September 30, 2015

To: George Solomon, Director
Division of Adult Correction
North Carolina Department of Public Safety

Thru: Terri Catlett, Deputy Director
Health Services

From: A. F. Beeler, Chair
Mental Health Task Force

Subj: Recommendations of Mental Health Task Force to Improve the Provision of Mental Health Services in the North Carolina Division of Adult Correction

The unfortunate death of an offender in custody led the Commissioner of Public Safety and the Director of Adult Correction to appoint a Task Force to review and make recommendations concerning mental health care changes in the North Carolina Division of Adult Correction. This task has been met head on by a group of dedicated professionals that include representatives from the Department of Public Safety, the Department of Health and Human Services, academia, and mental health professionals and administrators from the community. Over the last eleven months, this group has met on a routine basis reviewing current practice, examining best practices and making recommendations for change. The Task Force has reviewed more than 1,000 reports, articles and newspaper stories dealing with mental health in corrections. Additionally, although our task was not to review restrictive housing; restrictive housing and mental health are linked. Accordingly, we reviewed the housing of offenders with a mental health diagnosis who are housed in restrictive housing. In addition to Dr. Mark Mattioli, Deputy Chief of Mental Health Programs, and Steve Waddell, Captain, Central Prison, from the Division of Adult Correction the following participated as members:

Dr. Mark Jones, Professor, East Carolina University, Department of Criminal Justice
Dr. Megan Davidson, Assistant Professor, East Carolina University, Department of Criminal Justice
Dr. Charles Vance, Forensic Psychiatrist, NC Department of Health and Human Services
Dr. Gary Cuddeback, Associate Professor, University of North Carolina at Chapel Hill School of Social Work
Sonya J. Brown, Justice Innovation Team Leader, NC Department of Health and Human Services
Dr. Bob Kurtz, Program Manager, Justice Team, NC Department of Health and Human Services
Anne Precythe, Director, Division of Community Corrections, NC Department of Public Safety

While the impetus for this task force was the death of a mentally ill offender, the Task Force did not focus specific attention on his death, since the DAC already had groups of people reviewing the death and since at the beginning of our work the case was in litigation. Our group attempted to develop recommendations for the present and the future. We were cognizant of fiscal limits

and in some cases we modified recommendations because of fiscal realities. In some cases we provide for an incremental strategy for implementation or a modified strategy for implementation without compromising the overall goal to improve the provision of mental health care in the DAC. The report does not address juvenile facilities or jails, although we have had discussions with both and recognize there are similar systemic concerns.

In addition to our task force members, some advocacy groups (Disability Rights, NC; NAMI; North Carolina Psychiatric Association) have had observers present during our discussions. There are some differences between what the members and observers would recommend, but our process has been much more robust given their input. Many of their comments have been incorporated into this report. We thank them for their work with the Task Force.

When looking at the provision of mental health in the North Carolina Division of Adult Correction, we looked at several themes, including:

1) Using documented science to assess offenders;
2) Review and development of policy;
3) Staff training;
4) Offender placement within facilities to include transitional care units and restrictive housing;
5) Program compliance and risk management;
6) Staff recruitment, retention and cultural antecedents;
7) Diversion of some mentally ill offenders from prison to treatment;
8) Offender aftercare upon release;
9) Development of collaborative relationships among stakeholders who have responsibility for the provision or maintenance of care for offenders in custody or in aftercare.
10) Transportation of offenders with diagnosis of mental illness; and,
11) Restraint use for those with mental health diagnosis

(Aufderhelde, 2013)

The scope of the criminalization of persons with mental illness is well documented. Since the deinstitutionalization of mental health hospitals, more persons with mental illness have found themselves confined in our prisons and jails. In 1955, there were approximately 500,000 inpatient mental health beds in the country; today that number approximates 35,000. Nationally, most estimates suggest that about 20% of the prison offender population has severe and persistent mental illness. Attached as an appendix to this report is how some other states are defining serious mental illness. Indeed, at any given time, there are approximately 35,000 persons with severe mental illness in our nation's state hospitals, juxtaposed with over 100,000 persons with severe mental illness in jails, over 250,000 in prisons and almost three quarters of a million on probation or parole (Crilly et al., 2009; Ditton, 1999; Steadman et al., 2009; Slate, Buffington-Vollum, and Johnson, 2013).

Moreover, today, there is a release of persons with mental illness from the criminal justice institutions (jails and prisons) that mirrors the deinstitutionalization of our state mental hospitals

that began over 40 years ago, and this is of particular concern given that offenders with mental illness have difficulty accessing housing, obtaining employment and developing support services. Nationally, those offenders with serious and persistent mental illness have high recidivism rates (Cloyes et al., 2010; Fisher et al., 2007; Gagliardi et al., 2004; Lovell et al., 2002; Mallik-Kane & Visher, 2008; Skeem & Louden, 2006; Skeem & Petrila, 2004; Scott and Gerbasi, 2005).

There is a plethora of literature in academia and the press concerning offenders with mental illness in our prison system, and persons with mental illness in the criminal justice system has become one of the most pressing public safety and public health issues facing our nation today. Particular concern and debate revolves around the use of restraints and administrative segregation and offenders with mental illness. This discussion is timely and of significance; however, as much as the information is well-meaning and grounded in some evidence, little of it attempts to take into consideration the actual management of offenders with mental illness in a custodial environment; an environment all acknowledge was not designed to care for mentally ill offenders.

North Carolina is no different than many other states diligently working to find the best practices, policies and solutions measured against custodial realities. The Task Force recognizes the necessity of relevant treatment and services for offenders with mental illness but realizes these services and treatments must be delivered in an environment dominated by security and control. We believe this is possible but recognize and acknowledge the cultural shifts necessary to reform how mental health is managed in correctional settings will require leadership on the part of the legislature, the department and the division.

1. Intake and Assessment: The need to identify offenders with mental health problems along the continuum of mental illness – from episodic adjustment disorders and severe major depression to chronic and persistent severe mental illness – is critical. At the more serious end of the spectrum, major mental disorders such as schizophrenia, psychotic disorders, bipolar disorder and posttraumatic stress disorder should be identified using reliable and valid screening assessments. Positive screens on brief mental health screening instruments should initiate more in-depth screening and diagnostic assessments by qualified mental health professionals.

Recommendation 1.1. Continue to use reliable and valid brief screening instruments to identify offenders with mental health problems. Identify valid and reliable diagnostic tools (e.g., SCID, MINI) to establish major mental disorders for those who screen positive on initial mental health screen.

Recommendation 1.2. Establish protocol for re-administering brief and/or more in-depth mental health assessment at regular intervals or during critical events (e.g., bizarre behavior, indication of auditory or visual hallucinations).

Recommendation 1.3. Revisit inmate classification system to establish if current system is meeting the needs of offenders with mental illness. Can diagnostic classification be aligned with inmate classification? How is classification information developed, shared within and

across facilities, communicated to staff, tracked and updated, and shared with community providers prior to or upon community release?

Recommendation 1.4. It is the recommendation of the Task Force that a reliable and valid measure of trauma be used to assess for and treat posttraumatic stress disorder. (One resource which may be of assistance is SAMHSA's publication, "Roadmap to Seclusion and Restraint Free Mental Health Service.")

Recommendation 1.5. Develop memorandums of understanding (MOUs) with other state agencies to share information with the Division of Prisons. To the extent possible, ensure receipt of mental health information and data from other sources (e.g., community-based behavioral health services, managed care organizations, jails, probation, and state hospital).

2. Housing, Special Units and Control Status: The use of restrictive housing is one of the most important issues to address as there are offenders with mental illness in many different restrictive housing units across the state.

Recommendation 2.1. We concur with the decision of creating transitional care units (TCU) at each closed custody facility. We believe that before any TCU is opened admission criteria must be established, treatment curriculum should be developed and the unit should be fully staffed. The development of these TCU's represent the best hope for moving seriously mentally ill offenders from restrictive housing to treatment units.

Recommendation 2.2. It is the recommendation of the Task Force that the current number of classifications for control status be reduced from three to two. The Task Force recommends that the Division of Adult Correction consolidate Maximum Control (MCON) and Institutional Control (ICON) into one control status and develop criteria for this consolidated classification. It is the hope of the Task Force that the overall number of offenders in restrictive housing control classification would be reduced by this measure.

Recommendation 2.3. Given that the deleterious effects of restrictive housing are cumulative, it is the recommendation of the Task Force that for any offender with an M-2 to M-5 designation who is placed in restrictive housing two or more times during a calendar year, he or she should receive out-of-cell treatment within the first week of placement in restrictive housing. Here, for the purposes of this recommendation, restrictive housing includes administrative segregation, disciplinary segregation and all control statuses.

Recommendation 2.4. It is the recommendation of the Task Force that the current provision in the practice which specifies that offenders not be afforded recreation during the first fifteen days of administrative segregation be eliminated for all offenders.

Recommendation 2.5. It is the recommendation of the Task Force that persons who have an M-2 to M-5 mental health designation and who have not achieved their 21st birthday should not be placed in restrictive housing for more than 24 hours without the permission of the Director of Prisons or his designee (Schiraldi, Western & Braden, 2015).

Recommendation 2.6. The Task Force reviewed and discussed at length the recommendations from all parties concerning out of cell treatment/activity. The Task Force concurs the ultimate goal would be to have every M-2 to M-5 offender housed in restrictive housing receive twenty hours of out of cell activity each week with at least 10 of those hours devoted to structured activities. The Task Force recognizes that this recommendation requires increased resources, staff and space. Until the time when sufficient resources are available to support 20 hours of out-of-cell activity, the Task Force recommends that every M-2 to M-5 offender housed in restrictive housing for more than 15 days receive 10 hours of out-of-cell structured therapeutic activity in addition to the five hours of unstructured time they receive for recreation and showers.

Recommendation 2.7. Currently many offenders at NCCIW are being moved back and forth between mental health units and restrictive housing units. It is the recommendation of the Task Force that a behavioral health restrictive housing unit be opened in Robin Unit at NCCIW in order to provide more continuity of care for offenders with mental illness, while also holding them accountable for their behavior. The physical space currently exists at NCCIW for this to occur. It is recommended that a study be conducted to determine if something similar could be accomplished at Central Prison.

Recommendation 2.8. Historically, offenders have been released directly from restrictive housing to the community without therapeutic intervention. It is the recommendation of the Task Force that mental health offenders housed in restrictive housing not be released directly to the community or to post release supervision without some specified course of therapeutic intervention or pre-release curriculum. The type and intensity of the intervention or curriculum will be determined by the mental health treatment team.

Recommendation 2.9.. It is the recommendation of the Task Force that the DAC explore the development of criteria about when to end administrative segregation for offenders with mental illness. Currently, there are no guidelines outlining how long a mentally ill offender may remain in administrative segregation status in the prison. (In many jurisdictions and in the academic literature anything beyond 31 days is considered long-term segregation. The Task Force did not recommend a specific guideline, but believes NCDAC should do so.)

3. Suicide Prevention – The issue of suicides and suicide prevention in correctional facilities across the country has for several years been of concern to the public. The latest data reveals that for prisons the suicide rate nationwide is 15:100,000 while in jails the rate approximates 45:100,000. In North Carolina Division of Adult Correction (2014) the rate is 10.5:100,000. As of this writing, the 2015 rate for inmate suicides is 5.4:100,000. Along with the rate of suicide for offenders, we need to be cognizant of the rate among correctional workers. Data demonstrates that the crude rate nationwide for correctional officers is 35:100,000 and the Bureau of Justice Statistics reports a higher suicide rate for correctional officers than any other occupation.

Recommendation 3.1. It is the recommendation of the Task Force that the DAC develop a separate policy for suicide prevention.

Recommendation 3.2. All staff should receive suicide prevention training during the academy as well as refresher training.

Recommendation 3.3. Given the rate of suicides among correctional workers nationwide, the DAC should take steps to recognize this issue as well as providing training on how to recognize the need for help. During this training, the issue of correctional officers historically not seeking help should be addressed.

Recommendation 3.4. Each facility regardless of security level have room(s)/cell(s) identified and designated as suicide watch cells. Each suicide watch cell is designed in a manner to ameliorate physical design attributes which may contribute to opportunity.

4. Transportation: The Task Force has spent a significant amount of time discussing the transportation of offenders to medical units. If it is determined an offender is to be transported by state vehicle rather than ambulance, we believe more oversight is necessary. While we would like to have a medical staff member assist in the transportation of any offender being transferred for medical or mental health care to Central Prison, NCCIW, or Maury, for example, we also recognize this may not be possible. As an alternative, we are recommending every medical transport vehicle be equipped with a camera. It is also recommended transportation be recorded on this closed system. Transportation decisions should be made in consultation with medical staff. Policy should also be developed to advise transporting staff about what to do in case of a medical or psychiatric emergency.

One of the issues which continues to arise is the medical and mental health conditions of offenders coming to the North Carolina Division of Adult Correction. In most jurisdictions across the country, an in-transit medical form is completed at the local jurisdiction prior to the offender being transferred to state custody. This will require the assistance of the Sheriff's Association.

Recommendation 4.1. For all offenders, particularly those with mental illness, an in-transit medical form be developed and used.

Recommendation 4.2. Through a memorandum of understanding between local jails and the Division of Adult Correction, county jails will be required to complete the in-transit medical form, to the extent possible, when an offender is transferred to a state facility.

Recommendation 4.3. At an absolute minimum, through a memorandum of understanding with local jails, medication lists for all jail offenders should be sent to the DAC with the

offender. Medication types, last administration, and directions for administration should be noted on the in-transit medical form.

Recommendation 4.4. Cameras should be placed in any institutional vehicle transporting an offender for medical or mental health reasons to another facility, such as Central Prison, NCCIW or Maury. The screen for this camera should be placed so that the second escorting officer has view of the person(s) being transported.

Recommendation 4.5. We would prefer that a medical staff member be required to escort any offender moved to a facility for medical reasons but have been told this is not possible. At a minimum, transport of an offender with mental illness should be conducted by staff who have had advanced mental health and crisis training.

Recommendation 4.6. Any decision to transport an offender to a medical facility should be a joint decision between custody and medical. The medical staff shall be consulted on the type of transportation to be provided.

Recommendation 4.7. Transport officers should receive initial and ongoing training on what to do in case of a medical or psychiatric emergency during movement. This training must be accomplished for one of the two transport officers moving any offender for medical or psychiatric reasons.

5. Disciplinary Policy and Hearings for Offenders with Mental Illness. The Task Force spent significant time discussing disciplinary policy and hearings for offenders with mental illness, with two main themes guiding our discussions. First, when appropriate, the disciplinary process should consider mental illness as a factor. Second, when appropriate, offenders with mental illness should have representation to facilitate offenders' full understanding of the entire disciplinary process. Moreover, after reading the UNC report on solitary confinement, there is significant discussion about the adequate representation of those who have received a rule violation. The UNC report suggests that counsel be allowed to represent offenders, especially those with who are learning disabled or have mental health diagnosis. We believe more representation is necessary, but do not recommend that counsel be the person to provide this representation. Prior court cases requires offenders have the right to staff representation to ensure that due process is followed and that some evidence is used.

For those who have a mental illness diagnosis or are learning disabled, we believe practice be developed to afford credible staff supervision. Different jurisdictions accomplish this in different ways; and we believe it can be done through trained staff representatives who accomplish this as a collateral duty or by employing an inmate advocate at any facility where rule violations are heard. The two roles of this representative insofar as learning disabled or mentally ill is concerned will be: is the person competent to understand the charges and participate in their defense, and to make sure the offender has assistance in making sure due process of the disciplinary process is by policy. During our discussions there was lots of consternation regarding the concept of staff representation as a collateral duty. It is interesting that in some jurisdictions, there are now inmate advocates, who are provided to make sure the offender understands the charges, the evidence and assists the offender in facilitating an appeal.

Recommendation 5.1. After much discussion, it is the recommendation of the Task Force that the disciplinary policy be amended to require the disciplinary hearing officer to consult with a licensed and privileged mental health professional to make a determination if a mental health offender charged with an offense understands and can cooperate in the disciplinary hearing process and whether the inmate should because of mental health reasons be held not responsible for their behavior.

Recommendation 5.2. The Task Force is of the opinion that for M-4 and M-5 offenders this determination should be made within a day of a hearing officer making an inquiry. For M-3 offenders, this determination should take no more than seven days after making an inquiry. The impetus of this recommendation is to make sure offenders with mental illness who do not have an understanding of disciplinary charges or processes or are believed not responsible for their behavior are not held in restrictive housing for long periods of time. The Task Force believes under no circumstances should an M-3 to M-5 inmate be held in prehearing confinement for more than 14 days without a hearing.

Recommendation 5.3. It is further recommended that M-3 to M-5 offenders who go to a hearing be provided with a properly trained mental health advocate (staff representative) to assist them with understanding the charges and their due process rights. Toward this end, a training curriculum should be developed for staff representatives and hearing officers and training should be designed to include directions for how mental health can be a mitigating factor in the hearing process.

6. **Restraints.** Nationally, the use of restraints, along with administrative segregation, has become a topic of particular debate for correctional practice, policy and research. For any offender, the use of restraints can increase stress and can result in psychological trauma; however, the use of restraints among offenders with mental illness, particularly severe mental illness, can be especially stressful and traumatic.

In the world of corrections, you often hear words like medical restraints, clinical restraints and custodial restraints. We believe this categorization of restraints is dangerous as it leads one group to say, well that is not our responsibility because the offender is in custodial restraints or clinical restraints. Except for restraints used for escort and restraints used to keep a medical patient from falling, restraints are restraints. While there will be a lot of disagreement with this analysis, all correctional staff must understand that four- or five-point restraints are only used for the absolute minimum of time needed to control an offender's behavior, or there will be abuses of the use of restraints. Restraints are never to be used for punishment. We also suggest four-point or five-point restraints should be used only as a last resort to control behavior. There are many times progressive restraints are effective in the control of recalcitrant behavior. The continuum of supervision does not always necessitate placement of an offender in four points, but the placement of any offender requires monitoring and reporting.

The placement of restraints on those diagnosed with mental illness is sometimes necessary. But every health care authority, including the Joint Commission, indicates restraints should only be

used as a last resort to protect the patient or others around him or her. Moreover, persons in restraints are to be constantly monitored, which should include a check to make sure the circulation of the person restrained is not compromised, that the person is properly hydrated, that the person has an ability to toilet and that an assessment is made to determine if the continued use of restraints is necessary.

The Task Force recommends policies regarding the use of restraints are changed to require at a minimum an assessment every four hours of every offender in restraints. This assessment is to be conducted by two people, preferably a health care professional and a correctional supervisor. The assessment is to be conducted by physically checking the offender, not reviewing placement from a window or observation area, but in person. At a minimum, the offender will be allowed to toilet, will be allowed to drink water, will be checked to determine if circulation is satisfactory, and is to determine if the use of restraints continues to be necessary. If one of the two persons conducting the assessment is medical, vital signs will be taken. Documentation of this assessment is to be placed in appropriate systems of records.

We believe three levels of monitoring need to be implemented. First, the institution's Chief Executive needs to be notified anytime it is believed to be necessary to place an inmate in restraints. The Chief Executive must be satisfied that the use of restraints is necessary to maintain the behavior of the offender. If an offender remains in restraints for more than eight hours, the Regional Director shall be notified by telephone and in writing by the institution's Chief Executive. If the offender continues for 24 hours or more the Deputy Director for Operations shall be notified.

Recommendation 6.1. It is the recommendation of the Task Force that restraints should never be used as punishment.

Recommendation 6.2. When restraints are used, an in-person assessment of any offender placed in restraints should occur every four hours at a minimum. If medical personnel are available, the assessment is to be conducted by medical and custody staff. If medical personnel are not available, two custody staff shall complete the in-person assessment. At a minimum, circulation is to be checked, the offender given the opportunity to toilet, the offender given the opportunity to hydrate and a determination made if restraints are needed to continue to control the inmate's behavior. If a medical person is one of the two providing the in person assessment, vital signs are to be taken. Regardless, the offender's vital signs should be checked at least once every 8 hours or more frequently if medically indicated.

Recommendation 6.3. If restraints are ordered for an offender with mental illness (i.e., classified M2 – M5), the placement of restraints should be reviewed by medical staff or custody staff who have received advanced mental health training.

Recommendation 6.4. In addition to the in-person assessment, when any offender with mental illness, is placed in restraints to control behavior, the facility head or designee is to be notified immediately. If the offender continues in restraints for more than 8 hours, the regional director is notified in writing via email. If the offender continues in restraints for more than 24 hours the regional director and the deputy director are notified. These

notifications are to be made by phone and followed up with e-mails. A copy of the emails shall be placed in the offender's record.

Recommendation 6.5. Crisis protocols should be established to deal with offenders who are non-responsive or noncompliant with requests to stay hydrated.

Recommendation 6.6. The DAC currently has multiple policies regarding the restraint of offenders. It is the recommendation of the Task Force that these policies be consolidated into one. It is recognized that different types of restraints will be discussed in this one policy; however, it is the opinion of the Task Force that multiple polices on restraints creates confusion and increases the possibility of error.

7. Behavioral Health Services. Offenders with mental illness may need ongoing treatment and support, including medication, psychiatric assessment and services, and psychosocial programs and supports. The Task Force is impressed with the treatment mall witnessed at Central Prison. Providing offenders with mental illness "out of cell" treatment is noteworthy of comment. The need for treatment which incorporates more than just medication is essential if the goal is to return these offenders to the general population and ultimately the community.

We are encouraged by the plan to open transitional care units at all closed custody facilities. We recognize this is a significant funding issue; however, we know without such units any ability to remove the most serious mentally ill offenders from restrictive housing will generally not occur. The development of alternative housing for many offenders is essential to their treatment and hopeful reintegration into general population. While we are encouraged, we also caution the leadership to ensure that appropriate multi-disciplinary staffing is accomplished prior to opening these units and that a treatment curriculum is developed which measures activities such that staffing and programming across units are standardized and consistent.

Recommendation 7.1. In any institution having mental health or medical staff, policies should be developed to require that custody, medical and mental health staff should meet daily in person or by conference call to discuss significant cases or issues for the day.

Recommendation 7.2. Assessment and treatment of trauma disorders, and provision of trauma-informed care, should be provided to all our offenders, especially women. Although the incidence of trauma is high among male prison offenders, the experience of trauma is nearly universal among incarcerated women. Various programs for the treatment of trauma disorders have been developed (Seeking Safety, TREM, and Cognitive Processing Therapy). However, the effectiveness of these treatments will be limited unless efforts are also made to provide this treatment within an environment that is trauma-informed. Developing a Trauma-Informed Care (TIC) environment will require a commitment by prison administrators to examine and reform the processes and practices of the prison system to minimize the re-traumatization of offenders. Training on TIC would need to be provided to correctional staff, as well as treatment staff, to assist them in building a supportive, compassionate and emotionally safe environment that will allow the inmate to begin to heal from their trauma. Trauma-informed care has also been found to improve the outcomes of women's prison

systems by decreasing their number of disciplinary infractions, reducing violent conflict between offenders in these institutions, and reducing inmate-on-staff assaults.

Recommendation 7.3. Ensure that appropriate multi-disciplinary staffing is accomplished prior to opening transitional care units and that a treatment curriculum is developed which measures activities such that staffing and curricula across units are standardized and consistent.

Recommendation 7.4. Explore the creation of specialized case managers to coordinate care and services for offenders with mental illness (i.e., M2 – M5). Case managers will follow offenders from intake to release. The Task Force appreciates this may require additional staff and will require additional specialized mental health training. These case managers additionally take on the responsibilities traditionally managed by social workers at facilities were social work is not on site.

Recommendation 7.5. It is recommended by the Task Force that the Director of DAC put out a memorandum to the Wardens' at Central Prison, NCCIW and Maury reiterating that medical and mental health beds are system beds and should only be used as "security beds" in rare circumstances that are justified in writing and authorized in writing by the warden. Guidelines for when these system beds can be used as security beds should be outlined. It is also recommended the Director conduct a six-month follow-up to see if hospital beds continue to be used.

Recommendation 7.6. It is the recommendation of the Task Force that the distinction between outpatient and inpatient mental health departments should be eliminated at medical centers. Moving forward, one supervisory organizational structure should be responsible for the provision of all mental health services at each of these facilities.

Recommendation 7.7. It is also the recommendation of the Task Force that physical health and mental health services are integrated under one organizational structure for all offenders at the institutional setting and that one physician is responsible for overseeing the provision of all health and mental health services at each institution. Moreover, interdisciplinary team meetings should be standard practice for all facilities (from 1997 NIC Recommendations). The purpose of this recommendation is to emphasize the integration of services. Nothing in this recommendation should be construed to suggest how the hierarchy of positions be organizationally managed.

Recommendation 7.8. The electronic medical record (HERO) is essential to the provision of continuity of care for all offenders. It is the recommendation of the Task Force that the EMR (HERO) for DAC be funded and completed for all male facilities. Currently, the EMR has been implemented at female facilities. Moreover, it is the recommendation of the Task Force that the DAC receive two new positions to be devoted to EMR data management and analysis, communication and monitoring and reporting.

Recommendation 7.9. Pharmaceuticals are a costly part of providing care to all offenders, especially those with mental illness. It is the recommendation of the Task Force that the DAC

be granted permission by the state legislature to participate in a federal prescription drug program called 340B Drug Discount Program. Though it is targeted for medications to treat sexually transmitted diseases, such as HIV, participation in this program could free up resources that are needed to treat other illnesses. That is, by participating in the program, money saved from not having to pay for pharmaceuticals for sexually transmitted diseases could be put towards medications for offenders with mental illnesses. This would require the cooperation of UNC Hospitals.

Recommendation 7.10. When the demand for psychiatric services at any facility in the DAC outpaces capacity of in-house staff to meet the demand, the DAC should be prepared to provide for required services commensurate with good care. It is suggested that DAC develop a strategy to obtain telemedicine services not from a university provider where you always have to deal with unused capacity, but from a vendor providing such service as part of their business model.

8. Hiring and Retaining Medical and Mental Health Staff. Hiring and retaining qualified medical and mental health staff is a critical but an ongoing challenge for the Division of Adult Correction. The Task Force finds that the announcement that there will be a pay increase for psychologists is long overdue. This pay increase complements an earlier pay increase for medical clinicians. Recruitment and retention of medical and mental health staff is essential. It is well documented and known that the recruitment and retention of medical and mental health staff has been problematic. The policy makers in and out of the Department of Public Safety have to develop an understanding that managing the human resources around medical and mental health staff is different than with other staff. This in no way says that other staffs are less significant, but recruiting and retaining medical and mental health staff is a specialty in and of itself. We applaud the decision to increase American Psychological Association approved internships for psychologists. We acknowledge the need to develop recruitment modalities for master-level psychologists.

Recommendation 8.1., We find a first step to improve the hiring of medical and mental health staff be made by hiring a medical recruiter who will be responsible for ensuring that strategies are developed for the hiring of medical and mental health staff.

Recommendation 8.2. Develop special management and human resources policies specific to medical and mental health staff in relation to hiring and retention.

Recommendation 8.3. Concerning compensation of mental health professionals, it is the recommendation of the Task Force that DAC efforts be undertaken to ensure that similarly situated professionals, no matter their departmental affiliation, be paid commensurably throughout state government.

Recommendation 8.4. The nature of providing for the health care of patients throughout the DAC has often resulted in the hiring of temporary employees as defined by the state office of personnel. There is a provision that all temporary employees hired by any department must take a 31-day hiatus in employment at the end of their eleventh month of employment. The

rationale for this process is understood; however, the 31-day hiatus policy causes undue burden on facilities and can be extremely disruptive to patient continuity of care. It is the recommendation of the Task Force that the DAC request an exemption to this policy.

Recommendation 8.5. The Task Force has been advised that many medical positions have not undergone a personnel classification review since the 1980's. It is the recommendation of the Task Force that all medical positions should be reviewed a minimum of every five years, or more frequently if necessary. The manner in which medical care is provided to all populations, including offender populations, is significantly different than it was 30 years ago. Further, it is the recommendation of the Task Force that all position classifications be reviewed every five years. Position classification, given they are different from job classifications, should be used to determine pay and compensation. It is understood that this process is not the responsibility of the DPS and the responsibility lies with Office of State Human Resources; however, we strongly support any efforts that can be made to educate others about the importance of reviewing DAC medical staff and ensuring that their pay is commensurate with those in the community.

Recommendation 8.6. It is the recommendation of the Task Force that the interview process for medical positions be amended such that persons who apply for a position at a facility can remain on a list of eligible candidates for 180 days, and this policy change should be extended to all medical positions. The current policy, which forces institutions to interview the same candidates multiple times, is a waste of time and resources for institutions and applicants.

Recommendation 8.7. The Task Force also recommends that that DAC considers advertising for positions in the American Psychiatric Association Journal, the American Psychological Association Journal, their state journals, and/or other professional journals. These advertisements should be professionally created and maintained in the journals continuously.

9. Training and Employee Support. There are many positive things happening in the Division of Adult Correction regarding the care and treatment of offenders with mental illness. The initiation of Crisis Intervention Training (CIT) for correctional staff will help staff learn how to manage the supervision of offenders who present difficulty, with the hope to reduce the use of force. However, while the CIT training previously referenced is important, we have been told that staffs at the academy are not trained on how to deal with special needs offenders, including those with mental illness. We suggest meaningful training to all staff at the academy is warranted. Refresher training is essential for any training provided. As an alternative to training being developed in-house, the American Correctional Association is offering training for behavioral health.

Additionally, we believe the specialty staff, such as mental health providers, nurses and other medical staff, should receive additional and on-going training and supervision as to how to provide care in a correctional environment. Compassionate care within a correctional environment is not antithetical to good custody, but it takes strong leadership to effect. The majority of training and experience for managers and leaders in corrections is about security. It

is essential as first-line supervisors become mid-managers that they receive training on their responsibility in effectuating care. All management and leadership courses should include a component on providing care within a correctional environment.

Recommendation 9.1. A brief training module focused on mental health, signs and symptoms of mental illness and special offender issues should be developed and provided for all staff at the Academy. An alternative is the behavioral health training module which has been developed by the American Correctional Association. The ACA modules may be completed on-line. Moreover, it is recommended that the DAC have access to the online mental health training modules that are currently being used by the division of community corrections.

Recommendation 9.2. Training be developed for institutional leadership on how to effectuate the supervision of medical and mental health departments and staff.

Recommendation 9.3. The DAC should be commended that it is offering CIT training to all officers assigned to closed custody facilities. Thus, CIT officers should have on-going training and support, with particular emphasis around de-escalation techniques and other critical components of the CIT training program. Delivery of CIT training should be explored to meet the needs of the state. It is the recommendation of the Task Force that a continuous quality improvement plan or process be applied to the implementation of CIT.

Furthermore, a strategic plan for training and re-training all CIT officers should be developed and implemented. For example, the Task Force recommends consideration of something like the following: (1) modified mental health first aid or similar program for all officers and staff; (2) mental health training modules at the academy; and (3) CIT training for all officers at closed custody facilities and (4) refresher training for all staff depending upon the type of training they receive.

Recommendation 9.4. Training should be developed for mental health and medical staff on how to provide care in a correctional environment. Special emphasis should be placed on teaching appropriate boundaries when providing care.

Recommendation 9.5. For facilities not having CIT trained staff, mental health first responders be identified and trained. These staff should be available on all units and all shifts. These volunteers will receive advanced mental health training and ongoing supervision, and will be the "go-to" staff members when questions about mental health or mental health crises arise.

Recommendation 9.6. It is the recommendation of the Task Force that critical incident debriefing for incidents regarding offenders with mental illness be made a priority and that debriefing should be accomplished through a multidisciplinary team. Also, the published literature on critical incident debriefing should be reviewed to inform best practices for North Carolina.

Recommendation 9.7. With respect to offenders with mental illness, it is the recommendation that communication between officers who are changing shifts is improved and there are strategies for improving communication about offenders who are mentally ill. Different levels of institutions have different needs; mandatory criteria should be established for each institution on what pertinent information needs to be reported during shift change related to offenders with mental illness. It should be the responsibility of medical, mental health and custody to develop this criteria.

Recommendation 9.8. We support the Department's We Care initiative. With the nationwide staff suicide rate being crudely provided as 35:100,000, more than twice the national average for the general public, we believe a specific program addressing the needs of staff needs to be taught every year at refresher training. It is the recommendation of the Task Force that the DAC provide more information and details about its employee assistance program (EAP). Specifically, the DAC should provide more information about the purposes of EAP, the benefits of, how to access, confidentiality, etc. Although beyond the purview of the Task Force, we would encourage the General Assembly to review the statewide EAP program to determine if it is possible to expand services beyond the one-pay visit.

Recommendation 9.9. It is the recommendation of the Task Force that the interview process for new correctional officers include question(s) about attitudes of working with offenders with mental illness. If it is not possible for such questioning to be provided during hiring, perhaps some sort of measure should be provided to staff assigned to work with mentally ill offenders. Research has demonstrated the efficacy of treatment is supported when correctional officers assigned to treatment units have good attitudes toward the process. Standardized measures of attitudes about and perceptions of persons with mental illness could be used to identify officers who have potential to become specialized in working with offenders with mental illness.

Recommendation 9.10. It is the recommendation of the Task Force that interview questions for any person applying for a management or supervisory position include questions about the management of offenders with mental illness.

Recommendation 9.11. It is the recommendation of the Task Force that DAC personnel have access to computers and email accounts. Staff with aftercare responsibilities should have access to voice mail to facilitate contact with community providers. In addition, in – reach to prison inmates should be eased for community providers who will be serving soon to be released offenders. A mechanism should be established to pre-approve certain providers who frequently serve releasing offenders. Training would be provided to these providers concerning issues of prison security. Secure video conferencing technology should be developed to enable community providers, probation officers and others in the community to establish relationships with the offender prior to release – particularly when the prison is not in close proximity to the community in which the offender will reside.

Recommendation 9.12. It is the recommendation that health and wellness checks be integrated into an employee support plan. Moreover, assessments and discussions about vicarious trauma should be included. Officers' self-care should be a priority.

Recommendation 9.13. The Task Force recommends that the DOP develop a continuing medical education program (capped at a certain amount such as $500 a year for physicians) to assist those mental health and medical staff who need to maintain a licensure or continue their education. This program will help defray the cost. This should be a recruitment and retention tool and clearly stated that it is not an entitlement.

10. Discharge and Community Transition Planning. Few transitions are more difficult to achieve than from life in prison to freedom in the community. Offenders live in an institutional environment with routines prescribed to the minute, where choices are few, freedom is limited, movements are restricted, but where all essential needs for food, clothing, and shelter are provided. Upon release, offenders are thrust into the community where options are many, choices are overwhelming, movement is unlimited, but where they are also suddenly responsible for their own well-being. Their transition to the community is further hampered by the barriers presented by their legal histories to obtaining employment, housing, and social support.

When released to the community, offenders who are beset with mental illness and/or substance abuse problems face even greater challenges. While they have the same barriers to success as other offenders returning the community, they have fewer mental and emotional resources to overcome them. Transitions are stressful, and people with mental illness are vulnerable to stress. When under stress, their symptoms may be exacerbated, their behaviors may regress, and the emotional turmoil created by those transitions makes more difficult the process of learning new behaviors necessary for success in the new environment. Such individuals require intensive support and assistance through this transition process, or risk failure. And failure for such individuals might not only result in their re-incarceration, but may endanger the lives and welfare of others in their community.

Below, the Task Force provides recommendations for improving the transition of offenders with mental illness and/or substance abuse problems to our North Carolina communities. Because the re-entry of offenders with mental illness to the community requires the coordination of prison staff with agencies and organizations available to support them in the community, the recommendations contained herein address both policies and practices of our prisons, as well as those of the various organizations in the community to which their care is transitioned.

These recommendations are <u>not</u> the result of an exhaustive or comprehensive review of all of the mental health services in our North Carolina prisons; such a review would require more time and resources than are currently available. Therefore, the conclusions and resulting recommendations contained below should be considered tentative and as only a preliminary step towards a more thorough examination of ways to improve services to offenders with mental illness being served in our state's prison system.

Recommendation 10.1. Improve the mutual understanding of and collaboration between the LME-MCO and prisons social work staff on behalf of releasing offenders needing public mental health systems services.

a. Educate LME-MCO access staff members about the administrative process involved in releasing offenders from prison to the community, and the needs of such inmates who are returning to the community.

Prison social workers consistently report frustration with the community service system's lack of familiarity with the administrative requirements and challenges in developing release plans for offenders. For example, although prison social workers are required to develop release plans no less than 30 days in advance of an inmate's release, some LME-MCOs are reluctant to schedule appointments more than two weeks in advance.

In addition, a consistent and effective response is needed for scheduling appointments for people discharged from prison. For example, while most consumers prefer "same day access" approaches to appointments, prison social workers reported that inmates need specific appointment times, as they become frustrated with walk-in appointments, and are not willing to wait for "the next available appointment."

The availability of a LME-MCO staff who specializes in prison issues might help the LME-MCO and prisons work together more effectively. However, all LME-MCO access staff need to be aware of the needs of both inmates being released and the prison social workers who are planning for their release. Many of prison social workers serve different facilities, and some do not have telephone voice mail capability. Therefore, they are not easily reached via return phone call, and they need assistance from whomever they contact at the LME-MCO, rather than relying on a return phone call from a single staff member.

b. Educate prison social workers about the changing mental health system and role of LME-MCO's.

Changes to NC's mental health system have left prison social workers unsure about how to access services for releasing inmates, and unclear about the role of LME-MCO's. Mergers between LME-MCO's have further complicated referrals to service providers, as entities and individuals they used to contact to arrange referrals may no longer exist in the same capacity. Furthermore, LME-MCO's may differ in their processes, procedures and service availability, as they are charged with meeting the needs of a variety of people in diverse communities within each of their catchment areas – with limited state funding.

Periodic trainings about the state's mental health care system and meetings between LME-MCO staff and prison social workers many not only help the prison social workers better understand the community mental health systems and roles of the LME-MCO's, but would enable them to develop relationships with the LME-MCO's that they could then rely upon to help solve problems related to release planning. Consideration could also be given to cross training LME-MCO's and prison social work staff members on their assessment and treatment planning forms and processes, with an eye towards sharing these forms, and even establishing (where feasible) similar assessment and treatment planning forms and processes in hopes of facilitating as seamless as possible continuation of care.

If approved, with the assistance of DHHS staff, a meeting should occur between staffs as soon as practicable.

Recommendation 10.2. Establish services and needs aligned with critical time points prior to discharge (i.e., needs two weeks before release, needs on 1st day of release, first week of release). In addition, develop a release checklist prior to release to community and standardize this checklist across facilities and communities.

Recommendation 10.3. Coordinate care across mental health, substance use, physical health, domestic violence, sex offender, probation/parole etc. Address training and staffing needs for discharge planners and case managers.

Recommendation 10.4. Develop dedicated mental health discharge planner with dedicated resources and training (i.e., SSI/SSDI Outreach, Access and Recovery [SOAR] training). Assisting inmates to obtain Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) benefits and other entitlements prior to their release from prison will help assure that those inmates with disabilities receive reliable income and supports necessary for their transition to life in the community. The SOAR program has a proven track record of success in training social workers to help persons with disabilities successfully apply for these benefits. Often, without SOAR training, applications for these benefits are denied, requiring reapplication or a lengthy reconsideration process that delays their receipt of these benefits. Providing SOAR training to prison social workers will help assure that offenders who are disabled have financial assistance for support upon their release.

Recommendation 10.5. Establish Memoranda of Understanding/Agreement between, Division of Adult Correction, Division of Community Corrections and LME-MCOs to facilitate data sharing and planning regarding offenders' treatment needs. The medical files of offenders in the custody of the DAC contain information that is essential for meeting their treatment needs following their release. However, often that information is not conveyed to the LME-MCO responsible for their care once released from prison. Developing MOU/MOAs with the LME-MCOs would enable to prisons to share data commensurate with legal regulations will help assure these offenders' continuity of care in the community. Continued development of the HERO system may help facilitate information sharing between the prisons and LME-MCOs.

Recommendation 10.6. LME/MCOs should designate a prison reentry specialist to increase the LME/MCOs' understanding of the needs of offenders with mental illness and co-occurring substance use disorders who are returning to the community. Improve the mutual understanding of and collaboration between the LME-MCOs and prison social work staff on behalf of releasing offenders needing public mental health system services.

Recommendation 10.7. Partner with LME-MCOs who are providing care coordination for re-entering offenders with severe mental illness through policy adjustments that take into account in-prison health histories. This would require additional resources at DHHS. To inform this issue, more data on the numbers of offenders with co-occurring mental illness and substance use disorders are needed.

LME-MCOs and prisons should work together on prioritizing care coordination for those releasing inmates with mental illness who may present a risk to their communities, and particularly for those whose mental illness is severe, who have co-occurring substance abuse problems, and who have been incarcerated for lengthy periods of time.

Recommendation 10.8. It is the recommendation of the Task Force that prison and probation should communicate with each other about offenders with mental illness and their prison treatment needs and experiences (use of services, medications) prior to release and post-release.

Recommendation 10.9. It is the recommendation of the Task Force that housing providers should be incentivized to house offenders with mental illness who are reentering their communities. The Task Force recognizes that this recommendation goes beyond the scope of the DAC but is a critical issue that must be addressed if any long-term success at reintegration of the mentally ill is accomplished. Moreover, the Task Force recommends that the DAC establish contracts with vendors to establish transitional care facilities for sex offenders and offenders with mental illness in 10 locations across the state. These facilities and their effectiveness toward facilitating successful community reentry and reducing recidivism should be evaluated using indicators of effectiveness, length of stay, recidivism rates, etc.

Recommendation 10.10. It is the recommendation of the Task Force to consider piloting Critical Time Intervention (CTI) for offenders with severe mental illness who are returning to their communities. These programs are typically designed and implemented by community mental health centers. Where expansion of the mental health specialty probation officer program (see below) is not feasible, or when probation caseloads are too large to meet their mentally ill probationer's needs, development of a Critical Time Intervention (CTI) initiative should be considered. CTI is a nine-month long intervention strategy designed to help persons transitioning from homeless shelters and psychiatric institutions to the community by providing intensive support, particularly in the first several months, to help engage transitioning persons to services and supports in the community. CTI may also assist releasing inmates with mental illness to successfully transition back to the community.

Recommendation 10.11. It is the recommendation of the Task Force that the DAC develop a collaborative relationship with state vocational rehabilitation and work more closely with local vocational rehabilitation offices. Prison social work staff should meet with and receive training from the state Department of Vocational Rehabilitation (DVR) regarding eligibility requirements and processes for applying for DVR assistance, as this may help them to better guide their releasing inmates in applying for DVR services. This training could include a presentation about the Client Assistance Program - a federally-funded agency charged with providing advocacy, assistance and advice to people with disabilities, including disabled ex-offenders who are seeking DVR services. Developing relationships with staff in local DVR offices may help the prison social workers to better understand and influence local DVR polices, thereby easing the application process. Also, establishing relationships with the

state's DVR staff may help assure better state-wide consistency in DVR's provision of support to releasing inmates with disabilities.

Recommendation 10.12. It is the recommendation of the Task Force that the DOP consider developing a standardized prerelease programs unique to offenders with mental illness – particularly those with lengthy incarceration histories – to help them begin to readjust to community life. The program should be implemented prior to and following release and should include all relevant supports.. Offenders with mental illness completing a lengthy prison sentence will need help learning new ways of relating to others. They may need assistance in understanding how prison life has changed them, and help understanding how to respond to people outside of prison. Programs aimed at educating these offenders about this adjustment process may better prepare these offenders for their release. In addition, family members and loved ones supporting the offender may need help understanding the ways in which he or she has changed, and how to best support the inmate's readjustment to life outside of prison.

Recommendation 10.13. Improve the employability of offenders with mental illness who may be able to work by providing them training in job skills and supports to maintain employment. Gainful employment is a crucial ingredient for successful post-release adjustment and recovery – especially for offenders with a mental illness and substance use disorders. In addition to income, work provides structure and a sense of purpose to individuals lives. Research has demonstrated that individuals with serious mental illness are capable of working competitively in the community. Whenever possible, offenders with mental illness should be considered for job training programs, including within Correction Enterprises, with a focus on learning job skills that are in demand in the community. In addition, opportunities for these offenders to learn "soft skills" such as getting along with fellow employees, avoiding conflict, and cooperative work relations, should be provided. Upon their release supportive employment programs be made available for offenders with mental illness to assist them in obtaining and maintaining employment, through DVR and community mental health programs. This will require coordination with community corrections.

Recommendation 10.14. Increase opportunities for LME-MCOs and community providers to learn more about evidence-based and best practices in supporting justice-involved persons with mental illness in the community. Efforts should be made to develop mental health professionals' ability to support persons with mental illness who are involved with the criminal justice system. Although community providers are often well-versed in the provision of evidence-based treatments for mental illness, few of them are aware of evidence-based practices for reducing criminal justice recidivism.

Although beyond the scope of DAC, community-based mental health staff who manage the care and those who provide direct services to offenders in our public mental health system need to know how to work with mentally ill offenders in the community to reduce their likelihood of returning to prison. They need to be aware of the evidence-based practices for effective interventions with offenders, including the risk-need-responsivity principles, and on ways to address the central risk factors for criminal justice recidivism. Trainings on working

effectively with a mentally ill criminal justice-involved population could be provided through workshops at professional conferences, through adjustments to curricula taught in professional schools, and through targeted efforts to cross train mental health professionals, community corrections and prison staff.

Recommendation 10.15. Expand the mental health specialty probation officer program. A specialty mental health probation officer program is currently being piloted in two North Carolina counties (Sampson and Wake). Research conducted in other states has found such programs effective in reducing criminal justice recidivism among probationers with mental illness. Once the evaluation of the North Carolina mental health probation officer pilot program determines its effectiveness and refines this model, it should be expanded statewide, with priority given to offenders with severe mental illness who have experienced long periods of incarceration. Such offenders may be in great need of support to transition successfully to the community. Although there may be pressure to expand the caseloads of mental health probation officers, these must remain low to enable the probation officer to provide services at a level of intensity and frequency sufficient to meet the offender's needs.

Recommendation 10.16. The Task Force recommends the Administrative Office of the Courts review methods of diverting low level offenders prior to their confinement to DAC. We further recommend that (1) mental health courts be expanded and that (2) outcomes data collection for mental health courts is standardized.

Recommendation 10.17. It is recognized that the collection and aggregation of specific data is essential to determine effectiveness and efficiency, it is recommended that DAC enter into initial discussion with NC Government Data Analytics Center to develop appropriate performance indicators for the treatment and housing of mentally ill offenders.

10. General Policy and Culture. Correctional institutions must be about custody, care and correction. Generally, the custody and correction components are met but the care component is difficult to obtain. Part of our Task Force is reviewing the antecedents between custody and medical staffs to make a determination if the two cultures generally act as mutually exclusive entities.

Initial interviews with staff demonstrate that the schism between custody and medical is significant. The interviews demonstrate there is little if any respect between the two disciplines. Having compassion for inmate patients is viewed as wrong and in some cases cited as a violation of policy. There is little education for nursing to demonstrate how to ethically provide compassionate care to their patients. The need to teach how to provide care within appropriate boundaries needs to be emphasized. The interviews found that custody has a punitive philosophy, which nursing tends to follow.

The Task Force has also found that medical staff believe they do not always have a seat at the table during management meetings and there is a lack of understanding of the responsibilities of all involved in inmate management. The most significant issue found by this workgroup is that some facility heads discourage communication or reporting to regional staff and may disregard clinical recommendations of regional staff.

Recommendation 11.1. Upper management should issue a statewide policy requiring better collaboration between medical and custody. This policy shall promote a culture of mutual respect. Leadership of the facility shall be assessed when performance evaluations are conducted on how well these disciplines work together. Policy should be developed from upper management of the Division indicating that cooperation and collaboration between custody and medical is expected. Facility heads shall be apprised that they will be assessed on how well this collaboration exists.

Recommendation 11.2. A practice be developed for custody and medical to have a daily meeting, which can be accomplished by phone and or in person, to discuss any issues/goals for the day. For example, if there is a mentally ill offender who is in segregation who needs to be removed from his cell to get labs, a discussion of how to effect this is had. When dealing with offenders who are mentally ill, these discussions need to occur daily. While this is especially relevant at facilities with medical missions, it is just as relevant at smaller facilities where the mentally ill or medically ill may be confined.

Recommendation 11.3. It is especially critical that when dealing with difficult offenders with medical or mental illness that a treatment team approach be established. Policy needs to be developed such that prior to any major activity, like that described above in Recommendation 10.2., a team review of the case occurs and is documented.

Recommendation 11.4. At larger facilities, medical facilities, and those with transitional care units, nursing, custody, physicians and program managers round weekly.

Recommendation 11.5. There is concern that medical staff are supervised by other than medical staff. This practice needs to be reviewed. If non-medical staff supervise medical staff, then the supervisor must receive appropriate training on the issues relevant to medical staff and must give proper attention to them. The clash of cultures is not necessary if leadership is developed and trained to provide appropriate supervision to all disciplines.

Recommendation 11.6. Risk management is critical to the success of any program offering mental health treatment. We have been told comprehensive guidelines have been established to determine compliance with policy and practice for medical and mental health issues. In discussions with staff, it is clear that they do a credible job in identifying issues that need to be addressed. Yet, there are no enforcement tools or methodologies. It is essential an enforcement methodology be developed to ensure that facility heads certify that recommendations are enforced, or if not, what alternative(s) have been implemented to meet the intent of the recommendation(s). The Deputy Director for Health Services must be satisfied with any enforcement report prior to closing the review. Along the same lines, it is the recommendation of the Task Force that all risk management activities be consolidated in a separate department in the Central Office that reports directly to the Deputy Director for

Health Services. If there is disagreement with a finding of a reviewer, the facility head may appeal through their Regional Director to the Deputy Director for Health Services.

Recommendation 11.7. One of the issues missing in risk management is analysis. When you are establishing systemic health and mental health care, analysis of reports and reviews must occur. This analysis provides to division leadership information that targets persistent issues, which may occur at several institutions or within a region. Toward this end, it is recommended that person(s) be employed to conduct analysis and develop reports to advise the leadership of the department of ongoing concerns. One way to strengthen this is to incorporate ongoing analysis of data.

Recommendation 11.8. For the purposes of credibility and program fidelity, the Task Force supports the need to those institutions with major health care facilities be accredited.

Recommendation 11.9. All risk management activities for health services needs to be consolidated under one umbrella.

In an effort to supply the readers of this report with additional information, Dr. Megan Davidson has compiled a list of best practices found in the field. We have not examined all of these best practices or others which may be reviewed. The following is a compilation of practices found in other jurisdictions and primarily published by the National Institute of Corrections.

Best Practices:

- *Intake Process:*
    - Early, expedient, and through intake and classification process
    - Use of validated assessment tools, such as the PAI (Personality Assessment Inventory)
    - Recommend this process begins no later than 48 hours upon intake
    - Evaluation and identification of mental health needs by trained mental health professionals
        - Key Elements of mental health evaluation:
            - Psychiatric history, including hospitalizations and outpatient treatment
            - Current use of psychotropic medications, if any
            - History of suicidal behavior & current suicidal ideation
            - Current and prior drug and alcohol usage
            - History of sex offenses
            - History of violent behavior
            - History of being victimized by criminal violence

        - History of special education placement
        - History of seizures or cerebral trauma
        - Emotional response to being incarcerated
        - Intelligence testing for cognitive disabilities
        - Motivation for Treatment and Readiness for Treatment
        - Ethnic, cultural, and gender considerations
    - Objectives:
        - Identify inmates at risk for injuring themselves and others.
        - Determine whether the inmate is capable of functioning in the prison.
        - Determine whether the inmate should be transferred to a mental health facility.
        - Determine whether the inmate can benefit from treatment at the prison
- Classification and housing assignment based on mental health issues
- Develop treatment plan for inmates with serious mental health needs
- Also important to monitor general population inmates to assess emergent mental health needs. Some inmates may not have pre-existing mental health conditions, but they may develop over time.

- *Treatment & Management:*
    - The APA has recommended a variety of therapies be made available for inmates with serious mental health issues:
        - **Inpatient Treatment:**
            - Crisis Intervention program with hospital beds available for short-term treatment (less than 10 days)
            - Acute care program- inpatient treatment for inmates with serious mental illnesses that temporarily impede their ability to function in general population.
            - Chronic care program- special housing unit for inmates with chronic mental illness who do not need acute treatment but cannot function in general population.
        - **Outpatient Treatment:**
            - Inmate receives services while residing in general population
        - **Case Management:**
            - Critical to oversight and monitoring of inmates with serious mental illness.
            - Also responsible for Discharge planning for inmate being transferred to different facility or released.
            -

- Key treatment modalities:
  - Psychotropic medication
  - Individual psychotherapy provided by trained mental health staff
    - Psycho-education and develop improved coping strategies
    - Focus on cognitive-behavioral interventions
  - Group psychotherapy provided by trained mental health staff
    - Psycho-education and develop improved coping strategies
    - Develop interpersonal and communication skills.
    - Develop anger management skills.

- *Mental Health Staffing & Training*
  - The APA does not provide specific standards in terms of staff to inmate ratios regarding number of treatment staff needed in a correctional facility
  - Numbers and types of providers required at a particular facility depend on number of inmates being treated and types of services being provided.
  - Very important for mental health staff to be properly trained and certified to provide treatment- Should meet state licensure, certification, and registration requirements.
  - Line correctional staff should also be trained to work with inmates with mental illnesses since they are often the first to recognize and respond to mental health crises.
    - Recommended that they receive the same training as direct care workers in psychiatric hospitals.
    - Basic training should include:
      - How to recognize early signs and symptoms of mental illness and suicide
      - Nature and effects of psychotropic medications
      - The mental health services provided in the prison
      - When to refer an inmate for mental health services
  - Measure performance of mental health staff in relation to intervention, treatment, and management of mentally ill inmates
  -

- *Disciplinary Processes & Restraint Use*
  - It is recommended that the disciplinary committee consider the inmate's mental health status when making decisions about sanctions.
  - Was the illness related to the behavior? Did inmate understand wrongfulness of action?
  - Seek psychiatric evaluation/consult for inmates in crisis.
  - Minimize use of solitary confinement as disciplinary sanction.
    - When using this, must provide mental health services during this time.

        - Recommended that mental health staff make weekly checks on inmates in solitary confinement.
        - When inmate is in acute crisis, they should be removed from segregation until stabilized.
    - Use of restraints:
        - Agency should have clearly defined policies regarding use and administration.
        - Recommended standards:
            - Only soft restraints may be employed.
            - Only a physician or other health provider permitted by law may order restraints or seclusion.
            - Health staff may only use restraints or seclusion as part of a treatment regime and not for disciplinary or custody reasons.
            - Any single order for restraints or seclusion cannot exceed 12 hours.
            - Inmates in restraints or seclusion must be checked at least every 15 minutes.
            -

- *Suicide Prevention:*
    - Recommendations for inmate suicide prevention:
        - A written policy and procedures to ensure that all special management inmates are directly observed at least every 30 minutes.
        - More frequent observation for inmates who are violent or have a mental illness than for inmates who are not violent and do not have mental illness.
        - Continual observation for actively suicidal inmates.
        - A written suicide prevention and intervention program approved by a qualified medical or mental health professional.
        - Training for all correctional staff in the suicide prevention and intervention program.
        - Intake screening, identification, and supervision of inmates who may be prone to suicide.

*** Many of these recommendations are derived from the following source: National Institute of Corrections (2004) *Effective Prison Mental Health Services: Guidelines to Expand and Improve Treatment.*

It has been an honor and a privilege for the members of the Task Force to work together and present this to the leadership of the Division of Adult Correction. We know that any report such as this cannot be all inclusive, but we believe we have addressed the major issues which need to be reviewed. Any member of the Task Force remains ready to assist the leadership should there be other areas which require analysis or review.

Descriptions of Some other Jurisdictions Current Policy

MASSACHUSETTS DOC

Massachusetts Definition of Serious Mental Illness ("SMI")

The term "Serious Mental Illness" shall be defined as the following:

a. Inmates determined by the Department's mental health vendor to have a current diagnosis or a recent significant history of any of the following types of DSM-IV-TR Axis I diagnoses:

(1) Schizophrenia (all sub-types)
(2) Delusional Disorder
(3) Schizophreniform Disorder
(4) Schizoaffective Disorder
(5) Brief Psychotic Disorder
(6) Substance-Induced Psychotic Disorder (excluding intoxication and withdrawal)
(7) Psychotic Disorder Not Otherwise Specified
(8) Major Depressive Disorders
(9) Bipolar Disorder I and II

For the purpose of this definition, the term, "recent significant history," shall be defined as a diagnosis specified above in section a (1)-a (9) within the past year upon discharge from an inpatient psychiatric hospital.

b. Inmates diagnosed by the Department's mental health vendor with other DSM-IV-TR Axis I disorders that are commonly characterized by breaks with reality, or perceptions of reality, that lead the individual to experience significant functional impairment involving acts of self-harm or other behaviors that have a seriously adverse effect on life or on mental or physical health.

c. Inmates diagnosed by the Department's medical or mental health vendor with Mental Retardation, a dementia or other cognitive disorders that result in a significant functional impairment involving acts of self-harm or other behaviors that have a seriously adverse effect on life or on mental or physical health.

d. Inmates diagnosed by the Department's mental health vendor with a severe personality disorder that is manifested by episodes of psychosis or depression, and results in significant functional impairment involving acts of self-harm or other behaviors that have a seriously adverse effect on life or on mental or physical health.

Clinical Guidelines for Assessment of Significant Functional Impairment

Factors for consideration when assessing significant functional impairment shall include the

following:

1. The inmate has engaged in self harm which shall be defined as a deliberate act by the inmate that inflicts damage to, or threatens the integrity of one's own body. Such acts include but are not limited to the following behaviors: hanging, self-strangulation, asphyxiation, cutting, self-mutilation, ingestion of a foreign body, insertion of a foreign body, head banging, drug overdose, jumping and biting.

2. The inmate has demonstrated difficulty in his or her ability to engage in activities of daily living, including eating, grooming and personal hygiene, maintenance of housing area, participation in recreation, and ambulation, as a consequence of any DSM IV-TR Axis I or Axis II disorder.

3. The inmate has demonstrated a pervasive pattern of dysfunctional or disruptive social interactions including withdrawal, bizarre or disruptive behavior, etc. as a consequence of any DSM IV-TR Axis I or Axis II disorder.

Clinical Factors Upon Initial Screening or Ongoing Assessment That May Lead to a Temporary Delay in Placement or Temporary Removal from a SMU/DDU

1. The inmate is assessed as being actively suicidal.
2. The inmate has engaged in a recent serious suicide attempt.
3. The inmate appears acutely psychotic.

In all of the above scenarios, the inmate will be placed on a mental health watch. They will be assessed to determine if they meet the criteria for transfer to an inpatient psychiatric hospital. They will additionally be assessed to determine if they meet the criteria to be considered SMI.

4. The inmate has a medical condition requiring placement in an infirmary of Health Services Unit setting.

In the case that an inmate with an SMI designation receives a long-term segregation sanction in the Departmental Disciplinary Unit (DDU) the inmate will be placed in either the Behavior Management Unit (BMU) or the Secure Treatment Program (STP). In the case that there is a wait list the inmate will receive "enhanced services."

Schedule of "enhanced services" (Mental Health Contact and Additional Recreation) for inmates in segregation with a designation of SMI or mental health classification of MH-4

MH Classification:	# of out of cell structured contacts per week	Any additional information:
MH4 in segregation under 30 days	2 out of cell structured contacts	2 additional hours of out of cell recreation/leisure time
SMI in segregation under 30	1 out of cell structured	Opportunity to speak with

days	contacts	MH staff 5 days per week
MH4 in segregation over 30 days	4 out of cell structured contacts	4 additional hours of out of cell recreation time
SMI in segregation over 30 days	1 out of cell structured contacts	Opportunity to speak with MH staff 5 days per week

MH Classification:	**# of out of cell structured contacts per week**	**Any additional information:**
MH4 in DDU under 30 days	2 out of cell structured contacts	2 additional hours of out of cell recreation/leisure time
SMI in DDU under 30 days	2 out of cell structured contacts	2 additional hours of out of cell recreation/leisure time
MH4 in DDU over 30 days	4 out of cell structured contacts	4 additional hours of out of cell recreation time
SMI in DDU over 30 days	2 out of cell structured contacts	2 additional hours of out of cell recreation time

GEORGIA DOC

The below is the GDOC SOP definition for "Serious Mental Illness" as is found in the MH SOP on the subject of "Mental Health Evaluation".

"Serious Mental Illness: A substantial disorder of thought or mood that significantly impairs judgment, behavior, capacity to recognize reality or cope with the ordinary demands of life within the correctional environment and is manifested by mental suffering or disability. Serious mental illnesses include, but are not limited to, major mood disorders (i.e., bipolar disorder, major depression), psychotic disorders (i.e., schizophrenia, schizoaffective disorder), and any disorders involving suicide attempts, suicidal plans, suicidal thoughts or self-injurious behavior."

By the above definition, we have offenders both in General Population and in the Supportive Living Units who could fall under the criteria of having a "Serious Mental Illness".

When housed in General Population, they are seen once a month by their assigned MH Counselor and every 90 to 120 days by their assigned Upper Level Provider (Psychiatrist/APRN if on psychotropics, Psychologist if not on psychotropics).

These are individuals who are classified as being Level II MH and are capable of interacting appropriately in General Population housing.

The next level of MH (MH Level III) is when an individual is not able to interact appropriately in General Population (due to MH related concerns) and requires greater structure to their daily environment. These offenders are housed in a Supportive Living Unit which consists of 2 man cells (usually 25 cells per unit). These offenders are seen 2 times a month by their assigned MH Counselor and every 60 days by their assigned Upper Level Provider.

For those offenders who are unable to tolerate a cell mate (due to the nature and degree of their MH symptomology), they are made a MH Level IV and, while residing in a Supportive Living Unit, are housed in one-man cells. These offenders are seen on a weekly basis by their assigned MH Counselor and every 30 days by their assigned Upper Level Provider.

In addition to individual MH appointments with their assigned clinicians, all MH offenders are eligible for a variety of Therapeutic and/or Psychoeducational groups based on their MH Level and Individualized Comprehensive Treatment plans.

Every offender on the GDOC MH caseload has a MH file that is maintained and contains all treatment related documentation; this file is kept in the facility's MH offices and transfers with them should the offender be transferred to a different facility.

MARYLAND DPSCS

SEVERELY MENTALLY ILL
PRIORITY POPULATION DEFINITION - ADULTS (SMI)

INCLUDED DIAGNOSES (DSM-IV):

295.10 Schizophrenia, Disorganized Type
295.20 Schizophrenia, Catatonic Type
295.30 Schizophrenia, Paranoid Type
295.40 Schizophreniform Disorder
295.60 Schizophrenia, Residual Type
295.70 Schizoaffective Disorder
295.90 Schizophrenia, Undifferentiated Type (*includes ICD-9 diagnoses 295.10-295.95)
296.33 Major Depressive Disorder, Recurrent, Severe Without Psychotic Features
296.34 Major Depressive Disorder, Recurrent, Severe With Psychotic Features
297.1 Delusional Disorder
298.9 Psychotic Disorder, NOS
301.22 Schizotypal Personality Disorder
301.83 Borderline Personality Disorder
296.43 Bipolar I Disorder, Most Recent Episode, Manic, Severe Without Psychotic Features
296.44 Bipolar I Disorder, Most Recent Episode, Manic, Severe With Psychotic Features
296.53 Bipolar I Disorder, Most Recent Episode, Depressed, Severe Without Psychotic Features
296.54 Bipolar I Disorder, Most Recent Episode, Depressed, Severe With Psychotic Features
296.63 Bipolar I Disorder, Most Recent Episode, Mixed, Severe Without Psychotic Features
296.64 Bipolar I Disorder, Most Recent Episode, Mixed, Severe With Psychotic Features
296.80 Bipolar Disorder, NOS
296.89 Bipolar II Disorder

-and-

In order to be included in the PRIORITY POPULATION, individuals must meet the target diagnostic criteria and meet the following functional limitations:

Serious mental illness is characterized by impaired role functioning, on a continuing or intermittent basis, for at least two years, including at least three of the following:

- Inability to maintain independent employment,
- Social behavior that results in interventions by the mental health system,
- Inability, due to cognitive disorganization, to procure financial assistance to support living in the community,
- Severe inability to establish or maintain a personal support system, or
- Need for assistance with basic living skills.

The diagnostic criteria may be waived for the following two conditions:

1. An individual committed as not criminally responsible who is conditionally released from a Mental Hygiene Administration facility, according to the provisions of Health General Article, Title 12, Annotated Code of Maryland. Or
2. An individual in a Mental Hygiene Administration facility with a length of stay of more than 6 months who requires RRP services, but who does not have a target diagnosis. This excludes individuals eligible for Developmental Disabilities services.

The care Maryland provides for SMI in GP and Seg:

- All inmates are maintained on our caseload once diagnosed with SMI, even if they refuse treatment
- They are seen at a minimum of every 90 days by psychiatry
- Psychology staff see the inmates once every month
- When the inmate is being released from incarceration an extensive release planning process is initiated and re-entry staff work closely with the state's re-entry staff
- Currently we are working with the state to determine in an inmate with a SMI diagnosis can receive modified segregation time for infractions that may have occurred due to MH illness
- Any inmate that is housed in segregation is seen at a minimum of once every week by a mental health staff member during walking seg rounds. If any inmate is found to be decompensating, they are immediately referred to psychiatry or even transferred to an inpatient MH unit (if necessary)
- All inmates with a SMI diagnosis are maintained on a database to ensure all are followed-up and seen timely helping to eliminate any being allowed to "fall through the cracks"

MICHIGAN DOC

SMI definition: Michigan had a definition previously but moved to a broader definition which states:

"Mental Disability - Any of the following mental conditions:

1. Mental illness, which is a substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality, or the ability to cope with the ordinary demands of life.
2. Severe chronic brain disorder, which is characterized by multiple cognitive defects (for example, memory impairment resulting from a medical condition or brain injury due to trauma or toxins).
3. Developmental disorder, which usually manifests before the age of 18 years and is characterized by severe and pervasive impairment in several areas of development (for example, autism; retardation)."

Treatment requirements

Counseling Services and Intervention
QMHP provides mental health services as directed by treatment plan. Treatment plans should be specific in the total number of visits that will occur.
Prisoner is not on medication and no psychiatric provider contacts.

OREM (Outpatient in remission)
QMHP meets with prisoner to provide case management services no less than every 90 days.
Psychiatric provider meets with prisoner every 90 days for medication renewals.
Crisis management as needed.

Outpatient
QMHP meets with prisoner to provide case management services no less than monthly.
Psychiatric provider meets with prisoner every 90 days for medication renewals. Thirty days if there's a medication change.
Crisis management as needed.
Treatment plan reviews occur every 6 months.

Residential Treatment Program
QMHP meets with prisoner every two (2) weeks to review and coordinate services. There are various programs/groups that the prisoner attends. These are biweekly or monthly.
Psychiatric provider meets with prisoner every 90 days for medication renewals. Thirty days if there's a medication change.
Team review meetings are held at least every six (6) months, unless clinical status requires earlier review.

Acute Care
QMHP meets with prisoner two (2) times a week to review and coordinate services.
Psychiatric provider meets at least every seven (7) days for psychotropic medication renewals.

Team review meetings are at least every seven (7) days, unless clinical status requires earlier review.

Rehabilitative Treatment Services
QMHP meets with prisoner every two (2) weeks to review and coordinate services.
Psychiatric provider meets at least every thirty (30) days for all psychotropic medication renewals.
Team review meetings are held at least every 60 days, unless clinical status requires earlier review.

Crisis Stabilization Program
Treatment team meets with prisoner daily and implements approved Treatment Plan.
QMHP meets with prisoner daily to review and coordinate services
Psychiatric provider meets with prisoner, completes assessment and reviews medication daily.

Adaptive Skills Residential Program
QMHP meets with prisoner every two (2) weeks to review and coordinate services.
Psychiatric provider meets at least every ninety (90) days for psychotropic medication renewals.
Team review meeting is held at least every six (6) months, unless clinical status requires earlier review.

Special Alternative Incarceration (boot camp)
Mental health programming offered at SAI is limited. A QMHP is assigned part-time and commits about 4 hours twice a week for brief individual and group therapy focused on adjustment difficulties and to provide evaluations as requested by nursing or custody. Prisoners arrive with psychotropic medication and renewals to sustain them while in the program. There is limited psychiatric involvement.

Prisoners in segregation
Rounds are conducted at least weekly in order to identify segregation prisoners who are manifesting symptoms of mental disorder or deterioration of mental status.
Prisoners identified as mentally disabled are closely followed by the OPT team. Safe and secured observation rooms are used to house and protect suicidal/self-injurious prisoners.
Each day mental health reviews reports to identify prisoners newly placed in segregation who have a mental disability. These prisoners are seen no later than one business day after identification. If it is determined that the prisoner is in need of inpatient treatment, the prisoner is released from segregation and transferred as soon as possible.

A. **Definition of Serious Mental Illness will include:**

1. Inmates determined by the Psychiatric Review Team (PRT) to have a current diagnosis or a recent significant history of any of the DSM-IV-TR diagnoses:
    a. Schizophrenia (all subtypes)
    b. Delusional Disorder
    c. Schizophreniform Disorder
    d. Schizoaffective Disorder
    e. Brief Psychotic Disorder
    f. Substance-Induced Psychotic Disorder (excluding intoxication and withdrawal)
    g. Psychotic Disorder Not Otherwise Specified
    h. Major Depressive Disorders
    i. Bipolar I and II

    NOTE: For the purpose of this definition, the term "recent significant history" shall be defined as "currently in existence or within the preceding three months."

2. Inmates diagnosed by PRT with DSM-IV-TR disorders that are commonly characterized by breaks with reality, or perceptions of reality, that lead the individual to experience significant functional impairment involving acts of self-harm or other behaviors that have a seriously adverse effect on life or on mental or physical health.

3. Inmates diagnosed by PRT with Intellectual Disability, a dementia or other cognitive disorders that result in a significant impairment involving acts of self-harm or other behaviors that have seriously adverse effect on life or on mental or physical health.

B. **Clinical Guidelines for Functional Impairment**

Factors for consideration when assessing significant functional impairment shall include the following:

1. Whether the inmate has engaged in self-harm which shall be defined as a "deliberate, intentional, direct injury of body tissue with or without suicidal intent. Such acts include but are not limited to the following behaviors: hanging, self-strangulation, asphyxiation, cutting, self-mutilation, and ingestion of a foreign body, insertion of a foreign body, head banging, and drug overdose, jumping and biting themselves.

2. The inmate has demonstrated significant difficulty in his or her ability to engage in activities of daily living, including eating, grooming and personal hygiene, maintenance of housing area, participation in recreation, and ambulation.

3. The inmate has demonstrated a pervasive pattern of dysfunctional or disruptive social interactions including withdrawal, bizarre or disruptive behavior.

C. Intellectual Disability

Inmates scoring 70 or below on the BETA will be administered an individual IQ test (WAIS 4) at the parent facility. If their full scale IQ is 70 or below then a measurement of adaptive behavior including the following will be assessed:

1. Conceptual skills – language and literacy; money, time and number concepts; and self-direction.

2. Social Skills – interpersonal skills, social responsibility, self-esteem, gullibility, naiveté, social problem solving, and the ability to follow rules/obey laws and to avoid being victimized.

3. Practical Skills – activities of daily living (personal care), occupational skills, healthcare, travel/transportation, schedules/routines, safety, use of money, use of telephone.

NOTE: An assessment to determine if the disability originated during the developmental period should be conducted to establish if the intellectual and adaptive deficits were present during childhood or adolescence. This assessment should include corroborative information obtained from complementary reliable and valid sources, which reflect functioning outside of the prison setting. Additional factors to take into account include the community environment typical of the individual's peers and culture, linguistic diversity, cultural differences in the way people communicate, move and behave. Assessments must also assume that limitations often coexist with strengths, and that a person's level of life functioning will improve if appropriate personalized supports are provided over a sustained period.

PHILADELPHIA PS (JAIL)

SMI diagnoses are determined by the Philadelphia Office of Mental Health in order to facilitate diagnostic and treatment consistency in our geographic locale. The general categories are: Psychosis NOS, all forms of bipolar, all forms of Major Depressive Disorder, all forms of schizophrenia, and borderline personality disorder.

All inmates with a current SMI diagnosis are put on the behavioral health (BH) caseload. All BH caseload inmates must have a treatment plan completed in the following time frames:

- BH inpatient unit - within 72 hrs of admission to the unit, then updated at least every 7 days
- Transitional Unit - within 5 days of being placed on the unit and then updated within 30 days, and then updated every 60 days after that.
- General Population - within 14 days of being placed on the caseload, then updated within 30 days, and then every 60 days after that.

Inmates on the caseload also are seen at least every 45 days by the social worker or prescriber. If the inmate is on psychotropic meds, are to be seen by the prescriber every 90 days.

Also, inmates who are SMI are to be seen within 4 hours for segregation clearance, prior to being placed in segregation. Inmates who are on the caseload but are not SMI can be placed on the segregation unit and then cleared within 24 hrs.

So, treatment services are more related to BH caseload status and whether the inmate in on a BH unit or in GP, rather than SMI status. The only care piece that is different for SMI inmates is related to the segregation clearance process.

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