Vermont Department of Corrections – Unified and Integrated System

Majority of US State Systems

- Probation and Parole Departments are county based and sit with the Judicial Branch – reporting to the Court
- Separate detention facilities administered by the courts, sometimes co located with jails
- Jails are county based and are often administered by an elected official- i.e. Sheriff
- Prisons are state based and are administered through the Executive Branch – predominantly located with the Department of Public Safety

Vermont State System

- Probation and Parole is administered at a State level and sits in the Executive Branch
- Jails and Prisons are not distinct buildings or locations and are administered at a State level and sit in the Executive Branch.
- Probation, Parole, Jail and Prisons are all located in the Executive Branch and sit in the Agency of Human Services
- Detention lodged with the Department of Corrections but authority sits with Judiciary.

Comparison of Criminal Justice and Treatment System Paradigms

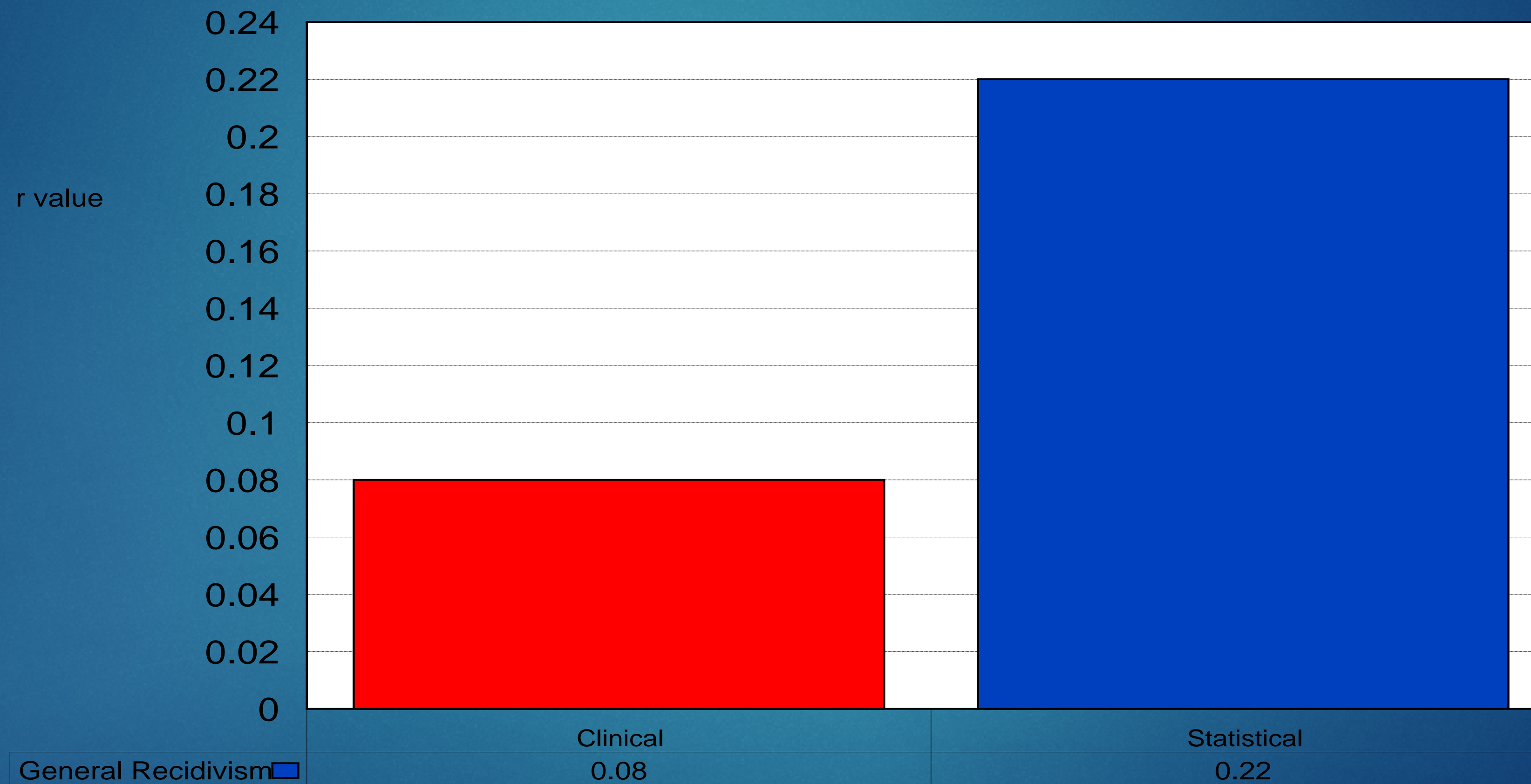
Treatment System

- Customer is the Patient
- Purpose is remediation of individual symptoms
- Individual can refer self and majority of participants in service continuum must voluntarily agree to participate in services
- Emergency Evaluations must meet thresholds of pose current danger to self and/or others
- Civil commitments – restrictions in civil liberties based upon immediate threat of harm to self or others (short term and behavioral based)

Criminal Justice System

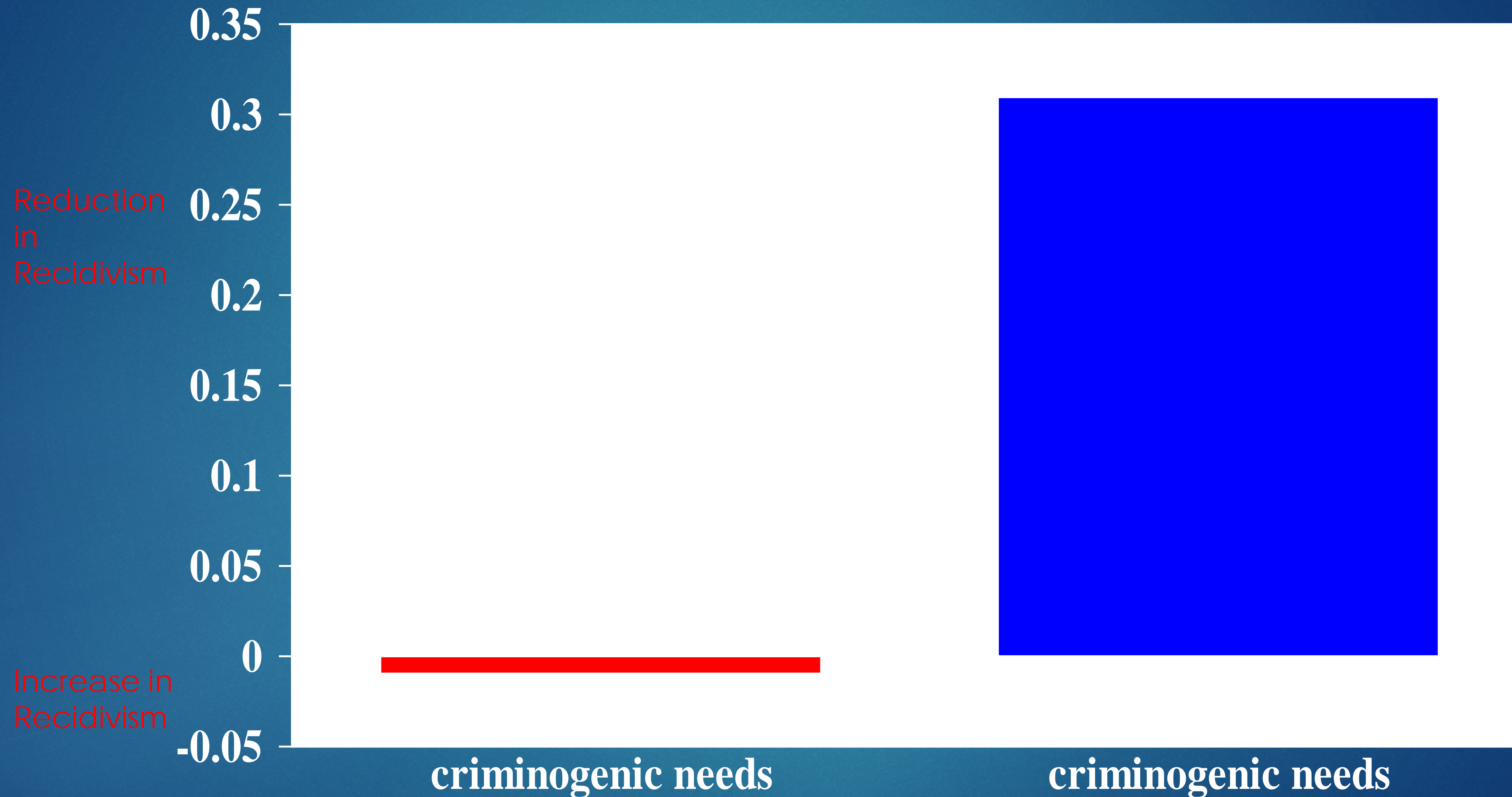
- Customer is the community;
- Purpose is the community safety (risk management and risk reduction)
- Individual is cited through legal proceeding/s, involvement is predominantly involuntary
- Can be lodged per the determination of the court without a standardized threshold of behavior
- Restrictions in civil liberties based upon penalty and/or public safety

Comparison of Clinical vs. Statistical Prediction of Recidivism



Goggin, C.E. (1994). Clinical versus Actuarial Prediction: A Meta-analysis. Unpublished manuscript. University of New Brunswick, Saint John, New Brunswick.

Targeting Criminogenic Need: Results from Meta-Analyses



Source: Gendreau, P., French, S.A., and A.Taylor (2002). What Works (What Doesn't Work) Revised 2002. Invited Submission to the International Community Corrections Association Monograph Series Project

Need Principle

By assessing and targeting criminogenic needs for change, agencies can reduce the probability of recidivism

Criminogenic

- Anti social attitudes
- Anti social friends
- Substance abuse
- Lack of empathy
- Impulsive behavior

Non-Criminogenic

- Anxiety
- Low self esteem
- Creative abilities
- Medical needs
- Physical conditioning

Major Risk and/or Need Factor and Promising Intermediate Targets for Reduced Recidivism

Factor	Risk	Dynamic Need
History of Antisocial Behavior	Early & continued involvement in a number antisocial acts	Build noncriminal alternative behaviors in risky situations
Antisocial personality	Adventurous, pleasure seeking, weak self control, restlessly aggressive	Build problem-solving, self-management, anger management, & coping skills
Antisocial cognition	Attitudes, values, beliefs & rationalizations supportive of crime, cognitive emotional states of anger, resentment, & defiance	Reduce antisocial cognition, recognize risky thinking & feelings, build up alternative less risky thinking & feelings Adopt a reform and/or anticriminal identity

Adopted from Andrews, D.A. et al, (2006). The Recent Past and Near Future of Risk and/or Need Assessment. Crime and Delinquency, 52 (1).

Significant Findings (effects were stronger if):

- Sessions per week (2 or more)
- Implementation monitored
- Staff trained on CBT
- Higher proportion of treatment completers
- Higher risk offenders
- Higher if CBT is combined with other services

Ineffective Approaches

- Drug prevention classes focused on fear and other emotional appeals
- Shaming offenders
- Drug education programs
- Non-directive, client centered approaches
- Bibliotherapy
- Freudian approaches
- Talking cures
- Self-Help programs
- Vague unstructured rehabilitation programs
- Medical model
- Fostering self-regard (self-esteem)
- "Punishing smarter" (boot camps, scared straight, etc.)

Meta-Analysis of Risk Factors by Simourd Mean Adjusted r

Risk Factor	Adjusted R	#Studies
Lower social class	.05	38
Personal distress/psychopathy	.07	34
Family structure/parental problems	.07	28
Minor personality variables	.12	18
Poor parent-child relations	.20	82
Personal educational/vocational achievement	.28	68
Temperament/misconduct/self control	.38	90
Antisocial attitudes/associates	.48	106

Source: Simourd, L. (1993) Correlates of Delinquency: A Look at Gender

Factors Correlated With Risk

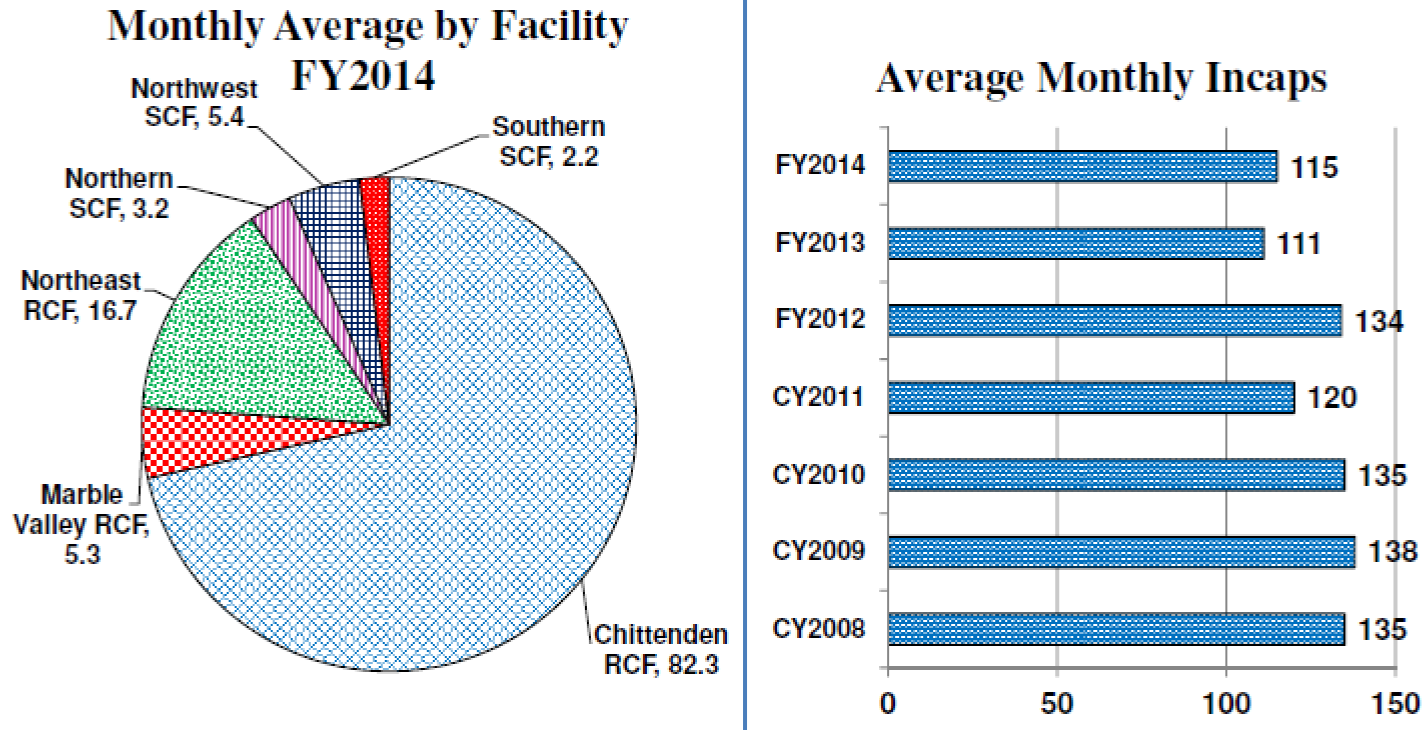
	Mean r	# of studies
Lower class origins	0.06	97
Personal distress/psychopathology	0.08	226
Educational/Vocational achievement	0.12	129
Parental/Family Factors	0.18	334
Temperament/misconduct/personality	0.21	621
Antisocial attitudes/associates	0.22	168

Note: A re-analysis of Gendreau, Andrews, Goggin & Chanteloupe (1992) by

Public Inebriate Bill

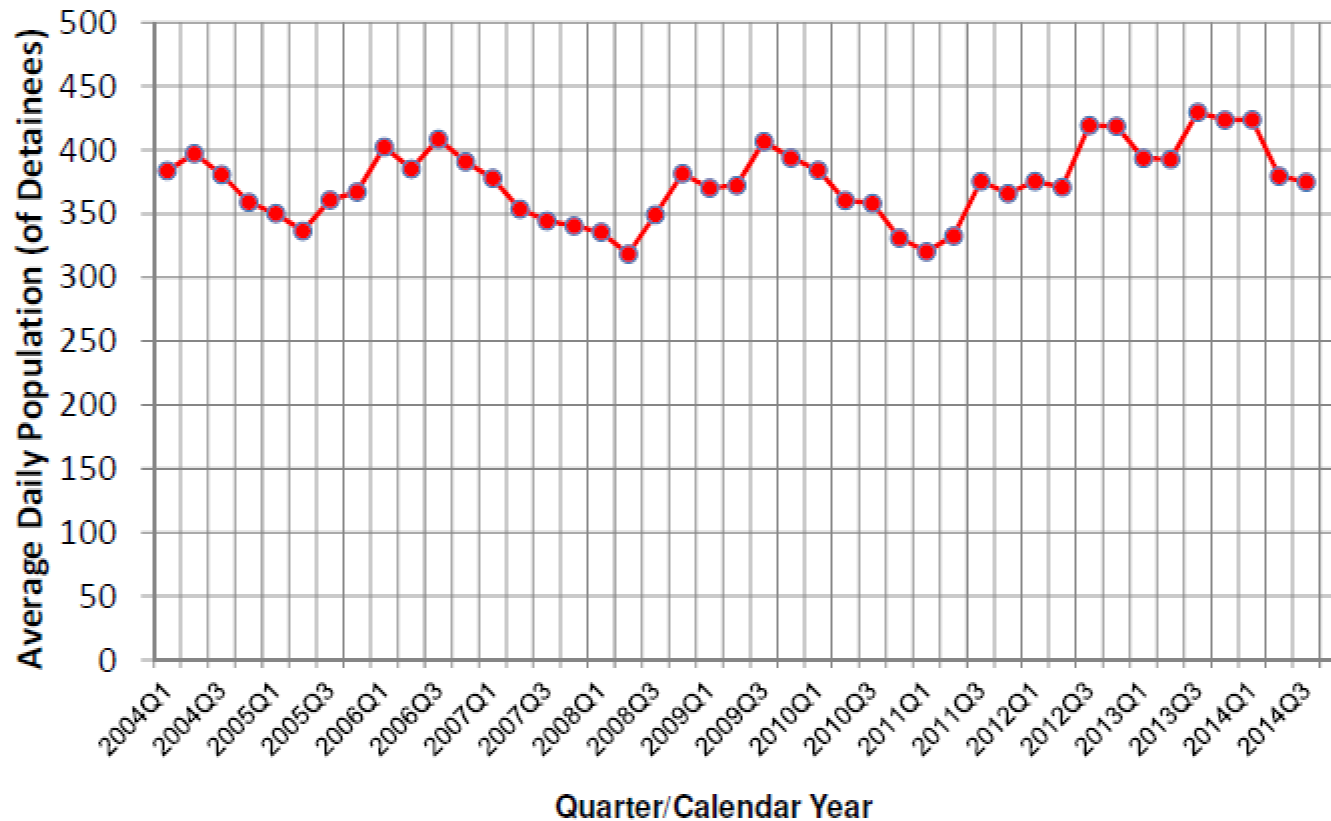
- 2010 Sec 1.1 Findings; Purpose
- Vermont Alcohol Services Act of 1978 decriminalized public intoxication and established a program to move public inebriates into treatment rather than being charged and jailed.
- VTASA was insufficiently funded resulting in insufficient treatment or shelter beds and makes the correctional system a de facto system of care where public inebriates are placed in protective custody for up to 24 hours.
- A significant number of people placed in protective custody do not meet the statutory definition of "incapacitation"
- In 1988, 550 people were jailed after being charged with public intoxication. In 2006 2,332 were held under protective custody in state correctional facilities due to public inebriation.

Admissions of Incapacitated Persons



Source: Monthly reports from the contracted medical service provider at VTDOC facilities. INCAP data is not counted in the VTDOC "incarcerated" totals shown elsewhere in this report. Incapacitated person is defined as an individual, as a result of his or her use of alcohol or other drugs, is in a state of intoxication or mental confusion resulting from withdrawal, such that the person: A) appears to need medical care or supervision by approved substance abuse treatment personnel to assure his or her safety or B) appears to present a direct active or passive threat to the safety of others. A person judged by a law enforcement officer to be incapacitated, and who has not been charged with a crime, may be lodged in protective custody for up to 24 hours or until judged by the person in charge of the facility to be no longer incapacitated.

Detention – Average Daily Population



Source: VTDOC Population Statistics (Popstat). These are persons without sentences held only for detention pending Court procedures (bail, pre-adjudication). This would include probationers held pending violation proceedings. Persons with simultaneously active sentences would receive credit for time served while held for further Court procedures and are not counted here.

VT DOC SFY 17 Population: Total Population: 1780 average

Detention: Total ADP 425

- 285 ADP serve < 7 days
- 100 ADP serve < 71 days
- 100 (60 Federal) serve <71 days

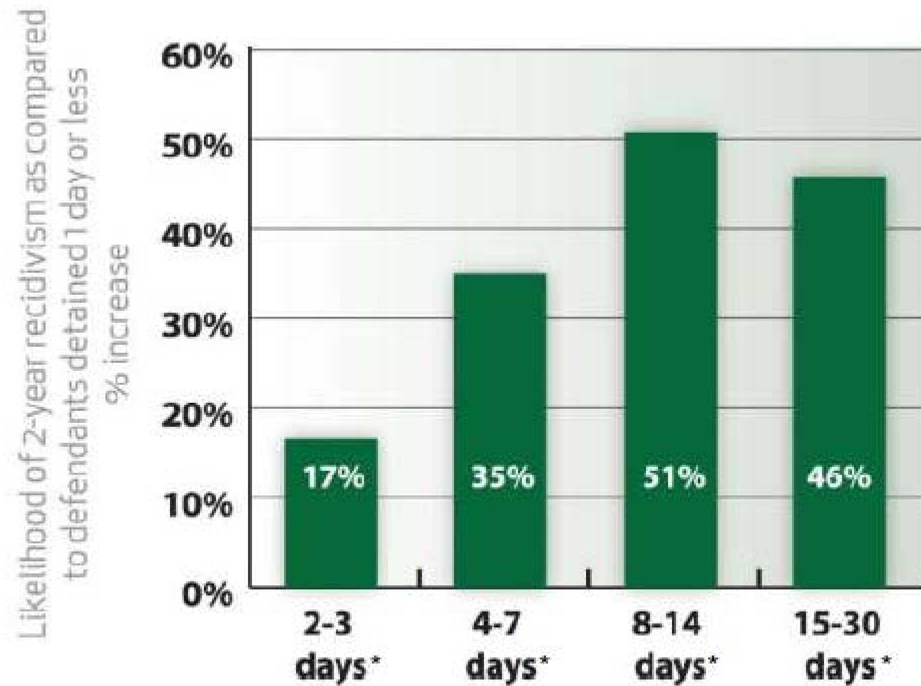
Misdemeanor: serve 44 days ave

Mandated (listed violent: ADP 150 in programming

- 270 Out of State

The impact of detention on low-risk defendants

2-year recidivism



** = statistically significant at the .01 level or lower*

Between 1980 and 1995, the total number of individuals incarcerated in American jails and prisons increased from 501,886 to 1,587,791, an increase of 216 percent. During this time, the general population increased by only 16 percent.[43] The vast majority of this increase has been fueled by changing demographics, more stringent mandatory sentencing laws, and the increasing availability of cocaine and other street drugs. Have the mentally ill, however, contributed more than their expected share to the increasing population of jails and prisons?

Several lines of evidence suggest the answer is yes. First, in 1939, Lionel Penrose, studying the relationship between mental disease and crime in European countries, showed that prison and psychiatric hospital populations were inversely correlated, As one rose, the other fell.[44] This has become known as the balloon theory -- push in one part of a balloon and another part will bulge out. In 1991, George Palermo and his colleagues published an extensive analysis of the balloon theory utilizing data on U.S. mental hospitals, jails, and prisons for the 83 years between 1904 and 1987. They found the theory to be valid and concluded:

> The number of the mentally ill in American jails and prisons supports the thesis of progressive transinstitutionalism. The authors believe that the statistical evidence derived from the national census data corroborates their clinical observation that jails have become a repository of pseudooffenders -- the mentally ill. Our opinion is that our results probably reflect the state of most

State	Patients in Public Mental Hostpitals Dec. 31, 1955 *	Patients in Public Mental Hostpitals Dec. 31, 1994 +	Actual Deinstitutialization Rate (percent)	Theoretical Number of Patients in Public Mental Hospitals in 1994, Based on Population Change since 1955 #	Effective Deinstitutionalization Rate (percent)
Rhode Island	3,442	63	98.2	4,156	98.5
New Hampshire	2,733	137	95.0	5,514	97.5
Arkansas	5,086	183	96.4	7,203	97.5
Vermont	1,294	63	95.1	1,975	96.8
Massachusetts	23,178	793	96.6	23,889	96.7
West Virginia	5,619	224	96.0	5,410	95.9
California	37,211	9,814	89.8	91,641	95.8
Wisconsin	14,981	891	94.1	20,680	95.7
Ohio	28,663	1,849	93.5	35,273	94.8
Colorado	5,720	775	86.5	13,470	94.2
Oklahoma	8,014	675	91.6	11,575	94.2
Illinois	37,883	2,845	92.5	47,153	94.0
Idaho	1,221	138	88.7	2,225	93.8
Kentucky	7,700	645	91.6	10,108	93.6
Arizona	1,690	462	72.7	6,947	93.3

Vermont – Institutional Populations

Brandon Training

Opened 1915

Closed 1993

Population: 700 in 1968

450 in 1976

reduction of 250 in early 1980s

Primary Population: developmentally disabled

Brattleboro Retreat

Opened 1834

Remains open but population shifted 1981 with Waterbury opening

Population: 1861 437 ave

1940 810 ave

Waterbury State Hospital

Opened 1891 (received 185 from Brattleboro Retreat)

Peak 1728 in 1930s

Primary population

Epilepsy, depression, alcoholism, senility

Displaced Psychiatric Patients – inpatient evaluation orders by court

- DMH Care Management Information
- Calendar Year 2015
- Requests for screening: 103
- Number Inpatient Orders: 59
- Number Held in DOC: 30
- Number not meeting criteria 4
- Average wait time placement: 3.82 Days

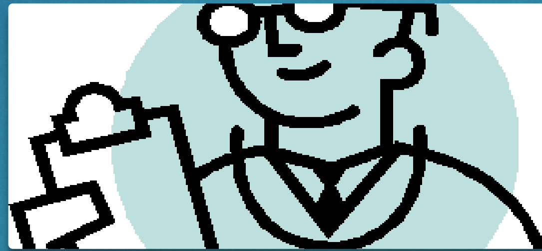
VT DOC Substance Abuse Services Snapshot

EBP SUD Tx Facility 150 qtr/5200 hours yr

Field SUD Tx 460 qtr/9500 hours yr.

Tapestry – 33 bed/2880 hours

CRCF – 25+/ 1740 hours



MAT- provided all facilities

1. 90 day pilot 323 unique individuals. 1.7 % discontinued misuse/diversion.
2. Average 47 MAT per month
3. ~$600,000 costs
4. SAMSHA: correctional facilities interim maintenance sites – can provide up to 120 days.
5. 50 – 80 % intake placed on detox protocol COWS/CIWA
6. Intake screenings for MH, SUD and referred for further evaluation as clinically indicated
7. Vivitral pilot MVRCF, CRCF

Sober housing – 340 beds (NL, Mandela, Sanctuary, RISE, Pathways)

Additional efforts:

SBIRT – screening at intake & re entry, not opiate specific (May 16 – April 17;

Field 1158 screenings/399 positive.

Facility 562 screenings/330 positive

Peer Recovery Pilot NSCF - $250,000

Assessments

- Supervision Level Assessment
- Conviction and Violation Summary
- Sexual Violence Assessments- STATIC 99, VASOR, SOTIPS
- Domestic Violence Screening- DVSIR
- Forensic Evaluations- VRAG, psychosexuals
- Clinical Screenings- MoCA, SSI SA,
- Academic and Workforce Readiness Assessment- CASAS, SIM:WJIII, JSAIL, BESI,
- General Risk of Recidivism- Ohio Risk Assessment System

VT DOC – Implementation of EBP and Quality Assurance Structures

Clinical Foundations of Supervision

Monthly direct observation

Observation Audit sheet

Individual Feedback

Performance Development Plan based on Competencies

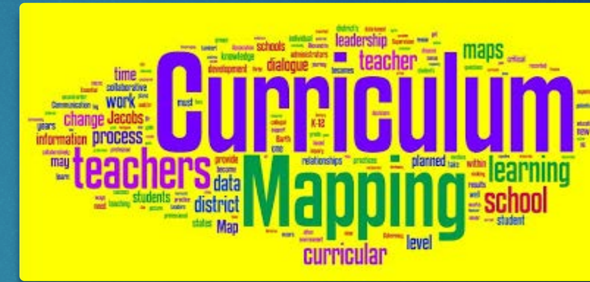
CJ Competencies

CJ MATRS

EPICs

Pilots: Caseworkers/Probation officers training in CJ Competencies; CJ MATRs and Effective Practices in Correctional Supervision

Training, tech transfer and audits



Adoption of Manualized CBT Curriculum

Monthly direct observation

Audit sheet includes planned lesson delivery, positive reinforcement, addressing of anti social cognitions, skill practice

Policy and Implementation Considerations

Deinstitutionalization has resulted in trans institutionalization.

- Criminal justice system is being used as default civil containment/commitment
- Current populations (PIPs, DPPs, low risk detentioners) lodged in jails increases the risk of recidivism, further de stabilizes the population and the current evidence is that they do not pose a public safety threat.
- Every general fund dollar expended on treatment in a correctional setting fails to leverage potential .40 federal match if same service delivered in community setting
- Workforce/Systemic Development efforts need to increase and improve adherence to meta analysis evidence and quality assurance