

# Behavioral Health Services in North Carolina's State Prison System: Challenges and Opportunities

Brian Sheitman, Joseph B. Williams

There has been a dramatic increase in the number of individuals incarcerated in the United States during the past several decades. Providing behavioral health care services to incarcerated people within North Carolina's prison system presents several challenges, and progress is being made to deliver care that is consistent with accepted community standards.

The care of individuals incarcerated in correctional facilities presents several challenges, and high on the list is the treatment of those who are suffering from mental illness and substance use disorders. It is difficult to overstate the breadth of mental illness and addiction within US correctional settings. An estimated 16%-20% of the more than 2 million Americans who are currently incarcerated suffer from serious mental illness (typically defined as a psychotic or severe mood disorder), compared to 4% in the general population [1, 2]. While there are several factors that have contributed to the high prevalence rate of serious mental illness within the offender population, the dual phenomena of de-institutionalization (the transitioning of individuals out of inpatient psychiatric institutions and into the community) and trans-institutionalization (the shifting of individuals from psychiatric hospitals to correctional institutions) have undoubtedly played major roles. In 1955 there were over 550,000 available state psychiatric hospital beds (339 beds per 100,000 population), and by 2016 that number had dropped to under 38,000 (11 per 100,000) [3]. This reduction in state hospital beds coincided with a dramatic rise in the US correctional population, as well as an increase in the proportion of incarcerated people suffering from mental illness. It is estimated that 10 times more individuals with serious mental illness are in US jails and prisons than in state psychiatric hospitals [1], and some of the nation's largest facilities housing the mentally ill are correctional centers. Similarly, there has been a rise in the number of incarcerated individuals suffering from substance use disorders in the past several decades, which is likely attributable in part to the nationwide "War on Drugs." In terms of 12-month prevalence rates, published data have revealed that approximately 55%-60% of prisoners meet diagnostic criteria for

alcohol or drug use disorder [4], compared to approximately 8% for the general population [5].

## Overview of Behavioral Health Services Within North Carolina's State Prison System

Unlike the general public, the incarcerated are constitutionally entitled to receive medical and mental health treatment, as the US Supreme Court has held that failure to provide these services represents a violation of incarcerated people's rights [6]. The North Carolina Department of Public Safety (NC DPS) offers a wide range of behavioral health services to its 36,000 incarcerated people, including inpatient and outpatient mental health treatment as well as an array of addiction treatment services. These services are designed on a continuum ranging from supportive counseling to inpatient hospitalization, with the goal of offering care to incarcerated people that is consistent with accepted community standards.

At the time of entry, every incarcerated person is administered a mental health screen by NC DPS nursing staff. If any mental health concerns are noted or the incarcerated person has a prior history of receiving mental health treatment, he/she will be referred for a full mental health assessment that is completed by a social worker or psychologist. If the incarcerated person is identified as having more serious mental health needs or is being prescribed psychotropic medication, he/she is then referred to a psychiatrist. Psychiatry and behavioral health services staff work in partnership within NC DPS to determine the most appropriate care plan to address an incarcerated person's behavioral health needs. At any time during his/her incarceration a prisoner can request mental health services. Also, any prisoner identified by custody staff as potentially having a behavioral health need is referred for assessment.

Unlike most other state prison systems, NC DPS operates

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Address correspondence to Brian Sheitman, Chief of Psychiatry, North Carolina Department of Public Safety, 831 West Morgan St., Raleigh, NC 27603 (brian.sheitman@ncdps.gov).

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a prison psychiatric hospital at Central Prison and manages inpatient beds at North Carolina Correctional Institution for Women (NCCIW). States that lack this resource are required to transport incarcerated people who need inpatient psychiatric treatment to hospitals based in the community. There are 144 designated inpatient mental health beds for male prisoners at Central Prison and 22 beds for female prisoners at NCCIW. There are also 168 residential beds for incarcerated people who are unable to function adequately within the regular prisoner population as a result of their mental illness; these beds are located at Maury Correctional Institution (144 beds for men) and

NCCIW (24 beds for women). Recently NC DPS has pioneered the use of Therapeutic Diversion Units (TDUs). These programs, located at Central Prison, NCCIW, and at Foothills, Alexander, and Maury Correctional Institutions, are designed for incarcerated people in restrictive housing and utilize a standardized evidence-based curriculum with the goal of developing skills that will enable them to function appropriately around others and thus safely reintegrate into the general prison population. Restrictive housing, also known as solitary confinement, involves segregation of certain individuals from the general prison population for disciplinary or security reasons, and prisoners held in solitary

confinement may be kept in their cells for up to 23 hours per day. The negative psychological effects associated with restrictive housing are well documented in the literature [7], and the TDUs serve to minimize the number of prisoners in NC DPS custody who are kept in solitary confinement.

In addition to the TDUs, NC DPS offers other specialty behavioral health programs. The Sexual Offender Accountability and Responsibility (SOAR) Program is a residential program based at Harnett Correctional Institution that provides treatment to those incarcerated for sexual offenses. Incarcerated people enrolled in SOAR participate

in programming 30 hours a week for a period of at least six months. Also, NC DPS operates a 59-bed day treatment program located at Pender Correctional Institution designed to assist incarcerated people with intellectual/developmental disabilities with improving social and vocational skills. The Alcohol and Chemical Dependency Program (ACDP) provides addiction services formed by evidence-based principles established by the National Institute on Drug Abuse. ACDP has a residential treatment component. DART Cherry is a 300-bed residential treatment facility for men and the Black Mountain Substance Abuse Treatment Center is a

60-bed residential facility for women; these two facilities offer a 90-day addiction program to probationers who are court-ordered to receive treatment as well as parolees released from the state prison system who are transitioning back to the community. In addition, NCCIW coordinates with a licensed opioid treatment program in Raleigh to offer medication-assisted treatment (MAT) to incarcerated pregnant women with opioid use disorder (as opioid withdrawal represents a significant medical risk in this population); over a recent 19-month period 91 incarcerated pregnant women were provided with MAT.

The bulk of mental health services offered to incarcerated people are provided at the various NC DPS prisons located throughout the state. In 2018 approximately 6,100 prisoners were on the NC DPS mental health caseload, with about 5,100 being prescribed psychotropic medication. All incarcerated people who are assigned to the mental health caseload have access to psychology services located on site. Like many state prison systems, NC DPS relies upon the use of telepsychiatry in order to meet the needs of prisoners who suffer from mental illness and require pharmacotherapy. Telepsychiatry is a treatment modality that has been successfully utilized for decades and has been shown in studies to be as effective as in-person care in treating a wide range

of psychiatric conditions [8]. Within NC DPS, telepsychiatry has been invaluable in linking providers to incarcerated people housed in remote prisons where it is not feasible to have a provider based on site.

Interestingly, not all people incarcerated in NC DPS prisons have been convicted of criminal offenses. NC DPS provides inpatient treatment to individuals from any of North Carolina's 100 counties who are awaiting trial for a criminal charge and require behavioral health services that exceed what can be administered at the jail. These pre-trial detainees are admitted to NC DPS facilities on safekeeping court orders, often because they are considered a threat to harm themselves/others and are in need of more intensive observation. There are 24 beds at Central Prison designated for male safekeepers, while all female safekeepers are admitted to NCCIW. Male juvenile safekeepers are treated at Foothills and Polk Correctional Institutions.

### **Challenges**

There are notable differences between the behavioral health care that is administered within the prison system and what is provided in the community, and it is important to highlight some key distinctions that can present challenges from a treatment standpoint. The most striking difference

relates to the fact that the primary mission of the prison system is public safety; all other functions (including health care delivery) are secondary to this primary mission. For example, if a security threat arises that requires a prison lockdown, any clinics scheduled during that time must be rescheduled. Another difference involves restrictive housing. Prison systems including NC DPS utilize restrictive housing for management of incarcerated people who are being disciplined for rules infractions or are designated as a significant threat to the facility. Incarcerated people in restrictive housing are confined to their cells for up to 23 hours per day. Providing mental health services to individuals in restrictive housing can be challenging, and it is well known that solitary confinement for extended periods of time can have deleterious psychological effects, including anxiety, depression, anger, cognitive disturbances, obsessive thoughts, perceptual distortions, and psychosis. These effects can be especially pronounced for those prisoners who suffer from illnesses such as schizophrenia, schizoaffective disorder, bipolar disorder, and major depressive disorder [7].

The ability to differentiate bona fide mental illness from symptoms or behaviors feigned to achieve a secondary gain

(which is known as malingering) is a challenge for even the most experienced clinicians [9]. While malingering is encountered in many behavioral health settings, there are factors unique to corrections that make this phenomenon more pervasive in jails and prisons. For example, pre-trial detainees who are facing a court action may feign mental illness in the hopes of avoiding trial or bolstering an insanity defense. Incarcerated people may also present as seriously mentally ill with the goal of being transferred to an inpatient psychiatric facility for personal safety reasons; it is not uncommon for prisoners to attempt to change location in order to get away from members of security risk groups (gangs) who are threatening or extorting them. Also, incarcerated people may engage in malingering so that they can be prescribed sedating psychotropic medications, which allows them to "sleep away their sentence." Occasionally, incarcerated people will go to extremes to display "evidence" of a fabricated mental illness, including engaging in significant self-injurious behavior. The aforementioned motivations for feigning psychiatric symptoms are largely non-existent in the general community, and this behavior places a burden on the NC DPS mental health staff to differ-

entiate those who are attempting to manipulate the system from those who are genuinely suffering from mental illness and in need of services. Further complicating the matter is that the suicide rate in correctional facilities is high, and incarcerated people who engage in such tactics often have personality disorders and other risk factors for suicide and thus cannot easily be dismissed as low risk for suicide [10].

A pervasive problem existing within US correctional settings is substance use, and NC DPS is no exception. Prisoners with mental illness who use illegally obtained substances frequently experience exacerbation of their underlying psychiatric disorder, which often leads to inpatient hospitalization. The misuse of substances by incarcerated people is not limited to contraband, as some will also misuse prescribed non-controlled substances; these medications are used either because they are sedating or because they will elicit a stimulating or euphoric effect. Two psychotropic medications commonly prescribed in the community but restricted for use within NC DPS are the antipsychotic quetiapine (Seroquel) and the antidepressant bupropion (Wellbutrin). These two medications have significant abuse potential and underground economic value within correctional settings [11, 12].

The primary systems-level obstacle to providing quality behavioral health care to state prisoners in North Carolina is the workforce shortage. This is not limited to behavioral health staff; unfortunately, it can be found across multiple disciplines. The compensation offered for these positions is often below what is available elsewhere, and the stigma associated with working in a prison results in many individuals never considering a correctional career. In order to provide a safe environment conducive to health and wellness, it is necessary to have stable and content custody and health care staff. Custody officers, who have a very difficult and stressful job even under the best of circumstances, are often asked to work more hours than what is desirable because of these shortages. This can lead to burnout and diminish staff's ability to be as tolerant and caring as they could be under better circumstances.

Another notable limitation is the lack of modern data systems that would allow for improved monitoring of the quality of care delivered. This information is critical for efficient management of a system that oversees the movement of many high-risk incarcerated people between facilities and back into the community upon release. In 2018 approximately 23,000 incarcerated people entered the North Carolina state prison system, with an equal number of individuals returning to the community. Coordinating behavioral health services within the state prison system and with agencies in the community is challenging. Furthermore, NC DPS and the North Carolina Department of Health and Human Services (NC DHHS) do not have compatible data systems; therefore, effective monitoring of potential improvements that are implemented by these two agencies is difficult. Also, most incarcerated people are admitted into the state prison system following

a period of incarceration in county jails. Many jails in North Carolina do not utilize electronic health records and there is not a standard medication formulary that is adhered to by all state and county correctional facilities.

## Progress and Future Directions

Despite the many challenges to effective mental health care delivery that are faced by NC DPS, there has been considerable effort made in the recent past to improve the quality of care for incarcerated people in North Carolina's prisons. There are now over 150 available TDU beds, which, as discussed previously, have been designed to help reduce the number of mentally ill incarcerated people who are kept in solitary confinement. There has been a concerted effort to improve evidence-based psychotropic prescribing practices in order to better treat incarcerated people with severe mental illness, and the number of incarcerated people receiving clozapine (the recommended antipsychotic medication for treatment-resistant schizophrenia) has increased markedly in the last few years.

There are more improvements underway. NC DPS is in the process of developing a plan that will provide MAT to incarcerated people suffering from opioid use disorder. Nationally, the leading cause of death following release from incarceration is overdose, and offering evidence-based pharmacotherapy for high-risk prisoners will go far toward addressing this crisis [13]. Work is currently being done to develop protocols to ensure a smoother transition back to the community for incarcerated people upon release. This will include more intensive follow-up if on parole, improved communication between NC DPS and community mental health providers, and greater efforts to have justice-involved people's health insurance reactivated upon release.

It has become evident that managing the behavioral health needs of the incarcerated population is part and parcel of a larger public health effort, given that so many individuals with mental illness transition in and out of jails and prisons. Indeed, research has revealed that approximately 40% of individuals with serious mental illness have been incarcerated at some time in their lives [1]. To this end, NC DPS is partnering with NC DHHS, the state psychiatric hospitals, and programs within the University of North Carolina at Chapel Hill (the Department of Psychiatry, the Formerly Incarcerated Transition Program, and the School of Nursing's Psychiatric Nurse Practitioner Program) to more effectively meet the behavioral health care needs of its incarcerated people. Furthermore, it is anticipated that new partnerships will develop over the coming years to leverage the considerable academic resources of the state in providing quality, cost-effective behavioral health care to the justice-involved population. **NCMJ**

**Brian Sheitman, MD** chief of psychiatry, North Carolina Department of Public Safety, Raleigh, North Carolina.

**Joseph B. Williams, MD** assistant professor of psychiatry, University of North Carolina School of Medicine, Chapel Hill, North Carolina.

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