

Prisons and the mentally ill: why design matters

By Dr Marayca López and Laura Maiello-Reidy

Scope of the Problem

Worldwide, mental health disorders among the general population are considerable, but they are even more prevalent among jail and prison inmates. Correctional health professionals have reported that both the number and the acuity levels of inmates with mental health disorders are rising – even in systems where the prison population at large is declining. Although prevalence estimates vary widely, the high level of mental disorders among the adult prison population is one of the biggest challenges facing correctional systems today.

The growth in the number of mentally ill inmates is mainly attributed to the gap between the need for treatment and the availability of mental health services in the community, especially for those who require in-patient care. In the United States, the deinstitutionalization of the mentally ill resulted in the closure of large psychiatric hospitals or “asylums” beginning in the 1960’s, leaving many providers ill-equipped to service the large number of patients in community-based settings. Over the last three decades, correctional facilities (and particularly jails in the USA) have become the de facto service provider for individuals with mental health disorders who come into contact with the law – even low-level offenders. In some countries, there are more people with severe mental illness in correctional facilities than in mental health institutions. The system has reached its tipping point.

A recent focus of global mental health has been to keep mentally ill offenders out of correctional facilities by providing alternatives to incarceration. These include “front end” deflection tactics such as training for police officers to diffuse mental health situations in lieu of arrest; diversion programs such as specialized mental health courts and intensive probation caseloads as alternatives to jail; and the creation of non-secure mental health support centers (i.e. non-correctional units) and other community-based facilities in partnership with health services providers as a release alternative. Some countries have established Psychiatric Penitentiary Centers and hospital prison wards to offer specialized care to inmates with severe psychiatric problems until they can be transferred to an outside forensic institution but, overall, the forensic care capacity that they provide is limited. And while deflection, diversion and treatment are the best and more sustainable approaches, the unfortunate truth is that correctional facilities will remain a central service provider for individuals with mental health issues who come into contact with the criminal justice system, for the foreseeable future.

However, the custodial nature of the prison environment is antithetical to the therapeutic setting required for inmates who are depressed, vulnerable, suicidal, or psychotic. In its current conception and design, it is far beyond the capacity of correctional facilities to address the crushing complexities of mental illness. Labeled by many mental health care professionals as ‘anti-therapeutic’, ***it is just not feasible to expect individuals to become healthy in an unhealthy environment.***

The purpose of this blog/article is to share international good design principles and knowledge from research studies that can help to significantly improve the living conditions of mentally ill inmates. By bringing thoughtful approaches and careful therapeutic design considerations into the discussion, our hope is to help with the creation of contemporary correctional buildings that have a restorative, not detrimental impact on inmates suffering from mental illness.

This report is informed by the co-authors' own expertise and experience at CGL/Ricci Greene in the planning and design of numerous correctional facilities and mental health settings within. In addition, we reached out to colleagues in the field, who provided valuable input and relevant project examples.¹ We also acknowledge Jessica Raimondo, Justice Planner at CGL, for her extensive literature review on correctional healthcare environments and best practice research.

Understanding the Environmental Impact

As discussed in previous expert blogs, correctional facilities are generally harsh and distressing social settings that are not conducive to mental stability or recovery. It is widely demonstrated that correctional environments can aggravate and amplify mental health conditions, with the period of incarceration having the potential to “heighten vulnerability and increase the risk of self-harm and suicide” (Bradley, 2009: Executive Summary para 1).

Segregation, often referred to as isolation or solitary confinement, is the norm for suicidal inmates, as well as to keep those demonstrating perceived or misunderstood mental illness away from the general population. Although intended as a protective measure, long periods of isolation with little mental stimuli contribute to intense feelings of anger, frustration, distress, anxiety, violence and self-harm. The increased risk of suicide in prisons and jails is, unfortunately, one common manifestation of the cumulative effects of these factors.

Overcrowding, violence, bullying, enforced solitude, lack of meaningful activity, isolation from social networks, and insecurity about future prospects are all part of the prison experience. These, coupled with the physical environment – dark and narrow corridors, bad acoustics, limited natural light, temperature fluctuations and lack of privacy – are counter to the therapeutic conditions necessary for mental health and rehabilitation. This uneasy climate puts many mentally unstable inmates in a downward spiral and makes any recovery attempt a distant possibility.

Often these conditions are through no fault of prison administrators. Physical plants are outmoded, lack adequate funding and were built in a different era. Corrections staff are not trained in clinical diagnosis or in treatment modalities. Internationally, there has been discussion about the ministry of health having oversight for prison health instead of the ministries of justice/prison administration or of the interior.

Operational and Design Considerations

Irrespective of the crime committed, every person deserves our respect and our best practices. As justice planners, architects and design practitioners, it is our responsibility to continually evolve the way we design spaces to better serve those who occupy them – particularly the disenfranchised.

Given the high percentage of mentally ill offenders in correctional institutions, it is imperative that the facility environment provides humane settings that support stabilization, recovery and rehabilitation.

¹ Research sources for this blog include telephone interviews and email exchanges with the following contributors: Ken Ricci, FAIA and Stephen Carter, AICP (CGL); Dr. Randy Atlas (independent consultant, USA); D. Bruce Henley, AIA, LEED AP and Margaret S. (Meg) Bower, MPA, AICP, LEED AP BD+C (Dewberry Architects Inc., USA.); Paul Y. Nagashima, AIA, LEED AP (HDR architects, USA); Robert Boraks and Roberta Somlo (Parkin Architects Limited, Canada); Don Thomas, CID (BWBR architects, USA) and University of Technology Sydney (UTS)/Kevin Bradley, Australia).

When the setting is conducive to positive change, the conditions of those suffering from mental illness can be stabilized – or even improve during incarceration, which can also reduce recidivism in the long run.

Environment

Therapeutic and healing mental health environments in a correctional setting are defined by the following characteristics:

A safe environment that “does no harm” – the root of psychiatric or psychological distress for many individuals (particularly females and youth) is past trauma – physical and/or emotional abuse, neglect, violence, etc. Meeting the basic need for physical safety and security is the most critical aspect of trauma-informed design. This includes wide open and predictable spaces, clear sightlines throughout the facility, no blind spots, and curvilinear rather than edges on furniture and other surfaces. Operationally, safety is accomplished through a dynamic security approach that promotes and sustains normalized communication between staff and residents.

A supportive and nurturing environment – healing happens through relationships and meaningful sharing. A supportive and nurturing environment promotes human interactions and values such as empathy, trust and hope, known to be essential to treatment. In a benevolent environment, the physical, emotional and spiritual needs of the residents are recognized, honored, and met by staff. There is enthusiasm among staff for transforming lives and they are expected to foster strong relationships and spend more time interacting with residents, encouraging them to attend therapy groups or just checking in on them to offer a compassionate voice. The design should minimize the barriers between staff and the residents. Any barrier or separation of staff from residents should be based upon documented levels of risk.

A calming, comfortable environment – achieved with color, texture, nature views, furnishings and materials.

A stimulating environment where individuals have some personal control and greater responsibility for their own health and well-being through freedom of movement, choices, and increased independence. Sense of control and ownership over the environment can be encouraged through elements such as lighting flexibility, furniture options and diversity of space layouts.

A normalized environment that reflects the types of situations residents will encounter when they leave the correctional facility. As much as possible, the environment should strive to provide a sense of normalcy, since prisons that “resemble” the world outside have been shown to offer inmates a better chance of successfully reintegrating into society upon release.

A normative environment with a more residential character meant to diminish the sense of institutionalization and its attendant psychological stresses.

A correctional facility that uses these environmental design principles to address the unique needs of the mentally ill will be less punitive and far more treatment-oriented. Paul Y. Nagashima also points out, “these same environmental improvements provide a better work environment for staff. This reduces staff stress and aids in recruitment and retention.”

Spatial Attributes

Certain attributes and applications in the design of interior spaces enhance health and well-being, optimizing the residents' potential for recovery. For example, numerous studies in other fields have demonstrated the positive impact of natural light on student test scores and hospital recovery time, as well as the ability of nature views to reduce heart rate, blood pressure and other stress indicators. These benefits are directly transferable to a correctional setting, particularly important for special need inmates.

Quality lighting and **ample natural light** are critical to improving well-being and expediting the healing process. In a recovery-focused environment residents are afforded plenty of access and exposure to natural sunlight.



Delaware Co-ed Forensic Mental Health Facility, RicciGreene Architects Design
Photo credit: CGL archives

Connection to nature is therapeutic and can positively influence behavior. Adding aspects of nature into design is known to reduce stress and aggression². Incorporating nature into space means introducing features like plants, small courtyard gardens, open recreation with seating areas, and the like. In situations where this is not practical or possible, placing realistic landscape art on the walls, green walls, or the use of furniture with organic shapes that evoke nature can help with stress management and emotional restoration.



² The Healing Power of a Health Facility, New York
Photo credit: Alyse Bredy from the series "Prison Landscapes" view to nature.

Large, tall windows with views to the outside also provide a sense of distance, perspective and hope. By blurring the lines between interior and exterior, the benefits of the outdoors can be “brought inside”. This connectedness with the outside helps to counteract feelings of isolation by conveying a sense of time, weather and changing seasons.



Photo credits: CGL archives

Outdoor Spaces that carefully address proper safety concerns of a secure setting can be calming, positive and therapeutic distractions. Positive distractions can help individuals to be more receptive to treatment and to be treated with fewer medications.

The large yards of the typical prison are not well suited to the needs of the mentally ill. A more appropriate layout is smaller enclosed courtyards that are calm, uncluttered and clean, offering a variety of possibilities: a quiet space to meditate, read, a chance to engage with others, a comfortable chair to relax in. Vegetated spaces, generous landscaping and therapeutic gardens tended by residents can improve an individual’s self-esteem and mood, while the presence of water can have a relaxing effect.



Intensive Learning Center, Mid North Coast Correctional Centre. NSW. Australia

Photo credit: Kevin Bradley & UTS, Australia

Color is another key factor in establishing a desired “room experience”. Certain colors can be stimulating or calming, so it depends on the type of ambience desired for a particular function. For instance, a recovery/time out room expected to have a calming effect needs a cool, restrained, peaceful dominant color choice (e.g. white, light blue paint, ice cream colors, etc.) with limited decorations and distractions, as shown in the images below.

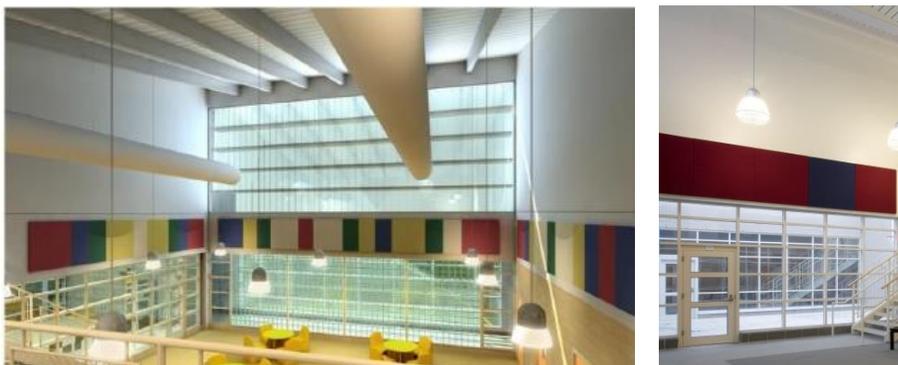


Alvin S. Glenn Detention Facility, Richland County
New Mental Health Services Center – Recovery rooms interior concepts
Photo credit: CGL archives

More active environments that lift the spirits and appear friendly can also be calming. In these instances, warm more optimistic color palettes and color accents make the interiors more interesting, brighter, cheerful and personalized.

Temperature and good air quality – Extreme temperature fluctuations are uncomfortable, confusing and disturbing to individuals with mental illness. As one inmate informed the BWBR design team, ‘when it gets too cold, bad things happen’.

Acoustics - Hard concrete spaces create noise levels that can disturb those with brain disorders, while softer, more natural environments can help to de-stress any environment. Controlling sound levels in mental health settings is especially important as therapy is based on verbal communication and patients’ privacy, all of which require good acoustics. In the facility below, the decorative panels provide an acoustical buffer as well as add color to the unit.



Union County Juvenile Detention Center, NJ, RicciGreene Architects Design
Photo credit: CGL archives

Materials, finishes and furniture choices should provide safety for residents and staff and confer a trusting and positive environment for patients' recovery and rehabilitation. Normal materials, fixtures, and domestic furnishings appropriate to the security requirements of each population should characterize the design of the spaces housing mentally ill offenders. Solid, securely mounted or built-in furniture may be appropriate for populations where the furniture must be stationary. In units where the population has more autonomy, movable furniture provides greater flexibility.



Dallas County Medical Modernization, HDR
Furnishings designed to withstand vandalism
Photo credit: Emily Hagopian



Intensive Learning Center.
Mid North Coast Correctional Centre. NSW. Australia
Photo credit: Tasman Munro & UTS, Australia

Open planning affords better sightlines and it eliminates the anxiety and uneasiness created by crowded and cramped conditions. The design of mental health facilities should anticipate an orderly sequence of spaces that are designed to provide a secure, yet calming and safe environment. Good orientation is of particular importance when dealing with vulnerable populations. "A building layout that can be easily understood reduces stress and confusion" adds Don Thomas.

Specialized Housing

In many countries, prisons lack the strategies to identify, separate and treat inmates with mental health conditions. Margaret S. (Meg) Bower points out that, "when the mentally ill are treated the same as the non-mentally ill criminal population, there is no difference in housing or treatment." As a result, there is a dearth of specialized housing accommodations and services for the mentally ill in prisons internationally.

Not all inmates suffering from mental illness require specialized housing while incarcerated. But for those inmates that do require a higher level of care (acute and sub-acute populations), a correctional facility must be prepared to address those needs or risk the inmate's further decompensation and/or victimization.

Correctional and health services professionals agree that management is facilitated and outcomes are better when housing is differentiated for inmates with serious mental health conditions. The type of accommodation used to house mentally ill offenders can vary depending on the severity of the mental health problem. A person-centered medical and psychological care approach should be used to assign inmates to the appropriate living unit and level of supervision, with the least restrictive response appropriate to the classification risk. Security must take top priority, which poses a challenge to architects

aiming to design a sense of autonomy into a secure prison environment. This challenge should be tackled in much the same way as designing a mental health facility in non-institutional settings - the guiding principle should be the “creation of healing environments that are secure as opposed to secure environments with a little bit of healing” highlights Robert Boraks.

Smaller is better. Generally, inmates with mental health challenges tend to do better in small units (20-30 recommended as an optimal size), designed as single story units vs. units with a mezzanine configuration.

Suicidal inmates should be placed under constant watch in a suicide prevention cell with visual access to patients at all times, and a large view panel on the cell door to improve visibility into the cell. The assignment of an inmate to and from a suicide prevention setting should be with the authority of a mental health practitioner, with the unit ideally located in immediate proximity to or within the facility Health Services component.

Opinions differ about the use of single vs. multi-occupancy rooms for suicidal inmates. Some forensic professionals have promoted the concept of small, close watch, purpose-built dormitories for suicidal inmates. This mitigates the potential psychological deterioration that solitary confinement can cause, and it provides monitored social interaction that helps to assess the inmate’s recovery and readiness for a general population environment. In Colorado, Georgia and New York, CGL Ricci Greene designed and/or programmed jail mental health units that contain a combination of small dormitories, multiple occupancy rooms and single occupancy cells for addressing the continuum of management, supervision and treatment needs of mentally ill offenders. The Dutchess County facility is designed to allow one officer to directly supervise 3-4 constant watch cells, enhancing staffing efficiencies without reducing “24/7 eyes on” requirements for suicidal inmates.



Female Suicide Dorms
Douglas County Jail New Health Services Facility
(RicciGreene Planning and Architects Design)
Photo credit: CGL archives



Close Watch Single Observation Cells
David L. Moss Justice Center Mental Health Expansion
for Tulsa County (Dewberry Architects Design)
Photo credit: Jon B. Petersen Photography, Inc

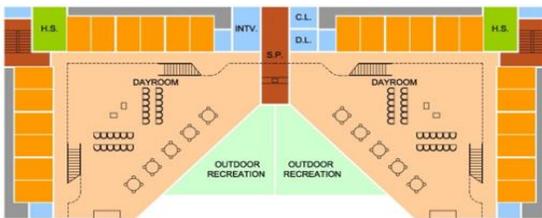
In areas with the highest level of concern for suicide, specifications for lighting fixtures, ceiling systems, furniture, mirrors and hardware must be considered carefully to prevent self-harm. Advancements in tamper-resistant equipment, furniture, and fixtures have reduced the incidences of self-harm.

Some inmates who have mental health problems do not require constant or intermittent watch. However, this segment of the population often cannot handle the stress of being housed in a traditional general population unit. Within this category, several levels of acuity can be differentiated, each one requiring a very specific type of setting. For improved health, research supports single rooms. Most experts who were contacted support single and double occupancy rooms, having concerns about dormitories.

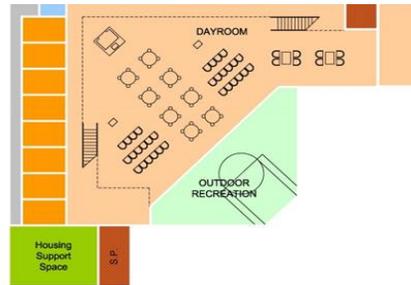
For those exhibiting **acute mental health symptoms**, single cells should be considered, as there are fewer disruptions and incidents than typically can occur in multi-occupancy cells. Single cells also promote a quieter environment, leading to better sleep for most and lowered levels of agitation for some. For **sub-acute populations**, double bunk with other patients is appropriate, as health allows. Finally, for those transitioning back to the general population double bunk or multi-occupancy (4-person alcoves) or open dormitory configurations can be used, depending on the standard accommodation applied to the general population based on different security and classification levels, which differs among countries³.

Continuum of Housing Unit Prototypes / Cell Typologies

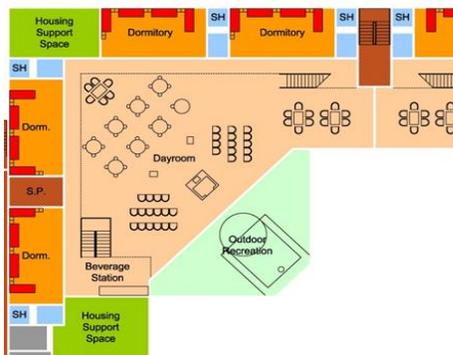
Close Watch Unit – Single occupancy cells



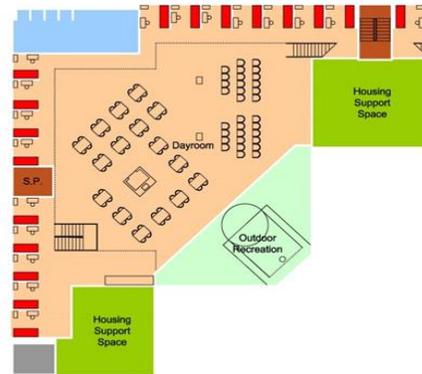
Acute Housing Unit – Single occupancy cells



Sub-acute Housing Unit – 4-person cells



Sub-acute Housing Unit – Open dormitory sleeping alcoves



— Photo credits: CGL renderings

³ For many reasons, including improved health, reduced stress and enhanced behavior management, research supports single rooms. However, in the USA, medium-security inmates are usually housed in cells designed for two people, while minimum-security inmates are housed in multi-person cells or large open dorms. In Europe, as per Rule 18.5 of the European Prison Rules “prisoners shall normally be accommodated during the night in individual cells, except where it is preferable for them to share sleeping accommodation.” As such, the preference (and aim) of European prison systems should be the provision of individual cells to all inmates, regardless of their classification and risk levels.

In all instances, the goal should be the creation of a therapeutic and healing environment that stabilizes conditions and expedites movement into step-down status as quickly and safely as possible. Other important design principles include ample space to avoid special and social crowding and the provision of some personal space, even in open dormitories. As Don Thomas points out, “when mentally ill residents are escalating to a crisis mode, their personal space becomes much larger. Confining them to a small or crowded environment only makes it worse and more unsafe for the resident and staff.” Since lack of privacy can aggravate behaviors and present safety concerns, ensuring a modicum of visual privacy is key. Even in a dormitory, this can be accomplished with “sleeping alcoves” and partitions that provide some boundaries of personal space.

Some inmates suffering from mental illness and under active treatment for mental health conditions are capable of living in a regular general population housing units. No particular regimen is required, except periodic monitoring of their mental health status with a re-assignment (step-up) to specialty housing units, if warranted.

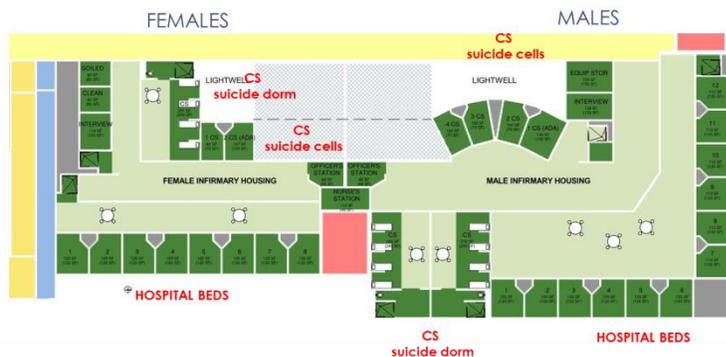
Provide a continuum of housing/treatment environments. Having worked on several correctional mental health projects, the authors of this blog concur with the need to provide a continuum of housing unit configurations that address the different acuity levels of inmate-patients, from stabilization to stepdown. This “step-down model” also allows for increasing levels of autonomy, socialization and decision-making to better prepare the individual for successfully reintegrating into the general population – and ultimately into society upon release. Routine and scheduled monitoring of patient outcomes is a critical aspect of a stepped model of care, allowing low intensity minimal interventions and treatments to be stepped up, should this be required.

*Proposed New Health Services Building. Travis County Correctional Complex, Austin, TX
CGL Planning and Architecture*

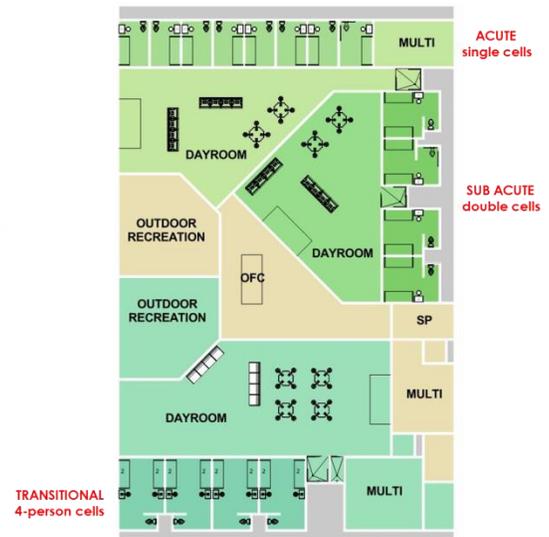
This concept was clearly demonstrated in Travis County TX, where the Adult Correctional Facilities Master Plan includes a new 468-bed Health Services Building providing a variety of cell typologies and housing units for male and female inmate in every identified mental health needs category. The plan reflects the County’s position to “provide a level of medical/mental health care for incarcerated individuals comparable to that which is provided in the community”. This specialized facility will include a full continuum of small mental health care housing settings, in addition to medical housing for physical conditions and acute mental health patients. Most units are planned to be smaller than those provided for the general population (24 vs 48 cells), and single story configuration rather than mezzanine style units. Many units have additional support spaces to provide mental health counseling and treatment programs in place.

Special Needs	Males	Females	Totals # Beds
Medical	112	29	141 beds
<i>Infirmery</i>	8	4	
<i>Acute</i>	56	25	
<i>Detox</i>	48		
Mental Health	251	76	327 beds
<i>Acute</i>	11	4	
<i>Sub-acute</i>	48	24	
<i>Transition</i>	192	48	

Mental Health Wing



Co-ed Medical Wing



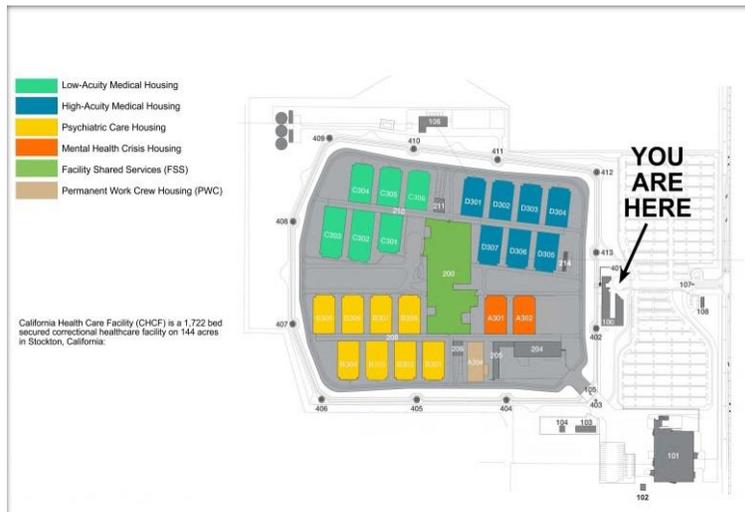
New Health Services Building Concept – Housing Continuum

Photo credit: CGL renderings

The following purpose-built facilities are also good examples of how these objectives can be met.

*California Health Care Facility. Department of Corrections and Rehabilitation, Stockton, CA
CGL Functional and Architectural Programming and Site Master Planning / HDR Architects Design*

- This facility has been designed to provide care for inmates with long-term chronic health conditions. It has also been designed around interdisciplinary treatment teams, which included the inmate himself along with clinicians and custody staff.
- The site is organized in several housing “neighborhoods” based on the different medical and mental health acuity levels. This village analogy is part of the treatment/training where inmate-patients are responsible for making their way to and from their various appointments and programs as part of their Activities of Daily Living.
- The neighborhoods are organized along ‘streets’, one for medical and one for mental health, both leading to a ‘Main Street’ where centralized services and treatment programs are located. Graphics/way-finding systems were deliberately designed to allow inmate-patients with physical or cognitive challenges to more easily navigate the campus.



CHCF – Stockton Site Plan courtesy of HDR



CHCF – Stockton Main Street
Photo credit: Robert Benson



CHCF – Stockton Medical Street View
Photo credit: Robert Benson

*David L. Moss Justice Center Mental Health Expansion, Tulsa County
Dewberry Architects*

- Working closely with mental health providers, the new Mental Health Unit provides a total of 98 beds distributed in two housing pods, a close watch pod and a transitional pod, offering three levels of step-down from close watch to supervised watch to single cells. The mental health transitional housing dorm is reserved for inmates who, once stabilized, will be transitioning back into general population housing. As described by architect D. Bruce Henley, “each piece of the physical design of the pod is a graduation of sorts until they finally reach the point of caring for themselves and interacting in a controlled general population environment”.

- Cells are all on one level, vs the mezzanine (two-story) configuration typical of many general population units throughout the United States.
- Clerestory windows allow eastern morning sun to fill the pod while allowing a glimpse of the occasional tree top. “This connection to the outside as compared to the reality of the physical restraint was a no compromise design element”, notes the architect. “Not only does the natural light save energy - artificial light is rarely required during the daylight hours – but more critically it brings a sense of outside to the inside for the inmate who may struggle with more personal connections.”
- The transitional unit operates under the principle of direct supervision promoting the active interaction between staff and inmates. Treatment and breakroom areas for counseling ensure that medical staff and psychiatrist are only steps away and can be accessed without leaving the pod.



Close Watch, Step One Observation
Photo credit: Jon B. Petersen Photography, Inc.



Controlled General Population, Step Four
Photo credit: Jon B. Petersen Photography, Inc.

Treatment, Care and Support Spaces

In addition to a benevolent environment, the healing and recovery of the mentally ill offenders needs to be accompanied by access to psychological therapy, counseling, psycho-education programming and mental health services in combination with rationally prescribed psychotropic medication and pharmacotherapy.

The daily regime for mentally ill offenders requires an array of structured and productive activities consistent with the individual’s mental health condition and security classification. This necessitates an appropriate and accessible mix of spaces to support therapeutic interventions. These include:

- Social spaces that function communally and increase opportunities for interpersonal contact, conversation, group activity, personal sharing and mutual support. This reduces the amount of time inmates spend alone in their rooms, counteracting feelings of isolation, contributing to the residents’ quality of life, and improving outcomes. These spaces should be designed for flexible use, e.g. meetings with family, casual interactions and structured therapy sessions.
- Private and semi-private support spaces designed to foster feelings of security, ownership, sanctuary and separateness (privacy). For example, meditation-style rooms that serves as a “quiet space”, decorated with comforting messages, affirmations and inspiring quotes.
- Spaces which facilitate participation in any fruitful occupation or simply leisure activity - exercise, recreational activities, art therapy, education or work – are beneficial in terms of increasing self-esteem, providing a sense of accomplishment and developing interpersonal and social skills.

- Basic physical and mental health clinic spaces including private offices for individual counseling, group counseling rooms and multipurpose spaces within or near the housing units.
- Dedicated spaces for de-escalation. As an alternative to the use of restraints and seclusion, some facilities are including spaces that de-escalate stress and aggression. One example is the so-called sensory rooms. In mental health settings, these might be converted quiet room spaces that are designed to be more sensory supportive and used primarily for crisis de-escalation. They are often used to promote relaxation and/or intense stimulation. As such, the space is designed using architectural features that are calming to the senses and where the user can experience visual, auditory, olfactory, and tactile stimuli.

Promising practices: a comprehensive approach to the Corrections Mental Health Challenge

A sustainable solution to the correctional mental health challenge requires the collaboration of a wide range of disciplines and an integrated, coordinated strategy. Initiatives that reduce the reliance on incarceration (prisons and jails) for mentally ill offenders need to be incorporated at every stage of the criminal justice process, from arrest to reception into custody, to aftercare following release. This holistic, multi-disciplinary approach recognizes that police, corrections officials, healthcare providers, social workers and voluntary and other support agencies all must play a role in reducing the prevalence of mentally ill offenders in prison. It requires a paradigm shift from the current response to mentally ill offenders, changes in existing policies and practice, the development of new resources, and commitment.

Worldwide, there are few examples of such an approach. Below is an example of a jurisdiction in the U.S. that is implementing a unique, systemic approach for addressing its correctional mental health dilemma, including alternatives to jail for mentally ill persons who come into contact with the criminal justice system.

The “Three-door” New Criminal Justice Complex. Montgomery County, MD CGL RicciGreene Planners and Architects

Through the collaboration of the Montgomery County Police Department (MCPD), the Department of Correction and Rehabilitation (DOCR), and the Department of Health and Human Services (DHHS), Montgomery County, MD utilizes an array of diversion programs and initiatives to reduce incarceration of the mentally ill. These include:

- A Police Department Crisis Intervention Team (CIT) and a Health and Human Services Mobile Crisis team (MCT) offering police officers the option to take a person with mental health problems to a crisis center for stabilization, rather than booking him/her to jail.
- A 24-hour Crisis Center where DHHS personnel provide psychiatric services to individuals encountered by police experiencing situational, emotional, or mental health crises
- A Stop, Triage, Educate, Engage, and Rehabilitate (STEER) deflection program implemented by the Police Department, which connects people to substance abuse treatment rather than arrest.
- A Specialized Mental Health Court for non-violent offenders diagnosed with severe mental illness, providing frequent court appearances and judicially supervised treatment services.
- A Clinical Assessment and Transition Services (CATS) team responsible for a) assessment and diversion services for inmates with behavioral health issues within 24 hours of booking into the jail; and b) discharge planning for inmates with behavioral health needs who are being released, including coordination of community-based services.

- Specialized Housing Units for individuals that must remain incarcerated: a Crisis Intervention Unit for acute or chronic individuals requiring continued observation and stabilization and a Therapeutic Housing Unit operated by DHHS for inmates with co-occurring disorders.
- A Comprehensive Reentry Project (CORP), which works to find stable housing and services for people with substance abuse or co-occurring disorders as an alternative to jail, after a stabilization period of about 60 days at the Pre-Release Center

Still, there is a shortage of residential treatment beds in the County for those in contact with the criminal justice system who require mental health intervention. As a result, many of these individuals are incarcerated. As an alternative, the County is constructing a new Restoration Center that will provide a number of *stabilization* and *sobering* beds for the deflection and diversion of mentally ill offenders. Collocated with a new County jail, the Restoration Center will work as a resource for law enforcement responding to situations where they encounter mentally ill people in need of crisis stabilization. Since most states do not allow a person to be committed to a mental facility without a valid court order, the stabilization modality requires skilled mental health staff to convince the arrestee of the benefit of staying overnight on a voluntary basis. The Center will be jointly operated by DHHS and DOCR.

CGL Ricci Greene planners and architects worked closely with County stakeholders to create the new paradigm by developing a totally different type of facility that incorporates a “three-door” approach under one roof: Detention, Diversion or Deflection. In addition to the Detention component, the proposed facility will provide Diversion resources and opportunities for steering mentally ill offenders into non-incarcerative alternatives; as well as short-term in-patient mental health and crisis stabilization beds to Deflect them from the criminal justice system altogether. This “three-door” approach will allow inmates with serious mental disorders to be moved out of the local jail, and into a more suitable therapeutic environment.

“As they stand today, correctional facilities are obsolete. But right now they are often the only tool for dealing with the mentally ill coming into contact with the criminal justice system.

The building solutions that are emerging to deal with the mentally ill in corrections will not resemble jails and prisons as we know them.”

Ken Ricci, FAIA
Principal Architect

Summary Conclusions

- The number and acuity level of inmates in correctional settings with mental health disorders continues to increase. The harsh, institutional climate of correctional facilities is the antithesis of a therapeutic environment, causing many mentally ill inmates to decompensate rather than recover.
- Correctional facilities can play a significant role in achieving a therapeutic mission – if the physical environment is designed with features that promote mental health, healing and recovery. These include an environment that provides ample natural light; views to the outside, calming and uplifting colors and materials; normative furnishings; clear sightlines for proactive supervision; good acoustical treatment, and an open, orderly sequence of spaces. The setting should be safe and comfortable, emphasizing personal empowerment and individual dignity.

- Supervision and treatment requirements differ for mental health inmates. A variety of housing units and accommodation typologies should be provided to reflect different needs and conditions, with the goal of using least restrictive response necessary. This continuum ranges from most restrictive/constant supervision cells for suicidal inmates and stabilization, to sub-acute and stepdown housing, to general population with enhanced services. Most mental health housing units should be smaller and of single level (one story) design configuration to promote good supervision, easy interaction, and a less institutional, less intimidating setting for vulnerable and special need inmates.
- Deflection and diversion of mentally ill offenders from incarceration is the most sustainable approach. This requires new initiatives and alternatives to incarceration for mentally ill persons who come into contact with the criminal justice system at each point in the process - not just in detention/corrections, but in law enforcement, the courts and community health.
- Paradigm shifts such as those described herein aren't always easy and they don't happen overnight. The kind of systemic and institutional changes needed require great political will and effort by all parties. But as evidenced by the examples provided, they are achievable.