

## MENTAL HEALTH ISSUES IN INCARCERATION

### **The Scope of The Problem**

Nine years ago the American public was shocked to read in a New York Times article posted on March 5<sup>th</sup>, 1998, an investigative report titled **ASYLUMS BEHIND BARS: A special report. Prisons Replace Hospitals for the Nation's Mentally Ill.**, by reporter Fox Butterfield.<sup>1</sup> One of the institutions profiled in that article was the Los Angeles County Jail which "is by default...**the nation's largest mental institution** (emphasis mine)". On average it housed in 1998, from 1500 to 1700 inmates daily who were severely mentally ill, with most of them being charged with relatively minor offenses, basically for being "public nuisances".

The article went on to describe the profiles of these inmates. While some had committed serious, violent offences, the great majority were either homeless who were charged with minor offenses which were a byproduct of their impairment, or others who were detained with no charges at all, simply for "acting strange", and euphemistically called by the police "mercy arrests". Dr. Laurie Flynn, the executive director of the National Alliance for the Mentally Ill, is quoted in this article as stating that "**Part of mental illness in America now is that you are going to get arrested.**" (Emphasis mine)

The author of this article, Butterfield, stated: "What experts call the criminalization of the mentally ill has grown as an issue as the nation's inmate population has exploded and as corrections officials and families of the emotionally disturbed have become alarmed by the problems posed by having the mentally ill behind bars."

At that time, Mr Butterfield reported that almost 200,000 inmates in our country's prisons and jails, or more than one in ten of our total number of incarcerated persons, were known to be suffering from one or more of the three most severe mental diseases---schizophrenia, manic depression, or major depression, which is four times the incidence in the general population.

A section of Mr. Butterfield's report is subtitled "The Delinquent Young, Mentally Ill and Bound For Jail". Because this section relates to the most vulnerable segment of our society, and our "sophisticated neglect" of the same, I quote parts of it verbatim: "The 16 year old girl suffered from delusions and hallucinations. The diagnosis was 'psychotic, not otherwise specified.' Her father was in prison for sexually abusing her sister. Her mother was an alcoholic. Not surprisingly, the girl began skipping school. She got pregnant. She assaulted her mother.

"Before most state hospitals were closed, the girl would probably have been committed to a state psychiatric hospital. But in Texas, where she lives, the juvenile court declared her a delinquent and sent her to the state's juvenile justice agency, the Texas Youth Commission. The commission referred her to its Corsicana Residential Treatment Center for seriously emotionally disturbed youths."

This girl personifies the problems facing many young people with mental disorders, according to Dr. Linda Reyes, a psychologist and assistant deputy of the commission. 'Unless you are wealthy and can afford private doctors, you have to get arrested to get treatment.' Emphasis mine.)

And the story did not improve for this unfortunate girl at the treatment center. Butterfield adds this: "The girl refuses to take anti-psychotic medication and because Corsicana is not a hospital, its staff cannot make her take it. She is not making progress---she walks around naked and urinates on the floor---but by law, when her term expires, she must be released."

States Dr. Reyes, regarding this case, "Incarcerating mentally ill adolescents is tragic and absurd. The system we have created is totally ineffective. It doesn't rehabilitate the kids. And it doesn't even take care of public safety, because when she is sent home she will just get picked up again."

Reporter Butterfield stated that one reason for the higher percentage of young people with mental illness in jail, according to specialists, is that many states have cut budgets for adolescent psychiatric hospitals even more than those for adults.

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**Let's See What Has Happened in the Intervening Years Since 1998**

(First, I give a quote from the Ohio Morning Journal of Sept. 9<sup>th</sup>, 2006, as reported in the October '06 issue of GRATERFRIENDS, a publication of the Pennsylvania Prison Society.)<sup>2</sup>

“Exactly how bad things are was driven home this week in a sad report from the U.S. Justice Department’s Bureau of Justice Statistics (hereafter BJS) entitled Mental Health Problems of Prison and Jail Inmates. The report’s two opening sentences tell the tale in a nutshell: ‘At mid year 2005 more than half of all prison and jail inmates had a mental health problem, including 705,600 inmates in state - prisons, 70,200 in federal prisons, and 479,900 in local jails. These estimates represented 56% of state prisoners, 45% of federal prisoners and 64% of jail inmates.’ That’s more than one million inmates.”

A Human Rights Watch commentary dated September 6<sup>th</sup>, 2006<sup>3</sup> deals with this same issue, and cites that BJS in 1998 pegged the estimated prison and jail inmates suffering from mental health problems at 283,000 at that time. “That number is now estimated to be 1.25 million.. The rate of reported mental health disorders in the state prison population is five times greater (56.2 %) than in the general adult population (11%).”

And women prisoners have an even higher rate of mental illness than men. The BJS in its current study found that females in state prisons had a higher rate of mental health problems than men: 73% versus 55 % for males.

Jamie Fellner, director of Human Rights Watch’s U.S. Program, who has co-authored a 2003 report, Ill-Equipped: U.S. Prisons and Offenders with Mental Illness, states that “Prisons are woefully ill-equipped for their current role as the nation’s primary mental health facilities.”

In consideration of the burgeoning problems represented by the mushrooming of our prison and jail populations in these United States, and the proven inadequacy of care for our incarcerated mentally ill, there are a number of forward-looking innovations being suggested and many already being initiated in some venues. These initiatives could well be characterized as “thinking outside the box”, with the box representing the *modus operandi* of past decades--- the attempt to solve this nagging problem of increasing prison population by expending massive amounts of dollars on new and larger prisons which rapidly again become seriously over-crowded. (For an interesting review of this era see The Prison-Industrial Complex article in The Atlantic Monthly, December 1998.)<sup>4</sup>

**What Are Some of These New Initiatives?**

**1).** Mental Health Courts: Allegheny County (PA) Mental Health Court <sup>5</sup> began operations in June 2001, (the first one in Pennsylvania,) with weekly court sessions. Criteria used for acceptance into this program are: **It’s voluntary; persons who are charged with a misdemeanor or felony; must be awaiting trial; must have diagnosis of mental illness or mental disability (and may have in addition drug and/or alcohol problems or dependence.)**

In the fiscal years between 2001 and 2003, this court had 633 referrals, with 219 accepted by the court. Results as of May 04:

- No consumer received more than five years probation
- Average probationary period is 18 months
- 11 individuals bonded out of jail
- Five individuals were hospitalized for inpatient psychiatric care ( a rate of 3%)
- 15 individuals (7%) were arrested on new charges during the time they were active in mental health court
- Positive reinforcement hearings---242
- Results of 32 “negative reinforcement hearings” were one of the following:  
Commitment to D&A rehabilitation; Service Plan revision or continuance;  
Five individuals returned to jail

Perhaps the best illustration of success for this new approach to the issue of mentally ill offenders is this case example we will call "Leslie": She is a middle-aged person with drug and mental illness issues and has mild mental retardation.

<u>Prior to MH Court</u>	<u>Post MH Court</u>
Several inpatient hospitalizations	Living in a personal care home
Several D & A rehabilitation stays	Service plan defines community behavioral supports
Returned to jail within months of previous release	No inpatient hospitalizations
Difficulty keeping appointments for physical and behavioral health	No re-arrests
	Is happy, acknowledges her issues and is addressing her personal challenges

Just this year (2007), under the sponsorship of the Council of State Governments, the Rand Corporation completed a fiscal impact study<sup>6</sup> of the Allegheny Mental Health Court, and found that in the first year of operation, the decreased jail expenditures approximated the increased costs of treatment., with the prospects of future increased savings to tax-payers, .due to a decrease in recidivism.

Corroboration for the cost-saving effects of better-management practices in regard to offenders with mental illness issues is found in a 2004 Miami-Dade County (FL) grand jury report<sup>7</sup> which revealed that taxpayers in that county spent \$18 per day to house inmates from the general population, and \$125 per day to house inmates with mental illnesses in the county jail.

(In June of 2005, the Council of State Governments conducted an online survey of the mental health courts in the U.S.<sup>8</sup> and had a response rate of nearly 80%---90 adult MHC's responded with details concerning their histories, communities, administration, clients, treatment plans, etc. Mental health courts "are a new and rapidly expanding phenomenon: in 1997 only four MHC's existed in the country; by January 2004, 70 courts were known to be in operation; as of June 2005, there are approximately 125 operational courts in 36 states.")

**2.) Crisis Care Centers:** Nicole Foy, medical writer for the San Antonio (TX) Express-News had an article posted on 12/09/05 which described such a development in San Antonio, and from which I quote:<sup>9</sup>

"Local officials took a step toward mending part of Bexar County's broken mental health system with the opening of a 24-hour crisis care facility aimed at getting non-violent detainees psychiatric help quickly while keeping them from clogging emergency rooms and jails.

"The Crisis Care Center at the University of Texas Health Center...also will put law enforcement officers handling such mental health cases back on the street more quickly. Previously, an officer could wait in an emergency room with a detainee up to 15 hours. "The new drop-off center is set to get an officer back in service in an average of 15 minutes.

." "This gives us a chance to divert people who shouldn't go to jail in the first place," said Leon Evans, executive director of the Center for Health Care Services Jail Diversion Program. "City and county officials concerned over the **criminalization of the mentally ill and the inefficient use of law enforcement** developed and helped pay for the new center. It places medical, psychiatric and jail diversion officials under one roof." (This latter emphasis mine).

Evans recalled one man detained at a fast-food restaurant after customers and employees there reported him reciting the Lord's Prayer loudly. Suffering from schizophrenia,...although he wasn't violent, the police officer took him to jail where he languished for six months, Evans said."

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Writer Foy states that the San Antonio Police Department had been spending about \$600,000 annually on overtime and additional shifts for officers forced to wait in crowded emergency rooms with people needing treatment.

For several years in the mid-nineties, this writer served as a part-time medical officer in several county prisons in central Pennsylvania. This experience confirmed a conviction that incarcerating (for any duration) non-violent, mentally ill or psychotic individuals constitutes cruel and inhumane punishment, and in some cases puts these inmates, the prison staff and other inmates at risk. ( See subsequent item on the phenomenon of “excitable delirium” on page No. 5. ) Also, there were many instances when papers for psychiatric commitment of a seriously mentally-ill inmate were completed, but there was no bed available at the psychiatric facility.

**3.) Re-Entry Programs Providing Prompt Provision of Health Care Benefits:** A serious flaw in the rehabilitation of offenders has been the numerous obstacles encountered by released offenders as they endeavor to get their lives back together again. This has been frequently an issue with discharges from the county jails, where the majority are discharged without supervision, as a result of having completed their sentence. And this fact of no supervision is directly related to the high recidivism rate for jail discharges. The re-entry process for the mentally ill prisoners, many of whom had specialized treatment plans while in jail, becomes an even more urgent re-entry issue: the continuation and close supervision of these treatment programs by the local mental health care providers.

Another significant problem in aftercare of mentally ill parolees often surfaces: the sheer number of such discharges yearly from our jails and prisons. With around nine million total releases per year from our jails and prisons (more than 650,000 from prisons, and the rest of the nine million from county jails), and using an estimate of 16% as the incidence of serious mental illness among our incarcerated population, one realizes the enormity of this mental illness burden. Furthermore, in many areas of our United States (especially the “ghetto areas” of our large cities) the delivery system for mental health care to this segment of our population is practically broken down .

On May 24, 2005, the Council of State Governments released a policy paper dealing with re-entry issues for prisoners with mental illnesses.<sup>10</sup> Texas State Senator John Whitmire, who was part of a multi-agency state team which helped formulate the documents, stated: “Like every state, we’re spending extra-ordinary amounts of money to treat people with serious illnesses while they are incarcerated. We squander these investments when we don’t ensure [that] people continue their treatment plans when they return to the community.(Emphasis mine).

This release by CSG quoted a study in Lucas County, Ohio, which found that nearly three out of four inmates with mental illness released from jail are arrested again within 36 months of their release. These parolees are the ones most likely to cycle in and out of jails and prisons, with the great majority charged with minor, non-violent misdemeanors.

The above press release from CSG (titled **New Resources Available to States Exploring Strategies to Connect People with Mental Illness Released from Prison and Jail, to Medicaid**) included two brief resource documents dealing with this issue of re-entry, and which profiled the efforts of four states--- Texas, Minnesota, Pennsylvania, and New York---to promote continuity of care for this segment of prison and jail discharges. These two documents, which spurred lots of changes in the after-care of the mentally ill, were titled:

**How and Why Medicaid Matters for People with Serious Mental Illness Released from Jail**

This first document demonstrates research that indicates that without continuity of care, mentally ill individuals released from prison or jail are likely to be re-incarcerated. One of the exhibits is from our own Pennsylvania: that of the Allegheny County Forensic Support Program.

This forensic service program, which operates under the direction of Allegheny County's Office of Behavioral Health, uses a holistic approach to the problems of mentally ill prisoners, including diversion (at the "front door" to the county jail, where other alternatives than incarceration are considered) and support (at the "back door" of the jail) where prior to discharge an array of intensive case-management issues are dealt with, including housing options, re-instating/obtaining Medicaid and/or SSI Benefits, contingency funds for housing support, clothes, bus tickets, etc., and importantly, 60 to 90 days follow-up and monitoring in the community, to make certain that appointments are kept, and that the treatment program is continued. This study of Allegheny County's program by the Rand Corporation revealed that the rate of recidivism (new arrests) was only 10%, and of these, none were sent to prison, only to the county jail. (Significantly, this program won the prestigious Innovations in American Government Award from Harvard's Kennedy School of Government.)

(How dismally inferior were the discharge procedures, if any, at the three central PA county jails with which I was familiar in the mid-nineties.)

#### **Ensuring Timely Access to Medicaid and SSI/SSDI for People with Mental Illness Released from Prison**

This second document "profiles the efforts of four states---Texas, Minnesota, Pennsylvania, and New York--to promote continuity of care for this population by ensuring their prompt enrollment in Medicaid and SSI/SSDI upon release." The paper resulted from a two-day forum of these states' officials from departments of correction, mental health agencies, and those responsible for administering Medicaid and other health benefits. Apart from the measure of success due to the efforts of these states, there surfaced challenges which impede the structuring of a seamless transition from incarceration to successful re-entry for hundreds of thousands of mentally ill individuals. Among these challenges are the following:

Insufficient staff with specialized training to assist inmates with applications

Wide variation and lack of communication among county systems

Inadequate follow-up, particularly for people who complete their maximum sentences while incarcerated (According to the PA Dept. of Corrections, inmates with serious mental illness are three times as likely as other inmates to serve their maximum sentences., not primarily because of behavioral issues but due to a dearth of referral options post-incarceration. Thus they "max-out" with little or no follow-up).

Difficulties identifying offenders who need release planning or benefits (Corrections officials' immediate concerns are sometimes given priority over the time-consuming applications for entitlements and benefits at time of discharge of the mentally ill inmate. Also, intake assessments done on admission may be of little use in planning, for release and follow-up, necessitating reassessment.

Confusion over federal benefits and entitlements eligibility rules (Officials in some states report that applications prepared for inmates prior to their release are routinely denied by Medicaid or SSI/SSDI administrators the first time they are submitted, because they do not meet a complicated set of requirements. Such obstacles can cause the best treatment plans to collapse, and the fragile, mentally ill ex-prisoner to decompensate.)

**4.) Significant Initiatives Undertaken by Pennsylvania in Conjunction with the Council of State Governments:** Numerous efforts to alleviate the needs of people with mental illness who are in the criminal justice system have been taking place at the local, county and state level in Pennsylvania over the past several years. In part, this was due to the significant work of the late Senator Robert Thompson (PA), who as a member of the Council of State Governments, was the founding co-chair of the "Criminal Justice/Mental Health Consensus Project", and at the same time served as chair of the PA Senate Appropriations Committee.

It was the late Senator Thompson's influence with our Senate Appropriations Committee, and his commitment to the issue of mental illness complicating incarceration, which led to his fellow Pennsylvania legislators appropriating funds in 2005 for the purpose of the convening of a Forensic Workgroup by the Pennsylvania Office of Mental Health and Substance Abuse Services (hereafter OMHSAS). I quote from the objectives given to this Forensic Workgroup, as reiterated in the Introduction to the finished **Recommendations**.

"To design a Mental Health and Substance Abuse System in which services and supports enable people to avoid incarceration, be diverted from incarceration, receive adequate treatment services while incarcerated and plan for successful return from incarceration"

The report was presented to OMHSAS in September 2006, with the title **Recommendations to Advance Pennsylvania's Responses to People with Mental Illness and/or Substance Abuse Disorders Involved In the Criminal Justice System.**<sup>12</sup> It is noted in the Introduction to this report that the "Forensic Workgroup's efforts were guided by OMHSAS's 2005 report, *A Call for Change: Toward a Recovery-Oriented Mental Health Service Delivery System for Adults*. (The report continues:) The *Call for Change* is a blueprint for transforming Pennsylvania's mental health and substance abuse treatment system into one that is 'integrated, uses best practices, and most importantly, is recovery-oriented.'" In their 2005 report OMHSAS described recovery as "*a self-determined and holistic journey that people take to heal and grow...facilitated by relationships and environments that provide hope and empowerment, choices, and opportunities that allow people to reach their full potential as contributing community members.*" These lofty goals hopefully will become the touchstone of care criteria for both normal and mentally ill prisoners.

##### 5.) The Nathaniel Project--An Alternative to Incarceration for the Seriously Mentally Ill in N.Y.C

This program, which began in 1999, is for people with serious mental illness who are charged with felony offenses in N.Y.C., and was named for a homeless man with schizophrenia who was untreated over some fifteen years of repeated incarcerations. The Nathaniel Project is a program of the Center for Alternative Sentencing and Employment Services (CASES).<sup>13</sup> The web page for CASES states: "For more than thirty years CASES has worked with the justice system to find sentencing alternatives that respond to justice system needs. By addressing the factors that underlie criminal behavior, such as poor education, lack of community support, inability to get and keep a job, substance abuse and low self esteem, our programs help young and adult offenders re-integrate into society."

Today, with a staff of 140, and a yearly budget of \$9 million, CASES provides services and supervision to over 10,000 offenders a year.. These offenders initially must be headed for prison and also have an axis one diagnosis, and tend to be homeless and suffering from substance abuse disorders, along with a host of chronic medical diseases like AIDS, heart problems, hypertension and asthma. After the initial intake assessment the individual enters treatment for a two-year period, and sentencing is deferred pending the outcome of treatment. In most cases the treatment involves a supervised residential program.

The program has an outstanding record of retention: 98 % of enrollees at 30 days after intake; 91 % after four months; 85 % at 12 months, and an over-all retention rate of 81 %. Also, "the number of arrests dropped from 101 (35 misdemeanor and 66 felony) in the year before entry into the program...to seven (5 misdemeanor and 2 felony) in the year since intake. The yearly cost? \$14,578, rather than the much more expensive year in state prison (\$29,678) or a city jail (\$53,224).

Another recent innovation among CASES programs is **the Parole Restoration Project**. Technical parole violators with special needs (like mental illness) usually are held in custody much longer than other technical parole violators (stated by CASES' web-site as averaging 165 days, versus 77 days), and this not because of more serious charges, but only because of the problem of obtaining the indicated treatment and services in their communities. "By linking special needs violators with community-based treatment options, the Parole Restoration Project expedites this process. As a result, appropriate violators are returned to parole supervision, freeing up costly needed jail space." (Emphasis mine. One asks in wonderment why this sensible and more humane approach isn't being used by our local judicial systems, especially when severe overcrowding is acknowledged?)

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6.) An Example of Innovation and Flexibility in The Management of Mentally Ill Prisoners: The Oregon DOC System of Classification<sup>14</sup>

In an article on this subject by Jim Montalto News Editor of \_\_\_\_\_, published 6/24/2006, Montalto states that "Oregon DOC behavioral services department takes on the challenge of managing 'untreatable in-betweens' and succeeds." He quotes Lonny Webb, Oregon DOC's behavioral services and risk assessment program coordinator: "Corrections likes to have particular segments [of housing] for certain types of offenders, but what about the ones who fall between the cracks?"

Montalto quotes Webb as saying that Oregon DOC facilities, specifically his supermax, hold many mentally ill inmates who have severe behavioral problems like indulging in self-mutilation; this erratic behavior can create an out-of-control atmosphere that disturbs and distracts inmates and officials. But, says Webb, "states in general aren't offering money for more programs to deal with these types... although, one idea is to build more prisons; this doesn't work because it doesn't alleviate the problem of managing these inmates." (Emphasis mine).

Says Arthur Tolan, Oregon DOC's corrections treatment service administrator. "If you try to address this issue with housing, you can never find enough secure cells to deal with all those who pose a security threat. So, what can you do?"

I quote the words of Montalto as he describes Tolan's response: "Tolan's answer is using the right risk assessment tools to create an offender management plan. This begins with a mental health evaluation for new inmates to find those who suffer from mental disorders or serve as a threat to others. Webb then creates a risk profile by looking at nine different characteristics that affect behavior, some of which include: developmental disability, history of sex offence, physical size, the ability or willingness to fight, and overall aggressiveness. He also performs a vulnerability risk appraisal. This helps him decide which offenders might be a target for violence, a big concern and focus since the Prison Rape Elimination Act of 2003."

"The important part that we're doing, which I have not heard of others doing, is that these assessments aren't the end of our contact with the inmate," Tolan explains."

"Webb adds, 'We're actually coordinating with various sections of the prison. Normally the mental health department would do an assessment and then leave. Through our method, we identify who's vulnerable and then we teach staff what to do with certain offenders once they notice if a guy's vulnerable or if he's exhibiting certain aggressive traits.'"

Editor Montalto describes how this might work out for a vulnerable inmate under the Oregon management system: moving the inmate to a cell closer to staff where predators would be observed, or recommending programs or courses which improve the inmate's ability to observe and cope with others' aggressive or hostile overtures.

"We will then ask corrections counselors, religious staff, security, and officials in other sections around the prisons to participate in this plan to help manage this case. The idea is that if everyone pitched in a little we could all handle this inmate (emphasis mine-JKK) ' says Tolan."

This article states that the Oregon officials have found that not only the vulnerable and the aggressive are better-managed, but also those who are suicide-prone. Typical statistics for people considering suicide among the general population tend to be white males aged 45 to 50, who have recently experienced a loss like divorce or death of a spouse. But Tolan explains: "In prison, this is different. It's not the old guy. It's the young one who has a five to ten year sentence who is mentally ill and is in maximum custody." And moving them [to maximum custody] often increases their chances of hurting or killing themselves.

Tolan states emphatically: “Taking this research and communicating it facility-wide has already benefited us. Inmate time in intensive management units has decreased dramatically. It usually costs us thousands of dollars a month in medical expenses for offenders who hurt themselves, but this has decreased. **In terms of suicide behavior, in the last year we have seen a 35 to 45% decrease in attempts. This is outstanding considering how costly it can be to deal with them.**” (Emphasis mine)

“Webb adds, ‘The long-term effect of using this planned approach is our ability to manage an increasingly difficult population with about the same resources.’ Both say their strategy’s success depends on the active participation of every department, from health and religious services to counselors and workforce development. This is crucial because all those interacting with these inmates will know how to observe them and will have the proper tools to best manage them.’

“ ‘ Having this plan successfully work in our facility really is a message of optimism,’ Webb says ‘We’re given any amount of variables on an individual and we’ve been able to come up with answers on dealing with them. **Often we’ve been told there’s nothing we can do with people like this, but we’ve been able to find ways.**’ (Emphasis mine. I’m a firm believer in that old adage that where there’s a will, there’s a way.)

“ ‘And there’s no better payoff than to have staff come up to us and say “this guy is really doing well.” Once people start seeing these kind of results, they’re sold that this works,’ says Tolan.”

( There will be persons reading this position paper who will react adversely to the suggestions indicated by the “Oregon plan” which has been dealt with at some length. The writer in his experience as a medical officer in county jails, knows that there are corrections officers who ascribe to the dictum that “one must employ brute force with brutes.” When dealing with those who have significant mental health problems, I much prefer the advice from Holy Writ, that “a soft answer turneth away wrath, but grievous words stir up anger.” (Proverbs 15:1) A drastic show of overpowering force along with dogs, can in these situations be quite counter-productive, and even tragic, especially if there has been recent hallucinogenic drug use or psychotropic drug prescribing.)

6.) The Phenomenon of “Excitable Delirium as a Complication of Severe Mental Illness: See attached articles.