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Self-Injurious Behaviors in Prisons: A Nationwide Survey of Correctional Mental Health Directors

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Et al.

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Center for Health Policy and Research
UMASS MEDICAL SCHOOL
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Background

- 3/29/07 UMCH convened mental health workgroup (at Academic & Health Policy Conf on Correctional Health; next in Atlanta 3-22-23-2012)
- Over twenty participants
  - Local and national
  - 6 medical schools and several private and public agencies
  - All with experience or interest in correctional mental health research

Objective

- Review state of mental health research in correctional settings
- Two main areas:
  - Opportunities
  - Barriers

General Perceptions

- Significant limitations in the current knowledge-base
- Several hot topics need attention
- Multiple barriers: match projects to stakeholder agendas and concerns (e.g., safety)
    - SIB at top of list

Background and Significance of SIB

- Distinct in concept from suicidal behavior
  - Usually lacks lethal intent
  - But can still → death
- SIB in correctional settings may differ in situational context, incidence, intent, and environmental impact
- Management consumes significant clinical and custodial resources

Background and Significance

- Serious consequences: health, safety, operational, security & fiscal:
  - Injury to inmate, other inmates, & staff
  - Freeze in facility operations
  - Need for outside medical attention
    - Staff diversion, costs, additional security risks
- Limited data: prevalence; characteristics

Background and Significance

One of first 2 surveys of the U.S. prison system:

- Appelbaum KL, Savageau J, Trestman R, Metzner J, Baillargeon J: A National Survey of Self Injurious Behavior in American Prisons. Psychiatric Services, 62:285-290, 2011
- Smith HP, Kaminski RJ: Self-Injurious Behaviors in State Prisons: Findings From a National Survey. Criminal Justice and Behavior, 38:26-41, 2011

Study Objectives

- Our study sought information about the prevalence and nature of SIB in the nation's prison systems, and interventions used to manage it, which could benefit efforts by clinicians and administrators to diminish SIB and improve the functional status of inmates with this behavior.

Methods

- Identified state and federal directors of correctional mental health services (N=51)
- Used paper-based, email and on-line data collection techniques with 3 reminders
- Sent a 30-item survey eliciting information:
  - Definition, frequency, tracked data, impact on operations & resources, diagnoses, management strategies, and roles of mental health & custody staff
- Collected data between November, 2009 and March, 2010

Methods

- Supplemented primary data collection with 2 secondary sources:
  - U.S. Department of Justice's Bureau of Justice Statistics
  - National Association of State Budget Officers 2008 State Expenditure Report
- Analyzed data using SPSS V17.0
  - Univariate statistics used to describe significant aspects of the national experience with SIB
  - Bivariate statistics used to examine relationships between variables

Results

- Of the 51 MH directors surveyed, 39 (76.5%) responded; 6 refusals; 6 non-responders
- Non-response was not related to:
  - system size
  - geographic location
  - operational or design capacity
  - total annual expenditures
  - annual non-capital expenditures
- Results were evenly distributed by population size and geographic location

Prison System Respondents (N=39)

Geography*	
Northeast	8 (21.1%)
Midwest	8 (21.1%)
South	10 (26.3%)
West	12 (31.5%)
Size of prison system**	
Range (# of inmates)	2,064 – 201,280
Mean (SD)	31,421 (46,824)
Median	20,661

* This does not include the one site representing the federal prison system.
* The Bureau of Justice Statistics (2008) was used to confirm size of prison systems and/or to supplement missing data from the few systems who did not provide this information.

Data Maintained by Prison Systems when SIB Incidents Occur

No	17 (43.6%)
Yes	22 (56.4%)
Housing unit	17 (43.6%)
Behavior	17 (43.6%)
Gender	15 (38.5%)
Shift or time of day	14 (35.9%)
Age	13 (33.3%)
Security level	11 (28.2%)
Race	10 (25.6%)
Diagnosis	10 (25.6%)
Precipitants for behavior	7 (17.9%)
Crime	6 (15.4%)
Sentence	6 (15.4%)
Sanctions for behavior	5 (12.8%)
Other	4 (10.3%)

Definitions of SIB and Determination of SIB Incidents

Is SIB defined by policy?	
No	25 (67.6%)
Yes	12 (32.4%)
SIB definitions include:	
Requires an act of self-injurying behavior	29
Behavior was intentional or deliberate	14
Explicit inclusion of suicidal intent	4
Explicit exclusion of suicidal intent	12
Injury severe enough to receive medical intervention	4
Does system distinguish between SIB incidents and suicide attempts?	
No	10 (26.3%)
Yes	28 (73.7%)

Determination of SIB Incidents and Their Responsibility

Who makes the determination that the incident was SIB?	
Medical clinician	21 (53.8%)
Mental health clinician	37 (94.9%)
Custody staff	9 (23.1%)
Did not answer question	2 (5.1%)
Who has primary responsibility for dealing with SIB?	
Mental health staff	16 (41.0%)
Custody staff	0 (0.0%)
Both	23 (59.0%)

- For nearly all systems, a mental health clinician makes the determination that an event was self-injurious but more often shares the responsibility of dealing with the incident.

Prevalence of SIB Events: Calendar Year 2008		
Inmates engaging in SIB	**N**	**%**
Range	2 – 5000	0.03 – 8.93
Mean (SD)	321.5 (948.1)	1.30 (1.89)
Median	92	0.44

- For all 39 systems collectively, 0.71% of inmates engaged in SIB.

Frequency of SIB Incidents	
More than once a day	5 (14.7%)
Once a day	2 (5.9%)
Several times per week	17 (50.0%)
Once a week	5 (14.7%)
Once a month	0 (0.0%)
Less than once a month	5 (14.7%)

- In 85.3% of systems, SIB events occur at least weekly.
- In 20.6% of systems, these events occur at least daily.

Results: Where Do SIBs Occur?

- Segregation and other lockdown units had the highest rate of occurrence in most systems (75.9%)
- Among general population units, higher rates occurred in maximum than in non-maximum security units (40.2% vs 21.7%, respectively)

Effects of SIB Incidents on Operations and Resources

	Disruptions to facility operations	Drain on mental health resources
Minimal	7 (18.4%)	3 (8.1%)
Somewhat	13 (34.2%)	8 (21.6%)
Moderate	11 (28.9%)	16 (43.2%)
Extreme	7 (18.4%)	10 (27.0%)

- In 47.3% of systems, SIB events at least moderately disrupt facility operations.
- In 70.2% of systems, these events put at least a moderate drain on mental health resources.

Effect of SIB Incidents on Need for Outside Medical Services

	Required medical treatment outside of the prison facility
< 5 %	12 (38.7%)
5 – 10%	7 (22.6%)
11 – 25%	7 (22.6%)
26 – 50%	4 (12.9%)
> 50%	1 (3.2%)

- In 61.3% of systems, SIB events resulted in need for outside medical treatment 10% of the time or less.

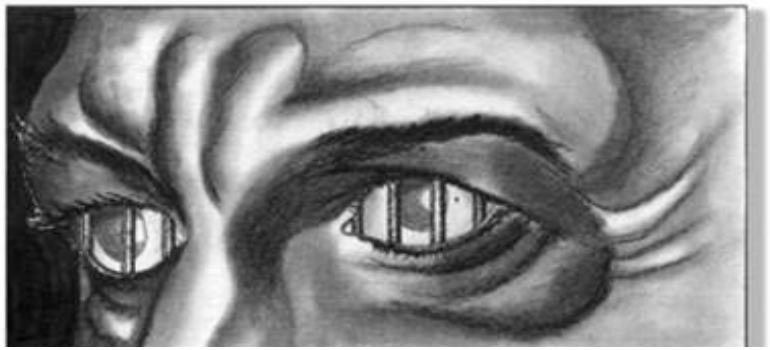
Mental Health Diagnoses of Inmates Engaging in SIB

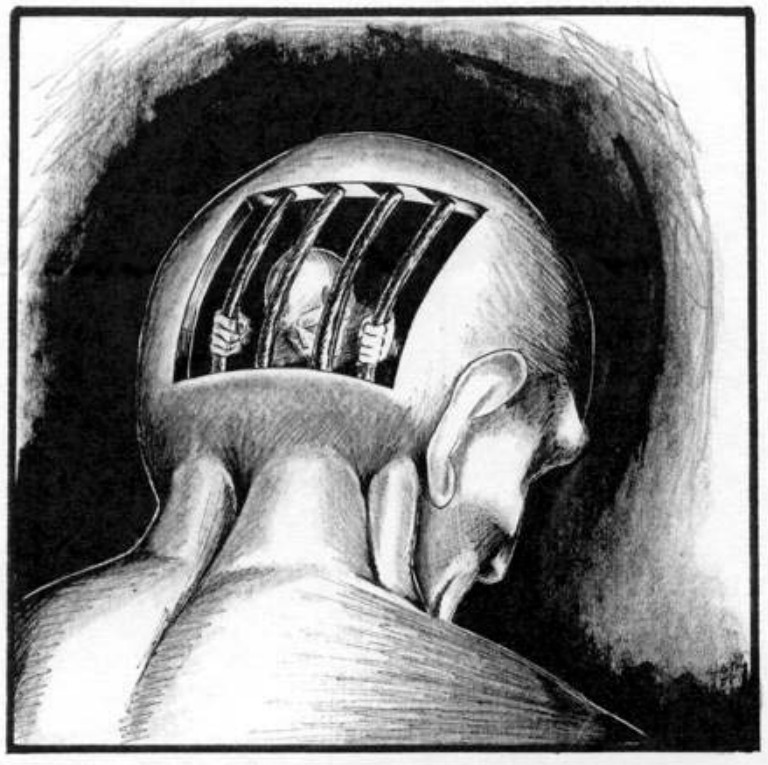
Disorder	Range	Mean (SD)
Psychotic	0 – 20%	7.6% (5.3)
Mood	0 – 35%	15.5% (9.7)
MR / PDD / Autism	0 – 10%	3.2% (3.1)
Cluster B Personality	4 – 95%	52.2% (25.7)
Mixed Personality	0 – 35%	12.2% (10.7)

- Cluster B Personality disorders, followed by Mood and Mixed Personality disorders were the most prevalent mental health disorders among inmates engaging in SIB events.

Results: Management Techniques and Interventions

- Most systems used SSRI's (86.4%)
  - Followed by antipsychotics and anticonvulsants
  - Least frequent use: Naltrexone, anxiolytics, and beta blockers
- Involuntary medications used by 33 (84.6%) of systems
  - Most systems use these < 5% of the time (69.0%)
  - 94.3% of systems have policies and procedures
- 100% of systems have policies and procedures for security- and/or mental health-ordered restraints
  - Most systems use these < 5% of the time (security: 45.2%; mental health: 46.7%)
- 48.6% of systems have a behavioral management program or unit
  - Bed sizes ranged from 15-620 beds (Mean: 136 beds; SD 182)





A special note of thanks to the artist Todd (Hyung-Rae) Tarselli whose art work graphically displays the devastating effects of prison on the mental health of its inmates. LA Rhoades, AJPH, October 2005;95(10):1692-1695.

Discussion

- High response rate attests to perceived importance
  - Most systems interested in research
- Lack of a widely & consistently used definition complicates research
- Prison systems keep limited, if any, data about SIB events

- Few inmates; frequent episodes
- Serious consequences:
  - Health, safety, operational, security & fiscal
- Management approaches lack widespread consistency
- Infrequent use of:
  - Restraints
  - Involuntary meds
  - Behavior management plans/programs

Limitations

- Absence of tracked data
  - Impressionistic responses?
- Lack of a consistent definition
  - Measuring different phenomena?
- Self-reported data
  - Biased by social desirability?
- Small sample
  - Under-powered to find correlations & differences?

Next Steps

1. **Identify distinguishing characteristics of SIB inmates, including those most associated with increased frequency and severity of harm**
   - Demographics;
   - Criminal, medical and psychiatric history
   - Past self-injurious behaviors
   - Current functioning

   Identify subgroups

2. Identify circumstances and settings of significant SIB events

- Timing and location
- Precipitants
  - interpersonal conflicts, changes in legal status, disciplinary actions, victimization, etc.

Relationship of these factors to:

- inmate-specific characteristics
- type and severity of injury

3. Examine relationship between apparent intent (self-report and staff perceptions) to type of behaviors and outcome

- Concordance between staff and inmate
- Is presumed intent predictive of severity, outcome or recidivism

Select Recent References

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Implications of this study from a mental health systems perspective

- Staff resources
- Working relationships between custody and mental health staff
- Needed programs

Staffing resources

- Disproportionate amount of mental health and custody staff's time
- Impacts utilization of crisis beds and medical emergency facilities
- Potential for havoc in the segregation units

Impact on working relationship between mental health, medical and custody staffs.

- Facility disruption
- View as an opportunity to “show your stuff”
- Avoid the “mad versus bad” conceptual model

Issues related to handling SIB as a rules infraction

- Expense
- Lack of effectiveness

What does not seem to work…

- “Cutters’ units”
- Punitive settings — healthcare or segregation units
- Not addressing the “secondary gain, manipulation and/or underlying dynamics” related to the SIB

What seems to help…

- Recognizing that inmates with SIB are not all the same, although there are similar useful interventions to implement

- Define achievable goals/outcomes of treatment (e.g., decreasing the frequency and severity of SIB over time)

What seems to help…

- A behavioral management plan developed and implemented by a multidisciplinary team that includes custody staff
- Individual therapy provided on a regular basis by the same clinician
- Consider placement in a residential mental health treatment level of care (i.e., a special needs unit)

What seems to help…

- Psychotropic medications if affective instability or impulse control problems are present
- Address both transference and countertransference issues (see NEJM: The Management of the Hateful Patient)

Managing Extreme Behaviors

The Connecticut Behavioral Engagement Unit

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DISCLOSURE

I have no actual or potential conflicts of interest in relation to this program/ presentation.

ACKNOWLEDGEMENTS

CURRENT TEAM MEMBERS:

- ***Thomas Kocienda PsyD*** Team Leader Robert Melms, Capt. Unit Manager
- Nancy Bertulis CSWA Mary Bento CSW
- Jeffrey Brockett RT
- Oleh Kusen CN Nancy Niemeth CN
- Tom Criscitiello CC Gary Hancock CO

BEU Review Committee:

- Dr. Thomas Kocienda Capt. Robert Memls HSA Rick Bush
- DW Amonda Hannah CHNS Pat Morris

- ***Alexis Gendell PhD*** Developer/ Prior Consultant
- Robert Berger MD, Director of Mental Health and Psychiatry, CMHC
- Suzanne Ducate MD, Director of Psychiatry, CT DOC
- Scott Semple , Warden GCI
- James Dzurenda, Deputy Commissioner
- Leo Arnone, Commissioner DOC

Case Vignette

- 27 yo male, crime: murder, long sentence
- Repeated cutting, hanging attempts, flooding cell, destruction of property, disobeying orders
- Failed several BMPs

- Axis I: Mood Disorder NOS, PSA
- Axis II: PDNOS(Borderline and Antisocial Traits)
- Meds: antidepressant, anxiolytic
- Prior Meds: most everything
- Hx: fire setting, fighting, threatening family with kniives

The Behavioral Engagement Unit at Garner Correctional Institution


612
613
614
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619

FORMULATION

- Adult men
- Eight bed unit
- Significant disorders:
- self-injurious acts
- threats of self-harm
- maladaptive behaviors, repeated facility disruption

- Help the inmate reduce or eliminate these behaviors
  - structured environment
  - behavioral modification techniques
  - treatment team approach.

- Not designed to replace RHU or as an alternative to IPM.

STAFFING

- Psychologist (part-time)
- Psychiatrist (part-time)
- First Shift Social Worker (Dedicated)
- First Shift Nurse Clinician (Dedicated)
- Second Shift Social Worker (Dedicated)
- RN First Shift – (part-time)
- RN Second Shift – (part-time)

ADMISSION CRITERIA

- Impulsive/dangerous to self or others
- Persistent disturbances in the facility
- Result in multiple Disciplinary Reports
- Resistant to Behavior Management Plan(s) that attempt to extinguish ongoing maladaptive behaviors

TEAM APPROACH

- Collaboration between mental health, medical, and custody staff

COMPONENTS

- Voluntary program
- Three phases, each requiring 30 days.
- As part of the incentive, pending or current sanctions are reduced or eliminated.

- “Non-ticket block”, requires a Disciplinary Report to be written and maintained for reference. Exceptions are considered.

REFERRALS

- Generated state wide
- Coordinated by the BEU team leader
- DOC's Director of Psychiatric Services for initial review.
- If appropriate, forwarded to the BEU team
- If approved, the BEU team leader and referral source coordinate admission

BEU TREATMENT

- Initially admitted in safety attire.
- Team Leader & Unit Manager orient
- Initial **Probationary Period** (14 days)
- Assigned to one social worker
- A psychiatric evaluation, treatment planning, Computerized Measures and other evaluative data

BEU TREATMENT

- Once 14 days of appropriate behavior has been attained, the inmate will progress into **Phase 1**.
- Each phase is composed of 30 “good days”.
- Medications as clinically indicated
- Target behaviors:
  - impulse control
  - frustration tolerance
  - stress management

MONTHLY REVIEW

- Inmate meets with review committee
- Progress reviewed
- Recommend next phase privileges
- Inmates air concerns, ask questions and comment on their program and progress

SEQUENTIAL PHASES

As the inmates progress through the 3 phases:

- greater potential for privileges
- expected to participate in increased level of clinical programming
- anticipated increase in prosocial behavior.

RESULTS: GENERAL IMPRESSION

- Great benefit to the system
- Respite
- Decompress power struggles
- Very hard to maintain program fidelity

INITIAL OUTCOMES

- Total of 18 inmates admitted to the program.
  - 12 completions (2 inmates repeated)
  - 4 removed
  - 2 in program

INITIAL OUTCOMES

- 4 removed inmates
  - One transferred out of state (unrelated to program)
  - One reassessed and transferred to GP in another facility (power struggle resolved)
  - One reassessed and transferred to a low functioning MH-4 unit at GCI
  - One repeatedly aggressive and returned to NCI

INITIAL OUTCOMES

- 14 Completers (12 unique people)
  - 11 improved to varying degrees
  - Two repeated the program
  - One Discharged to WFI at End of Sentence

CHALLENGES: Axis I I

- Difficult time adjusting to the unit
- Individualized interventions a challenge
- Test limits
- Once tested, rapidly progress through the program, sanctions “wiped clean”
- short term decrease in maladaptive behavior
- Ongoing need for new coping skills

CHALLENGES: COGNITIVE IMPAIRMENT

- Not Successful: Mental retardation, acquired brain injury or other neuropsychological deficits
- Require sustained structure
- unable to adapt to the behavioral concepts of the BEU

CONCLUSION

- Ongoing support from DOC and CMHC
- Need to refine admission criteria
- Aftercare and skills training continuity
- Continue gathering data of extended outcomes