

Access to Mental Health Care
Del Med J, January 2009, Vol 81 No 1

ACCESS TO MENTAL HEALTH

Delaware's Institution of Choice for Mental Health Treatment = Prison

(Is Access to Inpatient/Outpatient Mental Health Services Dependent on an Individual's Legal or Financial Status?)

Janet P. Kramer, M.D, FACP, CCHP

The United States incarcerates a larger proportion of its population than all other countries in the world. In 2001, the U.S. average was 699 persons per 100,000 population. Delaware is significantly above the national average with an incarceration rate of 895 persons per 100,000.¹ “In many instances, incarceration is used (in Delaware) as a policy of first resort rather than the policy of last resort,” according to University of Delaware Professor Danilo Yanich, author of Ex-Offender Reentry in Delaware- A Preliminary Report of the Delaware Reentry Roundtable.²

Physicians who have not followed the flow of mental health services over the past 30-plus years may not be aware that the advent of deinstitutionalization of mental health services beginning in the early 1970s occurred just prior to the advent of harsher sentences for drug use, possession, and sales, the so-called Rockefeller Laws. The psychiatric institutions that were downsized were mostly state owned and operated and originally provided services for the communities' mentally ill. The wealthy mentally ill patient never did come into these institutions unless he was committed – adjudged to be “a danger to himself and others.”

This set up the perfect storm in public policy administration and mental health services with which we are still attempting to deal 40 years later.

By 1990, the same number of state/public psychiatric beds vacated by patients who were to receive psychiatric services in the community were provided in federal, state, and local correction institutions through out the United States. Ironically, many former state mental institutions have been recycled into correction facilities.

Janet P. Kramer, M.D., FACP, CCHP, is a Physician Surveyor for the National Commission for Correctional Health Care (NCCHC) and Retired Director of Adolescent and Young Adult Services at Christiana Care Health System.

BACKGROUND

There have been a number of pivotal decisions, missteps, and non-decisions which have set us on the wrong course. Psychiatric and mentally challenged patients, who were institutionalized for long periods of time due to mental illness and were stabilized on medications, were released with few services actually established in the community.

Much lip service was given by proponents of deinstitutionalization to provide full service community mental health centers but funding streams in the economic environment of the early 1970s were not available due to the recession. Many of those released did not receive the intense community support they needed for this transition. Consequently they stopped medications, became homeless due to their inappropriate behavior in public housing or their homes, self medicated their mental illness with street drugs and quickly ended up in jail due to drug possession, public inebriation, or property crimes. Few then, as now, were charged with violent crimes.

Correction institutions have public safety as their major mission and few institutions prior to 1985 had mental health or medical staff. Inappropriate behavior in a correction environment was viewed as maladjustment, manipulation, or poor conduct and not as a symptom of mental illness.

Mentally ill who were incarcerated frequently were not released on their own recognizance because of their behavior, were not able to post bail because of poverty and sometimes family abandonment, and when they were released became the most likely “offenders” to end up back in custody because of parole violations. Confinement of the mentally ill and developmentally/cognitively impaired without treatment and skill building (rehabilitation) while confined is a waste of taxpayer funds. In fact, without skill building for any inmates makes incarceration a waste of taxpayer funds and increases the rate of recidivism since 97 percent of all offenders eventually return to the community. Correction Departments have been supported by the public to build larger and larger facilities to house more and more prisoners. On a state level, the Department of Correction in many states have more state employees than any other department, with most of the employees serving as correction officers.

Untreated mentally ill and mentally challenged in correction facilities cause administrative, ethical, and humane nightmares.

Many of these inmates are exploited financially, physically, and sexually by other inmates; two of the frequent causes of death in correction facilities are suicide and medical consequences of HIV and hepatitis B and often occur in those with mental illness and developmental delays who exploited.³

WHO DOES DELAWARE INCARCERATE?

What are their treatment needs? Is treatment provided?

Adult correction – not juvenile correction – inmates are discussed in the following unless indicated otherwise. Delaware has an average daily census of 6,700 prisoners, including 137 who are 18 years of age and below, in the five Adult Correction institutions. In

addition, about 20,000 adult Delawareans were on probation and parole in the state. Over 26,000 Delaware adults – out of an adult population in Delaware of 625,000 – are either supervised or in custody of the Department of Corrections.

In 1990, Delaware's Prison for Women had an average daily census of 80 inmates; today Baylor Correctional Institution for Women maintains an average census of 400 inmates, many of whom have significant mental illness. Inmates with mental illness – including addiction, technical parole violations, (a violation which violates a condition of probation but is not a crime for the general public such as not attending a meeting with the probation officer or traveling outside the state, etc.), and nonviolent offenses, such as not paying a fine or driving without a license, constitute the excess population between 1990 and 2008.

Below are statistics from national sources that most likely apply to Delaware's inmates:

1 The most common mental health and mental developmental disabilities within the correction settings (juvenile and adult) are: addictions, more than 75 percent of all inmates; attention deficit disorder, more than 25 percent; major mental illness, 25 percent; mental retardation, more than 7 percent; and psychotic disorders, 6 percent.^{3,4}

1 Up to 18 percent of male prisoners and up to 25 percent of female inmates are identified as having a major mental illness, independent of addiction, needing ongoing treatment. Five to 7 percent of adults have a diagnosable mental illness at sometime during their lifetime.⁵

1 More than 75 percent of prisoners have an addiction including substance abuse. Seventeen percent of the general public are addicted.⁵

1 The substance most commonly abused on a *daily* basis prior to incarceration by both men and women is alcohol.⁶

Justice and correction professionals generally agree that public safety cannot be achieved without appropriate evaluation, diagnosis, treatment and rehabilitation of the offender. The Delaware Department of Correction today provides a mental health and suicide risk screening on admission to all correction facilities. In addition, a mental health evaluation is provided by an appropriate trained mental health professional within 30 days in all prison settings. Addiction services are provided; appropriate and psychiatric recommended pharmacologic treatments are available; and some direct group and individual therapy takes place.

However, unlike in a well run psychiatric institution, the first services that are decreased or eliminated in a time of financial downturn are treatment services; public safety not inmate treatment/rehabilitation is the predominant law enforcement/correction mission.

Successful transition from custody can only occur when a strong working relationship exists between correction re-entry services and community service providers and agencies.

The data show that a large number of persons are entering prison in Delaware every year. That most often makes the news. However, there is, necessarily, the opposite side of that coin. A large number of persons also leave Delaware's prisons every year. In fact, about 97 percent of those who enter the state's correctional facilities eventually leave prison. Unfortunately, based on the recidivism rate, almost two-thirds of those who leave prison will return.²

WHAT CAN BE DONE?

Medical and Mental Health Professional Societies must work with the Department of Justice to develop appropriate policy with the goal of service to the mentally ill who come into the Justice System because of behavior symptomatic of the mental illness.

Some limited progress has been made in Delaware by establishing mental health and substance abuse courts. With few exceptions, first time offenders who are charged with misdemeanors are sentenced in this court. However, because the court requires offenders to attend therapy and work closely with probation officers who monitor compliance with other recommended treatment, recidivism and re-arrest is very low compared to those offenders with comparable charges.

The Delaware public, including many legislators, still maintain the attitude and apparently are comfortable with the fact that those with mental illness are acceptable until they exhibit behavioral symptoms that either offend the public or break the law. If the mentally ill is a first time offender and is charged with a felony, he goes to jail rather than a secure mental institution where better assessment and treatment of mental illness can take place. For example, psychotic mentally ill offenders, including women with post partum depression who assault their newborns, are held for prolonged times in a correctional facility where they are vulnerable to attack from other inmates and do not receive the level of treatment they require. Policy and implementation of policy must change.

Some Delaware judges have noted privately that the quality of the pre-trial mental health assessment has varied as funding for evaluations decrease. Frequently a judge notes an accused offender in court who seems to have mental illness but the judge is unable to obtain an adequate mental health assessment with which to make a decision regarding culpability, ability to defend, or public safety.

Sentencing guidelines must be flexible enough so that judges are not held to minimum mandatory standards for any crime resulting from diagnosed mental illness.

Delaware is fortunate to have good judges who are vetted by the Delaware Bar Association and nominated by the Governor, rather than being elected through the political process. Here competence trumps political savvy and party affiliation. That being said, Delaware still has draconian minimum mandatory laws which do not

take into consideration the circumstances of the offense or mental health condition of the offender. Two examples include a psychotic individual who self medicates with a parent's medication and sells a large quantity to a drug user and an offender with psychosis or severe developmental delay who solicits a minor or is sexually inappropriate. Under these circumstances, these offenders face mandatory minimum sentences in a correctional facility irrespective of their mental illness/cognitive challenges and our judges are generally required to impose the minimum mandatory sentence.

Mental health service provision in the community and in secure mental health institutions and funded support and coordination services, such as social services, must be available for those under custody with the Department of Correction.

There is a good forensic unit, the Mitchell Building at the Delaware State Hospital; unfortunately the limited capacity of less than 70 patients prevents referrals from outside the Department of Correction. In fact, frequently DOC referrals must wait in prison until a bed in Mitchell is available.

Mental health professionals must review – with Delaware's Department of Justice and the Division of Substance Abuse and Mental Health under the Department of Health and Social Service – a better way to get emergency care to and continuity of treatment for individuals who need mental health service, including those mentally ill who request service and those who are refusing help but have a need for service that is apparent to caretakers, a reasonable concerned adult, or a professional.

We are many years past the point in which individuals were indiscriminately carted off against their wishes to mental health hospitals at the request of unscrupulous others. However, today the only reason a person can be placed, against his wishes, in a secure mental health environment is if the person is an **imminent** danger to himself or to others. This is so rigidly adhered to that law enforcement is placed in the situation of having to disarm a person with any weapon who is mentally ill. Death by cop is all too frequently a term used in the news and recognized as a suicide equivalent.

A policy which requires a preliminary mental health evaluation by a mental health professional with the option of a short term assessment and stabilization in a secure mental health setting seems to be a reasonable alternative to the dilemma of what to do with a citizen threatening suicide or injury to others or self harm by the manner in which they are living or behaving. Impulsive behavior is characteristic of more self harm, suicide, and assault than deliberate planning, which generally requires rational thought. In addition, law enforcement officers must be trained to understand mental health issues from the perspective of mental health professionals and law enforcement.

Community mental health professionals and mental health professional organizations are strongly encouraged to volunteer their expertise to their local and state community. Few community mental health physicians, other mental health professionals, or mental health professional societies have recently volunteered to evaluate the training of Justice Department and Department of Correction employees, to work on policy initiatives, or to

serve as consultants for the Department of Correction. Of course, the Department of Correction and Department of Justice also need to be willing to review and discuss this input.

Volunteering professional expertise for the improvement of the community improves the public opinion and respect of our profession; always requiring public funds for consultation does damage to the profession because the public views this as self-serving and self-aggrandizing.

Departments of State Government should be expected to work together to help find State solutions for State problems and should support each other in professional areas.

A positive example of this interagency/interdepartmental cooperation is the Division of Child Mental Health and Division of Youth Rehabilitative Services in the Delaware Department of Children, Youth and Their Families working with the Department of Education and the Department of Health and Social Services' Division of Medicaid and Medical Assistance.

Unfortunately an observed negative example is the lack of interest and support by the Division of Substance Abuse and Mental Health (DSAM) in the Department of Health and Social Services toward the Department of Correction. Many of the inmates in the Department of Correction have used the services of the state mental health centers for medication and therapy, but there appears to be little cooperative case management, including direct individual concern for that patient, when one of the mentally ill arrives in the Justice system or the Department of Correction. Confidentiality issues have some impact on this, however, explicitly are not to hinder appropriate coordination of care.

Expand appropriate mental health service availability in the community to meet the needs of citizens with and without an ability to pay.

The good news is that the Medical Society's VIP program provides a list of physicians willing to provide service for a sliding scale fee. Of the 506 total physicians who have agreed to volunteer for this program, 221 are primary care physicians and six are psychiatrists. Delaware has 1148 primary care physicians and 86 psychiatrists who have agreed to take Medicaid. We primary care physicians must encourage more of our psychiatry colleagues to volunteer for the VIP program, to actively participate in public discussions for the benefit of our mentally ill patients, and to be willing to provide services to the mentally ill indigent.

Finally, here is a word of caution about repeating the mistakes of the past in regard to the mentally ill. As we develop a more humane course of service provision for our mentally ill and begin to transfer the responsibility for the nonviolent mentally ill to community services, let's make sure that the services are available by appropriately funding the development and implementation of services in all our communities – in New Castle, Kent and Sussex counties.

Delaware facts:

- The cost of keeping a mentally ill person in the Delaware community and providing needed mental health services averages \$10,000 per person per year in mental health services, in addition to the cost of living in the community.
- The average cost of **containing** a mentally ill person in a correction facility is \$29,300 per person per year.
- The negotiated cost of providing appropriate mental health treatment in a secure private mental health facility for juvenile offenders is \$660 per day per person plus the cost of a security officer, until the offender is stabilized for discharge to the community or to the juvenile justice facility.
- The cost of appropriate mental health hospitalization for an adult offender at the Jane Mitchell Forensic Unit on the grounds of the state hospital is \$648.85 per person per day until the offender can return to his community or back to the Delaware correctional facility.⁷

Cost is always a concern. However in a just world in which the well-educated acknowledge mental illness, has degrees of intensity and types just as a medical illness such as cardiac or renal disease, where and for how long a mentally ill offender is housed should be dictated by the level of care to fulfill treatment needs, stabilize the mental illness, and promote safety of the patient and the public. Delaying the appropriate provision of mental health, rehabilitation, and support services for the mentally ill and cognitively or developmentally delayed keeps compounding the actual and social costs for all of us.

REFERENCES

1. Beck AJ, Karberg JC, Harrison PM. *Prison and Jail Inmates at Midyear 2001*. Washington, DC: US Dept of Justice; 2002.
2. Yanich D. *Ex-Offender Reentry in Delaware – A Preliminary Report of the Delaware Reentry Roundtable*. Newark, Del: Center for Community Research and Service, School of Urban Affairs and Public Policy, University of Delaware; 2006.
3. Puisis M, ed. *Clinical Practice in Correctional Medicine*. 2nd ed., St. Louis, Mo.: Elsevier/Mosby; 2006.
4. Hurley P, Eme R. *ADHD and the Criminal Justice System, Spinning Out of Control*. BookSurge Publishing; 2008.
5. US Dept of Justice. *Arestee Drug Abuse Monitoring Program Annual Report*. Washington, DC: 2002.
6. The National Center on Addiction and Substance Abuse at Columbia University web site. Available at www.casacolumbia.org.
7. Delaware Dept of Children, Youth and Their Families and Delaware Dept of Correction. Dec. 2008.