National Institute of Corrections

TRANSCRIPT

Care and Treatment of Inmates with Mental Illness in Prison

Slide 1:
New Directions in Corrections:
NIC Virtual Conference
June 10, 2015
Graphic: NIC Image

Dr. Cynthia Lenning: Hello, my name is Cynthia Lenning and I am the Chief Psychologist at the Federal Correctional Institution in Sheridan, Oregon. I've been the Chief Psychologist for five years and I'm here today with Dr. Jessica Hinman.
Dr. Jessica Hinman: Hello, I am Dr. Jessica Hinman and I am the Advanced Care Level Psychologist here at FCI Sheridan and I've been here just over a year now.

Slide 2:
Care and Treatment of Inmates with Mental Illness in Prison
FCI Sheridan Presenters:
Jessica Hinman, Psy. D.
Cynthia Lenning, Ph.D
Graphics: none

Dr. Cynthia Lenning: Today Dr. Hinman and I are going to talk with you about a treatment program that we have developed for inmates with severe and persistent mental illness at the federal correctional institution, Sheridan and I'll just refer to it from this point forward as FCI Sheridan. We have had many struggles and many successes along the way and we believe that this is not the only way to conduct treatment with mentally ill inmates in prison, but we think that's it's produced some very positive results for our population and we feel excited about being able to share our experiences with you today.

Slide 3:
Objectives

- Discuss a comprehensive correctional care and treatment program for inmates with severe and persistent mental

illness and personality disorders at the Federal Correctional Institution (FCI) Sheridan.
- Identify obstacles to, and benefits of, implementing a comprehensive structure in which to care for mentally ill inmates.

Dr. Cynthia Lenning: So, our approach to treating inmates with mental illness in prison is comprehensive and by that I mean we are looking at providing psychological and psychiatric care for our inmates. But we're also looking at the environment in which they live and we're looking to foster skills for them to be able to use when they go back out into our communities. And so, we're not just looking at providing psychological therapy in a room, we're really looking at a holistic approach to use with these inmates so that it benefits them for their lives.

Slide 4:
Paradigm for Delivery of Service

Graphic: Radial Cycle graphic – Inmate (center), Psychology (top), Corrections (right), Health (bottom), and Ancillary (Left)

Dr. Cynthia Lenning: So, in order to do this, I want to start out by giving you a little bit of information about The Bureau of Prisons and the way that we categorize classify inmates along a spectrum. So we use diagnostic criteria, of course, but we also classify inmates on a scaled approach using a care level system and what the care level system denotes is the severity of mental illness and it's a four tiered approach. And so we look at inmates who have no mental illness or very minor mental illness, perhaps a mild depression for which they take Prozac and we might classify them as a care-level 1mental health, which means they don't typically require a lot of intervention from psychologists and they pretty much function very well in the prison population. So that's the lower end of the spectrum. And all the way to a care-level-4 inmate who is in need of psychiatric hospitalization because their mental illness is such that they cannot function in a mainline institution. Some diagnoses that people with a care-level-4 classification might have are schizophrenia or other psychotic disorders. Organic brain impairment, bi-polar disorder, sometimes they are untreated, but sometimes the psychiatric treatment simply isn't sufficient for them and they require a more structured environment to be able to function. FCI Sheridan is classified as a Care-Level 3 Mental Health Institution and what that means is that we have a fairly large percentage of inmates who have severe and persistent mental illness who require increased contact with psychologists and psychiatrists. And we have inmates with all sorts of diagnoses to include schizophrenia, bi-polar disorder, other psychotic disorders, personality disorders and organic brain impairment and mental retardation. So we have approximately 25 inmates right now who have a Care-level-3 designation. We also have approximately 80 inmates who have a Care-level 2 designation. A Care-level 2 designation is somebody who may have a mental illness but who is functioning fairly well and they require contact with a psychologist approximately once a month, sometimes maybe a little bit more, but they require that level of contact to be able to function adequately. So we have our Care-Level system that is, that ranges from Care-Level 1 to Care-Level 4 in which we classify severity of mental illness. So as we were, about four or five years ago we started noticing that we were getting an increase percentage of inmates with mental illness and our population of Care-Level 2 and Care-level 3 inmates started to increase. And so what we realized was that we wanted to get a paradigm and program onboard at our institution so that we could effectively manage this population. And so we began to develop our culture and our institution toward recovery and we looked at creating a recovery community. And what that meant for us is that we began to bring inmates in to our treatment program with the idea that as they completed their treatments they would begin to establish relationships with other people who were less far along in their treatments. And so this created a service orientation among our inmate community, which really was the birth of our recovery community here at FCI Sheridan. So we began to develop that but in conjunction with that we looked at developing a paradigm of service of delivery so that we as psychologists could begin to talk with each other about how best to deliver services to the inmate population. And the slide that you see on your screen really denotes our inmate centric approach to treatment. Of course

we know in corrections that inmates are our business and we are here to help the inmate population but also anybody who works in corrections know that in a practical way the system doesn't always support and promote inmate health. And so our paradigm for service delivery is that psychology services, correctional services, health services, and particularly unit and case management work together in support of the inmate. And we establish communication that allows the inmate to grow and thrive in our environment. Along those same lines our service delivery is multi-disciplinary and all of the disciplines that I just mentioned meet on a monthly basis to talk about individuals that we have in our population who have mental illness and figure out the best way to support them, either by adjusting their medications, providing additional psychological intervention, modifying their housing environment or recommending ancillary services such as educational programs or religious service programs that will support the inmate in their growth.

Slide 5:
FCI Sheridan Mental Health Program

- Support Services
  - Supported Employment
  - Peer Support/Mentor Program
  - Environmental Support
- Treatment Services
  - Evidence-Based Treatment Groups (IMR, DBT, SST, Cog)
  - Wellness Program

Dr. Cynthia Lenning: So along with the paradigm that we use to deliver services, in 2012, I read an article that was published by Jamie Fellner, and it was entitled Corrections Quandary: Mental Illness and Prison Rules and the article really solidified my thinking on the necessity of a creative approach in a prison environment to managing mentally ill inmates. And what we thought was that it's not enough to provide psychological and psychiatric services, it is a necessary component, but it's insufficient in the promotion of overall health and functioning in this environment. And the way that which we conceptualize our services at FCI Sheridan is really under two broad umbrellas. And one is support services and the other is treatment services. In a little while I'm going to have Dr. Hinman talk to you about the treatment services that she provides but I am going to speak about the support services that we have developed at FCI Sheridan.

Slide 6:
Supported Employment

Graphic: Four photos of inmates doing various jobs

Dr. Cynthia Lenning: The first of our goals in developing our program was to foster self-sufficiency because these inmates will be released back to our community and we do them a disservice if we don't teach them how to support themselves. The problem with that is that sometimes people with mental illness have a really hard time working in regular jobs in a prion environment. And so what we found was that many of our mentally ill population lose support from their family when they are incarcerated and they become dependent on the charity of others, which sounds, it's kind of a nice way of saying that they beg for things a lot of the time they ask other people for coffee, they ask other people for hygiene supplies and what ends up happening or what can happen is that, that kind of relationship with other inmates can make them very vulnerable to being taking advantage of in our inmate population. And so we recognized that what needed to happen is that we needed to create employment opportunities for our mentally ill inmates. And so we have two ways that we assist with this. And the first is through a sheltered employment experience. Psychology services created a work detail we currently have 22 inmates working on our psychology services day crew and what it is, is a garden assignment and they are on our compound raking and planting flowers and tending the grounds of our institution. And it's all people, the day crew is comprised of all inmates who have mental illness either our Care-level 2 or Care-level 3 inmates so they have

moderate to severe and persistent mental illness. And we also have inmates who are classified as mentors - working with those inmates and we'll talk about our mentor program in a little while. But our day program has been very successful we have two details, one occurs in the morning and one occurs in the afternoon and this work detail is really for our inmates who cannot, because of the symptoms that they have work in other areas in our institution. So for those that's the sheltered employment. For those inmates who are perhaps a little bit more capable or a little bit more willing to go into a mainstream job we have supported employment experiences. And our supported employment program is an evidenced based program that we in psychology work with other work with other work detail areas to create job opportunities for inmates with mental illness and currently we have supported employment opportunities with our food service department, with our housing units as orderlies, with the facilities department, which are the workers who maintain the additional grounds and who may work in heating and air conditioning or repair and we have supported employment opportunities with prison industries which is called Unicore. Our supported employment program works in a way that we in psychology services the primary psychologist typically will contact the work detail supervisor and will share with that work detail supervisor certain ways that the inmate can be useful to them in employment. And the work detail supervisor and the supported employment job site and the psychologist will work together to help that inmate navigate all of the challenges that he will face as an employee. So there's a lot of communication between the psychologist and the work detail supervisor and the inmate knows that we are communicating with the work detail supervisor so when there's a problem. For example, if his symptoms are really bad on a particular day, he will go to his work detail supervisor and he will talk to them about his symptoms and the work detail supervisor will kind of make an assessment about whether or not they can handle assisting that inmate on the job site or they may send him to psychology services or we may have another task for the inmate to do on that day so that he can remain in that job. That has been very very successful for us in having inmates learn new skills and also become productive participants in our workforce at FCI Sheridan. In conjunction with our employment opportunities we also have a specific horticulture apprenticeship program that is run through our education department and through the department of labor that allows inmates who are in our psychology services day crew, which is the sheltered employment opportunity, it allows them to develop an apprenticeship program and gain credits towards an apprenticeship and job skills for the community in horticulture and landscape maintenance, which can be, I think, very useful for our inmates when they release to the community.

Slide 7:
Peer Support/Mentoring

Photo of hands with the following text – informal, understanding, express, inspiration, share, value, open, passion, pro-recovery, listen, support, mind, non-judgmental, opportunity, students, honesty, positive, confidence, motivation, talking, safe health, positive

Dr. Cynthia Lenning: The next support service that I would like to talk with you about is Peer Support and Mentoring. So just in the same way that we realized that inmates required employment experience to be able to function both in the prison environment and also when they release to the community. We believe that peer support is critical for people's acclamation into the prison environment and also their success and so as you know for many people with mental illness outside of a correctional environment it can be very difficult to socialize and develop healthy and supportive relationships. That is particularly true inside a correctional institution when people who have mental illness may not be able to accurately judge people's intentions or motives and interactions and so they have a higher than average likelihood that they could be victimized in a prison environment. So we felt it necessary and very important to be able to develop a Mentoring Program. This initially was received with some skepticism among the staff members at the prison. They were not at all convinced that having some inmates responsible for taking care of other inmates was a good idea- they felt that people might get taken advantage of, so I think that's a valid concern and one that we too were thinking about and were not sure how to implement a peer support program. So what we did was we had a lot of conversations with our Unit

management team, and our unit management team consists of correctional counselors who help inmates navigate things like the phone system and visiting list and take care of the hygiene on the housing unit, case managers who are responsible for looking at transition of care from incarceration to the community as well as their programming while they're in the institution and then Unit managers who oversee the general running of the housing units. So we worked closely with unit management and one of the counselors who happened to be a very well respected counselor who was involved with all sorts of other activities like tactical operations, so he was very well respected happened to think this was a good idea and what he did was he started using some inmates on the housing units to assist with some of the mentally ill inmates. And our other staff members saw that he was doing this successfully and they realized that it could really work. And so it was through this collaboration between psychology services and unit management that our Mentor program really got off the ground. We started small, we started with only three inmates, and we found that it would work better if inmates were assigned to tasks rather than to specific mentally ill inmates. And so we have currently inmates that are assigned to tasks like our gardening crew, we have inmates assigned to our wellness program, we also have inmates that are assigned to specific treatment groups and Dr. Hinman will talk about that a little bit later. So, the mentoring program was kind of slow to get off the ground and we did that purposefully so that we could control the types of interactions that our mentors had with inmates. One of the things that was very important to us in developing our mentoring program was to select the right inmate to be mentors. And so what we did was we had inmates who had a lot of involvement with psychology services prior to us developing our mentor program and I think I'll let Dr. Hinman enter into the conversation here and talk to you about our mentoring selections and also the current state of our mentoring program.

Dr. Hinman: Thank you Dr. Lenning. Just want to give a little bit more information about how this mentor program or what we also refer to as the Inmate Mental Health Companion Program works. As Dr. Lenning said because of the sensitive nature of this assignment as a mentor there needs to be a lot of attention paid to how we are selecting these individuals. The way that we select these individuals, like Dr. Lenning said is we typically pull from a group of individuals who are already on the radar and providing services or checking in with Psychology relatively frequently so we can know that we have a good understanding of what their motivations are and so once somebody expresses interest or is referred to become an inmate companion or mentor we first screen them through a pretty lengthy process where we talk with their work supervisors, we talk with their unit team staff, we also talk with staff who are familiar with any affiliations, gang involvement, disciplinary issues, kind of the internal investigative group of staff here to see if they're on the radar in any negative way that would put them at risk for potential issues as a mentor. There's also things that we have to look at like disciplinary history – individuals who are considered mentors can't have a serious disciplinary issue within the last 3 years. They have to be financially responsible, meaning that they are making contributions to their restitution or legal fees; they can't be in refusal of doing those things. And of course, we want to make sure they don't have any history of sexual offense against an adult. Once we determine that they meet that screening criteria we interview them and gather more information about why they're interested in this position, what they think they can contribute and what specifically they would like to do if they are selected. After that we decide to bring them on as a mentor. These individuals will still have a job assignment with whatever their original job was, so they have this mentor assignment in addition to their original job. And then from there they receive training frequently, they also have weekly meetings with the psychologist where they're provided training on how to interact with individuals with mental health issues, they're educated about specific diagnoses and the symptoms to look out for. We talk a lot about social skills, validation, radical acceptance, pulling in some of the DBT materials, which we'll talk about a little bit later just overall communication skills. We talk a lot about stigma, and the stigma associated with mental health issues and how that can play a part within the prison environment. And we talk about bullying and what role bullying plays a part in and talk about how prison culture and kind of the unwritten rules of prison really kind of goes against the expectations of mentors and how they can work with that and still have some involvement and participation without feeling like they're putting themselves at risk with the other inmates in the population. And we also provide a lot of training on suicide prevention and warning signs to look for and how to communicate those concerns to staff if they do arise. We have these individuals involved in activities with the inmates with mental illness as well, we think that's an imperative part of this program, is that they're participating in the groups right

along with the individuals that are experiencing mental health symptoms because that shows an alliance and it shows that it's not us versus them, we're all here to learn together. We really talk to the mentors as if they're here in treatment as well. Maybe not for significant mental health issues but we bring in a lot of criminal thinking and the fact that we need to focus on re-entry and being compassionate individuals, and that showing compassion for your fellow man is a re-entry offer and so we do bring in a lot of that as well. So the mentors are participating in the evidence-based group right along with the individuals who have mental health symptoms and they're learning the skills right along with them that they can incorporate those coping skills outside of group with the inmates, you know, in the day to day interactions they have with them, whether it's their cellmate or it's out on the recreation yard or at work and so we think that's a really important aspect of the program as well. I'm going to hand it over to Dr. Lenning to continue on.

Slide 8:
Environmental Support

- Open Door Policy
- Incentive Program
- Communication between Correctional Services and Psychologists

Dr. Lenning: So I want to talk a little bit about environmental support because it's so difficult in a prison environment to really create the kind of environment that allows people to grow and flourish and that's really what we've tried to communicate and to create here at FCI Sheridan. And some of the things that we have done for our inmates who have severe and persistent mental illness is that we've created a drop in center and so during the intake screening process psychologist always meet with inmates, we meet with 100% of our inmates whether or not they have mental illness, but for those inmates who are identified as having some mental illness they are informed at intake that our doors are open for them and so we have controlled moves in our institution and they are allowed to come down and talk with us during a controlled move if they need to. And so what that looks like is that we may have an inmate show up say at the 10 o'clock move and we will allow that inmate to spend a few minutes with us talking to see what the issue is and if we think that they require additional intervention at that point in time we will find out where that inmate needs to be and we will communicate with staff members that we have that inmate so that we have accountability and control of our inmate population. So the drop in center sometimes looks like somebody listening to some relaxation CD's, sometimes we allow people to sit in a quiet space and perhaps draw for a little while, sometimes we bring them into the psychologist's office and we have a crisis intervention center, but it's a safe place where people can go if they are experiencing symptoms that they don't know how to handle themselves and we're always working, when we have these drop in contacts we're always working toward self-sufficiencies. So we're teaching inmates skills at all times about how to better handle their own mental health symptoms so that they decrease their reliance on this type of an intervention. We also have for support, we have an on-call psychologist, who is on call, we rotate through the psychologist list and they work very closely with the Lieutenants in our institution to ensure that after hours inmates who are having symptoms have support. And so if we get a call we are on call we come in and we talk with the inmates and we make sure that those inmates are able to manage their symptoms and are not experiencing any kind of a suicidal crisis. Another aspect of our environmental support is the development of an incentive program and currently we have an incentive program to improve hygiene skills and to increase medication compliance. And that is simply a behavioral reinforcement program where inmates can earn specific incentives if they conform to treatment requirements or other behavioral requirements that we have for them. We have a radio program, which is, we have a number of inmates who are indigent who don't have any money at all coming in from the outside and still have very serious psychotic symptoms that music helps them manage and so for those specific inmates we in psychology services have a cache of radios that we will loan out to inmates so that they can use music or listening to other kinds of talk radio or news programs or sports programs so that they can use that to better manage their symptoms. This is particularly effective when an inmate who has severe and persistent mental illness and specifically psychotic symptoms goes into special housing, which is our segregated housing. Most of us are aware that when somebody with psychotic

symptoms is placed in special housing and restriction their symptoms can worsen and we want to make every effort to give them the tools that they can use to help reduce their symptoms. And so the radio program has been very successful for our inmates who have mental illness who have been in special housing. One of the things that we do is increase our communication and to look at managing and treating our mentally ill inmates with, as a team effort, and so we have established communication through multiple modalities. We communicate with correctional services and unit management and people in other departments, staff members in other departments, informally, all of the time through email and phone and in casual conversation when we do our rounds throughout the institution. So being visible to other staff members, and to show that we are supporting, we in psychology are supporting the efforts of other staff members who, I think, have been instrumental in the success of our program. Dr. Hinman also creates a document that all staff have access to that identifies those inmates who are in our mental health program and who sometimes may become unstable because of their mental health symptoms and in this document she makes suggestions of things that staff members can try to de-escalate an inmate if he is becoming agitated or appears to be having an exacerbation of his symptoms. We have information for our unit officers that is in the officer station, which is where the office is, and every day Dr. Hinman and I are walking and talking with staff to make sure that staff members if they have any questions have an avenue to be able to get their questions answered. Another way that we facilitate good communication is through our work with our Disciplinary Hearing Officer. So one of the things we noticed was that mentally ill inmates are not very effective advocators so when they get in trouble sometimes their symptoms are influencing the way that they act and behave and yet they often can't really communicate with the necessary insight what has been happening for them so they may receive more severe sanctions than inmates who are better able to articulate their position within a disciplinary process. And so some of the ways that psychologist work with our Disciplinary Hearing Officer is that we conduct assessments of competency and responsibility for our inmates who have mental illness and we put that information forward to our Disciplinary Hearing Officer so that he or she can have a better understanding of all of the influences in the inmates behavior at the time of the act and also for us to be able to weigh in about whether they are competent to proceed with the disciplinary procedures. Psychologists and particularly I do this more than the other psychologists I act as a staff representative and I will attend the disciplinary hearing with the inmate and help the inmate walk through that process of explaining what his thinking was at the time of the offense so that he can better communicate with our disciplinary hearing officer. And finally what we do is that we recommend creative sanctions for individuals who have mental illness and that may look like recommending one sanction instead of another. So for example, I worked with an inmate who had recently reestablished communication with his family and he got into trouble and one of the sanctions that's available to the disciplinary hearing officer is to restrict his phone privileges and so the inmate had just recently established communication again with his family and I felt like that would really be a setback for this inmate. And so in the course of the proceedings, I recommended that the inmate not lose his phone privileges so that he could keep up that family support that he had recently established. And our disciplinary hearing officer has been very willing to work with us in that regard. In terms of environmental support training has been a critical aspect of the things that we do and I've already mentioned that Dr. Hinman and I provide a lot of informal training to our staff members, but we have provided formal training as well. Recently back in November we conducted a 3 day training seminar for 35 of our correctional staff and that was a 3 day experience of teaching staff how to manage mentally ill inmates when they are in crisis, how to establish good working relationships with our inmates who have mental illness and how to increase their comfort level in dealing with people with mental illness. And so we had that training experience and then every year during our annual refresher training all correctional workers go through that in the Bureau of Prisons and every year we also offer a seminar during that training about dealing with inmates who have mental illness. So those are some of the environmental supports that we have in place at FCI Sheridan. But probably the most impactful source of environmental support has been the development of our mental health unit. And I'm going to turn it over the Dr. Hinman so she can talk to you about that.

Slide 9:
Mental Health Unit Population Characteristics

- 36 inmates with diagnosed mental illness, not including substance abuse

- 31% Psychotic Spectrum
- 44% Mood Disorders
- 33% Personality Disorders
- 5% Organic/Developmental Disorders

Dr. Hinman: Thank you Dr.Lenning. So, as Dr. Lenning previously mentioned, we have a large number of individuals incarcerated here who have either Care-2 or Care-3 designations as far as their mental health condition goes and we have individuals with mental health issues and Care-2 designations across the whole compound meaning their not all living in one particular housing unit they're spread out across the compound. However, what happened is that we established a unit that's referred to as the Mental Health Unit, and we do put all Care level 3 inmates in that housing unit and as Dr. Lenning mentioned our cap per the Bureau of Prisons will be 25 as far as that number goes, but we brought over approximately 20 to 30 Care level 2 inmates as well. The housing unit itself has a max capacity of approximately 120 so as you can see that leaves a lot of other beds open for individuals who aren't Care 2 and Care 3. The purpose of this is that we do not want to have the unit solely for individuals with mental health issues and the reason for that is we really want to make the experiences individuals that are here for mental health issues and for treatment as close to general population as the rest of the housing units, we don't want to kind of isolate them from the rest of the inmate population we want them to be acclimated and to develop skills and to be out there working and participating in education and recreation activities just as all the other inmates are doing. And we recognize that by secluding them together in one housing unit apart from the rest of the population wouldn't necessarily provide us the best opportunities to do that. And so as I said, there are 25 Care 3s, approximately 20 to 30 Care 2s and the rest of the population of inmates are going to be just general population inmates that we have had support to select from the general inmate population who are relatively more pro-social don't have history of bullying or trying to run inmates off the housing unit for any particular reason, more tolerant, respectful, not necessarily in there with the mentors helping day in and day out, but providing a supportive environment that's more conducive to the individuals with mental health issues feeling safe, feeling comfortable, feeling supported. And so we have had support from our executive staff and the unit teams to be very selective in who we have with in the housing unit apart from the mentally ill individuals for that purpose and that's been a huge component of this program as well. In addition to those individuals that are living there, that are Care level 1 relatively pro-social we also have our inmate mentors which I previously described residing on that housing unit. Now we also have a large number of our suicide companions who are those inmates who provide observation for individuals who are on suicide watch, a large number of them are located in this housing unit as well. Every inmate who comes and lives on the mental health unit and is not there for mental health treatment is given a kind of tutorial and sort of expectations are put out there very clearly, very firmly about what the expectations of them are. They're told they don't have to necessarily involve themselves in the programming that's available but they are expected to be pro-social, supportive, helpful, and that any straying away from that expectation in any way they are kind of rolling the dice of potentially getting moved out of that housing unit and into another one. And for the most part individuals like to live in that housing unit, they find that there are more opportunities to engage in programming. There are activities happening on the unit, they have a psychologist on the housing unit if they ever need to speak with somebody and it typically is a quieter unit given that the numbers are a little bit lower than the other housing units, so there is some kind of incentive for these individuals to abide by these expectations that we have set for them. In addition to the evidence based treatments I'm going to get into next, we also do a group on the mental health unit that's called the alliance group. And that group is for individuals that are living on the housing unit who aren't necessarily official mentors and who aren't there for mental health treatment but we want them to have the opportunity to learn about mental health issues, to get some training, these are individuals that we see doing types of things that mentors do on their own without any expectations of something in return, it's not their job, it's not their assignment, they haven't signed a piece of paper saying that they're going to participate but we want them to reinforce their efforts by providing them opportunities to get some program participation points, so we've started a group where they're able to learn about mental health issues, learn about social skills from managing individuals with mental health issues and so that's been another thing that we've done. So as far as

the individuals that live on the housing unit who are there for mental health treatment you can see on the slide that you're looking at that diagnostically they're sort of across the board, while I said it's 36 right now at capacity it will be approximately 50 to 60, 31% of whom have a diagnosis of a psychotic disorder on that spectrum, 44% of whom have a mood disorder diagnosis, 33% of whom have a personality disorder diagnosis typically anti-social personality disorder or borderline personality disorder, sometimes dependent personality disorder, and sometimes a combination of those and then 5% with an organic or developmental disorder, you'll notice those numbers exceed 100 but we know that there are dual diagnoses that are often present and so that accounts for that.

Slide 10:
IMR

Radial Cycle graphic – Recovery (center), Self-Direction Responsibility Empowerment (top), Holistic Person-Centered (right), Non-Linear Strengths-Based Hope (bottom), Peer-Support Respect (left)

Dr. Hinman: So now we'll get into a little bit about our evidenced based treatment that we provide in the mental health unit as well as across the compound here at FCI Sheridan. Illness management and recovery or IMR is one of the evidence based treatments that we provide and not only is this a group that is provided to these individuals and the treatment protocol we actually use IMR and the tenants of IMR and the foundation and fundamentals of IMR really in our communication about mental health issues and this program when it comes to communicating with staff and some of these terms that I'm going to mention, you've probably already heard Dr. Lenning mention in this presentation. IMR is an educational evidence based treatment that provides psycho-education, it provides recovery strategies, it incorporate motivational strategies and it has 10 fundamentals that comprise this idea of what recovery is. Self-direction is one of them that Dr. Lenning mentioned we really want these individuals that are here for treatment to feel like they're self-sufficient like they are not relying on everybody else to provide for them or to tell them what they need to do or to make the choices for them. It's really about being self-directed; it's about making choices about goals and how to achieve them. We also talk a lot about responsibility, about setting goals, learning new skills and engaging in self-care. In group, individuals are setting goals, they're taking large broad goals and breaking them down into smaller more manageable goals and sharing their goals with one another and them the next week in group about they took a step towards that goal or maybe a barrier that got in the way of them meeting that goal and processing through those and giving each other advise and praising one another. We also talk about empowerment. People have appropriate power within their environment we want to show these individuals that they can find that in positive ways rather than maladaptive ways. It's a holistic approach to treatment, as Dr. Lenning, mentioned, recovery encompasses all parts of a person's life not just their mental health diagnosis and receiving psychiatry or psychology services, but also receiving recreational services, work, education, religious or spiritual support, so you really look at it as a holistic part of their treatment. And we really focus on the person, we look at each individual as what they are individually, we look at their specific needs and we tailor their treatment to their specific needs. It's non-linear, meaning that they understand that there's going to be set-backs along the way. They're in a constant process of growth and change, they may have set-backs but that doesn't mean that they've failed and we talk a lot about that pretty openly in group and we really encourage people to share their set-backs and not to judge themselves by them but to rather look at that as a strength to be able to identify them and continue moving forward from those experiences. We really focus on strength based treatment, building on strengths and coping skills not just talking about what's going wrong and what's not going well but what's going well. What are the positive parts of themselves? A lot of these individuals in treatment say, you know all I've ever heard, all that anyone wants to know is are you taking your meds, are you taking your meds, rather than asking about other things, how's your family, what's going well for you? You know, have you gone to church lately, how's your school going? So we really encourage people to focus on things other than just medication, although of course medication is an important component of treatment as well. In this idea of hope we really want to constantly focus on this idea of hope that individuals with mental health issues in the

community as well as in prison can live a life worth living and that having a mental illness does not mean that you can't have a positive and productive and happy life. So we really bring in this idea of hope in any way that we can. Peer support as we've previously mentioned is a huge component in the community when IMR is implemented they really bring in family members and friends, and sometimes those individuals are even coming to sessions with them or doing groups with them. We want to try to figure out a way that we can adapt that idea into the prison environment and that's where we utilize a lot of the mentors or cellmates of these individuals or even just individuals they've identified in the housing unit who are helpful and supportive to them, we try to bring them into their treatment also. And the last one being respect we really talk a lot about stigma and the stigma associated with mental illness. You know these inmates, they watch the news, they see the stories that are out there about individuals with mental illness and the things that they are doing out there and so to not talk about that would really be doing a disservice to what we know is happening. And so we bring it out and we process through it and we talk about it and they talk about how maybe they've encountered similar stigma and we talk about how we can fight that stigma both within ourselves but also in our interactions with others. So as I said it's a treatment that's provided via a group in the housing unit but it's also the framework that we really work from and all our interaction and communication with staff and inmates as well.

Slide 11:
Mental Health Unit: Evidence-Based Treatment Services

- Dialectical Behavior Therapy
  Skills Training Manual for Treating Borderline Personality Disorder (Linehan, 1993).
- Social Skills Training
  Social Skills Training for Schizophrenia: A Step-by-Step Guide (Bellack, et.al., 2004)
- Basic Cognitive Skills
  Basic Cognitive Skills, Breaking the Cycle Series (The Change Companies)

Dr. Hinman: In addition to illness management and recovery groups which I provide on the housing unit we also provide a few other types of treatment services both in the mental health unit but also in other housing units as well for the rest of our population who have mental health issues as well. One of which is dialectical behavior therapy or DBT, we incorporate the materials of Marsha Linehan's and we also talk a lot about given that a lot of our individuals who come here do have symptoms of personality disorder whether it be borderline or anti-social, we talk a lot about coping skills and developing adaptive rather than maladaptive strategies for having your needs met and how prison in and of itself an environment where you do have a lack of control and finding in ways that you can find control that doesn't end up putting your safety at risk or getting you into trouble. We also provide social skills training consistent with the social skills training for schizophrenia materials. And then we have the basic cognitive skills group, like the Change Companies materials on Breaking the Cycle Series. And as I previously mentioned we don't just include individuals that are Care-2 and Care-3 in these groups we also pull in, while keeping the group numbers somewhat low to account for the anxiety that comes along with being in a group, we want to bring in individuals on the housing unit who maybe don't necessarily have a diagnosed mental illness but they're interested in learning these skills and what that does is help bridge the gap between us, meaning the mentally ill individuals, and them, meaning the rest of the inmate population, it gets everybody else on board with the mission, as well. And also teaches skills good life skills to the other individuals who might not have significant mental health issues but also could benefit from the skills that evidence based treatments provides.

Slide 12:
Graphic of triangle with text: Wellness Program and 3 text boxes: 1) Leisure Skills 2) Fitness 3) Nutritional Education

Dr. Hinman: In addition to the evidence based treatments that we provide via group, we also have what's called the wellness program. And this has been a really large and imperative part of the mental health mission here at FCI Sheridan. What we found and what people can probably relate to is that individuals with mental health issues often do

feel comfortable A.) maybe even leaving their cell and certainly perhaps, leaving the housing unit and going to recreation where there's a large number of inmates many of whom maybe aren't the most supportive or maybe even fearful of getting wrapped up in the politics that come along with being in prison, sometimes the relevance of putting themselves in those situations they may avoid those situations altogether and they lose out on having their recreational fitness needs met, leisure skills met, so what was developed here was a wellness program. Monday thru Friday every morning for about an hour in a half to two hours there is a time set aside in our recreation department where individuals who we have identified and we try to keep the cap at about 25 just to keep the numbers low, they are able to go out to recreation when no other inmates are out there, no other individuals are out there and make use of all the facilities that are provided through recreation. That includes the basketball court that includes the cardio exercise machines, that includes the ping-pong tables, so there's social interaction available, there's physical health opportunities available and there are recreation workers out there, inmate workers who are supportive and encouraging to them. Some of them are also our inmate mentors and so that works out pretty well also. In addition what we found is that you know individuals with mental health symptoms similar to ours in the community don't always have the best nutritional knowledge or skills and so one thing that we've implemented recently is that we found some material that was put out by Boston University and it's an evidence based curriculum called food education for people with serious psychiatric disabilities. It's an actual manualized program that was developed by collaboration by Boston University's nutrition and fitness center and their center for psychiatric rehabilitation so those materials were provided by psychology to the recreation department and they're going to be stating a nutrition class for individuals who have both psychiatric disabilities but also struggle with nutrition and weight and that sort of thing. In addition to the wellness program through the recreation department on the mental health unit we also have additional activities that are available on the housing unit apart from recreation. Some of those include, we have guitars on the housing unit and we guitar classes that a couple of our inmates teach. So that's something that's been really helpful even for those individuals who don't necessarily want to leave and go up to the Chapel and use the musical instruments up there they still have the opportunity to do so on the housing unit. We also have yoga classes that are taught on the housing unit in addition to up at recreation so the inmates who are a little bit worried or anxious about going and doing that at recreation have the opportunity to do that on the housing unit as well, we have art supplies. We're going to be purchasing more exercise equipment and that sort of thing so we're really trying to have these types of services available both on the unit but as well as recreation and encouraging these inmates to slowly kind of acclimate to the prison environment and find themselves out recreation eventually.

Dr. Lenning: Thank you Dr. Hinman, Dr. Lenning back here and it's always exciting for me truly to listen to the things that we have incorporated for our inmates who have mental illness because I know that it is a unique experience for many of them being in prison and having access and having the support that they find at our institution and what I think about when I hear Dr. Hinman talking about all of the great things she's implemented is the fact that we have been able to alter our culture at our institution to support these innovative programs.

Slide 13:
Challenges

- Cultural Development
- *Stigma of Mental Illness*
- Staff Motivation and Establishing Buy-In
- Time Consuming and Labor Intensive
- Managing Liability

Dr. Lenning: So I want to talk with you about what some of the challenges have been that we have faced as we've done that and right now we are approximately five years into adjusting the culture of our institution and so we started by creating a recovery community and I have talked about that to enhance inmate participation and inmate support of individuals who are involved in changing their lives in support of the mental health mission as our facility. And it

really has taken that long to be able to kind of nudge the inmate population along to accept people who sometimes do very bizarre and strange things within the inmate population and so our inmates have been primed to demonstrate greater tolerance and some compassion and many have a helpful attitude toward other inmates who are struggling with mental illness or behavioral problems. One of the things that we did to really facilitate this cultural change was in our mentor selections. The mentors that we have chosen aside from all other criteria that they have met, that Dr. Hinman talked about, the mentors that we have chosen really are men in our environment who have been perhaps in prison for a long time who are strong and who are not afraid to stand up and say I am going to play cards with an inmate who is mentally ill and they're not going to threatened by that in any way, and I think that's been a really important piece of the puzzle, because once other inmates see inmates that they respect associating with inmates with mental illness it opens the door for greater acceptance of our inmates who have mental illness and so that's been very useful to us. In the development of our recovery community we have had numerous therapy groups that have had service work components attached to them and by this I mean, the inmates who do not have mental illness go in to participate in a group but as part of the group and completing the group they must complete service work projects and so we have tried to shift the focus of our inmate population generally to a more service oriented approach to life. In the course of developing our recovery community we have also increased our suicide companion work cadre, Dr. Hinman talked a little bit about that. Our suicide companions are inmates who are specifically trained to observe other inmates who are placed on suicide watch, there's many many perimeters of that but I don't really have time to go into today. But suffice it to day that when inmates do come off suicide watch and re-enter general population our suicide companions are instrumental in helping those inmates readjust into being off suicide watch, and they work closely with our inmates who come off suicide watch to really feel comfortable back in general population.

Dr. Hinman: One of the other challenges that comes along is clearly there is a stigma attached with people with mental illness, not just in the prison population, but in the community as well, but you can imagine the stigma that is present out in the community with regards to mental illness is only exacerbated within the prison walls. Staff as well as other inmates fear the unpredictability of inmates with mental illness, inmates avoid other people with mental illness. The use of the mentors as Dr. Lenning mentioned is something that we really use to sort of combat that stigma. I can't really speak to how much that has really helped in our selection of those mentors being respected individuals, being people who perhaps at one point would've never been on the radar to be selected as a mentor because of the lives that they were living. The fact that they've made the change is that they have decided to take a different path provides some credibility amongst the inmate population but in a positive way to where we can utilize them for the needs of our program. I think combatting that stigma amongst staff is just a matter of A.) providing training but it's also just being very aware of how we communicate about mental health issues in general when we are among our staff remembering those ten fundamentals of recovery and talking about hope and not referring to them as a lost cause. Pointing out inmates, oh see that individual over there out there at rec, he happens to be one of our Care 3's and look how well he's doing. Because often times all of the focus is on a select few inmates with mental illness who are not doing so well or who are taking up all of our time and resources, so we really have to balance that out by pointing out and discussing and talking about our success stories which are often times in greater numbers than the ones that are struggling but because the ones that are struggling take all the attention it seems like they are the bigger majority. As we previously mentioned we did a training back in November but we're not just that we're walking and talking and doing informal training day in and day out just in our conversations and when we go up to speak with an inmate on the housing unit who have mental health issues often times we'll pull over an officer as we're talking with this inmate so that he can, he or she, can really see how we're talking to them, what words we're using, things and then they'll realize oh I can do this to I don't have to be a psychologist to use some of the interventions and so we do that on an informal basis, nearly every day. Another thing that we do is that we really want to provide positive praise to those staff members, particularly the unit officers who are really kind of taking this mission and running with it, who are in there and wanting to learn about it, and they're working the housing unit and they're walking around the unit and talking to these inmates, learning about them, we really want to let them know how much we appreciate them and often times we will A.) will tell them that but other times we'll also let their supervisors know- Hey you know, Officer Smith has

done x, y and z, and he's a huge asset to what's going on here, Dr. Lenning is the supervisor over Psychology will often times recommend them for awards and incentives with their supervisors as well. And we also encourage staff to just give their honest opinions about how they think that things are going and then validating their emotions as well, letting them know I can understand why you have concerns about this mission because of things that have happened and that makes sense to me and what can we do with that emotion so kind of turn it into something positive. So we try to have very frank and transparent conversations with them as well. We also ask them for advice on what can we do to make things work better. A lot of them wanted the training so we provided the training. People recommended oh not everybody at that training or invited to training was able to attend, what do you think about taking these materials and putting them on the housing unit and so we did that. We also validate the fact that these individuals or inmate in general but especially ones that have mental health issues are often times very time consuming, very labor intensive for every department, not just psychology not just correctional services and so we don't try to hide that we try to just lay it out there and say you know what you're right they are but here's the strategies that you can use to really make the most out of that time. We talk a lot about reflective listening, validating the inmates and know that you can still have firm boundaries and let them know what the expectations are and hold them accountable in a way that's also going to give them a buy-in give the inmates to kind of do what you are asking them to do, you know taking a little more of a softer approach doesn't mean that you are being soft it just means that you are being strategic and that you are using your skills as a flexible correctional officer to have whatever you're needing to have happen in an effective way in a safe way. And so often times, we'll talk about that in training but I think the most beneficial way that we've communicated those strategies is just by modeling them and pulling along those staff right along with us and showing them, look I'm a psychologist, I provide treatment but I'm also holding these inmates accountable as well and here's a way to do that.

Dr. Lenning: Thanks Dr. Hinman, Dr. Lenning back here and I want to talk just for a few minutes about managing liability because in our world corrections that's very substantial part of what we do which is ensuring that we're behaving with integrity and in accordance with policy and documenting things as they happen and in a way that's accurate and shows that we have done our due diligence in the treatments and the interventions and the recommendations that we make. So one of the things that has been a challenge for us is to ensure that all of the stakeholders, and by stakeholders I mean all of the people who have a vested interest in what's happening at our institution are informed and on the same page with regards to the steps and actions that we are taking as psychologists in managing this population. And so specifically we have our executive staff which comprises the warden and our associate warden and our captain, and our executive assistant and we want to ensure that all of those people who are in charge and responsible for the daily operations of the institution agree with the perspective that we put forward and are on board with the way that the institution is being managed with regard to our mentally ill individuals. And so it's been very very important for us to be very knowledgeable about the Bureau of Prisons policies that govern what it is that we do. And so whenever we put an idea forward we are always seeking to find the policy that supports or in some cases doesn't support the things that we are thinking are good ideas and so in order for executive staff to feel confident that we are considering the potential liabilities and that our ideas are supporting the mission of the agency and the director of the bureau of prisons we have to make sure that we abide by policy and that our preventions are supported by policy. So that has been something that we have really worked hard to use in terms of policy and to communicate effectively with executive staff. The executive staff has also created what we call and refer to as advisory committee and the advisory committee has a multi-disciplinary panel including the executive staff, psychology services, health services, unit management and correctional services are representatives on this advisory committee and we meet on a monthly basis and we talk about the procedures and the interventions that we're implementing on the housing unit and with regard to special housing and our inmate population. So everybody knows exactly what we are doing with the inmates with whom we are working, and everybody has an opportunity to weigh in on the wisdom of those decisions that we're making and having that transparency across departments has been very important for us to ensure that we're making sound decisions. Finally, an important thing that I believe that we've done is create a very solid working relationship with our union and the union are the sole representatives of our bargaining unit staff and they have a vested interest in ensuring that the decisions that we're making with regard to our to managing our

inmates who have mental illness are in the best interest of our staff and so before we implement new programs or make any decisions about course of action that we're going to take we're talking with the executive staff and we're also soliciting the opinion of the union so that they can weight in and they can know exactly what it is that we're doing. So we have had challenges, we have had instances where or things that we thought were going to work out didn't work out as we thought we've had instances of very difficult inmates creating situations in our institution that have been challenging for staff so these challenges are not dealt with on a one time basis there are things that come up routinely and we just have to remain a psychologist who are in charge of kind of creating the programs we have to remain open and allow ourselves to hear the information and wisdom from other people so that we're able to modify our approach as needed.

Slide 14:

Teach this triple truth to all: A generous heart, kind speech, and a life of service and compassion are the things which renew humanity. Buddha

Dr. Lenning: I want to just conclude with this quotation: Teach this triple truth to all: A generous heart, kind speech, and a life of service and compassion are the things which renew humanity. And truly for us we know that prison and can be a truly de-humanizing experience for inmates and its especially difficult for inmates who have mental illness and one of our missions at our institution is that to help other people learn that compassion is healing so we have strived in the treatment programs and in our interactions with inmates who have mental illness and inmates in our general population to communicate those things which are compassion and kindness and truth and a life of service so that there is a healing experience and a corrective experience in our environment. I thank you for attention and I wish everyone well in their endeavors.

National Institute of Corrections
www.nicic.gov