NAMI North Carolina
National Alliance on Mental Illness

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NC Division of MH/DD/SAS
Attn: Ms. Marty Lamb
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Dear Marty,

Thank you for your time in meeting with me to discuss general issues regarding moving towards decriminalizing people with mental illness. In the course of our discussion I mentioned that I would summarize for you my concerns about changes that I believe we need to make in rule to improve the situation for people with mental illness who are in correctional facilities. We discussed options for policy changes, rule changes, and also statutory changes. The important thing is to achieve a better outcome; the strategy can vary.

I am pleased that the Rules committee has targeted Criminal Justice as one of the top (third in fact) priorities for rules changes. I was able to attend the retreat in February where this decision was made. My understanding from you is that the current proposed changes are very minimal in the criminal justice area. My hope is that by summarizing my recommendations for more far reaching changes below, that we can step up the change process to achieve better outcomes more quickly.

Here are the areas that I think need addressing:

1. Organizationally, it is confusing that **Substance Abuse** is not referenced in any of the Rules. As I understand it, Corrections is pursuing CARF accreditation, but that accreditation does not have a specific set of standards for prisons so is not as clear and compelling as a separate set of standards or rules. For that reason, I believe we need to revisit this issue and at least debate including substance abuse in the rules.
2. **Training** – Section 26D .0508 does require employee education and training, but it speaks to knowledge to administer, manage, and deliver quality MH, MR, DD services. There are no specific curriculum requirements or hours of training requirements. Research needs to be done on the Basic Law Enforcement Training requirements to see if

it is sufficient to cover what is necessary to ensure that people with mental illness and other disabilities are protected. One idea would be to include a 40 hour training requirement based upon CIT, with appropriate adaptations to the environment which is clearly not the community. Research needs to be done to determine the appropriate role if any for the Justice Academy. When people with disabilities are in special mental health sections of the prison, their needs are probably largely met, but when they return to the general population, it is really important that they be trained to identify when an illness is cycling towards a more severe state, thereby needing more treatment. De-escalation techniques should be a part of this training of the general prison staff.

3. **Communication** Issues should be included in rule, to include, but not be limited to: informing families, providers, and LMEs when people with disabilities are admitted into prison, and six months (approximately) prior to discharge so that those same people can participate in meaningful discharge planning. These rules should have clear time frames (within 24 hours of admission, or a similarly clear rule; more than 3 months prior to discharge).
4. **Transition Planning** – Rules need to be formulated to mandate discharge planning, the elements it addresses (treatment, housing, supports, vocational/job, medications, health, money, benefits restoration), and the timeframes for completing the transition/discharge plan. The rule should include responsible parties (LME, providers, social security, Medicaid, etc.) – and be clear on their actual responsibilities. There should be embedded in rule some follow up requirement, perhaps with probation being the responsible party.
5. **Access to Client while in Prison** - A rule needs to be developed that allows access to the client while in jail for continuity of care purposes. The past provider might confer with the prison staff about the treatment plan, including history of what works, what doesn't work. And that same provider should be involved in the discharge planning to ensure access to treatment upon discharge.
6. **Specific Treatment/Medication Access Rules** – Rules need to be drafted to speak to right to treatment and to a treatment plan, consistent with federal law, access to medications within x hours of entry into the system and access the entire time while in prison, and the right to have a small supply at discharge. Rules need to be promulgated on defining appropriate treatment while in jail, especially for those who have been identified as a risk of suicide. Rule .l00l SCOPE only specifies that clinical services shall be provided by professionals, and shall include but not limited to certain things. We are looking to add a rule that requires a more proactive statement.
7. **Screening Instruments at Admission** – I understand that the prisons largely do an assessment for everyone entering the prison system, which includes a MH, SA, DD component. But there is no rule that this be an instrument that we know by research that really works to effectively identify all those at risk. We need a rule that requires that the instrument that works is the one we use. And the rule needs to ensure that those identified then receive treatment, medications in a timely manner. Rule .1004 Testing services simply says that individuals who are privileged to use a particular instrument, shall perform testing on each client who is referred by a clinician in certain areas. A better rule would require global screening, ensuring that no one is missed.
8. **Seclusion and Restraint** – We need to draft rules, based on existing institutional rules that govern the use of seclusion and restraint for prisoners with disabilities.

Of course with the passage of Section l0.49 (f) of HB 1473, we have a statutory charge to move ahead with similar changes to many of the issues I have mentioned above in county jails. I suggest we use the wording there to guide what we do for our prisons, in terms of protocols for effective communication, daily log for booking of known consumers, etc.

I also want to remind the Division that the state of NC scored a D plus in Grading the States, and in particular, we scored a 0 out of 2 possible points in restoration of benefits post incarceration. This may not be a rules issue, but it surely is a policy issue. If it cannot be fixed at the policy or statutory level, I suggest it be handled at the rule level. The federal government allows states the option of suspending Medicaid and social security, rather than terminating it when someone is incarcerated. By suspending benefits, the process of restoring them when no longer in prison is much simplified and can be done far more quickly; and the vicious cycle of re-arrest may be stopped.

I appreciate your time Marty, and I will look forward to working to improve the conditions of people with disabilities in the prisons in NC through the rules process.

Sincerely,

Debra G. Dihoff, MA
Executive Director

Cc: Pender McElroy, Chair, MHDDSAS Commission
Mike Moseley, Director, MHDDSAS
Sally Cameron, Coalition Chair
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