

Mental Health Management in the Correctional Environment

Tonia Van Buren, Psy.D
Tonia.VanBuren@wisconsin.gov

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Mental Health & Incarceration- Overview

- Increased prison population since the 1960s
 - Rise in crime, mandatory minimum sentences and "tough on crime"
- Deinstitutionalization in the 1960s with little community resources
 - 40,000-70,000 people coming to prison versus mental health hospitals
- 64% of jail POCs, 54% of state POCs and 45% of Federal POCs report mental health concerns (2014)
 - Wisconsin DOC- 45% (2024)

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Non-suicidal self-injury (NSSI)

- Definition:
 - Favazza: "Deliberate, nonsuicidal destruction of one's own body tissue."
 - Includes socially and culturally sanctioned forms of self-mutilation
 - Walsh: "Self-injury is intentional, self-inflicted, low-lethality bodily harm of an unacceptable nature."
 - Most agree that non-suicidal self-injury (NSSI) requires direct/intentional harm and that the harm must occur immediately after the behavior
 - Differentiates between NSSI and indirect self-harm (i.e., eating disordered behavior, overdosing*)
- NSSI is associated with several diagnoses and can occur in the absence of any diagnoses

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Classifications

- Created by Favazza & Rosenthal
 - Major
 - Self-enucleation, amputation, castration
 - Stereotypical
 - Head-banging, biting, peering on eyes
 - Moderate/Superficial (most common)
 - Cutting, burning
 - Two categories:
 - Episodic vs. compulsive
- Difficulties between categorizing minor and moderate NSSI in the literature

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Methods/Frequency

- Methods
 - Cutting is most common (71-82.4%)
 - Arms, wrists, and legs
 - Burning, head banging, hanging*, hitting oneself, punching objects, biting
 - Most individuals use multiple methods
- Frequency
 - Changes vary per study
 - 20-100 times lifetime vs. 12.87 yearly vs. once a week

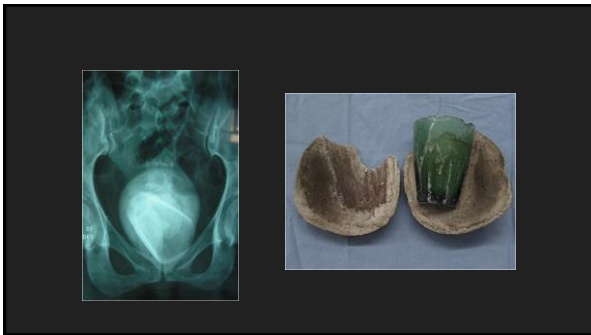
*Once a patient has engaged in self-mutilation more than twice, he is almost certain to engage in it again, and the more frequency he engages in any self-mutilation, the more likely he is to engage in severe self-mutilation.

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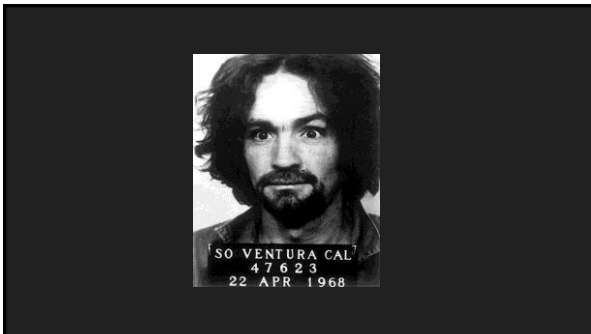
Methods/Frequency

- Ingestion (aka FBI)
 - Atypical, severe NSSI
 - Found to occur with other forms of self-harm, suicide attempts, and risk-taking behavior
 - Mostly reported in inpatient units or correctional facilities
 - Maintained by social reinforcers
- Insertion
- Amputation

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Corrections- NSSI

- Frequency*
 - Incarcerated females- 20- 42.3%
 - Incarcerated males- 5-38.4%
 - Majority have reported their first self-injury incident occurred while incarcerated
 - Number of incidents of self-harm vary per research
- Lane (2009)
 - "38 prisoner" identification- At least two incidents of self-harm with no genuine suicidal intent within any 12-month period during the current incarceration
 - Frequency: 40.9% engaged in NSSI in the past 6 months, 17.4% in the past 6-12 months, and 7.6% between 12-24 months.

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Corrections- NSSI

- Lane (2009)
 - Methods: 98% engaged in cutting, 36.8% banging/striking, 38.7% inserting/ingesting, 34.9% overdosing and 28.3% interfered with medical intervention
- Type of NSSI:
 - 24.2% engaged in only one type of NSSI (96.9% cutting)
 - 31.8% engaged in two types
 - 97.8% cutting, 21.4% banging/striking, 33.7% inserting/ingesting, 28.6% overdosing, 14.3% interfered with medical intervention
 - 43.9% engaged in three types
 - 44.6% cutting, 60.3% banging/striking, 58.6% inserting/ingesting, 70.7% overdosing, 43.1% interfered with medical intervention

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Suicide versus Self-Injury

- Intent
- Cognition/Feelings
 - Suicide
 - Helplessness, loss of control
 - No relief, may feel worse
 - Self-injury
 - Future-oriented, act to gain control
 - Immediate relief, shame may follow
- Methods
 - Suicide: Lethal, typically one method, low frequency
 - Self-injury: Nonlethal, multiple methods, frequent

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Suicide versus Self-Injury

- Overlap
 - 14-50% of self-injurers have also attempted suicide
 - Frequency of self-injurious behaviors also increase in these individuals
 - Comparable depression/suicidal ideation?
 - Some research has found less depression, anxiety, stress and suicidal ideation
 - Methods?
- Individuals who self-injure typically have fewer life stressors, more future-orientation, greater self-acceptance, and higher levels of family support

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Corrections- Suicide vs. Self-Injury

- Approximately 50% of complicated suicides in prison have a documented history of NSSI, several of which occur within one month of NSSI
 - 55% of those with a history of NSSI have attempted suicide
 - Strongest association with self-harm were past/current suicidal ideation, psychiatric difficulties and psychosocial impairment
 - Violence is not associated with NSSI once suicide attempts are controlled for
- A recent study (2023) found that those who engage in NSSI escalate in regards to shorter periods of time between episodes and in lethality
 - All deceased PIOC in the study died by hanging

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Functions of Self-Injury

- Nock and Prinstein's Four-Function Model
 - Automatic-Negative Reinforcement
 - Use to reduce tension/negative emotions
 - Most common according to research
 - Automatic-Positive Reinforcement
 - Use to feel pain
 - Social-Negative Reinforcement
 - Use to escape from other's demands
 - Social-Positive Reinforcement
 - Use to obtain attention

If one automatically believes NSSI is attention seeking/manipulative, there will be less accurate understanding of the function of self-injurious behavior

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Corrections- Functions of NSSI

- Research using Nock and Prinstein's Four-Function Model
 - The subjects
 - 145 men; 56 women (all with history of self-injury)
 - Most common method- cutting (81.4%), followed by head banging, hanging and burning
 - 42% of men reported starting self-injurious behavior after incarceration (7% of women)
 - The findings
 - Automatic Negative Reinforcement (29.4%)
 - Cope with negative emotions/experience relief
 - Automatic Positive Reinforcement (23.5%)
 - Method to punish self, denotation seeking/experience high
 - Creating excitement/relief from boredom

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Corrections- Functions of NSSI

- The findings
 - Social Positive Reinforcement (29.4%)
 - Females: Used to communicate emotional pain and trauma
 - Men: Institution-specific instrumental reasons
 - Obtain medication, move to a different cell, transfer
 - Women and men: Non-institution specific instrumental reasons
 - Influence over family, friends, and intimate partners
 - Social Negative Reinforcement (11.8%)
 - Hurt self as a way to substitute harming others

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Contagion

- Walsh (2004): "When acts of self-injury occur in two or more persons within the same group within a 24-hour period" and "When acts of self-injury occur within a group in statistically significant clusters"
- Direct vs. Indirect
 - Direct → knows the individual
 - Indirect → hears about the incident through the media
- Competitive self-injury
 - Formed using peer hierarchies
 - Self-injury solidifies an individual's "rank"
 - Methods of self-injury may differ
 - Self-injury epidemics are exclusive to self-injury exposure

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Corrections- Risk Factors

- General risk factors: victimization during imprisonment, poor social support, young male, low education level, Caucasian, personal/family history of psychiatric diagnoses, poor coping mechanisms, stressful life events, new conviction, shame/guilt, overcrowded conditions, life sentence, little staff supervision
- Restricted Housing Placement
 - Studies have shown that emotional distress, cognitive limitations, social withdrawal, anxiety, paranoia, lack of sleep and hallucinations are linked to suicide/NSSI in RHU
 - NYC Jail System: 6.9 increase in NSSI even after controlling for SMI, length of stay and other demographic information
 - A study in Louisiana in 2023 found that those with SMI were 5x as likely to engage in self-harm in RHU
 - "Dehumanization" restriction increased NSSI by 14% per restriction compared to violent force

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Corrections- Management Strategies

- Coordination between mental health, medical and security staff
- Avoid punitive/adversarial responses
- Understand/accept inmate's motives
- Behavior Management Plans
 - Use behavioral rewards/incentives
 - Behaviors become nearly impossible to reshape without
- Creation of secure behavioral management units
- Use medications only when appropriate
- Limit use of restraints (use similar standards to those in the community)

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Corrections- Management Strategies

- Understand/accept inmate's motives (i.e., is may not be manipulative)
 - More one believed myths→ the more negative attitude towards the PIOC
- The more negative the behaviors the inmate the inmate engaged in→ the more by correctional staff believe the myths
 - Low severity, repetitive NSSI is perceived negatively, particularly when the PIOC is considered "disruptive"
- In one study, PIOCs indicated that 85% of uniform staff responses and 67% of healthcare responses to NSSI were "unhelpful"
 - May cause PIOCs to "close up" or "make the situation worse"
 - Believe that staff are not trained or have the time to deal with NSSI

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Severe Mental Illness & Incarceration

- 6-15% of persons in jails and 10-15% percent of persons in state prisons have SMI
 - Wisconsin DOC- 37% MH-2as
- What is psychosis?
 - Thought disordered symptoms (loose association, word salad, clangng, etc.)
 - Can demonstrate flat affecton, avallion, impaired interactions
 - May not be able to repeat themselves without becoming tangential
 - Most individuals with psychosis have detailed delusional beliefs

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Psychosis- Auditory Hallucinations

- Most individuals hear voices of both genders
- The voices can be familiar and unfamiliar
- The voices are usually clear
- Research has been mixed on the locations of the voices
 - Voices can occur both internally and externally
- Themes
 - Threatening, obscene, derogatory
 - Content may focus on sexuality ("slut," and "queer")

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Psychosis- Visual Hallucinations

- 24-30% of clients with psychosis experience
- Usually of normal-sized people and in color
- Are usually benign in nature
- Don't change whether the individual's eyes are opened or closed/lights are on or off
- Drug induced psychosis
 - VH and paranoid ideation
 - VH seen better when eyes are closed

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How to Communicate (Northeast Ohio Medical University)

- Recognize that a person experiencing psychosis may find it difficult to tell what is real from what is not real. Understand that the delusions and/or hallucinations are very real to the person. Do not dismiss, minimize or argue with the person about their delusions and/or hallucinations.
- Try to empathize with how the person feels about their beliefs and experiences, without stating any judgments about the content of those beliefs and experiences.
- Communicate in a brief and uncomplicated manner and repeat things if necessary. You may need to break up your meeting into segments, meet on several different days or take breaks.
- After you speak, allow time for the person to digest the information and respond. Try to limit the number of decisions an individual has to make during a single conversation.
- Be aware that the person who is experiencing psychotic symptoms may deny that there is anything wrong or may not want treatment.

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Cognitive Deficits and Incarceration

- 50-80% of incarcerated individuals involved in the criminal justice system have a TBI
 - Higher among incarcerated women
 - General public: less than 5%
- Typically caused by interpersonal violence
- Coincides with trauma and substance abuse
- Kim Gorgens: The surprising connection between brain injuries and crime
 - https://www.ted.com/talks/kim_gorgens_the_surprising_connection_between_brain_injuries_and_crime?language=en

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How to Communicate

- Use simple, concrete language and clearly state what you want to happen
 - Avoid sarcasm, irony, and figurative language
- Keep instructions short, and allow time between instructions for the person to process one before hearing the next one
- Remember that you are speaking with someone who may not possess the skills to advocate for themselves and may have difficulties remembering simple tasks
 - May appear to have a low frustration tolerance

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Questions?

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