Memorandum on Mental Health Care Need Classifications in Connecticut's Incarcerated Population[1]

July 7, 2020

Prepared by

The Connecticut Sentencing Commission
Michael Chase, *Mental Health Subcommittee Chair*
Alex Tsarkov, *Executive Director*
F. V. Augur, *Policy and Research Contractor*

[1] This memorandum was prepared in response to a request from State Senator Catherine Osten.

I. BACKGROUND – MENTAL HEALTH CARE NEED CLASSIFICATION

When individuals are first incarcerated or transferred to a Connecticut Department of Correction (DOC) facility, they undergo a health screening process. As part of this screening, individuals who meet certain criteria are referred for a mental health evaluation. These triggers for a mental health referral and the required timeframe for an evaluation are summarized below in Table 1. In addition to these referrals at intake, individuals may be referred or may refer themselves for mental health services at any point during their term of incarceration. DOC mental health services are required by administrative directive to address these referrals within 72 hours of receiving them. Furthermore, administrative directive states that a qualified mental health professional shall evaluate any individual who commits or attempts to commit inmate-on-inmate sexual abuse. Mental health care staff are required to attempt this evaluation within 24 hours of the incident being reported.[2]

Table 1 – Triggers for Referral for Mental Health Evaluation Upon Admission or Transfer

Criteria	Evaluation Timeframe
Incarcerated for the first time	Within 24 hours of referral
Discharged from a psychiatric facility within the last 60 days	
Displayed or indicated a suicidal ideation within 60 days of incarceration	
Mental health concerns identified by the court or reported by a concerned party	
History of attempted suicide within past three years	
History of attempted suicide (over three years ago)	Within 72 hours of referral
Currently participating in outpatient mental health programs or services	
Prior sexual victimization or prior perpetration of sexual abuse	Within 14 days of referral

Source: DOC Administrative Directive 8.5, Mental Health Services (2015).

As part of the DOC's health screening and mental health evaluation, incarcerated individuals receive a mental health care need (MH) classification.[3] This classification is based on a five-point score and is separate from other DOC classifications, such as risk level or medical need. Definitions for the five MH scores are presented below in Table 2.

The mental health care need classification system is a tool used by the DOC to coordinate mental health care provision. These classifications do not constitute specific diagnoses under the Diagnostic and Statistical Manual of Mental Disorders (DSM), which are stored separately in the DOC's electronic health record system. Additionally, MH classifications do not reflect substance abuse disorders, which are captured by a separate classification system that is utilized by the DOC's Addiction Services unit.

[2] Connecticut Department of Correction Administrative Directive 8.5, Mental Health Services (2015).

[3] The DOC uses additional mental health subcodes to classify individuals who meet target criteria set by the Department of Mental Health and Addiction Services, have a developmental disability, or suffer from some type of brain injury. These subcodes are outside the scope of this memo, but may be addressed in a future addendum.

Table 2 – Mental Health Care Need Classification Scores		
Classification	**Description**	**Examples**
Mental Health 1	These individuals have no mental health history or current need and may be characterized as emotionally stable.	Individual denies any mental health history, denies any suicidal ideation or suicide attempts with no evidence of anxiety, depression or psychosis.
Mental Health 2	History of mental health disorder that is not currently active or needing treatment; or current mild mental health disorder, not requiring treatment by a mental health professional.	Individuals with a history of mental health treatment for adjustment disorder, depression, anxiety, attention-deficit hyperactivity disorder, conduct disorder, phobias, eating disorders, brief psychotic episodes, post-traumatic stress disorder, or developmental disorders with no current symptoms and no need for medication or follow-up services.
Mental Health 3	Mild or moderate mental health disorder (or severe mental disorder under good control); may or may not be on psychotropic medication.	Individuals with chronic schizophrenia or bipolar disorder who are compliant with medications and may have periodic psychotic exacerbations requiring hospitalization yet are able to function in a general population setting; Individuals with major depression who may have a history of suicidal behavior and need supportive services and/or medications and may require periodic hospitalizations; Individuals with personality disorders, e.g. borderline personality disorder and require supportive services and crisis intervention to prevent self-mutilation or suicidal gestures
Mental Health 4	Mental Health disorder severe enough to require specialized housing or ongoing intensive mental health treatment; usually on psychotropic medications.	Individuals with chronic schizophrenia or bipolar disorders with frequent psychotic exacerbations, who need medication and assistance with activities of daily living; Individuals with borderline personality disorder with frequent suicidal gestures or episodes of self-mutilation, who, due to chronic mood instability and impulsiveness, require daily contact and support; Individuals with intellectual disability in need of assistance with activities of daily living and self-care.
Mental Health 5	Crisis level mental disorder (acute conditions, temporary classification). Requires 24-hour nursing care.	Acute psychosis, severe depression, suicidal ideation, suicidal gestures or attempts, and overwhelming anxiety. Actively suicidal or self-mutilating individuals. Require suicide watch, 15 minutes watch or one-to-one monitoring.
Source: Connecticut Department of Correction Objective Classification Manual (2012).		

While all individuals with a mental health diagnosis requiring treatment will receive a classification of MH-3 or higher, their specific classification will depend on the severity of their treatment needs and how the DOC can best manage these needs. For instance, an individual who has been diagnosed with schizoaffective disorder but, with proper treatment, is capable of performing basic functions (such as eating, grooming, and bathing) in the general population would be classified as MH-3. By contrast, an individual who develops severe depression after the loss of a loved one may be temporarily classified as a MH-5, even if they do not have a "chronic" mental illness *per se*.

When possible, all mental health classifications are conducted by qualified mental health professionals.[4] In facilities with more limited resources, classification or general health services staff may issue classifications of MH-1 and MH-2. Any classifications that reflect a mental health disorder requiring active treatment (a score of MH-3 or higher) must be made by mental health professionals.[5] Additionally, mental health needs scores must be re-evaluated every year and any time there is a significant change in an individual's condition.

An individual's MH score serves as the starting point for the development of the individual's mental health care regimen. MH scores determine the minimum frequency with which an individual must meet with mental health professionals. These requirements are reported below in Table 3. Beyond these minimum requirements, mental health professionals will incorporate specific interventions, such as psychotherapy, psychotropic medication, and specialized housing, into individuals' treatment plans based on individual needs and diagnoses. Individualized treatment plans for incarcerated individuals receiving ongoing mental health services must be reviewed and revised by a qualified mental health professional every 90 days.[6]

Table 3 – Minimum Mental Health Care Requirements[7]

Classification/Criteria	Care Requirements
MH-1 or MH-2	Must have classifications reassessed once every year or when a significant change in condition occurs. Must be evaluated within 72 hours of a self-referral or a referral by a concerned party to mental health services
MH-3	Must meet with a qualified mental health professional at least once every 30 days
MH-4	Must meet with a qualified mental health professional at least once every 7 days
MH-5	Under continuous care of mental health care staff
Any individual prescribed psychotropic medication	Must meet with a psychiatrist or psychiatric APRN at least once every 90 days
Sources: DOC Administrative Directive 8.5 and DOC Objective Classification Manual	

[4] DOC Administrative Directive 8.5 defines "qualified mental health professionals" as "psychiatrists, psychologists, Psychiatric APRNs, clinical social workers, psychiatric nurses (e.g. nurse clinician) and others who by virtue of their education, credentials and experience are permitted by law to evaluate and care for the mental health needs of inmates."

[5] *DOC Objective Classification Manual.*

[6] DOC Administrative Directive 8.5

[7] Notwithstanding these requirements, any individual incarcerated at Northern Correctional Institution shall be evaluated by a qualified mental health professional at least once every 30 days.

II. DATA

On May 22, 2020, the Department of Correction queried its administrative database and provided the Sentencing Commission with a cross-sectional snapshot of the incarcerated population's mental health classifications. These data were accurate at the time of the query.

These data were collected in the midst the 2019-2020 SARS-CoV-2 pandemic. During this pandemic, the state experienced an unprecedented drop in its incarcerated population, which declined by more than 15% over a three-month period. In addition, during this time, various DOC programs and services were modified to reduce unnecessary physical contact and prevent the spread of the virus in correctional facilities. It is unclear whether these unique circumstances affect how representative this study's data are of a "typical" distribution of the incarcerated population's mental health classifications.

III. ANALYSIS

Overall Findings. Table 4 presents the distribution of mental health care need scores in Connecticut's incarcerated population as of May 22, 2020.

Table 4 – Distribution of MH Scores on May 22, 2020

Classification	# of Individuals	% of Individuals
MH-1	3,270	31.15
MH-2	4,240	40.39
MH-3	2,570	24.48
MH-4	379	3.61
MH-5	39	0.37
Total	**10,498**	**100**

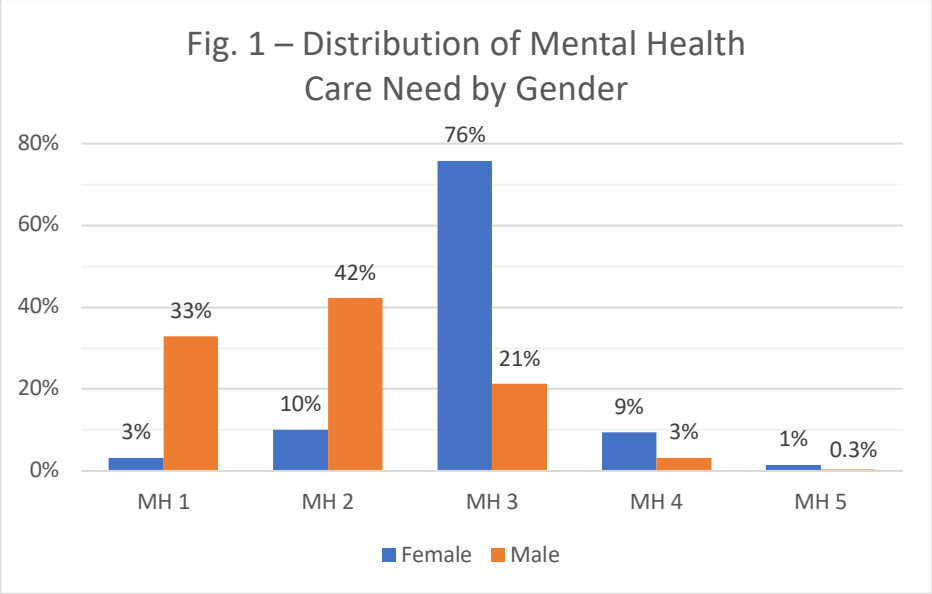
2,988 individuals were classified with a mental health care need score of 3 or higher. This corresponds to 28.46% of the incarcerated population having some mental health disorder requiring active treatment. Of these, 379 individuals were classified as having a severe mental health disorder (MH-4), and 39 were classified as having a crisis-level disorder (MH-5).

40.39% of the incarcerated population was classified as having a reported history of a mental health disorder but not requiring active treatment (MH-2). Lastly, 31.15% were classified as having no history of a mental health disorder (MH-1).

Demographic Analyses

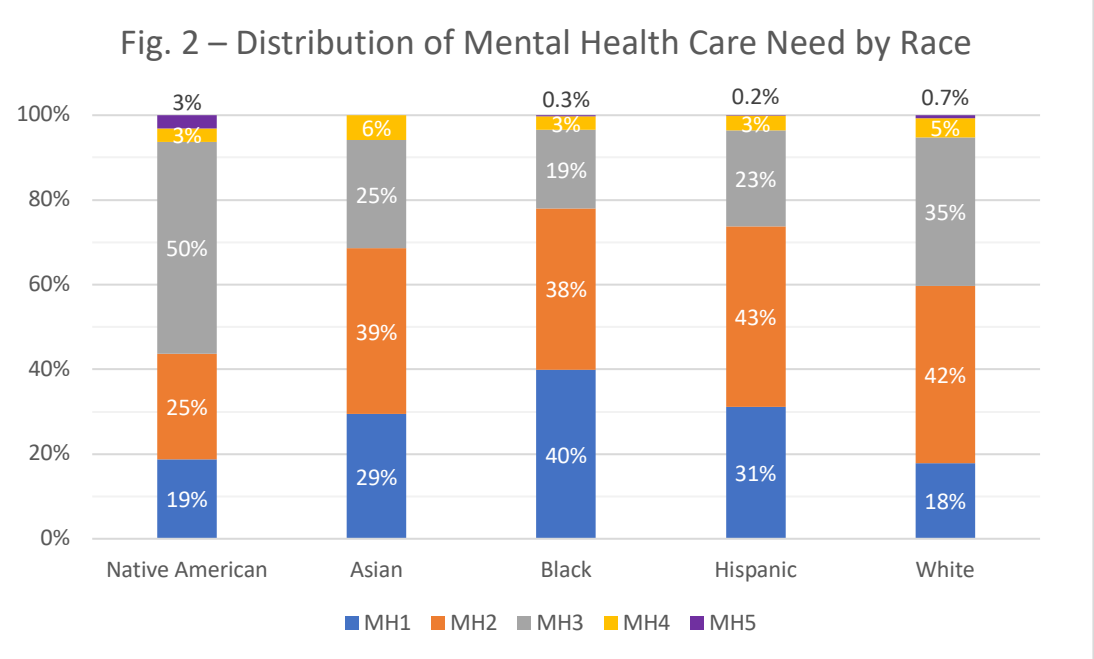
Gender: Table 5 and Figure 1 present the distribution of mental health care need scores broken down by gender. On average, females were classified as having higher mental health care needs than males. Over 86% of females were classified as having a mental health disorder requiring active treatment (MH-3 or higher), compared to 25% of males. This difference is statistically significant.

Table 5 – Distribution of MH Scores by Gender		
Classification	**# of Female**	**# of Male**
MH-1	20	3,250
MH-2	62	4,178
MH-3	466	2,104
MH-4	58	321
MH-5	9	30
Total	**615**	**9,883**



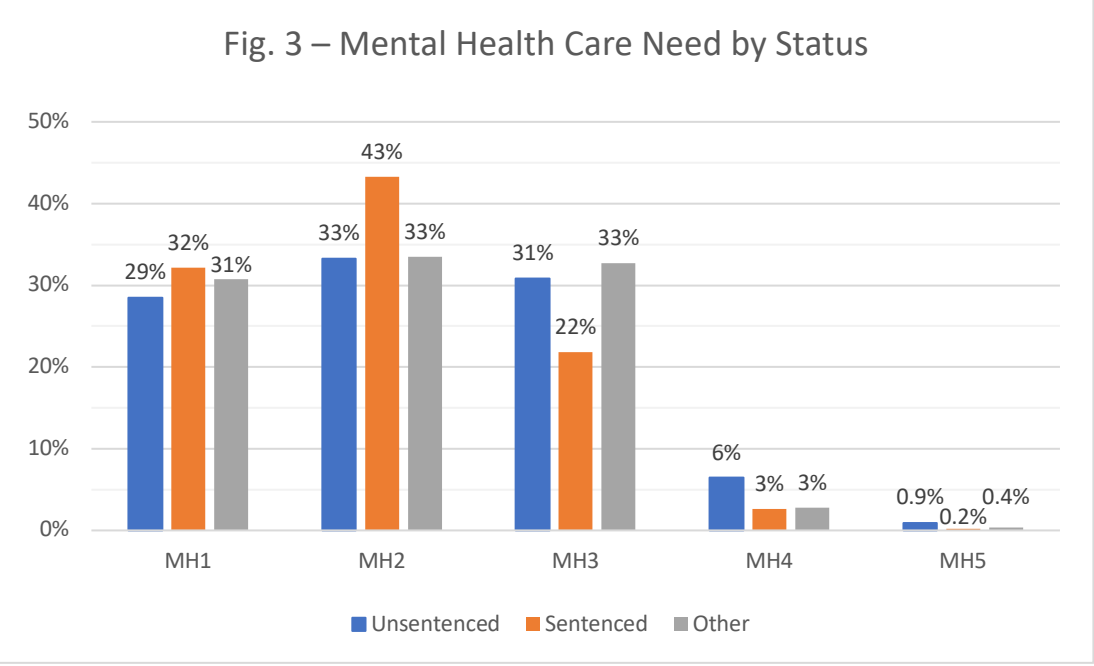
Race: Table 6 and Figure 2 present the frequency distribution of mental health care need scores broken down by race. There was statistically significant variation in mental health scores across different races. As a group, Native Americans were classified as having the highest mental health care need. 56% of the incarcerated Native American subpopulation was classified as having a mental health disorder requiring active treatment (MH-3 or higher), though, given the small size of this subpopulation (32 individuals), this statistic should be interpreted cautiously. White individuals had the next highest incidence of identified mental health disorders requiring treatment (40%), followed by Asian individuals (31%), Hispanic individuals (26%), and Black individuals (22%).

Table 6 – Distribution of MH Scores by Race					
Classification	**Native Amr.**	**Asian**	**Black**	**Hispanic**	**White**
MH-1	6	15	1,837	884	528
MH-2	8	20	1,756	1,213	1,243
MH-3	16	13	857	645	1,039
MH-4	1	3	144	95	136
MH-5	1	0	13	5	20
Total	**32**	**51**	**4,607**	**2,842**	**2,966**



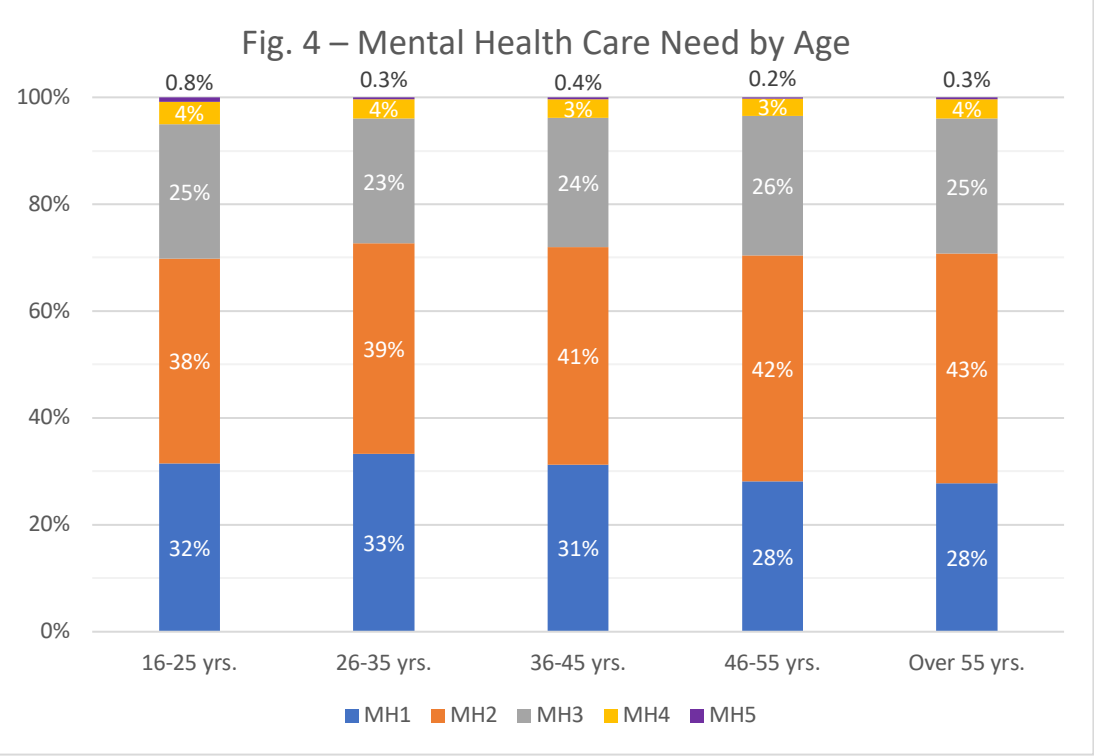
Legal Status: Table 7 and Figure 3 present the distribution of mental health care need scores by legal status. There were statistically significant differences in distribution of mental health needs scores across different statuses. Overall, the unsentenced population had a higher rate of mental health disorders requiring treatment (38.2%) than the sentenced population (24.6%). The "Other" population consists of special parole remandees and individuals in CT DOC facilities incarcerated under other jurisdictions. In this "Other" population, 35.8% had an MH score of 3 or higher.

Table 7 – Distribution of MH Scores by Legal Status			
Classification	**Unsentenced**	**Sentenced**	**Other**
MH-1	788	2,404	78
MH-2	919	3,236	85
MH-3	853	1,634	83
MH-4	178	194	7
MH-5	26	12	1
Total	**2,764**	**7,480**	**254**



Age: Table 8 and Figure 4 present the distribution of mental health care need scores by age group. While there is some variation in MH scores from one age group to the next, there were no statistically significant differences in the percent of individuals with MH scores of 3 or higher across the five age groups.

Table 8 – Distribution of MH Scores by Age					
Classification	**16 – 25 yrs.**	**26 - 35 yrs.**	**36 - 45 yrs.**	**46 - 55 yrs.**	**Over 55 yrs.**
MH-1	488	1,165	876	476	265
MH-2	593	1,381	1,139	717	410
MH-3	390	820	677	442	241
MH-4	65	127	96	56	35
MH-5	12	11	10	3	3
Total	**1,548**	**3,504**	**2,798**	**1,694**	**954**



IV. CONCLUSIONS

The Connecticut Department of Correction provides mental health care services to incarcerated individuals. Through a screening and evaluation process, the DOC uses a five-point mental health care need scale to manage mental health care provision. This classification, which can change in response to changes in an individual's current treatment needs, determines the level and frequency of mental health interventions individuals receive. This classification is separate from an individual's specific diagnosis, which is stored in an electronic health record system. Additionally, this classification does not reflect substance abuse disorders, which are captured by a separate DOC classification.

On May 22, 2020, 28.48% of Connecticut's incarcerated population was classified as having a mental health disorder requiring treatment (MH-3 or higher). 40.39% of incarcerated individuals were classified as having a prior history of a mental health disorder but not currently requiring treatment (MH-2). 31.15% were classified as requiring no treatment and having no history of mental health issues (MH-1).

Compared to the rate of active mental health disorders for the entire incarcerated population, the rate of mental health disorders was higher for females, Native American individuals, white individuals, and Asian individuals. Larger portions of the unsentenced and "other" populations were classified as having a mental disorder requiring treatment compared to the portion of sentenced population. There were no significant differences in the percent of individuals with MH scores of 3 or higher across different age groups.

V. FUTURE RESEARCH

The Sentencing Commission looks forward to continuing its work with the Department of Correction and other stakeholders on this important topic. Commission staff have requested but have not yet received data on specific mental health diagnoses from the DOC's electronic health records. This diagnostic data would provide critical insight into the specific mental health disorders and treatment needs of the incarcerated population beyond what is conveyed by the classification scores. Should the Commission be able to obtain this information and merge it with the data used in this memo, the Commission will publish an addendum detailing the incidence of certain diagnoses in the incarcerated population and the distribution of certain diagnoses across different MH scores.[8]

[8] Access to this data will be conditional on 1) the ability to generate a query from the DOC's electronic health records and 2) the ability to match these data at an individual level in compliance with healthcare privacy laws.