Raising the Bar

Improving resources for care and custody of
the severely functionally impaired
offender population of Vermont

Submitted to

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Executive Summary

Recent developments in the conceptualization of human services in Vermont, particularly for the lives of mentally ill Vermonters, has created an expanded mission for mental health care for the Department of Corrections, raising the goal and standards of housing and treatment within VDOC, and developing new standards and methods of service in our local communities. New missions require a re-assessment of VDOC's capacity to meet these challenges. A review of currently and recently incarnated inmates with Severe Functional Impairment identified forty-seven who would be likely to significantly benefit from resources different from those currently available within Vermont Department of Corrections facilities. Their specific resource needs include locations and staff for:

1. Acute stabilization
2. Intensive and integrated pharmacological and behavioral treatment
3. Dedicated sheltered or semi-sheltered housing
4. Dedicated high security housing

This same population needs options to support their re-integration into our civil communities, once their incarceration is no longer required.

The study concludes that more centralized treatment capacity within Corrections, strengthened de-centralized treatment in our communities, and a new level of logistical support are all needed in order to achieve the goal of better lives during incarceration and reduced recidivism for our mentally ill offenders. Some possible means to these ends are suggested.

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Introduction

Among state correctional systems, Vermont's level of commitment to caring for mentally ill offenders is uniquely high, and the state's small size means that mentally ill offenders are often personally known to the care and custody staffs. Most are, in reality, our classmates, our cousins, and our neighbors. But the small size of the correctional system, the age and design of its facilities, the distribution of inmates among six separate and widely dispersed locations, and the constant movement of population from one site to another create very substantial hurdles to providing ideal care and custody to those with the gravest mental disabilities. These same factors complicate the transition of individuals from incarceration to the community.

But while mental health delivery in the community and in corrections have the same goals, they face very different challenges. No one comes into Corrections willingly. The correctional population as a whole is more impulsive, more emotionally volatile and, by definition, less able to adopt common rules of socially appropriate behavior than those who do not become incarcerated. This is true of both mentally ill offenders and non-mentally ill offenders. The safety of all offenders and staff within jails and prisons relies first and foremost on order and the enforcement of rules in a way that is perceived by all to be both clear and consistent. So, the necessary practice of following all rules can conflict with efforts to teach self management and improve personal judgment and independent decision making.

Nevertheless, corrections and community are a circulating system. Virtually everyone who enters corrections will return to the community, and what happens in each place will affect the likelihood of success or failure in the other place. So community and correctional systems must connect in a positive , mutually supportive manner, whatever their differences.

The goals of correctional mental health have changed greatly over the last fifty years. Only a few decades ago the main task of correctional mental health was simply to "manage", as well as possible, the special threats posed by psychotic inmates. This was supplanted successively by the goal of preventing the seriously mentally ill from getting worse, then of helping people get better. Vermont and other states now must step up to an even higher goal: helping to create better lives for mentally ill offenders in a way that helps them serve

incarcerated time safely and productively and return to the communities with a better chance of avoiding future incarceration, and doing so while maintaining public safety in our communities and personal safety and order in our prisons and jails. The bar has indeed been raised.

Each step upward in correctional mission requires different environments and treatments. So at each step up we must assess whether facilities and methods appropriate to earlier concepts are suitable to the new needs and goals.

This study is an attempt to make such an assessment. Its focus is not on whether individuals "should" come to jail or prison. Nor is it an attempt to specify the type, quantity, or location of community facilities. Rather, it looks at what it takes to provide the least restrictive environments and most effective treatment for mentally ill offenders once they are here. [1]

And while Vermont is committed to providing appropriate medical and mental health treatment for all offenders, this study specifically focuses on the population designated as "severely functionally impaired". All state correctional systems recognize a group of severe mental illnesses, roughly defined as psychotic disorders and severe instances of depression and bipolar disorders. In Vermont this concept is extended to include certain severe instances of post traumatic stress disorder, mental retardation, developmental disabilities, traumatic brain injury, advanced dementia and specific personality disorders.

Approximately six to seven percent of all VDOC inmates are designated Severely Functionally Impaired (SFI) by the Health Services Division of DOC. Because the "safety net" is cast broadly, many individuals are designated SFI who are at risk solely by virtue of their underlying diagnoses. The result is that most SFI designated inmates are functioning at adequate or better levels. However, others are not. It is this latter group that formed the basis of this study.

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[1] Shortly after the beginning of this study, the Vermont State Hospital, and indeed the entire human services network of the state, experienced unprecedented strain and disruption as a result of Hurricane Irene. The VSH facility, located in the state office complex in Waterbury, Vermont, was closed and VSH patients were dispersed to multiple sites around the state, including temporary but extended housing within a designated unit of DOC. As of this writing VSH is accepting no new admissions. Things are not as they were, and some treatment possibilities available to VDOC inmates even a few months ago are now gone. As the service framework for serving the mentally ill Vermonters is reconstructed, the present study becomes even more relevant. It is a time of challenge and opportunity.

What are the Problems?

This study focuses particularly on inmates who are designated SFI and whose functioning and/or daily living is not well served by current jail and prison facilities in Vermont. Among them we may speak, in general terms, of a subset of four overlapping groups:

1. Inmates with moderate to severe psychotic conditions who exercise their right to refuse treatment (pharmacological and/or behavioral). When this is the case, and the inmate's behavior is unpredictably violent, DOC facilities have little choice but to house such inmates away from the general population and to restrict their interactions with others who could be harmed.
2. Inmates who are persistently self harming and so must be housed where they can be continually seen and monitored and where they have no access to the wide variety of things with which they could harm themselves. Even with the most compassionate of treatment, incarceration can exacerbate these impulses and lead to more extreme attempts. Providing constant observation of such inmates "24/7 – 365" is an enormous expense, and strains the provision of security staff for other essential duties that keep all inmates and staff safe. Inevitably, their access to programs and recreation are curtailed.
3. Inmates who, although they adhere to treatment, are still unable to interact safely with other inmates or participate productively in restorative justice programs. They can become overwhelmed and unpredictable when attempting to cope with the intense social and sensory environment of prisons. Incarceration can exacerbate these symptoms. An overlapping group consists of SFI inmates whose limitations invite predatory behavior by other inmates. Such persons may adopt extreme forms of self-isolation, or required administrative segregation for their own protection, with regrettable restrictions on their activities.
4. Inmates suffering from dementia or other organic brain conditions who are unable to conform to the necessary routines and self-discipline of daily life in incarcerations, and/or provide adequate self care related to nutrition, hygiene, or basic medical care. This group is increasing and will continue to do so as the baby boom and sentencing mathematics impact the correctional system.

What are the Goals?

The Health Services Division of VDOC hopes that the current discussion can lead toward the development of care facilities for inmates such as these that

- Reduce the necessity of restrictive housing including administrative segregation and "therapeutic management" cells.
- Improve daily functioning more rapidly through more intensive treatment.
- Reduce the necessity for use of force and the restraints common (and necessary) in jails and prisons.
- Use state resources efficiently by reducing the need for detailing correctional officers for one to one constant observation of unstable inmates.
- Provide settings and personnel appropriate to the delivery of intensive personal care.

Process of the Study

Two decisions made at the outset particularly guided this study. First, a case study methodology was adopted using as its subjects all currently incarcerated inmates who were designated SFI (approximately 130 at the time of the study). Second, the study question was stated as: "Among this group, who might be more effectively treated, and less restrictively housed, in settings other than DOC's current general population facilities, if such were available?"

First, the diagnoses, treatment records, and behavioral histories of each of the currently incarcerated 130 SFI inmates were reviewed and discussed by the study group composed of all current psychiatric providers, the Director of Psychiatry, the Director of Behavioral Health, the Chief of Mental Health Services, and the Director of the Health Services Division (Interim). This resulted in the identification of forty seven inmates of special interest. For each of these inmates a thumbnail psychiatric synopsis was developed, along with a summary of incident reports, disciplinary infractions, self harm, and other significant behavioral events.

Using these profiles, a further discussion then divided the needs of this group into four (overlapping) categories. Rather than basing categorization on diagnosis, the assessment was specifically of clinical opportunities, treatment or environmental needs.

Inmate Profiles

This study took as its starting point those inmates designated Severely Functionally Impaired in mid-July 2011. The "SFI list" changes daily as people leave and enter incarceration, but has average 130 in FY 2010-2011. SFI individuals were selected for inclusion in this study based on the personal knowledge of the psychiatric and other behavioral health staff. Nominations to the list were also solicited from Superintendent Mark Potanas of the Southern State Correctional Facility, and his administrative and case management staff. Forty-seven inmates were identified for further examination (that is, about one third of all such inmates). For each of these it was felt that another setting or a different array of resources might significantly affect his or her functioning and/or quality of life within corrections. [2]

[2] Obviously, many changes would affect the quality of life within incarceration, and this standard is very subjective. Here, however, we refer to changes that would bring the quality of life for these specific mentally ill or severely impaired offenders closer to the quality of life available to other inmates.

Later sections describe the general categories of resources that are needed in order to better serve this group, and its successors, within VDOC. But each individual is described below in a thumbnail sketch. This was done not only to assist the thoughtful reader in assessing our recommendations, but because these are the human stories that lie below the numbers.

1. [redacted]-y/o male with primary diagnosis of *schizophrenia, paranoid type.*
    a. Has prominent thought disorder with loose associations, paranoid delusions and auditory hallucinations that are abated but not eliminated with medication. Though he is largely adherent to his medication he remains quite symptomatic. As a result, he is unable to interact fully or be housed with other inmates (i.e. cannot share a cell). He tends to be isolative, easily overwhelmed and unpredictable when attempting to cope with the intense social demands of the correctional environment.

2. [redacted]-y/o female with primary diagnosis of *borderline personality disorder.*
    a. Has long history of self-mutilation, head banging and substance abuse to allay anxiety. Has carried out frequent episodes of violence toward others. She tends to respond to the climate on the unit on which she lives. Is currently receiving trial of Clozaril, which looks promising at the moment. Poor impulse control and aggressive stance result in brief but frequent disciplinary removals from general population.

3. [redacted]-y/o male with primary diagnosis of *borderline personality disorder* (has also carried Tourette's, Asperger's and ADHD in the past).
    a. Long history of getting into difficulty with law enforcement; often a management problem in corrections. Impulsive, chaotic, low normal intelligence. Can be disruptive in general population, and does not follow through with reduced sanctions for frequent rule infraction, resulting in occasional but brief removals from general population.

4. [redacted]-y/o male with primary diagnoses of schizotypal personality disorder (r/o schizophrenia), learning disability.
    a. He tends to be non-adherent with medication and has been assaultive on numerous occasions. He basic demeanor is to be withdrawn. He tends to be isolative easily overwhelmed and

unpredictable when attempting to cope with the intense social demands of the correctional environment.

5. [redacted]-y/o female with primary diagnosis of *anxiety disorder NOS* and *cluster B personality disorder.*

    a. She is maintained on low-dose anti-psychotics, which seem to minimize her impulsivity; tends to be a sexual predator. Can be disruptive in general population, with occasional assault on staff. As a result, she must at times be housed in therapeutic management cells, or in disciplinary restriction, as she becomes unable to interact fully and safely with other inmates and staff.

6. [redacted]-y/o male with primary diagnoses of *alcohol dependence, episodic delirium, and major depression.*

    a. He can become quite disorganized and disoriented with delirium. He is fairly fragile and is not well suited to a corrections environment. He tends to be isolative easily overwhelmed and unpredictable when attempting to cope with the intense social demands of the correctional environment. Must be housed away from general population due to inability interact predictably and safely with other inmates.

7. [redacted]-y/o male with primary diagnosis of *polysubstance abuse disorder, ADHD, PTSD* and *borderline personality disorder.*

    a. He is very intelligent and tends to indulge in self-injurious behaviors (often punching himself repeatedly in the face or head banging) and threats to staff. He must necessarily be housed much of the time where they can be continually seen and monitored and where he has reduced access to the wide variety of implements with which he might harm himself.

8. [redacted]-y/o male with primary diagnosis of *PTSD.*

    a. Was psychotic upon admission; remains withdrawn and anxious, and attempts to control aggression through isolation. Episodes of acute depression and suicidal ideation. Adherent with treatment. He tends to be easily overwhelmed and unpredictable when attempting to cope with the intense social interactions of the correctional

environment, including the implied and open aggression of other inmates. Improves with high structure and low stimulation.

9. [redacted]-y/o male with primary diagnoses of *polysubstance abuse disorder, borderline character organization.*

    a. Tends to accumulate an inordinate number of medications; very anxious much of the time. Reports of serious self-injury in the community; repeated verbal threats and gestures of self-injury while incarcerated. Tends to do better with predictable, stimulating structure. NOTE from ML: unclear whether SFI designation is appropriate for this individual. Self-harm history in the community may be primarily related to substance abuse, DOC record and dx do not support SFI designation.

10. [redacted]-y/o male with primary diagnosis of *bipolar disorder* and *generalized anxiety disorder, Asperger's disorder.*

    a. Generally tends to be fairly isolative; considered to be vulnerable in general population, with resulting restriction of activities within general population.

11. [redacted]-y/o male with primary diagnosis of personality disorder, reported history of traumatic brain injury.

    a. Engages in aggressive behaviors toward self and others, often of an "outrageous" character, such as fire setting and insertion of plumbing items into his body cavities, attacking staff. Persistently disruptive of correctional operations. Noncommittal engagement in treatment, resides primarily in therapeutic management environments away from the general population and its activities. Intense case management is likely needed to restore adequate functioning during what will be a long incarceration.

12. [redacted]-y/o male with primary diagnoses of *mild mental retardation, bipolar disorder, PTSD, ADHD, borderline personality disorder.*

    a. Persistently self-harms by cutting himself, inserting objects such as pens and other implements into his body and often requires close supervision. He has limited improvement with medication, but has inconsistent compliance. Very limited capacity to interact with other inmates constructively, and is easily disrupted by family interactions

that result in intense anger and feelings of abandonment. Although he has had moderate periods of residence in general population in the past, this has not been the case in recent years, resulting in long periods of residence in therapeutic management confinement.

13. [redacted]-y/o male with primary diagnoses of *intermittent explosive disorder* and *developmental delay.*

    a. He does not take medication and engages in mild self-harm, inappropriate sexual activities, and can become aggressive. May be the subject of exploitative behaviors by other inmates.

14. [redacted]-y/o male with primary diagnoses of *schizophrenia, paranoid type* and *antisocial personality disorder.*

    a. He experiences persistent and florid paranoid delusions and has severely assaulted and injured correctional staff under the influence of these delusions. He does not take medication. He will be released to the community in less than three years and poses an extreme threat to public safety unless he is more successfully treated before that time. Within corrections he requires consistent supervision and must be administratively segregated from open population situations.

15. [redacted]-y/o male with history left temporal distribution stroke 15 years ago and new onset behavioral changes approximately 3 years ago. Current diagnosis of dementia, r/o ASPD.

    a. He is housed either in the infirmary or in therapeutic restriction housing, exhibiting catatonic-like behavior interspersed with aggressive, sexualized interactions with nursing. He requires nursing care for personal functions including nutrition and hygiene. He refuses medication trials that might lead to improvement. He has developed the beginnings of decubitus ulcers on several occasions over his buttocks and has developed raw, red areas over his legs due to repeated kicking and banging. He often talks nonsensically but can be reasonably clear at other times.

16. [redacted]-y/o male with military experience with primary diagnoses of *PTSD, alcohol dependence, depression NOS, anxiety disorder NOS.*

a. He has multiple DWI convictions and recently drove his car into a bridge abutment. He has periods of intense suicidality. He is generally not a management issues in corrections, with the exception of his periods of intense suicidality. He reports having difficulty with the noise levels and continues to have difficulty sleeping despite adherence to his medication regimen. He manages correctional environment by isolating himself and so participates very little in activities other than common chow line

17. [redacted]-y/o male who has a guardian and a primary diagnoses of *mental disorder due to traumatic brain injury* and *alcohol abuse.*

a. Prior to his incarceration he was part of specialized residential program but was released due to "non-compliance with program planning". He has a history of impulsivity and physical aggressiveness. He is not adherent to treatment offered. He has had difficulty being maintained in general population because of his impulsivity and difficulty with interpersonal interactions.

18. [redacted]-y/o male with primary diagnosis of *schizoaffective disorder, bipolar type, untreated.*

a. He has chronic paranoid delusions and a disorganized thought form. He remains unwilling to adhere to treatment offered. He does not interact with other inmates or staff except when agitated, resides in general population but cannot be housed with a roommate due to extreme hygiene problems.

19. [redacted]-y/o with a primary diagnosis of *bipolar disorder, manic type.*

a. Adherence to treatment is intermittent. Charges plausibly related to manic states. He is generally cooperative but can experience and exhibit severely manic behaviors that interfere with successful correctional adjustment, ordinary social relationships, and stable housing within facilities.

20. [redacted]-y/o with a primary diagnosis of *traumatic brain injury, psychotic disorder with depression.*

a. Former construction worker with no psychiatric history incurred a serious head injury at work with resulting coma for 3 weeks and subsequent anxiety, then depression and now frank paranoia. He is

incarcerated as a detentioner resulting from actions prompted by his paranoid delusions. He is intermittently adherent to treatment, though largely not. He refuses to move from administrative segregation due to paranoid ideation, with consequent severe reduction of opportunities for programming and other ordinary facility activities.

21. [redacted]-y/o male with primary diagnoses of *personality change due to traumatic brain injury, alcohol dependence, cannabis dependence.*

    a. Successful in the community prior to a severe automobile accident and resulting brain injury, his charges of disorderly conduct stem from his impulsivity and substance abuse. He is frequently re-incarcerated for violations of probation. He was found "marginally competent to stand trial". In corrections, he has difficulty adhering to expectations and exhibits impulsivity resulting in conflict with correctional officers. Self-harm ideation is rarely acted upon, but can be extremely serious when he does follow through.

22. [redacted]-y/o male with a primary diagnosis of *PTSD.*

    a. He has nightmares of his abuse and is easily triggered, becoming agitated and sometimes violent. Refuses medication; uses regular contact with one particular mental health worker. Correctional environment contributes greatly to his vigilance, agitation and occasional violence.

23. [redacted]-y/o male with primary diagnoses of borderline intellectual functioning, *cluster B personality disorder with* borderline *features predominating.*

    a. Prominent history of very high lethality self-injurious behavior resulting in prolonged (over 1 year) use of constant observations. Principal self-injury routes are cutting and insertion of foreign matter into his wounds. Explosive episodes also frequently require use of restraints. Is intermittently adherent to treatment offered; historically has limited response to medication.

24. [redacted]-y/o male with primary diagnoses of *psychosis NOS, sexual sadism, transvestic fetishism and antisocial personality disorder.*

    a. Has a history of violence starting at an early age with severe assaults and attempted rapes. He reports onset of violent behavior

associated with intrusive thoughts and "voices" telling him to harm others; appears that there is some correlation of the intensity of this experience diminishing with antipsychotic medication. Is a sexual predator - including sexual assault on staff - unless confined to settings away from general population. Recent actions suggest he may also seek "suicide by cop. Has been unsuccessful in the community, and is likely to spend most of his lifetime in prison.

25. [redacted]-y/o male with primary diagnoses of *schizophrenia vs. psychosis due to a general medical condition, polysubstance abuse, HIV, dementia secondary to HIV.*

    a. Is generally adherent to treatment that moderates but does not extinguish impulsive dysregulation, assaults on other inmates, and self-harm. Can become profoundly suicidal for discrete periods of time. Periods of adequate general population adjustment are punctuated by repeated brief episodes of disciplinary segregation and somewhat longer periods of therapeutic removal from general population environments.

26. [redacted]-y/o male with primary diagnoses of *polysubstance abuse and dependence, ADHD, intermittent explosive disorder, borderline personality disorder; borderline intellectual functioning.*

    a. Generally adherent with medication with fair to good response; amenable to programming but intermittently compliant. He is persistently impulsive and explosive, with repeated assaults or threatened assaults on staff, minor self-injury, deliberate destruction of property, resulting in alternation between therapeutic restriction and administrative segregation.

27. [redacted]-y/o male with primary diagnosis of *schizophrenia, paranoid type vs. psychosis NOS, alcohol abuse/dependence.*

    a. Non-adherent to treatment; can be assaultive. He is often impulsive and explosive. May easily become victim of sexual harassment or other forms of inter-inmate exploitation. Difficulty abiding by ordinary rules communal living and safe facility management.

28. [redacted]-y/o male with primary diagnosis of *schizoaffective disorder, manic type.*

    a. Found not competent to stand trial but remains in custody. Non-adherent with medication. He can be seriously assaultive,

inappropriately sexual acts toward other inmates; cannot be routinely housed in general population.

29. [redacted]-y/o male with primary diagnosis of *schizoaffective disorder, borderline personality disorder.*

    a. Intermittently adherent with treatment. Regularly disruptive of orderly operation of correctional facilities; intermittent impulsive homicidal, repetitive non-suicidal cutting and other minor self-injury.

30. [redacted]-y/o female with primary diagnoses of *major depressive disorder with psychotic features in temporary remission.*

    a. Adherent to pharmacological but can become profoundly depressed and regressed. Responds well to ongoing therapeutic relationships. Serving very long sentence.

31. [redacted]-y/o female with primary diagnosis of *major depressive disorder, recurrent, borderline personality disorder.*

    a. Chronic suicidality; limited responsiveness to medication management. Impulsive behavior, with repeated self-harm comments and gestures while in corrections, though without serious injury. Has responded to DBT to some extent in the past. Must frequently be housed away from general population.

32. [redacted]-y/o male with primary diagnosis of *schizophrenia vs. autistic spectrum disorder*

    a. Multi decade sentence. Despite indication of history of responding to antipsychotic medication in the community; refuses medication in corrections. History of explosive anger and violent assaults within corrections and of persistent non-aggressive inappropriate sexual behavior. Once considered untreatable, he has made significant progress over the past two years and is capable of limited general population residence. However, his ability to handle the intense social and sensory stimulation of corrections living severely limits his ability to live a normal correctional life.

33. [redacted]-y/o male with primary diagnosis of *schizoaffective disorder.*

a. Has brittle diabetes, which complicates the concomitant treatment of psychosis and diabetes. Responds well to current medication regimen. He is at risk of exploitation by other inmates within the general population, and frequently engages in self-harm threats or mild self-harm.

34. [redacted]-y/o male with primary diagnoses of *cognitive disorder NOS, pervasive developmental disorder.*

a. He is exhibiting a gradual but progressive cognitive decline and is considered to be vulnerable in general population. He is easily overwhelmed when attempting to cope with the intense social demands of the correctional environment.

35. [redacted]-y/o female with primary diagnoses of *schizophrenia and polysubstance abuse.*

a. Refuses medication and is chronically delusional. Very bright and affable which bodes well prognostically were she willing to receive treatment. However, she is frequently cited for introducing contraband into correctional facilities with consequent frequent but brief disciplinary segregations.

36. [redacted]-y/o female with primary diagnoses of *PTSD, major depression and polysubstance abuse.*

a. Was allegedly violently raped while in the community which triggered history of childhood sexual trauma. Was profoundly suicidal and required constant observation for over 3 months; would instantly attempt to asphyxiate herself if given the chance. She was persistently self-harming, and needed to be housed where she was continually seen and monitored and where she had no access to the wide variety of implements with which they might harm themselves. Has recently returned to incarceration with resumption of these behaviors. She responded positively to intensely structure program of behavioral treatment beyond the resources of her current placement.

37. [redacted]-y/o female with primary diagnoses of *schizophrenia and polysubstance abuse.*

    a. Had been hearing voices telling her to kill herself for years; responded well to Clozaril. Can be assaultive of other inmates.

38. [redacted]-y/o female with primary diagnoses of *schizoaffective disorder, PTSD and polysubstance abuse.*

    a. Fragile, myriad symptoms that respond somewhat to medication. Symptoms of psychosis, depression exacerbated by correctional environment.

39. [redacted]-y/o female with primary diagnoses of *alcohol abuse and dependence, PTSD, borderline personality disorder.*

    a. Bright and affable, would benefit from intensive programming that could then bridge into the community. Multiple suicide attempts generally related to intoxications and impulsive, indiscriminate behaviors. She is easily overwhelmed and when attempting to cope with the intense social demands of the correctional environment.

40. [redacted]-y/o female with primary diagnoses of *PTSD, opiate dependence and borderline personality disorder.*

    a. Bright, predominantly depressive affect; chronically suicidal. Would likely benefit from intensive programming. She is easily overwhelmed and when attempting to cope with the intense social demands of the correctional environment. This inmate is not designated SFI but would benefit from enhanced behavioral treatment in a less intensely correctional environment.

41. [redacted]-y/o female with primary diagnoses of *PTSD, alcohol dependence, opiate dependence, anxiety disorder NOS, dysthymia, and borderline personality disorder.*

    a. Tends to erotize interactions with other inmates and with staff. Can be a predator with some inmates. Would likely benefit from intensive programming.

42. [redacted]-y/o male with primary diagnoses of *schizophrenia vs. psychosis NOS*

a. Spends most of his time in segregation; refuses medication because he believes it is contaminated. Refused food for weeks at a time for fear of contamination. Has a concrete thought form and paranoid delusions; refuses to go to court (which would likely result in his release in the near term) for fear that he would not be taken to court-requires direct invitation by the judge. Spends much of his time screaming. Cannot be housed in general population.

43. [redacted]-y/o males with primary diagnosis of developmental disorder

a. Continually housed in administrative segregation due to vulnerability to other inmates and because of his own history of sexually inappropriate behavior. Administrative segregation is provided with the knowledge of his guardian.

44. [redacted]-y/o male with primary diagnosis of *schizophrenia, paranoid type*

a. Long history of repeated incarceration due to assaults in the community driven by paranoia. Within corrections increasingly unresponsive to appropriate medication leading to loss of ability to function safely among other inmates. Currently refusing all food prepared by prison under the delusion that it is poisoned. Very high risk of successful suicide. Higher level of staff attention and greater flexibility regarding daily routines has demonstrated a calming effect.

45. [redacted]-y/o female with diagnoses of borderline *personality disorder, PTSD, substance dependence.*

a. Repeated incarcerations with adequate adjustment prior to recent rape while in the community. Since then has engaged ceaselessly in self-harming behaviors varying from mild threats to actions of extreme lethality. Unable to be housed in general population due to need for constant observation and highest level of safety precautions. Sentences have been relatively short to date, but are frequent and may become longer. Inconsistently compliant with medication.

46. [redacted]-y/o male with diagnosis of *schizoaffective disorder, bipolar, paranoid*

a. Aggressive and paranoid, he has been housed in therapeutic isolation from other inmates, despite which he successfully engaged

in assaults on staff. Long sentence. Inconsistent compliance with medication, which is unable adequately to control symptoms.

47. [redacted]-y/o male with diagnosis of *psychosis NOS, severe antisocial personality disorder (r/o high functioning Asperger's syndrome)*

    a. Unable to be housed in general population due to repetitive assaults on other inmates and staff, combined with frequent, almost continuous, mild to moderate self-harm. Charges of lewd and lascivious behavior have not so far carried lengthy sentences but this is likely to change in the future.

Security Profiles

The facts relevant to the needs of any inmate with mental illness are not confined solely to the medical record. Within the correctional setting, how an inmate behaves toward others and his or her ability/willingness to adhere to correctional rules and routines have much to do in determining what their experience will be. One effective way to quantify how successfully an inmate acclimates to the correctional culture is simply by monitoring the number and types of Disciplinary Reviews (DRs) and Unusual Incident Reports (UIRs) written by security officers. The DR and UIR history of each study subject over approximately the last 12 months was reviewed and is summarized on the following two pages. [3]

[3] The number and content of these reports gives a sense of each inmate's behavioral profile. The numbers cannot be compared inmate to inmate, however, as inmates were incarcerated for different durations over the past year. Someone incarcerated only 60 days would likely – but not always – have fewer DRs and UIRs than a similar inmate incarcerated for 6 months or the full year.

REF #	Dx	DRs in 12 months	DR Descriptions	UIRs in 12 months	UIR descriptions
1	Schizophrenia, paranoid	0		0	
2	BPD	17	Assault on DOC employee; obscene language, disruptive behavior	30	self harm threats, gestures, and actions; assaults on staff and others
3	BPD, Asperger's	8 in 4 months	breaking rules, then becomes disruptive	none	
4	Shizotypal, LIF	0		none	
5	Anx DO/NOS; BPD	15		2	assaults on staff
6	ETOH Dep; Episodic delerium, MDD	2	sanitary housing	1	SH statements; inappropriate sexual behavior
7	Poly sub dep, ADHD, PTSD, BPD	3	threatening	2	self harm - punches himself and bangs
8	PTSD; recuring acute depression	2	hygiene	0	
9	Poly Sub dep.	3	possession	3	SIB verbalizations,
10	Asperger's DO r/o Bipolar NOS	0	dna	0	dna
11	unclear: severe personality disorder	33	setting fire; assault on officers;destruction of property	23	insertion, hanging, assault on officers
12	MR; BPD	24	assault on officers; destruction of property	37	insertion; throwing bodily fluids
13	DD unspecified	10	contraband; assault on inmate	2	mild self harm;
14	Delusional Disorder; paranoid - untreated	2	Severe assault on officers	2	assault on officer
15	Dementia; r/o ASPD	45	Obscene language; improper hygiene	5	Other reportable event, usually in the course of attempting to deliver care related to personal hygiene.
16	PTSD w/ paranoid features	0	dna	3	PREA perpetrator; minor self injury
17	dementia	0	dnr	1	failure to cooperate with move
18	Schizoaffective-bipolar - untreated	4	improper hygiene		Use of force to control while in agitated state
19	Bipolar DO	0	dna	0	dna
20	TBI; psychotic DO w/depression	2	failure to follow orders	0	dna
21	TBI; extreme mood fluctuation; occasional SA	7	Disruptive behavior; property destruction	1	brief stay; returned to community in sheltered care
22	PTSD (community dx bipolar)	1	assault on inmate	1	aggravated assault
23	Borderline Intellectual Functioning; Cluster B PDO with Borderline features predominating.	6	Disruptive behavior	25	severe self harm;

REF #	Dx	DRs in 12 months	DR Descriptions	UIRs in 12 months	UIR descriptions
24	Major Depression severe with psychosis;vs. sexual sadism	5	indecent exposure; sexual acts; sex assault on staff	3	sexual acts; suicidal ideation
25	Schizophrenia, MDD, r/o Dementia related to HIV; CRT	9	Disruptive behavior; fighting	20	minor self harm; aggression to other inmates
26	Borderline intellectual functioning; CRT	23	assault on officers; tampering with fire alarms	21	assult and failure to comply -- occassionally minor SIB
27	Schizophrenia, paranoid type	3	Failure to abide by rules	1	victim of sexual harrassment
28		6	Failure to abide by rules	2	Fighting with serious physical injury; inappropriate sexual acts toward another inmate.
29	Schizoaffective DO; BPD	11	disruptive behavior	10	aggravated assulat on inmate; non suicidal cutting or other self injury.
30	MDD; PD NOS w/ Cluster B traits	1	Interfering with Officer	3	low level operational disruptions
31	MDD, recurrent	1	Disruptive behavior	8	self harm comments and gestures
32	Schizophrenia v Asperger's/Autism spectrum	11	indecent exposure; explosive anger	1	anger tantrum
33	PTSD w/ transient psychosis; CRT	2	smoking	2	self harm threat; victim of sexual harrassment
34	cognitive DO NOS	0	dna	3	medical emergencies
35	Schizophrenia	17	possession of tobacco	1	contraband
36	BPD, PTSD, CRTlow imulse control	9	Assault on DOC employees	23	moderate to severe self harm
37	schizophrenia	7	disturbance; misuse of medication	2	assault of other inmate
38	Schizophrenia, PTSD	4	posession of tobacco	1	contraband
39	BPD	4	interfering with an officer	1	resisting an officer
40	not SFI				
41	not SFI				
42	Schizophrenia; ASPD;	16	Disruptive behavior	17	yelling and chanting; minor self harm; throwing urine and feces on staff
43	Developmental DO NOS	4	Threatening	4	minor and serious self harm
44	Schizophrenia, paranoid type	1	Disruptive behavior	1	serious self harm during psychosis
45	Polysubstance dependence; PTSD; Borderline Personality Disorder	9	Assult on staff	29	self harm, mild, moderate, and severe
46	Schizophrenia, paranoid, ASPD	7	Assault on staff	1	unprovoked attack on female staff
47	Schizophrenia, paranoid type; ASPD	17	Disruptive behavior; assault on officer	52	mild to moderate self harm, assault

Categories of Need for Additional Resources

After reviewing and discussing each of the forty-seven inmates, an attempt was made to sort them into policy-relevant categories based on their greatest or most likely needs. The following table briefly summarizes this process.

Reference Code	Acute Stabilization	Behavioral Trestment	Quality of Life - Semi Sheltered	Quality of Life - High monitoring	Unable to classify
1			1		
2		1			
3				1	
4			1		
5		1			
6			1		
7		1		1	
8			1		
9					1
10			1		
11	1	1			
12	1	1			
13			1		
14	1			1	
15	1		1		
16	1		1		
17	1			1	
18	1		1		
19	1		1		
20	1		1		
21	1		1		
22					1
23	1	1			
24	1			1	
25	1		1		
26	1			1	
27	1			1	
28	1			1	
29	1	1			
30	1				
31	1	1			
32			1		
33			1		
34			1		
35	1	1			
36	1	1			
37	1		1		
38	1				
39		1			
40		1			
41		1			
42	1			1	
43			1		
44	1			1	
45				1	
47				1	
	25	13	18	11	2

Conclusions from the Case Studies

After reviewing the psychiatric, behavioral, residential, and security profiles of the 47 selected inmates, several relatively distinct needs emerged.

A. Acute stabilization

Acute stabilization refers to the provision of psychiatric care in emergency situations. Conditions requiring such psychiatric interventions may include attempted suicide, substance abuse, major depressive episodes, acute psychosis, violence or other manifestations of rapidly changing behavior. For persons with some mental illnesses the transition into and out of corrections is particularly chaotic and risky. These individuals experience and create very significant stress and danger.

Approximately 25 of the study group SFI inmates periodically required acute stabilization, either for the treatment of floridly psychotic presentations, or for the stabilization of life threatening self-harm or depression. Length of treatment for acute stabilization might be in the range of one to four weeks.

B. Behavioral Treatment

Behavioral treatment refers to a number of non-pharmacologic methods (that are often used in conjunction with pharmacologic therapy) which is based on learning theory and which aims to treat psychopathology through techniques designed to reinforce desired and eliminate undesired behaviors.

Approximately 13 patients in the study group could greatly benefit from intensive management and treatment that combined psychiatric and behavioral modes. Most, but not all, in this group are patients with multiple diagnoses that include borderline personality disorder (both males and females). Some, however, are patients with disorders such as severe depression, who must learn and solidity new habits and skills in order to be safe in a corrections environment. Successful treatment for these offenders would either enable these persons to return to general population living within the corrections system, or to be more safely and stably released to community housing and treatment. [4] Length of treatment for integrated behavioral and psychiatric treatment might be in the range of six to twenty four month, depending on patient circumstances.

[4] No one is kept incarcerated simply because he or she is mentally ill. However, when someone has been convicted of a crime, issues of inmate welfare and public safety must be considered in release planning. It is, for example, very difficult to find stable housing for psychiatrically unstable inmates, or to engage them in community programs and appropriate behaviors that would slow the revolving door of recidivism.

C. Quality of Life – Semi Sheltered Housing

Approximately 18 of the inmates in this study would be appropriate for placement in "Semi-Sheltered" housing. These are inmates who do not pose severe threats of harm to others, and are generally able to maintain adequate daily functioning. At present their However, patients in this group may be at high risk of predation by other inmates or may become over-stimulated and destabilized by the extremely high sensory and social demands of ordinary prison life. Common profiles for this group include severe cognitive disabilities, chronic (treated, non-violent) schizophrenia, and certain individuals on the Autism Spectrum. At present, administrative segregation, or intense self-isolation, may be the only available options. Length of stay in semi-sheltered placement could range from a few weeks to many years, depending on the circumstances and sentences of these inmates.

D. Quality of Life – High Security Psychiatric Housing

Approximately 11 of the inmates in the study would benefit from placement in an incarcerated housing situation that provided a greater range of activities and more room for physical movement than can feasibly be provided in current VDOC facilities. These are inmates whose untreated or unresponsive severe mental illnesses result in erratic and/or unpredictably violent behavior. At present, administrative segregation or therapeutic confinement are the only options. Length of stay would likely be measured in years.

Recommendations

The four needs that emerged from our review -- for Acute Stabilization, Intensive Treatment, Sheltered Housing, and High Security Housing – lead us to conceptualize the problem in two different and intersecting ways

1. "what do we need in order to deliver effective treatment and humane incarceration to our most severely impaired offenders while they must be incarcerated," and
2. "what do we need in order to provide the best chance of avoiding or shortening re-incarceration of this same group"

The answer to the first question lies in centralizing and integrating the highest levels of mental health treatment and housing. Treatment of patients at this acute level requires specially trained medical, mental health, and security staff, and depend and group skill building that isn't possible in the environment of administrative segregation, and cannot be effective when dispersed over six separate and widely separated locations. Nor can current facilities offer housing

that is both less restrictive and highly secure to inmates who have enduring needs. Resource concentration might be accomplished in various ways, such as

- Re- designing, re-arranging and re-engineering existing facilities to provide more clinically appropriate designs.

- Creating a small, separate facility, specially designed and staffed as a correctional forensic facility which could treat both men and women with the needs that are outlined here. with enhanced ability to create desirable clinical environments within the correctional system, or

- Developing collaborative treatment and housing agreements with other small states that face similar problems, thus allowing economies of scale and focus of treatment.

This list is probably not exhaustive, and it is not the purpose of these study to weigh the merits or estimate the cost of such alternatives. Only to say that raising the mission of correctional mental health treatment will require brick and mortar changes.

DOC and the Agency have another task as well: the successful and stable re-entry of incarcerated persons back into local communities. DOC, DMH, ADAP and other services and departments of AHS are actively developing reentry strategies that begin in the correctional institutions and continue throughout an offender's transition to and stabilization in the community. In contrast to the first goal, this second goal of re-integration may best be done in programs that are not centralized. Again, there is no single and obvious approach, but we may wish to consider

'Step down" facilities help severely functionally impaired persons to have care and guidance during the early weeks of re-entry.

- Services in this phase should include (but not be limited to) education, on going mental health diagnosis, treatment and risk assessment, substance abuse treatment and support, job training, and mentoring.

- Community facilities that provide 24/7 supervision and care for some severely impaired persons. For these people, housing, monitoring, life-skills and enduring community connections need to be added to the previous list.

- Enhanced systems of tracking, team management, and communication among community entities, and between community and corrections, that can provide the logistical foundation for better lives and "safer" safety nets.

By taking these steps together, simultaneously strengthening centralized facilities during incarceration and strengthening local facilities and logistics in the community, Vermont could go far toward creating a high quality, cost effective system that can improve outcomes without compromising public safety.

That needs exist is not due to a failure of caring or of the management of current resources. In fact Vermont provides a wide array of mental health services for an extraordinarily high proportion of its inmate. It is due, instead, to structural barriers inherent in Vermont's situation, and to the need and desire to raise our own sights. Most states have much larger total populations of jail and prison inmates, and are able to designate one or more specially adapted and staffed facilities for severely mentally ill and functionally impaired inmates. These are generally referred to as Forensic Psychiatric Hospitals, or Forensic Psychiatric Facilities. Lacking such specialized locations, VDOC must do its best to care for forensic psychiatric cases in facilities that were not designed for this purpose.

There will always be a proportion of offenders who suffer from serious mental illness and severe functional impairment, and a portion of the mentally ill who break the law. If national trends continue, the absolute number of incarcerated mentally ill individuals is going to increase, not decrease, in coming decades, and so will the severity and complexity of their needs. An aging prison population will include more individuals with dementia, while new and increasingly powerful drugs of abuse will render more of our offenders dually handicapped. Turning this trend around is a monumental and profoundly important task.

Any improvement will involve dedicating more public resources to the care and custody of mentally ill offenders by changing one or more of these elements. Any proposal to do so will raise thorny financial and political problems. But if, as a state, we are going to meet our legal and moral obligations at a higher level, these debates cannot be avoided.

In the face of such needs we are compelled to take a sober look at what can, and cannot, be done within current VDOC facilities, to entertain new ideas, and to compare benefits as well as costs.

The road ahead is not easy or obvious. VDOC will continue to provide the best custody and care that its resources permit. But a unique opportunity exists to take a fresh look at old problems and ask whether something more is possible.

This report was created by the Health Services Division of the Vermont Department of Corrections.

Meredith Larson, Psy.D., Chief of Mental Health Service, Vermont Department of Corrections, and Thomas Simpatico, M.D., Director of Psychiatric Services, Vermont Department of Corrections (contractually provided through Correct Care Solutions) worked collaboratively to conduct the study and produce the report.

William McMains, M.D., Medical Director for the Vermont Department of Mental Health, provided supportive collaboration and thoughtful critique throughout the project. Dr. Neil Metzner, Psy.D. made important contributions to the study, particularly through his personal knowledge of the treatment histories of inmates who were identified.

Special thanks are due, as well, to the psychiatry and behavioral health specialists who work with all the mentally ill inmates within VDOC, and to the case and security staff in each facility who contribute so crucially to the care and safety of Vermont's severely functionally impaired inmates.

Appendix A:
Structure and Function of VSH and DOC as related to Vermont's Mentally Ill Population

Historically, the Vermont State Hospital and the Department of Corrections have served functions that overlap at some points, but are fundamentally different in scope and focus. The purpose of this section is to acquaint the general reader with some of these issues.

Department of Corrections

The Department of Corrections houses individuals who have been convicted of crimes, or who are awaiting arraignment or trial for criminal charges.

The VDOC is a "combined" system, meaning that every facility is both a jail and a prison. Medical and mental health services are provided at every facility, while the Southern State Correctional Facility in Springfield includes a ten-cell "acute stabilization" unit. Treatment is provided on the basis of current needs. VDOC cannot, on its own, exclude any individual from legal incarceration, regardless of the severity of that person's medical or mental illnesses. Nor can someone be incarcerated solely for mental illness.

On average, about 2,200 Vermont offenders are incarcerated on a given day. Of those, approximately 600 are housed in facilities out of state; the remaining 1,600 are distributed among six in-state traditional facilities and two work camps. There is a continual flow of inmates among the in-state facilities to meet the need for housing, security, reparative programming, court calls, medical treatment and release planning. Very few inmates will spend their entire incarceration time in just one facility. This adds greatly to the logistical complications of providing for the special needs of serious mentally ill inmates. The specialized units at the Southern State facility can accommodate only a fraction of those designated SFI. Most must be housed and treated in facilities ill-designed for these purposes, and the small scale of the facilities introduces important dis-economies related to staffing and the development of treatment programs. The small scale of the facilities makes staffing for the intensive treatment of a small number of inmates financially unfeasible, while the physical architecture of unit and cell structure, chow halls, and exercise facilities makes sheltered housing virtually impossible.

DOC may request the Vermont State Hospital to consider for admission any incarcerated person whose symptoms would meet the criteria for admission to VSH, were that person residing in the community. In recent years, the ability of VSH to accommodate such requests has been limited. There is no current database by which to establish for certain how often this happens.

But it is fair to estimate that the total number of such admissions in recent years has been fewer than half a dozen each year, and that many return to DOC within days of their admission to VSH. It is important to stress that this is not the result of a lack of care or concern by VSH, but of the different and specific mission that it has had to date.

Vermont State Hospital

The Vermont State Hospital (VSH) houses individuals referred from the community for urgent care to address serious mental illness, particularly when a person poses an imminent risk of harm to self or others due to mental illness. The VSH facility of approximately 50 beds has been located on the grounds of the Waterbury state office complex, along with many other components of the Agency of Human Services (including the central offices of the Department of Corrections).

Patients enter from the community by referral from private and publically funded health and medical health care providers – psychiatrists, general practice physicians, psychologists, social workers and others. Patients may also enter VSH through the court system. At any point, but especially in the pre-trial period, the court may order that an individual inmate be evaluated to determine whether he or she is competent to stand trial, or may be held legally responsible for the crimes charged. These evaluations are arranged by the Department of Mental Health (DMH) and, at the instruction of the court, are either done "inpatient" or "outpatient". These evaluations are conducted by specially contracted forensic evaluators.

For an inpatient evaluation, the individual goes from the courtroom to the Vermont State Hospital, where the evaluation is conducted. Outpatient evaluations may be conducted either in a VDOC facility (if the person is incarcerated) or in a community location (if not incarcerated, for example out on bail).

If found incompetent, the person may not be incarcerated, and may, according to the discretion of the court, either be placed at VSH for continued care, or released back to the community.

DOC may request VSH to consider for admission individual incarcerated persons whose symptoms would meet the criteria for admission to VSH were that person residing in the community. In recent years, the ability of VSH to accommodate such requests has been limited.

Overlap and Differences

Within these broad outlines, the varying focus and scope of VSH and DOC create many significant differences between the two institutions and their activities.
Forensic psychiatry proper is defined as "a subspecialty of psychiatry in which scientific and clinical expertise is applied to legal issues in legal contexts embracing civil, criminal, correctional or legislative matters" (American Academy of Psychiatry and the Law 1989/1991).

Both VSH and DOC are engaged in the practice of forensic psychiatry, but in substantially different ways.
For the purposes of this discussion, the term *forensic service* is intended to mean psychiatric care provided to individuals who have come to the attention of the Vermont Department of Corrections where the objective is providing treatment and who enjoy traditional doctor-patient relationships.

The treating psychiatrist in forensic service is often confused a forensic evaluator, but there are important differences.

Doctor–patient relationship

Within DOC there exists a doctor-patient relationship, the sole purpose of which is to treat the patient. DOC mental health providers are not involved in decisions regarding the "liberty interests" of their patients.[5]

By contrast, during a forensic evaluation, the psychiatrist must inform the claimant at the time of examination that no doctor–patient relationship will be formed—that is, the psychiatrist will not *treat* the claimant. The sole purpose of the examination is to provide information to the party retaining the psychiatrist and potentially to the court.[6]

Confidentiality

Within DOC, there is an expectation of the confidentiality of medical information – that is, except for the purposes of treatment, medical (mental health) information will not be shared with other without the patient's explicit consent. [7]

During a forensic evaluation, however, the claimant must be informed that, unlike the traditional doctor–patient relationship, confidentiality surrounding the forensic evaluation may not exist. Once the retaining attorney decides to disclose the findings of the evaluation in litigation or in some instances if a claim or defense is relying on a mental state, the information will be made available to court and counsel. A Protective Order issued by the court may require that the forensic psychiatrist maintain the confidentiality of specified records and documents.

Some areas of focus for forensic evaluations

Criminal Intent (Mens Rea)

Under the common law, criminal culpability for most serious crimes requires 1) the

[5] Mental health providers do participate in the process of release planning by providing (with the patient's consent) summaries of mental health conditions, treatment, and likely community needs. However, they do not determine when an offender will be released.
[6] Psychiatric evaluations may also be conducted at the request of the prosecuting or defending counsel, but such examinations are not conducted by DOC.
[7] Treatment of incarcerated individuals may require sharing certain information with others who are directly responsible for the inmate's daily living such as case management and certain security staff. Information is shared only as needed t assure appropriate custody and care.

mental state or level of intent to commit the act (known as the *mens rea,* or guilty mind), 2) the act itself or conduct associated with committing the crime (known as *actus reus,* or guilty act), and 3) a concurrence in time between the guilty act and the guilty mental state (Bethea v. United States 1977). To convict a person of a particular crime, the state must prove beyond a reasonable doubt that the defendant committed the criminal act with the requisite intent. All three elements are necessary to satisfy the threshold requirements for the imposition of criminal sanctions.

Competency to Stand Trial

The legal standard for assessing pretrial competency was established by the U.S. Supreme Court in *Dusky v. United States* (1960). To be competent to make decisions during the pretrial process, at trial, and during an appeal, the court succinctly and without embellishment required that the defendant have "sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding" and "has a rational as well as factual understanding of the proceedings against him" (Dusky v. United States 1960).

Insanity Defense

Defendants with functional or organic mental disabilities who are found competent to stand trial may seek acquittal claiming that they were not criminally responsible for their actions because of insanity at the time the offense was committed. The retrospective assessment of the offender's mental state at the time of the crime in insanity defense cases is one of the most challenging evaluations that the forensic psychiatrist performs (Simon and Shuman 2002).

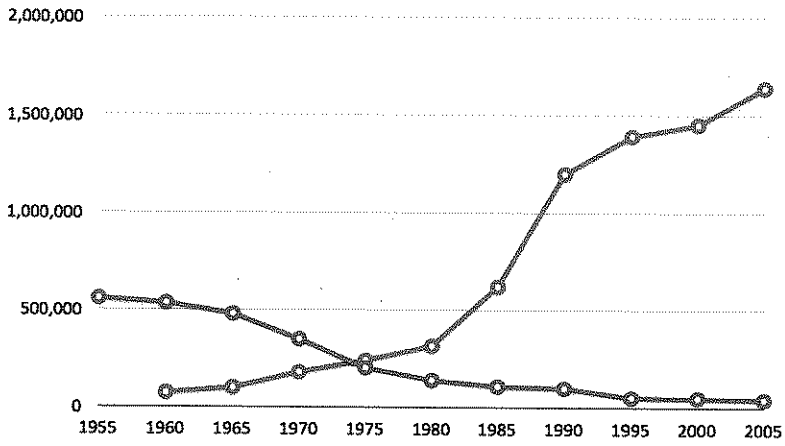
Diminished Capacity

Because the insanity defense is an affirmative defense, it is only presented in a case after the prosecution has presented sufficient evidence to persuade a reasonable juror that the state has met its burden of proof on *mens rea* and *actus reus*. There are, however, degrees of mental impairment that are relevant to *mens rea* but do not negate it. In recognition of this, the concept of *diminished capacity* was developed (Melton et al. 1997).

Mentally Ill Persons in Prisons and Jails – the National Picture

At a rate of 502 prisoners per 100,000 population, the U.S. incarcerates at a rate four to seven times higher than other western nations such as the United Kingdom, France, Italy and Germany.

Over the past decades, the absolute number of mentally ill persons in psychiatric hospitals has fallen, while the absolute number of mentally ill persons who are incarcerated has risen steadily and dramatically. Part of this increase may be the result of improved identification of both mild and severe mental illness among prison populations. And some part may be due to the increasing involvement of mentally ill persons with illegal drugs and their subsequent conviction of drug-related crimes. However, a portion of the increase is clearly due to our society's active or passive decisions about how, where, and to whom to provide mental health care.



Patients in U.S. psychiatric hospitals vs. incarcerates 1955-2005 in absolute numbers.

- The prevalence of severe mental illness in correctional facilities is two to four times higher than the general population rate. (Teplin 1984; BJA 1999)
- Recent estimates suggest that over one million people with serious mental illness (SMI) are booked into U.S. jails each year.
- The odds of a person with SMI being jailed are significantly greater than the odds of being hospitalized (Morrissey et al. 2007)

After their initial arrest, individuals with SMI are more likely to be detained in jail (as opposed to released on own recognizance or have cases dismissed), and once jailed, stay incarcerated 2.5–8 times longer in comparison to their non-mentally ill counterparts. (Council of State Governments 2005)

Mentally Ill Persons Within Corrections in Vermont

Vermont incarcerates at a rate of 277 per 100K, placing it below the national average but ahead of:

- Northeast
  - Maine 159 per 100K
  - Massachusetts 246 per 100K
  - New Hampshire 222 per 100K
  - Rhode Island 235 per 100K
- Midwest
  - Minnesota 181 per 100K
  - Nebraska 243 per 100K
  - North Dakota 221 per 100K
- South

    - All higher rates
- West
    - Washington State 273 per 100K

At any given time, the Vermont Department of Corrections houses approximately 2200 inmates, including both jail and prison populations. Approximately 1600 inmates are housed in facilities within the state of Vermont; approximately 600 are housed in out of state facilities but remain under the custody and supervision of the Vermont DOC. It is important to bear in mind, however, that these figures are a snapshot in time of the approximately 6000 bookings and releases that take place in the course of a calendar year.

At any given time, between 600 and 700 inmates in Vermont are actively receiving mental health services, both psychiatric and behavioral. This is one of the highest rates of service in the nation. Among them, a subgroup of approximately 6.5% is designated "Severely Functionally Impaired". Inmates may be designated SFI on the basis of psychotic disorders, mood disorders such as recurrent depression or bipolar illness, mental retardation, developmental disorder, traumatic brain injury, dementia, or personality disorders when the mental illness (or illnesses) severely impair an individual's ability to function safely and adequately in the correctional environment.