appropriate levels of mental health treatment to incarcerated, seriously mentally ill in the least restrictive environment.

Today's Learning Objectives

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1. Describe the structure of the MHSDS.
2. Identify the major mental disorders treated in the MHSDS and their related signs and symptoms.
3. Discuss core considerations related to patient safety at CDCR.
4. Identify effective strategies for pre-release planning and for continued care of mental health patients who are on parole

Learning Objective 1

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Describe the structure of the MHSDS.

Levels of Patient Care

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Correctional Clinical Case Management System (CCCMS): Basic Level of Care

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- ▶ Assigned a primary clinician
- ▶ Individual therapy at least once every 90 days
- ▶ Group therapy as offered (not required)
- ▶ Psychiatry follow-up every 90 days for medication monitoring (as needed)
- ▶ Treatment planning updates annually
- ▶ Pre-release planning

Enhanced Outpatient Program (EOP)

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- ▶ Highest level of **outpatient** mental care within MHSDS
- ▶ Patients whose symptoms impact their ability to function within GP
- ▶ Patients live in separate housing units but interact with non-EOP inmates
- ▶ More likely to be victimized by other inmates
- ▶ Provides substantially more treatment interventions
- ▶ Focus to provide short- to intermediate-term clinical care

Examples of Treatment Activities

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Activity

1. **Daily Living Skills**
2. **Medication Education**
3. **Symptom Management**
4. **Specific mental Health Issues**
5. **Social Skills/Communication**

Aims of Activity

1. Train & assist patients in developing improved skills in maintaining appropriate personal hygiene & grooming habits, such as bathing, dressing, & maintaining a clean cell.
2. Educate patients regarding the importance & benefits of regularly taking their prescribed medications. Discusses medication, interaction with alcohol & drugs, & teaches how to correctly take medication.
3. Teaches patients how to identify warning signs of relapse, persistent symptoms, & medication side effects.
4. Focused clinical support for specific mental health issues, such as depression or victimization.
5. Learning positive interactive skills with both staff & inmates.

Examples of Treatment Activities, cont'd.

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Activity

1. **Anger Management**
2. **Stress management**
3. **Substance Use Issues Group**
4. **Health Issues**
5. **Offense-Specific Therapy**

Aims of Activity

1. Teaches socially acceptable & appropriate ways of handling anger & expressing feelings. Geared toward reducing aggressive behavior toward self or others by developing self-control skills.
2. Teaches patients how to identify recurring prison stressors & provides specific stress reduction techniques to minimize the negative effects of stress.
3. Teaches patients about the relationship between substance use & criminality & emphasizes the effects of drug use on patients with mental disorders.
4. Provides education regarding basic physical, emotional, & mental health issues.
5. Provides clinical support for insight-oriented treatment related to causative factors in criminal behavior, emphasizing the development of alternative courses of conduct.

Mental Health Crisis Bed (MHCB)

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- ▶ Provide care for patients (typically less than 10 days) who
 - ▶ Are a danger to themselves
 - ▶ Are a danger to others
 - ▶ Have a serious impairment in taking care of daily needs (hygiene, cell cleaning, malodorous, and not eating—grave disability)
 - ▶ Are in acute psychiatric distress
- ▶ Licensed facilities per CCR Title 22
- ▶ Acute care that provides short-term treatment for severe episodes of psychiatric distress or mental disorder

Psychiatric Inpatient Programs (PIPs) or Department of State Hospitals

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Psychiatric Inpatient Programs (PIPs):

Acute Psychiatric Program (APP) located at CHCF, CMF, SQ (for condemned and non-condemned), and CIW

- ▶ **Intermediate Care Facilities (ICF)** located at CHCF, CMF, SVSP, SQ (for condemned) and CIW Department of State Hospitals (DSH)
- ▶ **Coalinga State Hospital (ICF males), Atascadero State Hospital (ICF males), Patton (APP & ICF females)**

The Interdisciplinary Treatment Team (IDTT)

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- ▶ Plans appropriate care and treatment.
- ▶ Gathers information from various disciplines to monitor patient progress
- ▶ Evaluates patient treatment needs and changes to treatment on an ongoing basis
- ▶ Optimizes the level of functioning of IPs in the least restrictive environment
- ▶ Treats and supervises IPs in the appropriate level of care

Members of the IDTT

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- ▶ Composed of medical, clinical, and correctional staff and the patient
- ▶ Role is to:
 - ▶ Identify symptoms that need to be addressed in treatment.
 - ▶ Identify treatment goals and evaluate effectiveness.
 - ▶ Identify barriers to meeting treatment goals .
 - ▶ Review and evaluate treatment effects, plans, and services to meet evolving needs.
 - ▶ Determine the most appropriate level of care.

Mental Health Care Staff Duties

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Social
worker

Psychologist

Psychiatrist

Nurse
practitioner

Recreation
Therapist

Psychiatric
Technician

Custody Provides Vital Information to Mental Health

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- ▶ Observes patient interactions during dayroom, on yard, and in work areas
- ▶ Provides information of gang affiliations and active participation
- ▶ Provides information on RVRs and 602's
- ▶ Has knowledge of legal issues such as child custody or new cases
- ▶ Has information regarding contact and visitation
- ▶ Observes eating, sleeping, and exercise relations
- ▶ Observes how patients and inmates interact with each other
- ▶ Can also have information related to victimization or predatory concerns.

Example of Custody's Support: Implementing Treatment

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For example, if a patient has an identified treatment goal of reducing depressive symptoms so they are no longer interfering with functioning, custody staff can play a vital role in the implementation of the treatment plan by encouraging the patient to come out of their cell for group participation or yard time. Often, certain custody staff who have developed trust with a patient are much more effective in getting that individual to attend appointments, engage in social activity or comply with directives. Custody staff is very effective at observing whether the patient is responding to treatment, or whether the depressive symptoms (for example, staying in bed all day, pacing at night, etc.) are still persisting. Many correctional peace officers have a real talent for ensuring safety by "calming the waters" in patients who are upset or agitated.

Learning Objective 2

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Identify the major mental disorders treated in the MHSDS and their related signs and symptoms.

Core Mental Disorders Treated in MHSDS

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Psychoses

Severe Mood
Disorders
(Bipolar & Major
Depressive DOs)

Exhibitionistic
Disorder (IEX due
to a Mental
Disorder)

Defining Mental Illness

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"...a condition that affects a person's thinking, feeling or mood...[and] may affect someone's ability to relate to others and function each day."



List of Disorders Treated in the MHSDS: Psychoses and Serious Mood Disorders

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Common Psychotic Disorders

- ▶ Schizophrenia & Schizoaffective Disorders
- ▶ Brief Psychotic and Schizophreniform Disorders
- ▶ Delusional Disorder
- ▶ Psychotic Disorder Due to Another Medical Condition (e.g., due to stimulant use, Alzheimer Dementia, etc.)
- ▶ Other Specified and Non-Specified Psychotic Disorders

Common Serious Mood Disorders

- ▶ Bipolar Disorders:
 - ▶ Bipolar I Disorder (with & without psychotic symptoms)
 - ▶ Bipolar II Disorder
 - ▶ Other Specified Bipolar & Related Disorder
 - ▶ Unspecified Bipolar & Related Disorder
- ▶ Major Depressive Disorder

Psychotic Disorders

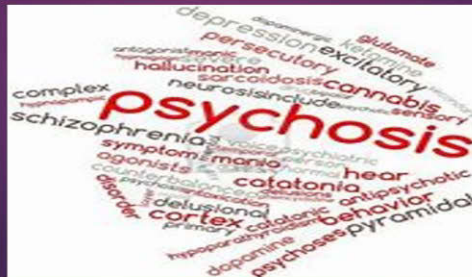
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Understanding Psychosis

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- ▶ Involves a loss of touch with reality
- ▶ Symptoms associated with several mental disorders
- ▶ Characterized by distortions in thinking, perception, emotions, language, sense of self and behavior



Signs & Symptoms of Psychosis

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Signs

- ▶ Disorganized speech
- ▶ Inability to care for oneself or one's environment
- ▶ Withdrawn
- ▶ Restlessness
- ▶ Fearfulness/looking over shoulder
- ▶ Lack of expression
- ▶ Inability to start/follow through with activities
- ▶ Talking/gesturing to imaginary people

Symptoms

- ▶ Hallucinations
- ▶ Delusions
- ▶ Paranoia
- ▶ Disorientation and confusion
- ▶ Feelings of emptiness, lack of emotion
- ▶ Depressive symptoms
- ▶ Vulnerability
- ▶ Feeling like nothing can hurt you

Two Case Samples of Psychosis

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- ▶ **Patient A.** is a male who is serving a life sentence with possibility of parole for killing his landlord during a fight, whom he claims was attempting to “steal my money by raising the rent.” Patient A. has a long history of substance use problems (since childhood), his drug of favor being methamphetamine. He suffers from thoughts of others out to do him harm, although there is no proof of this in reality. He also reports hearing “threatening voices” (starting at age 19) and seeing shadows in his cell that look like demons. During these phases of active psychosis, he can become very agitated and his speech is often confused and disorganized. Patient A. is currently prescribed psychiatric medication to deal with his hallucinations and the agitation caused by paranoid thinking. He is in EOP.
- ▶ **Patient B.** is a female who is serving her second term for selling drugs. She also has a long history of substance use problems, including heroin and prescription opioids (pills). She has a history of childhood trauma and prostitution, beginning at age 16. She has intermittent phases of hearing threatening voices and seeing “ghosts” on her cell wall during substance use. She is medication compliant and reports not having used heroin for the past 18 months. She is in CCCMS.

Severe Mood Disorders

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Severe Mood Disorders in MHSDS

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Bipolar I Disorder

1. Mania
2. Often depressive episodes

Bipolar II Disorder

1. Hypomania (type of "mania light")
2. Depressive episodes

Major Depressive Disorder/Episode

Signs & Symptoms of Mania

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Signs

- More active than usual
- Tangential speech
- Agitation, irritability, being "touchy"
- Appearing extremely happy while crying
- Engaging in provocative, compulsive, or impulsive behavior
- ▶ Requiring very little sleep

Symptoms

- Feeling "up," "high," "jumpy," or "wired"
- Racing thoughts
- Feeling on top of the world
- Lack of need for sleep/unusual sleep habits
- Grandiose sense of self
- Psychosis
- Invincible
- Seeking risky behaviors

Case Sample for Bipolar I Disorder (Manic Episode)

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Patient C. is a male who is serving a second term for assault with a deadly weapon. He has a history of severe impulse control problems, substance use problems beginning in his late teens, and making terrorist threats. However, Patient C. has discontinued his medication numerous times. He then becomes hyper, needs little sleep, has racing thoughts, beginning many projects (that he never completes). During the 2 weeks or so of his manic phases, he has performed risky behaviors in the community while driving while consuming alcohol, and uncontrolled shopping for expensive sports equipment. He is diagnosed with Bipolar I Disorder without psychotic symptoms. He is mostly med compliant and in CCCMS.

Signs & Symptoms of Major Depressive Disorder/Episode

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Signs

- ▶ Significant weight loss or gain
- ▶ Too much or too little sleep
- ▶ Too much (hyper) physical activity or too little (retarded) physical activity
- ▶ Withdrawn, isolates self in cell
- ▶ Cries or shows extreme sadness
- ▶ Difficulties in communication or socially interacting

Symptoms

- ▶ Depressed mood
- ▶ Recurrent thoughts (rumination)
- ▶ Diminished interest or pleasure
- ▶ Fatigue or loss of energy
- ▶ Feelings of worthlessness or excessive or inappropriate guilt
- ▶ Inability to think or concentrate, indecision
- ▶ Recurrent thoughts of death

Case Sample for Major Depressive Disorder (MDD)

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Patient E. is a male who is serving a first term for vehicular manslaughter and is a participant in the EOP. He has a history of severe alcohol use, and began drinking at age 15 when his parents divorced. He is married and has 2 adult sons and a 15-year-old daughter. Patient E. was diagnosed with Major Depressive Disorder after having received his first DUI at age 27. He experiences long periods of sadness, tearfulness and feelings of hopelessness. He reports not being able to "turn those thoughts off," and he feels heavy guilt due to his crime as well as "tearing my family apart." Patient E. has chronic suicidal ideation, reporting often that he wished he could go to sleep and never wake up. He also has had 3 suicide attempts (2 by hanging and 1 by overdosing on hoarded medications) and was admitted to the MHCB as a result.. He also has received 2 RVRs for possession of pruno. Patient E. is a participant in the EOP level of care, where he receives treatment for his symptoms and to help alleviate his depression and improve his coping skills.

Medical Necessity: Disorders Treated at CDCR

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MH intervention is necessary to protect life and/or treat significant disability/dysfunction in patients with a mental disorder. Examples:

Anxiety
Disorders

Trauma &
Stress-related
Disorders

Adjustment
Disorders

Substance
Use Disorders

Severe
Personality
Disorders

Learning Objective 3

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Discuss the core considerations related to patient safety at CDCR.

Suicide Rates in CDCR

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Suicide rates are highest among inmates who are or have:

- ▶ Level IV
- ▶ Violent
- ▶ Illegal substance users or dependent on illegal drugs
- ▶ Life or long sentences
- ▶ In segregated housing units
- ▶ A history of previous suicide attempts either in or out of custody
- ▶ A history of mental illness
- ▶ Convicted of crimes against persons/sex offenses

Risk Factors for Suicide

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- ▶ Prior suicide attempts
- ▶ Pain, especially chronic
- ▶ Serious and chronic medical condition
- ▶ Losses such as status among peers, unwanted housing changes, loss of job assignment
- ▶ Substance use (current and/or history)
- ▶ Isolation due to foreign language or culture
- ▶ Impending parole
- ▶ First term or early in new term
- ▶ Fear for personal or family safety

Importance of Mental Health Referrals

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- ▶ Ensuring inmates have access to care.
- ▶ Preventing further deterioration of an apparent condition.
- ▶ Assuring the safety of the inmates and staff.
- ▶ Helping prevent suicides.
- ▶ Enhances communication with mental health staff

Mental Health Referrals by BPH

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Inmates who present during their Board Hearings with signs or symptoms of mental distress can be referred to CDCR Mental Health Headquarters through the "Urgent Response"

Process. This ensures that these inmates are seen by a Mental Health clinician at their facility in a timely manner.

If you see an inmate exhibiting any of the acute signs or symptoms of a mental disorder or other mental health distress, you might want to consult with a mental health professional. When in doubt, **REFER!**



Learning Objective 4

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Identify effective strategies for pre-release planning and for continued care of mental health patients who are on parole

Mental health pre-release program



Institutional Mental Health Pre-Release Coordinator (IMHPC) Role

- ▶ Complete the Pre-Release Planning Assessment in EHRS
- ▶ Obtain a Release of Information (ROI) for any patient who is going to be released to Post Release Community Supervision (PRCS) so patient's mental health records can be sent to the CBHD. For patients releasing to parole supervision, the BHR clinicians have access to EHRS and can review the health records.
- ▶ Assess patient for possible 5150 referral and need for transportation. Submit chrono to C&PR office.
- ▶ Collaborate with appropriate stakeholders which may include: probation, parole, CBHD, POC, regional centers, hospitals, community treatment programs, custody staff, family members, medical, federal agencies, and other community resources. This includes making appropriate referrals as necessary to services in the institution or community.
- ▶ Participate in Pre-Release Coordinated Clinical Assessment Team (CCAT) teleconferences (for those in PIP or DSH HUB facilities). Special CCATS made be held for non-inpatient patients.
- ▶ Pre-Release Groups

Collaboration = Success



Collaborative Partners:

- Community Transition Program (CTP) - Parole Services Associate (PSA) and Parole Agent II
- Classification & Parole Representative's (C&PR) Office
- Case Records Staff
- Transitional Case Management Program (TCMP)
- Division of Rehabilitative Programs (DRP) – PSA, Correctional Counselor III, Transitions Counselors
- Division of Adult Parole Operations (DAPO)
- County Probation Department
- Behavioral Health Reintegration (BHR) formerly POC
- County Behavioral Health Department (CBHD)
- Re-Entry Coordination Program Unit

Stakeholders Specific to Parole Releases

- Parole Agents
 - ✓ Address verification and placement restrictions
 - ✓ County transfers
 - ✓ Conditions of parole
- Behavioral Health Reintegration (BHR) Clinicians
 - ✓ Clinical appointments to include medication appointments
 - ✓ Case management and referrals/linkages to community resources
- Re-Entry Coordination Program Unit (formerly known as Lifer Re-Entry Unit)
 - ✓ Parole agents work specifically on placement options for lifers who have been granted release by the Board of Parole Hearings (BPH)
 - ✓ Collaborate with medical and mental health for necessary cases to determine potential limitations of placement options



Collaboration with Community Partners

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- Whole Person Care pilot program in Los Angeles County
 - Community health workers
 - Referrals prior to release
- Current meetings with county behavioral health departments and BHR regarding access to mental health services for parolees
- Addressing challenges of placing those with severe mental illness and significantly impaired functioning

Q & A

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Your feedback is valuable!

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