Criminal Hospital

Growth in mentally ill prisoners sparks debate over incarceration vs. treatment.

BY ELIZABETH DAIGNEAU

Mark Dion never studied pharmacology. But every day, the sheriff of Cumberland County, Maine, hands out 1,000 pills to the men and women locked up in the Portland jail. Currently, 93 of the 373 inmates require psychotropic medication for depression, paranoia, schizophrenia or other mental illness. Without it, they've been known to bang their heads against cement walls, eat razors or smear themselves with their own feces. With it, they've propelled the county's contract for medical services from $800,000 in 2000 to more than $1.8 million in 2002. That's $4,800 per year for each inmate—about double the national average.

"We medicate," Dion says. "So the question is, are we a mental health institution serving as a jail or a jail serving as a mental health institution? Am I a public health advocate or the chief jailer of Cumberland County?"

People throughout Maine have been seriously pondering such matters since last fall, when a U.S. Department of Justice study revealed that its correctional institutions house a higher percentage of mentally ill inmates than those in almost any other state. Although citizens and lawmakers were startled to learn that at least one-quarter of offenders in Maine's state prisons receive some level of mental health services, the news didn't come as a surprise to police and corrections officials, the Department of Behavioral and Developmental Services and advocates for the mentally ill.

"We don't know why our rate is so high," says Carol Carothers, executive director of the Maine chapter of the National Alliance for the Mentally Ill. The situation is especially puzzling given the fact that Maine's incarceration rate is among the lowest in the country. One explanation is that the state may be diagnosing and treating people at a higher rate. Or the state may have failed in its responsibility to create and fund mental-health services before individuals reach the criminal justice system. What is clear, though, is that many of the mentally ill who might once have been housed in mental institutions are increasingly winding up in correctional facilities.

The problem is hardly unique to Maine. An estimated 16 percent of incarcerated persons nationwide are identified as mentally ill. At the Los Angeles County Jail, called "the largest de facto mental institution in the United States" by the Sentencing Project, an estimated 3,300 seriously mentally ill inmates are held each night. In Florida, mentally ill prison inmates outnumber patients in state mental hospitals by nearly 5 to 1. A study conducted by the Texas Senate Committee on Criminal Justice found that between 1988 and 1998, the state prison population increased by 262 percent while the number of mentally ill offenders in prison, and receiving outpatient health services, increased by 429 percent.

"There is a pretty broad perspective that the problems facing the mentally ill need to be addressed," says Marc Mauer, assistant director of the Sentencing Project in Washington, D.C. "People want to see the problem corrected. Prison is a severe option, and it's an expensive one."

The dilemma is that jails and prisons aren't prepared to care for the mentally ill. They are overcrowded and underfunded, contends Denise Lord, associate commis-

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sioner of the Maine Department of Corrections. Between 1990 and 1999, the department's budget grew by nearly 40 percent. The impact on taxpayers has been acute, with the state spending an average $35,000 a year to lock up each prisoner and thousands more to process them through the court system.

The deinstitutionalization of the mentally ill and tough-on-crime policy decisions at various levels of government increased the jail and prison population nationwide by 68 percent—to almost 2 million—between 1990 and 2000. The system was not prepared to deal with the rising prison population, let alone the mentally ill. In Maine, "we only have one psychiatrist for 700,000 prisoners, and they have to travel," Lord notes. "Some of our facilities are four hours apart."

Maine legislators, mental health advocates and jail officials have begun working together to address how much responsibility corrections officials such as Lord and Dion should have in overseeing the treatment and medication of the mentally ill. All involved agree that the lack of community-based programs should be the first issue tackled.

The state already offers 90 different programs for the mentally ill, at a cost of $68 million a year. That's nearly triple the 1995 spending level of $27 million. "Maine has greatly expanded its community-based services," Carothers says. "But it's still not enough."

Community-based programs were originally expected to replace traditional mental health institutions. Beginning in the 1960s, deinstitutionalization, a policy of hospital closures, developed in response to advocates who argued that Americans were being warehoused in state mental institutions and would receive better care in their communities. Furthermore, the development of more effective psychotropic medications promised better symptom control, and a greater chance that some patients could eventually care for themselves. In response, state governments dramatically accelerated the release of patients and the downsizing of state mental hospitals. In 1955, state mental hospital populations peaked at 559,000 persons. Today, 70,000 individuals with severe mental illnesses are housed in public psychiatric hospitals. In the past decade, 40 state mental hospitals have closed, while more than 400 new prisons have opened. "I'm very suspect of deinstitutionalization," Dion says. "It just cost-defected from the state mental hospitals to the jails. Now the state can say they have a more caring, loving system in their hospitals."

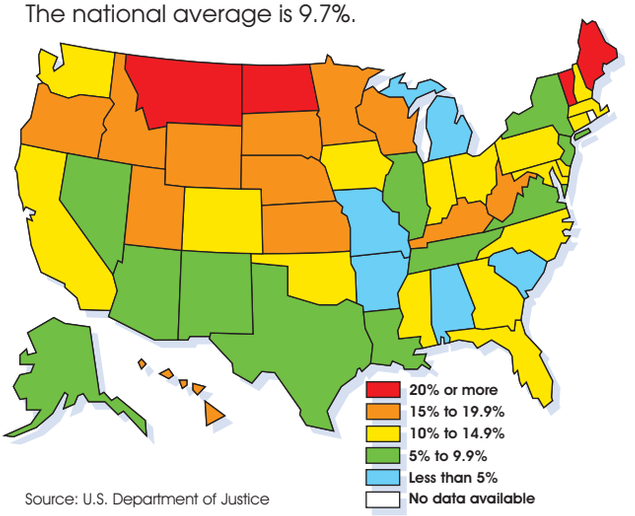
Many promises underlying the closures have not been kept. Community-based programs haven't taken care of the released hospital populations. "Deinstitutionalization happened pretty quickly, and the government has become pretty hesitant to provide funding for the services," Mauer says. "The community programs just fell through the cracks, so the criminal justice system became the default."

It is also not enough to expect the state to shoulder the entire burden, says Lynn Duby, commissioner for the Maine Department of Behavioral and Developmental Services. "Medicaid cannot be the main funder. When you have to fund something 100 percent through state funds, of course it's not enough."

State governments have traditionally been the major source of money for public mental health services, and remain so today. But according to the Bazelon Center for Mental Health Law, total state spending for treatment of the seriously mentally ill is one-third less now than in the 1950s. According to a 1998 study by the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration, the growth of spending for the treatment of mental illness and substance abuse nationwide has been lower than for health care generally. It is clear that the costs for caring for the mentally ill have shifted from the health care system to jails and prisons.

Pills in Prison

Percentage of inmates receiving pyschotropic medications in state correctional facilities, 2000. The national average is 9.7%.



Source: U.S. Department of Justice

Maine legislators commissioned a yearlong study on how corrections officials can better help mentally ill inmates become productive citizens. The Committee to Study the Needs of Persons with Mental Illness Who Are Incarcerated, created at the request of the Criminal Justice Committee, reported that Maine should spend more than $7 million on new programs and completely overhaul its system for handling mentally ill criminals because too often they leave jail in worse condition.

Shortly after the study was released, the legislature's Joint Standing Committee on Criminal Justice crafted legislation to divert the mentally ill away from incarceration, implement services for the mentally ill in jails and prisons and provide those inmates with after-care treatment.

That approach, NAMI's Carothers notes, was modeled on a small community-based program in Rochester, New York. Project Link does not depend 100 percent on Medicaid either, but instead is funded primarily by the Robert Wood Johnson Foundation, a private organization devoted to improving the health and health care of all Americans.

Project Link offers a broad array of services such as mental health and substance abuse treatment, housing and social services. It is the ultimate diversion program. It is exactly what the legislation calls for, Carothers says. "Project Link is an assorted community treatment team blended with a half-way house. They do all the hand-holding someone needs to get back on their feet."

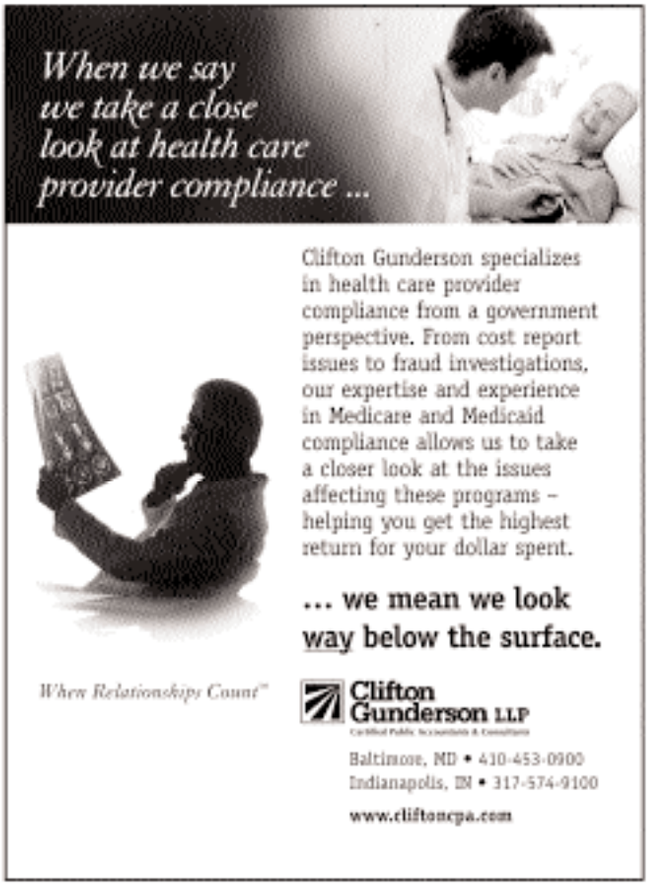
Run by the University of Rochester's psychiatry department, along with five other local agencies, Project Link "was designed to prevent the arrest and incarceration of the mentally ill," says Dr.

Steven Lamberti, director of Project Link. The program is often the only connection to reality for some of Rochester's most troubled individuals and their families. Of the 100 participants, about 85 percent have schizophrenia or some psychotic disorder. They were referred to the program after some attacked social workers or served time for robbery. One client was referred after he chased his brother around the house with a fork. Many are awash in drugs and alcohol.

The program features a "mobile treatment team," comprising a doctor, nurse and case manager. "So if one of our patients ends up sleeping under a bench," Lamberti says, "we can go to them and offer them whatever they need, be it a cup of coffee, food, a place to stay or a shot of their medication."

The project also has a close working relationship with the criminal justice system. Team members are present if a client is arrested, and they're frequently in courtrooms and jails trading insight and information with judges, public defenders, police and lawyers. And unlike other programs, Project Link "provides clients with a second chance, third chance, fourth chance..." Lamberti says.

A study conducted by the program shows that in the year before joining, patients spent an average of 109 days in jail and 105 days in the hospital. In their first year in Project Link, clients averaged 40 days in jail and 14 days in the hospital. The average annual cost of caring for a participant dropped as well, from $62,500 to about $14,500. But Lamberti stresses that the data should be taken with a grain of salt. Project Link works with "the most troubled individuals."



The Maine legislative bills encompass provisions for community-based services like Project Link, as well as for police contact or pre-booking, post-booking, trial and sentencing, probation and parole and treatment in jails and prisons. The legislation calls specifically for plans to establish procedures ensuring that a person receiving Medicaid does not lose that eligibility if incarcerated, even if Medicaid is limited or suspended during their time behind bars.

The legislation also would improve access for the mentally ill to inpatient beds at state mental health institutions, set up an ombudsman program for the mentally ill, and provide mental illness training for court, jail and corrections staff and others. It would create mental illness treatment pilot programs in at least three county jails that also deal with after-care planning. Treatment and after-care programs would be established in state prisons as well.

In addition, the legislation calls for law enforcement programs, such as ride-along services, to be reexamined. These are seen by the Sentencing Project and NAMI as one of the most important components of the solution. The Memphis Police Crisis Intervention Team exemplifies attempts to divert the mentally ill from the criminal justice system before arrest and incarceration. Operating on what Major Sam Cochran calls "responsibility and accountability," these specialized police units provide an immediate response to a crisis involving mentally ill people. Specially trained officers in these units focus on defusing potentially volatile situations by gathering relevant history, assessing medication information and evaluating the individual's social support system. The program works closely with community-based programs, NAMI, families and citizens to address the issue of whether the mentally ill should be put in jail or diverted to treatment.

"If you commit a crime, you go to jail," Carothers says. "That's not the real argument. If you commit a minor crime, you should be given treatment. We make people sicker in jail. They are in environments that would make a sane person go insane. It is stupid to do something that doesn't work over and over again, something that creates recidivism and worsens the already sick."

Cumberland County Sheriff Dion thinks the legislation is a good start, but adds, "Until there is a commitment to increasing beds at state mental hospitals, we are just spinning our wheels. We are allowing it to be a police problem. We have a problem forcing someone to take a pill, but we're okay with letting the police force someone into a squad car. What they really need is medical intervention, not police intervention."

While Maine has taken the first steps to address the issue, the road ahead is long and bumpy. Carothers estimates the spending package for the bill at $9.6 million. Given the state's current fiscal situation, it is not clear the legislation will receive any funding. "There is some language in the bill that doesn't cost money, so that will pass," Carothers says.

The Department of Behavioral and Developmental Services, Duby says, will proceed with a pilot program involving intake screening, a process to determine appropriate mental health care, case management/treatment and after-care.

Associate Commissioner Lord is encouraged by the new legislation but stresses the need to wait and see. "The question for me is, is what we're doing effective? Is it a coherent response? Just because we are doing more doesn't mean that what we are doing is effective." G