Corrections Inpatient Work Group

July 16, 2007 3:00 p.m. – 4:30 p.m.

DOC Small Conference Room, State Office Complex, Waterbury, Vermont

Next meeting: August 13, 2007 DOC Small Conference Room

\

Present: Ron Smith, DOC; Beth Tanzman, DMH; Larry Lewack, NAMI-VT; Ed Paquin, VP&A; Sue Ransom-Kelley, DOC Springfield (by phone); Harlow Ballard, MHM Services; Michelle Lavallee, DMH

Staff: Judy Rosenstreich, DMH

Beth reviewed some issues that have grown out of work group discussions as well as concerns within the purview of the Corrections Oversight Committee.

1. Interim legislative study by the Corrections Oversight Committee
   - The oversight committee held its first meeting this month.
   - The relationship between the Futures work group and the legislative oversight committee
2. Philosophical views of incarcerating people with mental or cognitive disabilities
   - Where is the stakeholder community on this question?
   - How we define mental illness is a determining factor.
3. Self-harming behaviors in a correctional setting
   - Major concern from Corrections point of view
   - How to handle; how to approach

As co-chairs, Beth and Ron brought these issues to the work group agenda and invited members to share perspectives on how to address them. The group's subcommittee will meet later this week to develop clinical guidelines for involuntary psychiatric inpatient admissions. The subcommittee will then develop guidelines for voluntary inpatient psychiatric care. Such guidelines are needed to estimate the number of inpatient psychiatric beds for Corrections in the Futures planning process for successor inpatient programs to replace Vermont State Hospital.

Comments and questions from the work group discussion have been organized by topic for these minutes.

Corrections Oversight Committee

The oversight committee identified issues at its first meeting last week, some of which the work group also may address. These include:

- Coordination with the legislature's independent consultants on the Futures project
- Data on the prevalence of acute mental health needs
- What MH/SA treatment services are offered and to whom
- How other states are providing mental health services for inmates

- Definition of SMI (seriously mentally ill)
- Prescription medications
- How to reduce the number of Vermont inmates confined to prison

SMI Definition and Implications

Beth thought it may be useful to the Corrections Oversight Committee summer study to review how mental illness is defined throughout Vermont statutes and has asked DMH legal staff to research this.

Ed raised an issue in Act No. 64 (S.97), the question of who does the worst in certain kinds of settings and interventions. He also made the point that a designation of SMI is a proxy for a set of legal protections but not a conduit for treatment of mental illness. For people with developmental disabilities, it may be appropriate to put them under the SMI designation if only to provide them with suchs protections. While not about treatment, the SMI designation does prescribe how Corrections implements certain directives, thereby offering safeguards to incarcerated people who are so designated when subject to one or more of the following directives:

- Segregation
- Use of force
- Restraint chair
- Categorization

Harlow shared that when MHM Services began providing mental health services for the Department of Corrections, replacing the former contractor, MHM found that people on the SMI list did not meet the criteria in some cases, resulting in fluctuation of the population figures for seriously mentally ill.

Sue commented from her perspective at the Southern State Correctional Facility (Springfield) that being on the SMI list dictates to us a set of procedures to use with that person. A change in the definition is not needed in Sue's opinion. She added that we do need to add others into the definition. Sue also concurred with Beth and Ed that it is widely misunderstood that the SMI list defines those people who receive mental health services in Corrections.

Discussion of Self-harming Behaviors

Sue described the issue of self-harming behaviors as a daily struggle for the Southern State Correctional Facility. There are multiple factors that challenge us, including the level of training of correctional officers, the lack of proven strategies, and the potential dangers of these behaviors.

Commenting that even the experts do not necessarily know the best strategy for responding to self-harming behaviors, Sue shared her facility's implementation of a plan, following advice from an expert in the field, without success. Ed suggested that it would

be helpful to understand what about the plan did not work as it might help us to get to the question of what settings will be successful for people who are inclined to self-harming behaviors.

Beth commented that of all difficult conditions to treat, self-harming behaviors may be the most difficult. Ed agreed that people whose psychiatric situation causes them to self-harm is about as hard as all the presentations DOC must deal with. Beth asked what the evidence suggests is helpful in an incarcerative environment?

Harlow confirmed that self-harming behaviors are among the most serious concerns as they carry a high risk of injury. This seemed to confirm that addressing self-harming behaviors is a major DOC concern.

Ron emphasized that DOC does not have a systematic way of responding to instances of self-harming behavior. He suggested that DOC's challenge is not only at the individual level but also at the system level. For repeated self-harming behavior by an individual, DOC may consider hospitalization.

Beth observed that Corrections, even with the most secure environment we know how to create and with the central task of keeping people safe, still cannot prevent self-harming behaviors. This must be extraordinarily difficult and painful for everyone.

The work group heard about a daylong training presented by Erik Thompson and Sue Swindell, ***Connecting at the Edge: Alternative Strategies for Working with Extreme Behaviors***. Erik and Sue, from Washington County Mental Health Services (WCMHS), are trainers and consultants in the field of self harm and Dialectical Behavior Therapy (DBT). Erik is the director of the DBT program at WCMHS and works with individuals whose behaviors generate alarm in the system. Interventions designed to control behaviors can sometimes escalate them. The training helps clinicians learn how to build relationships in the face of alarm to settle things more effectively as an alternative to implementing tighter controls. It was reported that they did an excellent job, suggesting that perhaps this seminar could be tailored to Corrections.

Beth explained that DMH rarely hospitalizes someone at VSH in response to self-harming behaviors. If admission to VSH is necessary, it is usually for a very short stay of 2-3 days.

Sue Ransom-Kelley offered her opinion that Senator Richard Sears (D-Bennington) was correct in his stated view that we did not deinstitutionalize people: we have put them in a different institution, namely, prison. She also stated that many incarcerated individuals have a history of aggression against others, predatory inclinations/sex offenders, and self-harming behaviors in addition to anxiety disorders and other mental health conditions.

Should people with mental or cognitive impairments be incarcerated?

Beth began discussion by asking for input from the stakeholder community on this question. Ed reasoned that the answer covers a wide range, from people whose behavior becomes an annoyance to neighbors and, after the third disorderly incident, are brought into the system. At the other end of the spectrum are really tough cases, for example, sex offenders. There are no real expectations on the part of the general public or stakeholder community that these people are not going to be incarcerated. There probably are 15-20 or more people who the court would say must remain incarcerated despite the fact that they are not doing well in the corrections environment.

Beth then asked about NAMI's perspective: Should people with mental illness *not* be incarcerated? Larry said "No." He did not think his members would say that someone who committed murder should not be in prison. It is more likely that NAMI members would consider incarceration inappropriate for people whose mental or cognitive impairment causes them to inflict harm on themselves *only*, while those who harm others must be accountable for their actions by serving jail time. A concern is for others in jail who haven't done anything harmful enough to warrant incarceration and are not receiving the services they need.

Is it NAMI's view that we resource the Department of Corrections (DOC) to enable them to provide mental health treatment to inmates? What about the legal standard of culpability, which is very different from the clinical standard?

Given that the central mission of Corrections is security and safety, the mental health services within the correctional system reflect this mission, stated Beth. The goal of mental health services is to stabilize a crisis and return the inmate to the general Corrections' population safely---it's not about rehabilitation treatment. DOC is not resourced to provide treatment services designed to promote recovery and change.

Individuals presenting personality disorders and other mental health issues are likely to serve longer prison terms, according to Ron and Harlow.

Beth cited data on the screening process for clinical evaluations of people charged with a crime each year to determine competency to stand trial and sanity or insanity at the time of the alleged offense. Granted, she offered, that there is an imperfect fit between the legal culpability and the clinical standards for mental illness. In Vermont, there are between 300-400 evaluations to determine sanity/competency each year. Only a subset, 100-120, are performed at VSH. The largest number are performed on an out-patient basis and a smaller subset in Corrections. The clinician consults with the court and recommends inpatient care if appropriate. Beth stated that the evaluation can occur in most any setting but that the site of treatment should be clinically determined. Evaluations are done not only at VSH but also at other hospitals by virtue of a change in the statute.

Mental health's front end screening system has been very successful, stated Beth, in the following respects:

1. Most of the time when an evaluation is requested, the court consults with a designated, qualified mental health professional.
2. Most of the time (well over 80% of the time), the court follows the recommendation of the mental health clinician as to the site for treatment and evaluation.
3. Most of the individuals recommended for inpatient forensic evaluation truly require inpatient care.

Therefore, one question to explore is that does the presence of people with mental illness and other cognitive disorders in Corrections indicate that this front-end screening process is failing?

General Discussion

In considering how the Futures work group could contribute to the broader dialogue taking place in the Corrections Oversight Committee and in the stakeholder community, Larry suggested documenting some of the statistics.

- How many evaluations are made each year?
- Where do people get their evaluations?
- Where are decisions made?
- How do violent offenders get treated when they come into DOC compared to others with lifestyle problematic behaviors?
- Does the current regime of DOC treatment distinguish between people with different mental health conditions?
- Are we expecting a carefully sequenced treatment plan from DOC? No.

Ron again pointed out that the bulk of DOC services are designed around safety of inmates. In Ron's opinion, there should be a treatment component, however, this would require different resources.

In discussing post-traumatic stress disorder (PTSD),[1] Ron shared that the underlying causes cannot be treated in a Corrections environment, concluding that DOC can treat only the symptoms of the disorder.

Beth talked about managing the emotions in self-harming behaviors in the first phase of DBT treatment. If Phase I is completed successfully, psychotherapeutic treatment of Phase II occurs. The goal of Phase I is for individuals to learn skills necessary for experiencing strong emotions (emotional dysregulation) and not resorting to self-harming or other negative coping mechanisms.

Ed offered his opinion that the work group should comment on the circumstances that result in some type of treatment, stating that submission of a sick slip is the more likely

[1] PTSD is an anxiety disorder that can develop after exposure to a terrifying event or ordeal in which grave physical harm occurred or was threatened.

reason an incarcerated person would receive treatment than a crisis intervention. The link that does not occur, suggested Ed, is care outside the correctional system. What the State decides to build for successor programs to the state hospital will depend, in part, on what goes forward in Corrections and, therefore, how much and what capacities are required. Ed continued that changes in policy affect the configuration of structures and that new structures can also drive policy changes.

Harlow informed the group that there is no one facility in the State correctional system where there are enough mental health providers.

Larry commented on his visit to the Alpha unit in Springfield, sharing that it did not resemble an acute patient psychiatric care program facility. If we opened up some possibilities outside of Corrections, it would provide access to the mental health care that would benefit some of our incarcerated population. Larry would like to see the work group address some integrated treatment options---MI and addictions---as prisons are not set up to do that at all.

Ed advocated including functionally impaired people, some of whom may be self-harming while others may have other disorders, on the SMI list. While the SMI designation does not mean that treatment is provided, it does require Corrections to implement certain directives differently than would otherwise be the case.

Larry suggested that DOC provide legislators with some individual examples, while protecting confidentiality, of the dilemmas that the system encounters daily in order to educate and advocate for appropriate treatment and facilities.

Harlow offered that, in addition to self-harm, one of the most difficult situations in Corrections is providing for the health and mental health needs of individuals who will not engage in the treatment process or consent to treatment. Since we cannot impose treatment, we have to wait until their situation becomes serious enough to warrant involuntary treatment.

Beth appreciated this opportunity to listen and learn from the discussion. What has evolved is the need, in addition to a planning number for inpatient psychiatric bed capacity, for us to consider the larger concerns of mental health treatment and needs in Corrections.

The meeting adjourned at 5:00 p.m.

SUBMITTED BY: Judy Rosenstreich
jrosen@vdh.state.vt.us