Interprofessional Partnerships between Mental Health and Corrections

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Focus of this presentation

- Inter-professional partnerships between MH and corrections

  - Security, Patient Care, Documentation

- Addressing re-traumatization as occupational hazard

  - Effects of Trauma on an Individual and Organizational Level
  - Correctional Fatigue

Security, Patient Care, and Documentation

- Role of Officers, Social Workers, and Patient/Inmates in all three of these goals.

    I: Inherent value of these three goals

    II: Paradoxical, inherent problems result from pursuing these goals

    A. Individual level: barriers to accomplishing these goals and resulting consequences

    B. Organizational level: barriers to staff retention and staff wellness, morale, and productivity. Consequences and Trickle down effects.

Security, Patient Care, and Documentation

- Role of Officers, Social Workers, and Patient/Inmates in all three of these goals.

  I: Inherent value of these three goals

  - **Safety**: A need for security policy appropriate for the setting

  - **Mental Health**: A need for mental health and other related services focusing on needs of all three stakeholders

  - **Documentation**: A need for accountability, continuity, ramifications

Security, Patient Care, and Documentation

- Role of Officers, Social Workers, and Patient/Inmates in all three of these goals.

    II: Paradoxical, inherent problems resulting from pursuing these goals

    A. **Individual level**: barriers to accomplishing these goals and resulting consequences
        - **Lack of safety (assault, trauma/retraumatization)**
        - **Burnout and Correctional Fatigue (MH sxs and Dx)**
        - **Compliance concerns from Management (documentation and adjustment to changing expectations)**

Security, Patient Care, and Documentation

- Role of Officers, Social Workers, and Patient/Inmates in all three of these goals.

  II: Paradoxical, inherent problems resulting from pursuing these goals

   B. **Organizational level**: barriers to staff retention and staff wellness, morale, and productivity. Consequences and Trickle down effects.
   - **Legal issues (NY state vs. NYC; staff v. NYC; inmate v. inmate; inmate v. staff)**
   - **Politics and Policy (Selective considerations and particular perspectives.) ie: Clinical concerns separated from Social Work lens (PIE Person-In-Environment), Changes to Decision-making/Consultation with SW direct service providers, Changes to Hiring Social Workers and their Designated Roles and Responsibilities**
   - **Impact System-Wide on inmate population (adequate/inadequate MH services)**

Collaboration between Front-Line Staff and Inmates

- Informal Interprofessional Partnerships (Social Workers and Correctional Officers)
  - Purpose: Safety and Mental Health in treating the needs of the collective population "where they are at"
  - Accomplishments: Crisis Intervention, Referrals, Psychoeducation, Open and Ongoing Follow-up, Relying and Learning from own and others' existing Strengths and Resources

- Oversight and Knowledge Base Development to better serve the Inmate Population
  - Jail-based MH HIPAA policy and Duty to Warn enhancing safety of patients and an informed approach to their presenting problems and needs as per Hierarchy of Needs

  - Unique and critical for the jail setting

Addressing Trauma and Retraumatization

CDC reported *"Rotating shifts and overtime are often required for correctional officers. Long hours, fatigue, and shift work may be linked with on-duty injuries and chronic diseases such as cancer and cardiovascular disease among public safety workers. Fatigue-related errors may also impact the communities and civilians these workers protect and serve. Nonfatal injuries are also prevalent among correctional officers. Between 2005 and 2009, their nonfatal injury rate ranked third only to police officers and security guards."
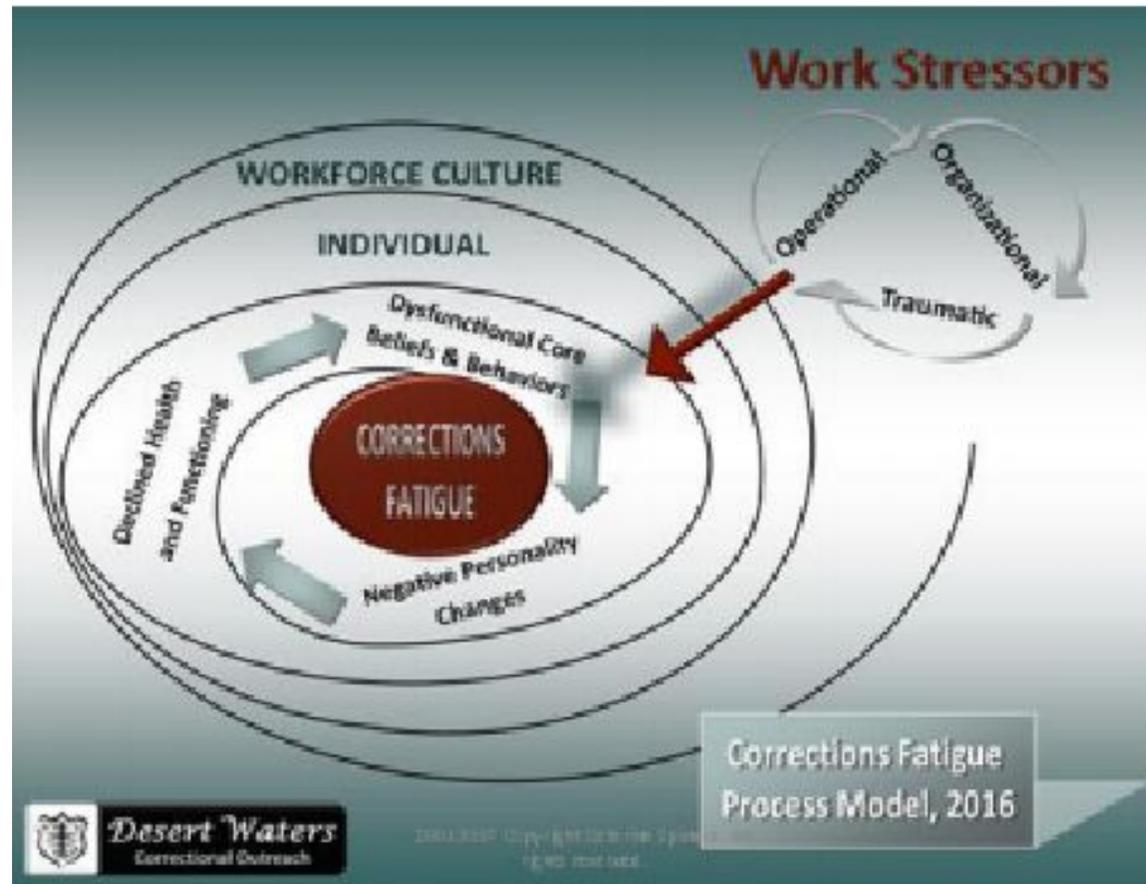
Retraumatization through Corrections Fatigue

Interaction of Work Stressors leading to Changes in the Individual and Workforce Culture:

ex) short staffing (Operational)

-> assault (Traumatic)

-> tension/conflict among staff or between staff and inmates (Organizational)

Corrections Fatigue Process Model, 2016

Rates of PTSD and VID (Violence, Injury, and Death) related emotions

PTSD rates higher than rates
In research data for war veterans
And EMS.

100% of the 3,599 subjects
Confirmed exposure to VID
Events (continued
on next slide)

PTSD etiology is established
In the data as being rooted in
VID Events

PTSD Positive
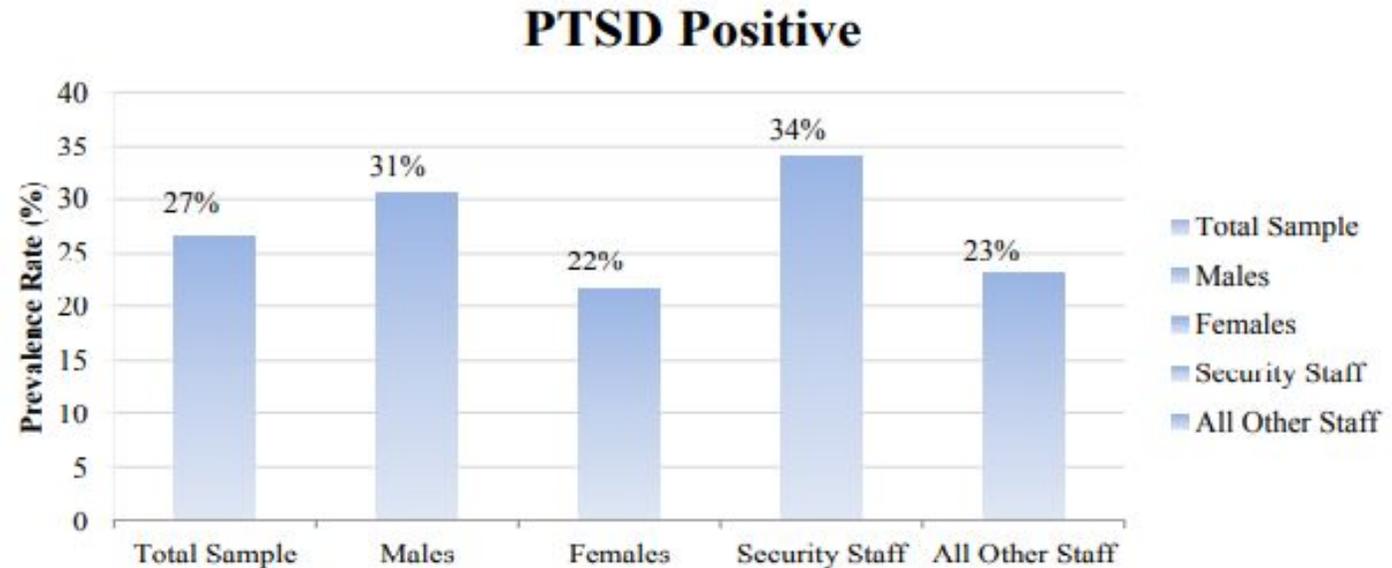

Figure 1. Rates of PTSD-positive corrections professionals (SCM method).
Notes: Total *N*=3599; PTSD-positive *n*=956; PTSD-negative *n*=2643.

Other MH diagnoses and sxs
Are positively correlated with VID Events (cont'd on next slide)

Rates of PTSD and VID (Violence, Injury, and Death) related emotions

Frequency and Risk of Specific VID Experiences According to PTSD Status

	% of Participants Indicating "Yes" to the Event	
	PTSD Positive (*n*=956)	PTSD Negative (*n*=2643)
You witnessed a sexual assault on another person	9.7%	3.3%
A family member of yours was killed by an offender	1.9%	0.8%
A hit was placed on one or more of your family members	4.4%	2.1%
A hit was placed on you by an offender	14.2%	7.5%
Someone threatened to sexually assault you	27.1%	14.3%
A death threat was made toward a family member	47.2%	25.7%
You witnessed a sexual assault threat against someone else	17.8%	9.8%
Someone inflicted physical harm on you	33.3%	19.7%
You witnessed a fire resulting from arson	28.7%	17.1%
A threat of physical harm was made toward a family member	44.6%	27.1%
You witnessed a riot	25.1%	16.4%
A death threat was made toward you	67.1%	44.1%
You witnessed a suicide attempt	55.6%	37.2%
You witnessed a completed suicide	28.9%	19.9%
You witnessed physical harm being inflicted on someone else	73.2%	54.9%
You observed someone being threatened with physical harm	71.3%	54.4%[b]
A threat of physical harm was made toward you	82.2%	63.2%
A sexual assault was inflicted on you	1.0%	0.9%

*Statistically significant at *p*<.05.

Cont'd: Rates of PTSD and VID (Violence, Injury, and Death) related emotions

VID Related Emotion/Feeling States and Risk According to PTSD Status

Emotion	% of Participants Indicating "Yes" to the Event		Effect	Confidence Interval (95%)	
	PTSD Positive (n=956)	PTSD Negative (n=2643)	Relative Risk	Lower	Upper
Shame	15.3%	4.6%	3.34*	2.65	4.20
Guilt	24.9%	9.8%	2.55*	2.17	2.99
Horror	22.1%	14.3%	2.42*	2.04	2.87
Numbness	60.4%	25.6%	2.36*	2.17	2.56
Helplessness	51.0%	9.1%	1.97*	1.80	2.15
Fear	57.9%	27.1%	1.67*	1.54	1.80
Indifference	50.0%	32.3%	1.55*	1.42	1.69
Anger	82.0%	59.3%	1.38*	1.33	1.45
Sadness	49.1%	37.5%	1.31*	1.21	1.42
Empathy	40.9%	34.8%	1.20*	1.10	1.32

*Statistically significant at $p<.05$.

Services currently in place

- C.A.R.E services (Correction Assistance Response for Employees)

- *"The primary goal of CARE is to provide various services to all employees to effectively increase the Department's efficiency, morale and productivity. The CARE Unit primarily provides support, comfort and resources to staff on a continuous basis who may be experiencing personal or family issues to include trauma debriefing, domestic violence, high anxiety, family crisis, PTSD, job related stressors, terminal illness, financial difficulties, alcohol and prescription drugs addiction and all other problems not in violation of departmental policies. The CARE Unit also provide referrals to community resources as an additional source for employees to attain further assistance when coping with unexpected situations. The services of CARE are available to all employees of the Department."

*https://www1.nyc.gov/site/doc/about/units-divisions.page

- Wellness Center
  - Located at GMDC directly on Rikers Island

Cont'd: Services currently in place

- C.A.R.E
  - Consists of uniformed/ civilian staff directly employed by D.O.C
  - The duties of the C.A.R.E unit is to provide support and resources for on- duty officers
  - C.A.R.E takes direct and in-direct referrals for officers who have faced on and off duty crisis situations.

- Wellness Center
  - C.A.R.E unit base
  - Juice Bar
  - Gym
  - Religious services

Challenges and barriers from the officer's perspective

- Officers and C.A.R.E services

  - Officers have reported that if mental health issues are reported to C.A.R.E unit staff they face risks of having their weapons, post and overtime removed.

- Officers have reported the need for services

  - Officers collectively reported they would receive services if they were available to them

  - Officers feel that they can be judged due to stigma related to receiving mental health services

  - Unclear rights related to receiving services in the community related to confidentially.

  - Unclear understanding of services they are eligible for through D.O.C directly or in the community.

Personal/Professional Outlook and Opinions

"It is what it is"

"This is jail"

"You gotta be crazy, but not too crazy"

"You gotta stick it up to get what you want"

"No one cares about us"

"Cover your ass"

"Be safe"

Personal/professional opinions about MH and officers

- Most officers do not see mental health due to being fearful of losing their Jobs, weapons and overtime opportunities

- Services like C.A.R.E are directly linked to D.O.C therefore there are issues with anonymity and confidentiality

- Stigma related to receiving Mental Health services.

- Lack of communication regarding the benefits of Mental Health treatment, particularly services that address officers' needs

Recommendations

- More research related directly to correctional officers
- Implementing services with less consequences /
  Identifying ways to address potential repercussions of help seeking
- Implementing education and trainings during academy related to mental health with a focus on personal care for the officers
- Additional services for Mental Health and officer care
- Greater visibility and transparency
- Additional trainings for Social Workers providing direct services to correctional staff

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