

Mental Illness and the Criminal Justice System in Indiana
The National Alliance on Mental Illness (NAMI) Indiana
Michael W. Kempf – Criminal Justice Team

The second half of the 20th century saw the down sizing and closure of the majority of state run psychiatric hospitals in the United States. The promise of community treatment and improved medication allowed many of those destined to live out their lives in a state-run institution, now free to pursue life in their community. For many others, for various reasons, they find that promise unfulfilled. Instead, many find themselves involved with the criminal justice system and housed in jails or prisons where the staff is largely under trained regarding mental illness and with treatment and access to state of the art medications limited or non-existent.

Effective treatment of mental illness first requires a correct diagnosis, the identification of an effective treatment and medication, access to that treatment or medication, and the willingness of the individual to accept the diagnosis and to remain treatment compliant. While this seems rather straightforward, some who suffer from a mental illness lack insight into their illness and therefore may fail to follow through with treatment. Would you take a medication for an illness you believed you did not have? Their families and society, in many cases, have abandoned others because their behavior is outside the bounds with which we are comfortable. Still others, because of their paranoia from the illness, abandon society and become homeless. These are but a few of the situations that can lead to a crisis situation that may involve law enforcement and further involvement with the criminal justice system.

The criminal justice system faces a very difficult challenge in balancing the safety of the public with the obligation to provide fair and equitable treatment to those, who, through no fault of their own, lack good judgment having had their view of reality impacted by mental illness. This article describes some of the issues the criminal justice system faces regarding mental illness and programs that address these issues, as well as recommendations to address unresolved issues faced by the mentally ill when involved with the system.

Its authors include Judy Spray, Director of Sentencing, Marion County Public Defender Agency, Virginia Caudill, Esq., criminal defense attorney and partner at Caudill & Caudill, Kathy Infanger, Prosecutor, Marion County Prosecutor's Office, Steven Fleece, Judge, Clark County Superior Court III, Robert Ohlemiller, former Deputy Director, Indiana Department of Correction and currently a consultant in criminal justice and corrections, Bill Elliott, Ph.D, Director of Mental Health & Behavioral Management, Indiana Department of Correction, Brian Barton, Marion County Community Corrections, Angela D. Vickers, JD NAMI FL 1st VP mental health advocate and bipolar lawyer in recovery 19 years, Joseph W. Vanable, Jr., Ph.D., President of the Board of Directors, Abby Flynn, NAMI IN AOT Chairperson, NAMI IN Board of Directors, Rosanna Esposito, Senior Policy & Legislative Counsel, Treatment Advocacy Center, NAMI Indiana and Michael Kempf, member of NAMI Indiana's Criminal Justice Team. It is clear that there is not complete agreement among the points of view of these authors. However, it is hoped that this article will lead to continued discussion and ultimate working out of the critical issues concerning mental illness and the Criminal Justice System.

Local Law Enforcement

Law enforcement officers are generally the first representatives of the criminal justice process that an individual with mental illness encounters when in crisis. The fact that the individual is in crisis means that those attempting to interact with the individual should not necessarily expect a rational response. While law enforcement officers generally have had some training regarding mental illness, experience has shown the need to augment this area of training. An Indiana statute now requires that all new officers receive a minimum of six hours of training on this subject. This expanded mental health training curriculum is now part of the training for new law enforcement officers at the Indiana Law Enforcement Academy (ILEA). A DVD that covers over 3 hours of the training is available from the ILEA for in-service training. Going further than this, a number of police agencies in Indiana and across the United States have adopted the Memphis, Tennessee, Crisis Intervention Team (CIT) model.

Under the CIT model, local law enforcement and mental health service providers join together with NAMI (National Alliance on Mental Illness) to develop a CIT program that fits the needs of their community. The mental health service providers also work with local NAMI representatives and law enforcement to develop and deliver a 40-hour CIT training curriculum. In larger communities, ideally, 20% of patrol officers receive this training. In smaller communities a larger percentage of officers are trained, thus assuring the likelihood of a CIT-trained officer's availability throughout the patrol shift cycle. Ideally, prospective CIT officers are volunteers who pass a screening process. One of the key elements that contribute to the effectiveness of the program is that the mental health service providers agree to work expeditiously with law enforcement when an individual is presented at an emergency room for assessment and treatment, thus allowing the officer to return to his or her duties with a minimum of delay. CIT programs have been instrumental in diverting large numbers of individuals with a mental illness and in crisis to treatment rather to jail.

The Fort Wayne (Indiana) police department is a prime example that demonstrates the effectiveness of the CIT model. During calendar year 2005, the Fort Wayne Police Department's CIT officers responded to 956 calls designated as CIT calls. Seventy one of the calls involved an armed individual and 457 were suicide related. A summary of the disposition of these calls follows:

Immediate Detentions (24 hr.)	635
Emergency Detentions (72 hr)	12
Voluntary Admissions	167
Stabilized at scene	122
No Action	9
Using Drugs	131
Arrests (5 individuals, 2 arrested twice)	7
Police action shooting death (3 hr. standoff)	1

Prior to the adoption of the CIT model in Fort Wayne, it is estimated that upwards of 30% of these persons would have been arrested and jailed. As evidenced by the above results, while CIT cannot ensure a positive outcome in all cases, it has clearly reduced the number

of individuals with a mental illness in our local jails and further involvement with the criminal justice system. Of even greater importance, more and more individuals requiring mental health treatment are now receiving treatment. Statistics also show that the likelihood of injury to law enforcement or to those in crisis is also greatly reduced with the introduction of the CIT program.

Local Jail Issues - Robert Ohlemiller, former Deputy Director, Indiana Department of Correction

Sheriffs hold the unenviable role of operating local jail facilities while having little influence on whom or how many enter or how long each inmate stays. In Indiana, there are about 14,000 inmates in local jails on any given day. Based on federal government (Bureau of Justice Statistics, 1999) estimates, 16.3 per cent are mentally ill, amounting to more than 2200 inmates. The true prevalence and severity of mental illness in jails is hard to gauge because of problems with definitions and deficiencies in screening/ recognition and staff training. Local jails frequently are crowded beyond design capacity, making it difficult to classify and safely house inmates who pose a threat to themselves and others. Jails are recognized as the point of highest risk for suicide in the correctional system. Because of reductions in the number of state mental health hospital beds, inmates needing hospitalization can wait in jail for months before becoming hospitalized. Furthermore, the availability of treatment services varies among counties.

Many counties struggle to cover the costs of psychiatric medications and have few resources to invest in mental health interventions. As many as one third of Indiana's counties have turned to private healthcare companies to deliver jail health care and mental health services. While advocates generally express concerns about managed care and restrictive drug formularies, there are corrections practitioners who see clear benefits. The LaPorte County Jail Commander, Captain Dick Buell, reports improved health and mental health care and reduced costs since the county hired a managed care company in September of 2004.

Almost one third of mentally ill jail inmates have histories of homelessness. According to one federal government report, 30.3 percent of jail inmates were homeless in the year prior to arrest. Even where adequate care is provided in jail, a lack of community ties and supports frequently contributes to poor continuity of care and re-arrest. Seventy-two percent of mentally ill individuals released from the Lucas County (Ohio) jail were reported to be re-arrested within 36 months (www.consensusproject.org). A case in point is reported by the Grant County Jail Commander, Lt. Cathy Lee, who tells of one male inmate diagnosed as being seriously mentally ill who spent eighteen months in jail before being released to a group home. He remained less than a day before failing the group home placement and returning to jail with minor charges. Lee asserts that the community does not have a residential setting that can provide adequate structure and services for the man to have a reasonable chance of success. And she is not alone.

Darius Randelia, mental health therapist at the Floyd County (Indiana) Jail, says the New Albany facility ends up with many inmates "who have no business being in jail" because of their mental illness. While sometimes the only alternative available, "isolation (in the county jail) is not an answer." He reports that the numbers of mentally ill inmates are "increasing steadily." He laments, "We need state hospitals." A significant incidence of

co-occurring disorders among the jail population only heightens the challenges faced by Randelia, an employee of Lifesprings Community Mental Health.

While there are daily challenges, Lt. Lee sees the level of collaboration and cooperation with local community mental health personnel increasing. A mental health therapist from Grant-Blackford visits the Grant County Jail weekly to review the cases of short-termers and make arrangements for medications and continuity of care. Another impetus to collaborative efforts involving Indiana communities and jails was a September 2004 Jail Mental Health Seminar conducted at Indiana State University by the Jails Division of the National Institute of Corrections. Maggie Scott, program supervisor for Shelby County Community Corrections says she and representatives from the local jail and Gallahue Mental Health Services are still building on what they learned in Terre Haute.

In the area of suicide prevention, the Indiana Sheriffs Association and DOC brought an acclaimed suicide prevention expert Lindsay Hayes, to Indiana, to present a well-attended Jail Suicide Prevention Seminar in July 2003. Paul Downing, former state jail inspector, estimates that 82 or more of the state's 92 counties now do mental health screenings upon admission. Forensic diversion statutes, effective July 2003, as well as DOC and DMHA funding for five pilot projects in 2004, are also proving to be catalysts for change benefiting local jails and individuals with mental illness.

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Public Defender's and Criminal Defense Attorney's Perspective - Judy Spray, Director of Sentencing, Marion County Public Defender Agency and Virginia Caudill, Esq., criminal defense attorney and partner at Caudill & Caudill

For attorneys, it is important to recognize signs of mental illness in their clients. Without such recognition, they can not provide effective representation. Clues that a client may have a mental illness include undue agitation or non-stop talking, trouble tracking in conversation or questioning, inappropriate mood or laughter, appearing withdrawn or refusing to speak at all. Attorneys may feel uncomfortable asking a client directly about mental illness; however, they can often get pertinent information by asking a client if he/she has ever been treated for a mental or emotional illness, or if he/she has ever been on medication for a mental or emotional illness. If they are able to obtain information from the client as to mental health treatment, current or past, they should have the client sign a Release of Information form, so they may speak directly to the treatment provider.

Marion County has developed the Psychiatric Assertive Identification and Referral (PAIR) diversion program, based on Indiana Code statute 12-23-5. Many mentally ill defendants, charged with low-level criminal offenses which may be directly attributed to their illness or lack of medication, languish in jail prior to sentencing. Too often, the mentally ill defendant has no one to post bond, nowhere to go if released, and may be unstable from lack of medication. Judges are hesitant to release such a person to the streets. This statute allows certain mentally ill defendants, on the basis of eligibility criteria listed in the statute, to have their criminal charges held in abeyance while they participate in mental health

treatment in the community. If the defendant successfully completes this 1-year diversion program, criminal charges are dismissed.

Because of the success of the PAIR diversion program, Marion County Community Corrections has added a Mental Health Component to its array of post-conviction sentencing programs. This program requires defendants who are mentally ill and otherwise eligible for Community Corrections to receive monitored mental health treatment in addition to regular programming. Those sentenced to the Mental Health Component are not required to pay the normal Community Correction fees, which have made Community Corrections inaccessible to many mentally ill defendants.

The Indiana Legislature recently passed a law, known as the Forensic Diversion Program. This new statute, which can be found at I.C. 11-12-3.7, applies to defendants who have a mental illness or addictive disorder and who have not been charged with a crime involving drugs or a violent offense. The program allows a defendant to receive treatment in the community, either in lieu of or in addition to other, lesser sentences such as probation. Typically, participation in the program begins with a court ordered evaluation at counsel's request to determine whether the defendant is an appropriate candidate for in-community treatment. Participation in the program can be either pre-or post-conviction, although for all practical purposes, there is little distinction, as pre-conviction participation (under the statute) requires that the defendant plead guilty to the pending charges. However, it should be noted that in Marion County, a guilty plea is not required to participate in pre-trial mental health diversion. Participation in the program, which can last anywhere up to three (3) years, depending on the circumstances, is overseen by the court, and only the court may order the defendant released.

Although this program is certainly a step in the right direction, as with PAIR, many defendants are ineligible if the pending charges are higher than felony D, or involve allegations of serious bodily injury. Be aware that although your county may not have a fully-developed *diversion program* in operation, judges can still use statutes 12-23-5 (PAIR) and 11-12-3-7 (Forensic Diversion) to direct defendants to treatment instead of incarceration.

To complicate matters further, Indiana's law regarding a defendant's competency to stand trial is presently set up to place individuals whose competency is at issue in a state institution to receive "restoration services." Significant problems arise, however, when it comes to those defendants who are incapable of being restored, due to developmental or other mental defects. A defendant in such a situation can languish in a state institution, never getting any better, until the prosecutor calls the matter back before the court. Needless to say, this is not high on the prosecutorial priority list, and more than a few cases can linger on a court's docket for years without resolution of the charges or the defendant's "restoration."

Unfortunately, the fact of the matter is that Indiana is far from having an adequate criminal justice response in this area, and it may be said that there are those within the system itself that are untroubled by this. For these reasons, it is especially important for defense counsel to understand what systems are already in place and zealously insist that they be used when it is in the client's best interests.

Prosecutor's Perspective - Kathy Infanger, Prosecutor, Marion County Prosecutor's Office

The prosecutor's goal in learning about a defendant's mental health history is twofold: to protect public safety and to work towards the furtherance of crime reduction for city neighborhoods. To this end, a prosecutor must balance the need for public safety and the hopeful outcome of reducing recidivism should treatment for a mentally ill defendant succeed.

People who have a mental illness exhibit many of the same traits as those who don't: some will lie, be mean, and hurt others, while others are honest, agreeable, and harmless. In determining the correct placement for a defendant in the criminal justice system, the deputy prosecutor must evaluate and identify those defendants who have a propensity to do real harm to others. Marion County law enforcement is still reeling from the deaths of two of their officers and injuries to others at the hands of people with mental illnesses in 2004. Defendants with mental illnesses must be evaluated on an individual basis, including the assessment of the facts of their cases as well as their criminal history. Any additional necessary information is often obtained from his or her treatment provider.

Cases referred to PAIR (Marion County's pretrial mental health diversion program) are screened carefully by members of a roundtable consisting of a deputy prosecutor and representatives of the Public Defender agency, the Mental Health Association in Marion County and treatment providers from several community mental health treatment centers in Marion County. If a defendant successfully completes the program, his/her case is dismissed, so the prosecutor relies heavily upon all members of the roundtable to ensure that dismissing the case would not compromise public safety. Additionally, the PAIR prosecutor keeps the deputy prosecutor assigned to the case informed about any progress. There are important reasons for this. If a victim is involved, then he or she must have input on the proper resolution of the case. Likewise, all others connected to the case must agree that assignment to a pretrial diversion program is appropriate; progressing well and will most likely help the defendant to reduce his or her propensity to commit a crime in the future.

Several factors are considered before a defendant may be accepted to PAIR. Crimes involving violence are not accepted. Certain other crimes are not eligible by statute (e.g., if a defendant is on probation and his probation officer objects) or prosecutor policy (e.g., operating a vehicle while intoxicated). If a defendant's criminal history reveals a propensity for violence or if a victim is strongly against diversion, the case is deemed ineligible for pretrial diversion and is referred to a post-conviction program for defendants with a mental illness run by Community Corrections.

Again, defendants are screened closely with the same considerations for violent behavior and compromise of public safety. The deputy prosecutor must consider opportunities for treatment both before the trial and after a conviction and incarceration to determine what is best for the citizens of the community. There are times that a defendant with a mental illness is found to be too dangerous to be out in the community, tipping the scales in favor of incarceration as the best placement.

The aim is that the current programs and considerations here in Marion County achieve both goals of a prosecutor: 1) to reduce recidivism by helping defendants who are willing to comply with treatment get the medications and treatment they need and reward their efforts at treatment by dismissing their case, and 2) protect the public by proceeding with prosecution when necessary to achieve a conviction and the appropriate consequence, whether treatment or incarceration, in the interest of public safety.

Judge's Perspective - Steven Fleece, Judge, Clark County Superior Court III

Traditionally, most lawyers and judges thought of criminal law and mental health issues as coming together only at two major intersections, both of which are statutorily defined. Those traditional intersections are: not guilty by reason of insanity, I.C.35-36-2: and, incompetent to stand trial, I.C. 35-36-3. When a judge or lawyer becomes aware that a defendant is or may have mental illness, the first response, and often the only response, has been to determine whether the mental illness rises to the level of an insanity defense or a matter of incompetence to stand trial. If the mental illness does not fulfill either of those criteria, the mental illness has all too often been deemed irrelevant to the legal proceedings. Mental illness not rising to the level of insanity or incompetence has been treated as if it did not exist, as if the judge, the defense attorney, and the prosecutor were all deaf, dumb and blind to the reality of mental illness as it affects their work.

For reasons to be discussed below, those two traditional categories form a totally inadequate paradigm for thinking about the relationship of criminal law and mental illness. To deal with a person with mental illness who is caught up in the criminal justice system only in terms of insanity or incompetence is to don an intellectual straight jacket that makes enlightened prosecution, meaningful defense, humane jurisprudence, and effective correctional all but impossible.

It is said that the railroads of this country suffered disastrous decline because railway company executives thought of their mission strictly as operating trains. If they had conceived of their mission more broadly in terms of providing transportation for people and goods by what ever means possible, they might have evolved and prospered. Similarly, if the judiciary conceive of their role in forensic mental health cases too narrowly, they risk failing to achieve what society has a right to demand of them in such circumstances, namely, effective intervention.

My perspective is that of an Indiana trial court judge who deals with what we refer to as "the county court function." Most of the former county courts in this state have been changed into superior courts with broader legal jurisdiction than they possessed in their original form. Yet the work that the county courts were created to do still exists- relatively high volume adjudication of misdemeanor and lower level felony cases, along with small claims, collections, landlord-tenant disputes, traffic infractions and other such matters which routinely sweep into our courts a broad sampling of human problems.

Although I have been on the bench for over twenty years, I have never had to deal with an insanity defense in a murder trial or a claim of incompetence to stand trial in the case of a major felony. I have, however, presided over hundreds of domestic violence cases where the defendant had mental illness and was "off his meds" at the time of the offense. I have presided over hundreds of disorderly conduct cases that escalated into felony resisting law

enforcement cases because the defendant was not receiving proper mental health care at the time of the eruption. I have presided over hundreds of public intoxication and operating a vehicle while intoxicated cases where the defendant suffered from a co-occurring disorders of addiction and mental illness and was seeking to “self-medicate” himself. I have presided over hundreds of theft, fraud and forgery cases where the mental illness of the defendant was the motivating factor. I have presided over hundreds of intimidation cases and violation of protective order cases where the victims were terrified by the actions of persons under the influence of mental illness. I have come to know dozens of defendants who have each accumulated case after case, year after year, because of untreated or inadequately treated mental illness or because of their own failure to comply with treatment, often because of the side-effects of medication.

In the last few years, my perspective has been influenced by participation in the National Alliance on Mental Illness (NAMI) local affiliate. I was introduced to the organization by a friend whose son, who had mental illness, struck his stepfather and had to face battery charges. Searching for ways to help her son out of his legal difficulties and hoping to avoid future incidents, my friend became aware of the NAMI affiliate in nearby Louisville, Kentucky.

NAMI educational programs were so helpful to her that she soon was helping to organize a Southern Indiana NAMI affiliate. She badgered me into becoming involved as a way to educate me. I was asked to be a guest speaker at one of the first meetings, forcing me to bone up on my understanding of the statutes traditionally associated with forensic mental health. I went to that meeting in a church basement intending to teach, but stayed and returned each month to learn. I learned directly from consumers of mental health services and from their families just how difficult it can be to “navigate the system.

I went to teach them how to “think like lawyers” and to translate their concerns into petitions that would correspond to our traditional legal categories of thinking. Was your son “insane” at the time of the offense or are you saying that he is now “incompetent” to stand trial? Alternatively, is it, perhaps, that he is “guilty but mentally ill”? Figure out which one of those doors you want to knock on, take two aspirins, and call us in the morning.

But as I listened to one heartbreaking story after another, one inspiring story after another of brave, loving persistence in pursuit of effective treatment for family members with mental illness, I came to realize that these people did not need to be trained to think like lawyers. Rather, judges and we lawyers need to think as creative and compassionate human beings. It is not for us to instruct our constituents and clients how to tell their tales of tragedy more succinctly and to frame their petitions so as to fit within our existing legal remedies. Rather it is our task to hear them out fully, to comprehend the full scope of their tragedies, and to fashion new remedies that will truly relieve human suffering.

Insanity, incompetence and guilty but mentally ill are categories that rarely get at what these consumers and family members are so desperately seeking. They are seeking help. They are seeking effective intervention. In the first place, these traditional forensic mental health issues are almost never raised in misdemeanor and minor felony cases. I have no statistics to support that assertion, but, it has been my experience that no more than one in a hundred such cases involving defendants with a diagnosed mental illness result in any

sort of mental health defense, formal exploration of competency or any consideration of pleading guilty but mentally ill. Perhaps our formal procedures are too cumbersome for either overworked public defenders or deputy prosecutors responsible for high-volume caseloads to think about invoking them, except in major cases. It is easier and faster and, therefore, far more likely that the mental illness will be treated merely as a bargaining chip to obtain a somewhat more lenient plea bargain. Hope springs eternal that somehow the probation officer will sort it all out, despite the probation officer's own excessive caseload and the lack of adequate community resources.

In the rare instances where a person does plead guilty but mentally ill, persons whom I trust including psychiatrists, tell me that the designation is meaningless to the department of correction. It would be pleasant to think that the department follows the law by providing treatment "in such a manner as is psychiatrically indicated for the defendant's mental illness" in such circumstances (I.C. 35-36-2-5). Yet everyone I know is of the impression that the department of correction views this legislative mandate as a sort of whimsical expression of utopian aspirations and nothing to be taken too seriously. If the legislature were serious about providing effective mental health services in the department of correction, they would provide serious funding. In the absence of such funding, the department is absolved from having to comply with the mandate-or so the thinking goes.

Assume for a moment that mental health services in the department of correction are much better than the anecdotal information I have been given would indicate. Then consider how these services would be impacted if everyone with bipolar disorder or schizophrenia facing a department of correction sentence suddenly decided to plead guilty but mentally ill and claim such services as a matter of right. According to a 1999 Bureau of Justice Statistics report, the U.S. Department of Justice estimates that at least 16% of adult inmates in U.S. jails and prisons suffer from a serious mental illness. What if they all pled guilty but mentally ill and demanded effective mental health services as a matter of right under I.C. 35-36-2-5? The fact is that we "can't handle the truth" when it comes to the large percentage of prisoners who suffer from serious mental illness and who are not receiving appropriate care while in custody. (This is true not only for offenders in DOC custody, but local county jails as well)

Imagine how all hell could break loose if an advocate for a person with a mental illness ever got hold of a copy of the Indiana State Constitution! That document was largely inspired by the ideals of Jacksonian Democracy. It was written by men with attitudes toward state authority not unlike those of Johnny Cash or Willie Nelson, men with some experience of the wrong end of a billy club. How else to explain its explicit requirement that "No person arrested or confined in jail shall be treated with unnecessary vigor." (Bill of Rights Article 15) and "The penal code shall be founded on the principles of reformation and not of vindictive justice." (Bill of Rights, Article 18) What if some wide-eyed radical lawyer was to insist that we live up to those demands of our state constitution! What if such an advocate were to convincingly demonstrate to the Indiana Supreme Court the nexus between inadequate correctional mental health treatment and "unnecessarily rigorous correctional practices?" What if "the principles of reformation" were found to constitutionally mandate more effective correctional mental health services including access to the most advanced psychotropic medications and psychiatrists and counselors with manageable caseloads?

It is time for judges and lawyers who care about justice to use the law on behalf of individuals with mental illness as creatively, passionately and effectively as it has been used in the past in defense of civil rights. It is time to consider measures which would require systemic reform and insure adequate funding for a correctional system that is truly “founded on the principles of reformation and not of vindictive justice” when it comes to offenders with mental illness.

Until necessary radical improvements are made in the mental health care delivery system, these are some specific measures that reform minded lawyers and judges can pursue:

1. Make sure that your Community Corrections Board has adopted the best possible forensic diversion plan under I.C. 11-12-3.7-7 and that the prosecutor is using it in appropriate cases.
2. Assist in the creation of Crisis Intervention Teams (CIT) in every community so that first responders receive special training in dealing with individuals with mental illness in crisis and so that the best possible institutional arrangements are in place for the immediate care of such persons.
3. Encourage the funding of enough Assertive Community Treatment (ACT) Teams throughout Indiana so that all offenders who have mentally illness benefit from placement in such an intensive outpatient mode would have access to such services.
4. Use the County Supplemental Adult Probation Fund in each county to support innovative probation services for offenders who have mental illness (I.C. 35-38-2-1).
5. Encourage individuals who have mentally illness and their families to make use of the excellent support and education network available through local NAMI affiliates. Imagine trying to impact alcohol and drug related crime without the help of Alcoholics Anonymous (AA) twelve-step programs. Dealing with mental health related forensic issues without taking advantage of the help NAMI has to offer is like trying to deal with alcohol and drugs without AA.
6. Urge the Indiana Judicial Conference to establish a Mental Health Committee to help educate the judiciary about the difficulties that families face in navigating the mental health system. This committee could be modeled on the highly successful Court Alcohol and Drug Program Advisory Committee. It could work with mental health care providers, consumers and advocates to design more effective interventions to keep persons with mental illness out of jails and prisons.

A recent Frontline program on the Public Broadcasting System dramatically illustrated the national disgrace of what they call “The New Asylums.” The state mental hospitals have been closed down, individuals who have mental illness have been returned to their communities without adequate provision for community-based outpatient care. Too many individuals who have mental illness have fallen through the cracks. Too many community mental health centers have failed to meet the challenge of addressing the needs of persons with the most severe mental illness in their communities. Funding for mental health services has been inadequate. Too many hospital emergency rooms lack adequate facilities

and personnel to deal with persons with severe mental illness who are in crisis. The result is that our jails and prisons have become “the new asylums” for persons with severe mental illness. An enlightened society should not tolerate this. Our criminal justice system should not forever be required to compensate for the chronic failure of an inadequate mental health care system. It is time for judges and lawyers to combat this national disgrace by committing their energy, authority, influence and skill to the goal of getting persons with mental illness out of jail and into treatment.

Department of Correction Perspective Bill Elliott, Ph.D, Director of Mental Health & Behavioral Management

While in Prison

The primary goal of Mental Health Services in the Department of Correction (DOC) is the treatment and management of those with serious mental illness as defined as an Axis I disorder, exclusive of Substance Abuse Dependence and (any) paraphilia, and a Global Assessment and Functioning (GAF) score of 40 or below. Available services include inpatient acute care, crisis intervention, residential transitional care, and outpatient care.

Mental health services as delivered by psychiatrists, psychologist, licensed clinical social workers, and licensed mental health counselors who are either employees of or subcontractors with Correctional Medical Services.

All juvenile and adult offenders entering the DOC receive a mental health assessment. At minimum, this entails a clinical interview and review of available mental health records. The depth and breadth of this assessment depends on the volume of admissions at each intake site. For example, a relatively small number of male juveniles are processed through the Logansport intake unit each week, thereby permitting an in-depth multidisciplinary assessment second to none in the nation. Conversely, with up to 80 adult male offenders entering the Reception Diagnostic Center daily, assessment is necessarily limited in both scope and duration.

Inpatient mental health services for adult males is provided at the New Castle Correctional Facility (NCCF). This unit consists of three 32 bed ranges in which prisoners with mental illness receive care similar to that provided in a mental health hospital in the community at large. Adult female prisoners requiring similar care are far fewer in number, and are managed in the Special Needs Unit at the Indiana Women’s Prison. Juvenile offenders requiring inpatient mental health care are managed in specialized housing units, although occasionally a youth is transferred off site to a public hospital facility.

Residential transitional services are provided to prisoners whose mental illnesses require a supportive setting but who do not require hospital-type placement. These are provided to adult males at the Indiana State Prison, to adult females at the Indiana Women’s Prison, to juvenile males at the Pendleton Juvenile Correctional Facility, and to juvenile females at the Indianapolis Juvenile Correctional Facility.

NAMI Indiana’s Criminal Justice team, with assistance from the Indiana University Department of Psychiatry, and with input from the Indiana Department of Correction’s Wabash Valley Correctional Facility staff, has developed a program to train and educate

correctional officers about mental illness. The program, “NAMI Indiana Criminal Justice Training,” consists of a series of five two-hour classes delivered over a five week period. Each class has a distinct focus.

They are:

- The Categories of Mental Illness
- The Biological Basis of Mental Illness
- The Treatment of Mental Illness
- Interacting with Persons with Mental Illness
- Criminal Justice & Mental Illness: Principles and Applications, A new Beginning

By educating correctional staff about mental illness and its treatment, participants better understand and communicate more effectively with inmates who have mental illness, thus enhancing staff’s personal safety and improving the quality of life for the offenders. Following training conducted at the Wabash Valley Correctional Facility Secure Housing Unit, staff’s use of force decreased by 70% and assaults by inmates on staff decreased by 50%. This has improved the working and living conditions for all concerned tremendously. Currently, the program has been expanded to seven correctional facilities, training in excess of 700 individuals.

Release from Prison

Prisoners leaving prison may depart on parole or probation or without supervision (if the sentence is fully completed). The DOC provides supervision only to prisoners who depart on parole; probation is administered by county agencies.

The DOC is not financially responsible for care provided after release from a confined setting except under special circumstances and as stipulated by the sentencing judge. However, the DOC recognizes its obligation to facilitate continuous care for departing offenders. Prior to release, the DOC arranges follow up care including appointments, bridge medications (for up to 30 days), supplies and equipment, and referral to agencies that can provide financial and social assistance. Medical and mental health records can be sent, upon request, to community-based treatment providers with or without the offender’s authorization. All of this makes it possible for departing prisoners to receive care in a seamless manner as they leave prison and return to the community.

Community Corrections - Brian Barton, Marion County Community Corrections

Even though community corrections prides itself on being progressive and adopting evidence based practices, like other institutions in the criminal justice system, it was far too slow to respond to the needs of individuals who have mental illness. This task was complicated by our initially being unprepared for this new challenge. Instead of trying to understand this special kind of offender, it was safer and easier to say these individuals were a risk or did not belong in a community based program.

That type of thinking has changed and now for the last six years, there has been a concerted effort statewide, within community corrections programs, to work with mental health professionals and forge partnerships so we can effectively supervise offenders who have mental illness. Mental Health programs, like those at Marion County Community Corrections, have created partnerships with correctional and mental health experts as they work together to design the supervision and treatment program for these offenders. Having both experts at the table allows for better communication and a better result. Proper diagnosis, effective treatment plans and access to medication are key components to any successful community corrections program. If these individuals are to succeed in a community-based treatment, heading off potential problems is vital.

The future looks very promising as community corrections practitioners from across the state are sitting down with professionals from the mental health field and developing Forensic Diversion Programs. These new initiatives focus on both addictive disorders and mental illness and how best to treat and supervise these individuals at the local level. Staff education and training, community education and outreach are important as more programs begin serving individuals with mental illness.

The days of an individual who suffers from mental illness being condemned to jail or prison without adequate treatment are numbered. Being mentally ill is not a crime, but failing to recognize the unique issues they bring to the criminal justice system is.

The Case for Change and the need for additional Education regarding Mental Illness for those who work within the Court System

by Angela D. Vickers, JD,

NAMI Florida 1st Vice President, a mental health advocate and bipolar lawyer in recovery 19 years

A matter of stigma, equal protection, and accuracy

Linking mental illness & criminal justice, without an explanation of how most people with mental illnesses live without any criminal behaviors, increases stigma. Reforms are needed to provide “justice” in the criminal and civil justice systems. People with mental illnesses often face injustice when the legal community is not educated about mental illness symptoms. Reports linking mental illness and criminal justice can discourage needed psychiatric treatment. Without proper mental illness treatment, people with psychiatric problems are more likely to self-medicate with substances of abuse. Stigma often creates behavioral problems which could be routinely prevented, if the public better understood brain illnesses.

Experts agree that 20% of our population - over 60 million Americans - have some degree of some mental illness. A significant omission in many criminal justice reports related to mental illness is the statement that the vast majority of people with mental illnesses do not engage in any criminal conduct. Most people with mental illness are law-abiding.

The media-generated view that psychiatric patients are violent and dangerous is held by many within the bench and bar. This view is false. The media chooses to cover the bizarre and thrilling stories [moms drowning babies; college professors becoming hermits and mailing bombs, etc.]. Journalists fail to cover the normal lives of 60 million Americans

who are living peacefully with mental illnesses in our communities – your neighbors, your co-workers, your child’s school teacher, your dentist.

Newspapers and horror movies or comedies do not accurately portray the average mental patient. The resulting stigma and shame caused by this one-sided reporting of violent, sensational criminals with mental illness has closeted millions of citizens. They fear serious discrimination, even from the legal community. Those who think people with mental illnesses are dangerous have fired employees due to a label of mental illness. Some parents with a mental illness diagnosis have lost custody of their children in custody battles, due to this “hate crime” mentality and prejudice that is based upon myths and misinformation.

Stigma delays treatment and justice

Mental health stereotypes make it more difficult for the many recovered or recovering mental patients to obtain employment. Medical insurance policies make it difficult for a psychiatric patient to get well. Troubling symptoms that are left untreated often lead to substance abuse as a way to find temporary relief. Psychiatric symptoms and intoxication increase DUIs, domestic violence, job loss, incarcerations, and divorces. These stress-triggered, inherited brain illnesses worsen without proper treatment. Worsening symptoms create worsening problems which create the stress that continues the worsening symptoms. Fear of discrimination keeps many with early, milder symptoms of mental illness from seeking prompt medical care – at a time when there is the greatest potential for recovery and continued employment and productivity.

Mental illness symptoms often first strike in our youth. Due to a lack of parental and professional education, psychiatric illnesses are often missed at first. Untreated mental problems account for many drop-outs, expulsions, and academic failures. Many young people are not diagnosed and treated for decades after their first onset of mental illness.

The prevention of criminal activities requires a system that supports early and a life-time of routine mental wellness screening. Doctors would help with public education and in dispelling myths and misinformation about the common, treatable mental illnesses. Early and continuing classroom information would allow the next generation of citizens to hold no stigma against brain illnesses.

Prevention dollars are more cost effective than punitive warehousing of people for actions caused by ill brains. Years of medical neglect and substance abuse create school and workplace drop-outs, incarceration following addiction, homelessness, and disability. Not unlike the case of problems of racial discrimination, the schools and our children are a logical place to begin transforming the lives of all who have inherited common mental illnesses.

Even within the bench and bar, too many professionals end up facing disciplinary charges for behaviors that are directly linked to untreated, or improperly treated, mental illness. Experts state that half of the citizens with substance abuse problems have underlying mental health issues – and the mental symptoms came first. In 50% of all cases substance abuse is known to be attempts to “self-medicate” as a way of finding relief from troubling mental symptoms. Fearing career loss or embarrassment if they seek psychiatric care,

legal professionals are among the many professionals who deny their mental illnesses and refuse needed evaluations and psychiatric care.

With early and proper treatment, recovery is possible for 60% - 80% of mental patients. Booking and incarceration provide an excellent chance to screen and recognize mental illness, as symptoms typically present during periods of stress. Once illness is recognized, the role of corrections can shift from punitive mode to true rehabilitation. Forensic peer specialists and other educators can teach those with mental illnesses how to follow the necessary medical guidelines needed to get and to stay well.

Experts agree that untreated mental illnesses get worse. The prognosis worsens the longer a person goes without proper medical treatment. This should not surprise the criminal justice system or the public. Society accepts that cancer, heart disease, and diabetes will worsen without prompt treatment. The same is true with mental illnesses. The longer a person goes without proper care, the less likely he or she will live a productive, healthy life.

When prosecuting attorneys, defense attorneys, and judges dealing with people with mental illness who are facing criminal charges understand the benefits of proper mental health treatment, the system will be much closer to having justice. Periods of incarceration, probation, or supervised diversion can be used to link mental health education and services to those in need. Presumptions that “the mentally ill” are doomed to be chronically and severely disabled are false. Our nation can no longer afford to keep so many Americans in a disabled, costly state of brain illness.

A new science requires a new education curriculum

Ninety percent of what is known about brain science and psychiatry has been learned in the last 15 years. An abundance of brain medicines now make recovery the expected norm, when there is early access to proper medication and education. However, most physicians are not screening patients for mental illness during either well or sick office visits.

Many showing mental illness symptoms in the jails have never been previously diagnosed. The stress of incarceration may trigger symptoms that were not present at the time of the arrest. Recent studies indicate that psychiatric illnesses often first strike during youth. A study from the National Institute of Mental Health found that 50% of all Americans who were ever going to experience mental illness symptoms began having symptoms by the age of 14. An additional twenty-five percent of all Americans who have mental illness – 15 million citizens – have their first symptoms between the ages of 14 and 24. Many younger offenders currently in jails and prisons have never seen a local mental health facility or a state mental hospital. They and their families have no idea that years of troubling behaviors were linked to a common, treatable medical condition.

Mental illness is a serious medical problem of the youth. As episodes of illness reoccur, and symptoms worsen, the youth and young adults with mental illness face juvenile justice and charges that are increasingly more severe. Felony charges may destroy potential job and education opportunities. Without proper mental health treatment and community supports, many of these youth will face life-long disability and recidivism.

The medical-legal problems presented require urgent attention. People are dying. Every year in America, 30,000 people kill themselves. Suicides are the final symptom of depression or bipolar disorder in 95% of all cases. Both of those common brain illnesses are very treatable by simply taking a few pills each day and receiving competent therapy. Suicide is the third leading cause of death among our teens.

Much of the severe nature of mental illness can be prevented. The illnesses are very treatable with existing medications. More ways to treat resistance symptoms are being developed. Currently, up to 80% of those onsetting with most psychiatric illnesses can recover. Even with schizophrenia, there is a 60% recovery rate for those diagnosed quickly and faithfully treated.

Schools can prevent crime and save brains

Those looking for reasons why so many with mental illnesses are in jail might look to the schools. Both education about common mental illnesses and early screening are lacking. Both are needed to prevent mental illness symptoms from ever resulting in criminal charges. Prevention is the best use of our funds in saving careers, families, and money.

Many view children who are involved in the Juvenile Justice system as being on the threshold of more serious adult crimes. School mental health programs are just beginning to realize the impact of mental illness symptoms on student behaviors and their academic performance. If proper measures are taken to intervene during childhood, adult felons can be prevented.

Of all the disabled school students, those with mental illness have the highest drop-out rate. Symptoms may interfere with school performance. Bad judgment and substance abuse may cause students to think any education is not important. Without a high school diploma, many young men and women are unable to find meaningful employment. Many turn to crime. Many may follow, or be, the ones with bipolar grandiosity and bad judgment. Substance use increases the risk of bad choices and incarceration.

A bipolar student's symptoms of aggression, grandiosity, or recklessness may often lead to expulsion. This frequently happens without any awareness by either the school or parents that the student had a mental illness. Truancy, absenteeism, academic failure, and under-productivity are often linked to mental health symptoms.

When students turn to substance abuse, their negative behaviors are often simply blamed on the alcohol or drugs. Without updated training among addictions treatment staffers, youth may not be provided with services needed to recover from both addiction and mental illness. The reform in criminal justice is just one piece in the transformation of the mental health system which our nation is finally tackling.

Justice demands training lawyers and judges about mental illnesses. With the existing misinformation and prejudice, millions of Americans currently lack justice. When I lost my children, I had no way to find an attorney who had received any training about mental illness, and recovery. I found that lawyers doubted my credibility, and treated me with condescension as soon as they learned of my medical diagnosis. What's a bipolar mother

to do when her children's behaviors show they are at risk? I lost mine to presumptions that I was at fault. I understand discrimination.

Indiana Needs to Use Assisted Outpatient Treatment (AOT and Stop Criminalizing Mental Illness

Abby Flynn, NAMI Indiana AOT Chairperson, NAMI Indiana Board of Directors Member at Large and Rosanna Esposito, Senior Policy & Legislative Counsel, Treatment Advocacy Center

Family members are the primary caregivers for individuals with severe mental illnesses who live in the community - more than half live with their families. The challenge is one that few understand, unless they have experienced it. A mother whose son has schizoaffective disorder recently wrote:

“It is hard to adequately convey what it is like to lose a smart, funny, sensitive child to mental illness, and to constantly worry about his safety and his future. But it is even more heartbreaking to know that effective medication is available to treat this terrible illness, but that my son refuses to take it.”

When our loved ones receive effective medical treatment for their illnesses, most can lead productive lives. When they do not, they are more likely to have contact with the criminal justice system due to arrests, incarceration, victimization, violence, and homelessness. They are also more likely to commit suicide.

The single largest reason some people with severe mental illnesses do not voluntarily take their prescribed medications is that, due to the illness itself, they have impaired awareness of their illness. Put another way - *they honestly do not know that they are ill*. Like some individuals with strokes, brain tumors, Alzheimer's disease, and Huntington's disease, some individuals with severe mental illnesses have impaired awareness into their illness. The neurological term for the deficit is “anosognosia.” Approximately 40 percent of individuals with bipolar disorder and nearly 50 percent of individuals with schizophrenia have moderate or severe impairment in their awareness of illness. In a nationally representative household survey of individuals with psychiatric disorders who were not receiving stable treatment, 55% of the respondents said that they did not believe that they were sick. Far fewer attributed nonadherence to a lack of access to services or even to side effects.

One legal option for decreasing contacts between people with severe mental illness and the criminal justice system and increasing medication adherence is Assisted Outpatient Treatment (AOT). Basically, AOT is a court order requiring that a person follow a treatment plan while living in the community. It is a less restrictive alternative to involuntary inpatient treatment for the small, but significant number of people who need something more than totally voluntary community services.

Like 41 other states, Indiana law permits AOT for certain individuals with severe mental illness (**IND. CODE ANN. § 12-26-14**). To qualify, the individual must meet a statutorily

defined set of criteria, including a finding that the individual is either “dangerous” or “gravely disabled.” The court order may require that the individual follow a specified outpatient therapy program, attend scheduled medical and psychiatric appointments, and reside at a court-determined location or other conditions as set by the court. If the individual does not comply with the court order, the court can reopen the commitment hearing and, among other options, decide whether the individual is in need of inpatient psychiatric treatment.

Unfortunately, only a few jurisdictions in this state actually use AOT, despite its proven benefits. Research from Duke University, widely regarded as the best studies on AOT, compared individuals who received routine intensive outpatient services (without a court order) to those who received the same level of services combined with a six-month court order. The research participants were from both urban and rural communities and “generally did not view themselves as mentally ill or in need of treatment.” The randomized control studies found that AOT reduced the risk of arrest by 74%, hospitalization by up to 74%, victimization by 50% and risk of violence by up to 50%.

The benefits of AOT can be life-changing for those involved. A mother, whose daughter was untreated, homeless, and victimized for years before she was placed in New York’s program testified that, “AOT has given my daughter a real life and new hope for the first time in fifteen long and terrible years...” The daughter was not the only one to benefit from AOT. In 2005, the New York Office of Mental Health released a report which detailed the first five years of their “Kendra’s Law” program. Among individuals with severe mental illnesses who received AOT orders, significantly fewer experienced hospitalization, homelessness, arrest, and incarceration. AOT increased participant adherence to treatment and overall quality of life. It also resulted in fundamental changes to the state’s overall mental health system, leading to enhanced accountability and improved treatment plan collaboration for all service recipients.

AOT can also make limited, existing mental health services more effective. As in New York, a program in Seminole County, Florida found that the majority of participants who received AOT orders were individuals who already were known to the mental health system, enrolled in services, and were receiving case management. However, prior to AOT, they also were not treatment adherent and exhibited “no” service engagement or “poor” service engagement. Because they were not effectively engaged in treatment for a sustained period of time, they did not experience the benefits of the resources that were expended. AOT changed that for the better.

One clear example where AOT can be used with existing services to improve outcomes is with the state’s 26 Assertive Community Treatment (ACT) teams, recently recognized by NAMI as a “bright spot in the state’s current system.” ACT is a service-delivery model for providing comprehensive community-based treatment in a timely manner to individuals with severe and persistent mental illnesses. Many ACT programs erroneously limit themselves to voluntary treatment participation, even though the ACT Manual specifically contemplates that, “Some clients who enter ACT treatment voluntarily later refuse treatment and may become candidates for involuntary services ...” In fact, one study of an ACT program that was totally voluntary for all patients revealed that at any given time one third of the patients were medication nonadherent.

Indiana needs to widely implement AOT to help treat individuals with severe mental illnesses and to decrease contacts with the criminal justice system. While we are grateful to the criminal justice system for seeking better programs for our loved ones, family members also believe that individuals with severe mental illnesses should not have to become involved in the criminal justice system in order to get treatment. As Supreme Court Justice Anthony Kennedy said:

“It must be remembered that for the person with severe mental illness who has no treatment, the most dreaded of confinements can be the imprisonment inflicted by his own mind, which shuts reality out and subjects him to the torment of voices and images beyond our powers to describe.”

Medical Records in the Criminal Justice System

Michael W. Kempf - NAMI Indiana Criminal Justice Team Member

From time to time, the National Alliance on Mental Illness (NAMI) Indiana receives calls or letters from family members whose relative, after transfer from a county jail to the Department of Correction (DOC), had been taken off their medication. In reviewing this issue, it was discovered that offender's medical records do not always follow the offender during a transfer. In addition, in many cases, an offender's medical records are non-existent at the county jail and that the same problem exists when an offender is transferred from county jail to county jail, or to prison.

Because the transferred offender is unlikely to self report his illness, which is quite often due to the stigma factor, and lacking input from any other source regarding the offender's condition, the medical staff at the facility is not likely to immediately recognize or appropriately diagnose the illness at the time of initial incarceration or when transferred to another facility. Failure to receive the appropriate medication is crucial for anyone with a serious medical condition, for an individual with a mental illness it is likely to result in behavior problems that can impact the safety of both the offender and the custody staff.

Furthermore, it should be noted that it is just as important to understand which medications are proven to be ineffective for the individual, as it is to know which medication has been effective.

Legislation addressing this issue was introduced and passed in the 2007 session of the Indiana General Assembly. The bill, HB 1338, became law on July 1, 2007. This new law contains the following language:

That a psychiatrist or behavioral health care provider may, with or without the offender's consent, provide a copy of an offender's health and mental health records to a facility, an agency, or a health care provider responsible for the incarceration of an offender. The facility or agency responsible for the incarceration of an offender shall maintain any health and mental health records as part of the offender's health record.

If an offender is transferred to a different facility, the operator of the facility or

agency from which the offender is transferred shall provide the offender's health and mental health records to the facility that is used to house or provide mental health treatment to the offender, including a county jail or a community mental health center.

That the health and mental health records for each offender incarcerated, after an offender is released from incarceration, shall provide the offender's health and mental health records, if any, to a mental health facility, mental health provider, or designated health care provider that is providing mental health treatment to the offender.

An offender's health and mental health records may be disclosed only if the records are necessary for:

- (1) the provision of health care to the offender;
- (2) the health and safety of the offender or other offenders;
- (3) the health and safety of others at the facility;
- (4) the health and safety of persons responsible for transporting or transferring the offender from one location to another;
- (5) law enforcement on the premises of a facility; or
- (6) the administration and maintenance of the safety, security, and good order of the facility.

All records are subject to privacy and confidentiality laws, rules, and procedures enacted by the state or federal government.

The objective of proposing enactment of this law is to ensure continuity of care. However, just as important as it is for the medical record to follow the offender, access to the appropriate medication at which ever facility they are held, is crucial for the health and stability of the offender.

Medication Formularies in Jails and Prisons

Joseph W. Vanable, Jr., Ph.D.

Typically, whether or not a given medication is available for use is governed by a formulary, a list of medications that are approved for use. In many instances, this practice can be cost-effective; but in the case of treating mental illness, formularies can be devastating. The rationale for favoring one medication over another usually follows this reasoning: if medication A and medication B both successfully treat condition X 60% of the time, but medication A's cost is half of medication B's, then medication A will be on the formulary and medication B will not. This argument is not properly applicable to treating severe mental illness for several reasons, the most important of which is this: severe mental illness has a biological basis that is governed in great part by the genes that the affected person has inherited. This hereditary component is complex: in the case of schizophrenia, for instance, there can be at least 10 genes involved, and a given person with schizophrenia can have any of a great number of combinations of these 10 genes. So, there are many different sorts of schizophrenia, and the 60% successfully treated by medication A and the 60% successfully treated by medication B are not the same persons. Furthermore, as has been found recently by Pitney Bowes and other major companies, the cost of treatment is only part of the issue. Only when the total worth of the wellbeing of

persons is taken into account can the true cost and benefits of treating effectively (or not) can be assessed. In the case of corporations, this is measured in terms of productivity of employees, and when this is taken into account, they have found the return on the investment of providing good health care to be 5:1. In the case of the prison population, the benefits are likely to be more in terms of the better behavior of inmates with mental illness translating into fewer injuries suffered by prison personnel, and in terms of shorter terms of imprisonment for the ill offenders.

It is also widely agreed that medications alone, even the proper ones, are not as effective as they are when accompanied by proper therapy. This is a matter that deserves more attention.

**Survey of the Status of Inmate Health in the State Prison System
Report Dated July 2007**

Michael W. Kempf - NAMI Indiana Criminal Justice Team Member

The Legislative Evaluation and Oversight Policy Subcommittee of the Legislative Council requested a survey of the status of state inmate health in the state prison system. The Legislative Service Agency (LSA) prepared the survey using adult intake data and one-day snapshots of the state prison population. The Department of Correction also provided a Health Services Report from Correctional Medical Services (CMS) for a six month period covering December 2006 to May 2007.

The section dealing with Mental Health presents Table 11, titled "Prisoners Prescribed Psychotropic Medications." The table presents six months of data for the months of December 2006 thru May of 2007. The table presents the following data:

	Dec-06	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Average
Number	1,975	2,278	1,274	1,649	5,397	3,971	2,765
Percent of Population	8.0%	9.0%	5.0%	7.0%	21.0%	15.0%	10.8%

To quote from the report, "A review of the number and percentage of prisoners with psychotropic medication prescriptions indicates a dramatic change." Two points can be made here; (1) A conservative estimate of the portion of the prison population with severe and persistent mental illness (SMI) is 16%. (One DOC estimate has put this at 50%.) In only two of these six months is that percentage approximated. (2) It is highly unlikely that the percentage of those with SMI could have fluctuated so wildly as the percentages in this table.

As the parent of a son with a serious mental illness who was diagnosed 1991, if there is one thing I understand about mental illness, it is that effective treatment of the illness requires strict adherence to medication. Considering the DOC is dealing with a truly captive population, and recognizing that the population will vary somewhat because of new admissions and release from custody, the numbers, even to a non-health care professional, do not reflect appropriate health care for the inmate population with a severe mental illness.

The next logical question you must ask yourself is, are the data accurate? That question was answered by Dr Elton Amos, the DOC Medical Director, in testimony at the August 14th meeting of the Indiana Commission on Mental Health. When questioned about the accuracy of the report, he stated that he found the figures presented in the survey to be accurate.

My question is, where is the outrage? The Survey Report can be viewed in its entirety on-line at:

<http://www.in.gov/legislative/pdf/InmateHealth.PDF>

State Prison Facilities - Authority of the Superintendent regarding contracted Medical Staff

By Michael W. Kempf – NAMI Indiana Criminal Justice Team

Currently, the Department of Correction contracts medical and mental health care to a private entity. However, those employed by the private entity (the contractor) at a prison facility do not report to the prison's superintendent. This situation leaves the superintendent with the responsibility, but not the authority to manage the facility on a proactive basis. The result is that it fractures the principle that the prison's superintendent is the ultimate authority at the facility and therefore is responsible for all that takes place within the facility. This present arrangement limits the authority of the superintendent in his/her ability to effectively manage the institution when questions arise concerning offender medical care. This is a dangerously unacceptable state of affairs.

Disciplinary Hearings for Mentally Ill Offenders in Jails and Prisons

Just as the courts have found the behavior of the individual with a mental illness and in crisis to be a mitigating factor in some cases, should not those conducting hearings regarding rule infractions in our jails and prisons do likewise? While this does occur in some cases, the Department of Correction and County Jails it should establish this principle as formal policy that the offender's mental illness is considered as a possible mitigating circumstance in rendering such decisions.

Law Enforcement Crisis Intervention Team (CIT) Model - Implementation in Rural Areas

A key element in the successful implementation of a CIT program is the timely availability of a psychiatric treatment facility. This element, generally, is not available in rural communities. In many cases, transporting a person in crisis to the closest mental health treatment facility can require rural law enforcement officers to be out of service for eight hours or more. Such a situation can leave a jurisdiction area with little or no law enforcement protection during this time, an unacceptable situation.

One solution to this problem could be the development of a regional mental health treatment transport component.

Homelessness

Improved medication access and the promise of community treatment were used to justify the closing and downsizing of state run psychiatric hospitals, beginning in the 1960s. To do this, it was argued, would allow many of those who had been destined to live out their lives in state run psychiatric hospitals, to be free to pursue life in their community.

One of the major areas that this concept has not adequately addressed over the years is housing for those who can not quite make it on their own, yet are not deemed ill enough to be hospitalized. The homeless who have mental illness, in fact, are many of the individuals who find their way into the criminal justice system. Group homes and other housing arrangements have attempted to meet the needs of this population, but often, the administrative rules governing acceptance into a group home or rules governing the behavior of the residents are applied so strictly that the individual with a mental illness is turned out on the street if the rules are broken. Psychiatric hospitals usually recognize such behavior as a symptom of the illness and treat it accordingly.

Therefore, if the existing group homes or other current supportive housing arrangements are unable to adapt to the needs of these individuals and the individuals are not deemed ill enough for hospitalization, some other form of supportive housing is required. Without such housing, we as a society will continue to bear the expense for housing such individuals as part of the criminal justice system.

Mental Illness Screening Assessment during Admission to Local Jails

This process is in place in the majority of Indiana counties, it should be legislatively mandated that this procedure be in place at all county jails.

Restoration of Social Security, Medicare and Medicaid Benefits upon release from Jail or Prison for the Serious Mentally Ill

The Indiana Department of Correction has instituted a re-entry program. One of the objectives of the program is to ensure that offenders in need of the disability benefits of the Social Security System, Medicare and Medicaid are available to the individual at the time of release. In 2006, the Indiana Department of Correction signed a Memorandum of Understanding with the Family and Social Services Administration enabling offenders to apply for Medicaid, Food Stamps and TANF prior to leaving incarceration. Local jails need to implement a similar program. The following provides information regarding reestablishment of these supports.

Social Security Administration's Pre-Release Agreements

Jails and prisons can enter into agreements with the local Social Security Office (known as pre-release agreements) through which staff of the institution can learn more about the rules for pre-release processing of SSI and SSDI applications and reapplications. When such an agreement exists, SSA processes claims more quickly, inmates have assistance in

gathering the information they need to support their application and benefits are often available immediately upon release or shortly thereafter.

Under these agreements, which are formal written agreements between the jail or prison and the local Social Security office, jails or prisons agree to:

- notify SSA of inmates likely to meet SSI or SSDI criteria who will be released within the next 30 days;
- provide to SSA current medical evidence and non-medical information that may support the inmate's claim;
- provide to SSA the anticipated release data and notify SSA if that changes; and
- notify SSA when the inmate is actually released.

In return, the Social Security Administration will:

- train jail or prison staff about SSI rules and work with them to ensure that the application procedures work smoothly;
- provide a contact person at the Social Security to assist jail staff with the pre-release procedure;
- process reapplications and new applications as quickly as possible, and
- promptly notify the jail of the decision on the released inmate's eligibility.

MEDICARE

Eligibility for Medicare benefits for non-elderly individuals with disabilities is linked to eligibility for Social Security Disability Insurance (SSDI). SSDI benefits are suspended, but not terminated, when an individual is incarcerated. Medicare benefits are similarly suspended but not terminated and should be restored when SSDI payments resume following release.

Medicaid

Timely restoration of Medicaid benefits continues to be problematic. A case manager for Midtown Mental Health indicates that in a perfect world, it takes a minimum of 90 days to get someone approved and we do not live in a perfect world. Clients who have been incarcerated often do not have the identification and other requirement to begin the application process.

Conclusion

Michael W. Kempf – NAMI Indiana Criminal Justice Team Member

First, I want to thank all who have contributed to this effort, especially, Randy Head, the then editor of the Indiana Bar Association's, Open Court publication and Dr. Joseph Vanable, the past President of the NAMI Indiana Board of Directors. Randy approached me about writing a piece for Open Court, following a presentation, I, along with other NAMI volunteers had given at Logansport State Hospital. At the time, Randy envisioned a three page article. Obviously, it has grown well beyond that.. Dr. Vanable has spent many hours discussing the paper with me and acted as its editor.

It is important for all who read this article to understand that there are many sincere, hard working individuals who police our cities and towns, work daily in our court system, in our local jails and at the Indiana Department of Correction. They struggle daily with how to help an individual with a severe mental illness and in some cases crisis, when performing their jobs. They are as uncomfortable and concerned as any of us. While much has improved over the past few years, much remains to be accomplished.

To quote Dr. Elton Amos, Medical Director of the Department of Correction, "It is all about the money." Dr. Amos is quite right. However, in considering this, it is crucial to take the long view: it is important to realize that while money might be "saved" in the short run by restricting access to treatment, much more will be spent ultimately for lengthened prison terms, lost productivity, and injuries to personnel. "For lack of a nail . . ."

The NAMI Indiana's Criminal Justice Team has been given the opportunity to present our 5 part, class on mental illness to the staff at a number of our state prisons. As a member of that team, I have seen first hand how lives are changed, once folks have the opportunity to attend these classes. When I speak of change, it is not only the lives of the offenders who live with a severe mental illness that are changed, but the staff as well. We have now trained over 600 individuals at the Indiana Department of Correction and another 200 in the Kentucky State Prison System. Without the support of the Indiana Department of Correction and the Kentucky Department of Correction, none of this would have been possible. NAMI Indiana sincerely appreciates the commitment of both departments to improve the lives of those they are charged to confine, as well as the lives of their employees.

As I look to the future, there are four observations regarding mental illness I want to share with you.

The first is that the medications that work today for an individual may become ineffective later. Therefore, observations by a caregiver (correctional officer for example) or someone close to the individual are a key to assisting the medical staff in understanding the individual's situation. The reason I tell you this is that the individual with the illness is often unlikely to have any personal insight into their situation.

The second point I want to make is by way of first asking you two questions. How many of you would take a medication for an illness that you believed you do not have? I am quite sure that none of us would. In addition, when prescribed a medication by your doctor, say for sore throat or a cold, how many of you take the entire prescription? Most of us generally take the medication until our symptoms subside and discontinue its use because we dislike the side effects of the medication. Therefore, with these two thoughts in mind, I think it is somewhat understandable why those who live with a severe mental illness may sometimes react as we would, given the same circumstances. However, mental illness is similar to say arthritis or diabetes when it comes to medication. If you fail to take your medication, the symptoms soon return. These illnesses cannot be cured, but they can be managed. In addition, this management is usually for a lifetime.

The third point is that just as with other illnesses, those who live with a mental illness are likely to cycle or to have relapse periods. A medication that had effectively treated the

symptoms may become ineffective. During these relapse periods, it is crucial that those around such persons continue to provide them compassionate understanding and support. I appreciate that this can be difficult for all involved, but our ongoing understanding and support is a crucial aspect of the recovery process.

The fourth point is the term recovery. Just as those who live with a physical illness, say cancer or a heart condition for example, recovery does not always mean a 100% recovery. Mental illness is no different. My reason for mentioning these four points is to suggest that we need to think of mental illness as being, in many respects, no different than physical illnesses and thus those who live with them should receive support from society that equals the support enjoyed by those with physical illnesses.

So why have I, along with the other authors of this paper told you this story. My hope for you is this: That if you were not aware of the lack of respect and understanding those with a mental illness face regarding their illness prior to reading this article, that you now have a glimpse into their world. That the behavior of an individual with a severe mental illness, which can be bizarre at times, is not necessarily within their control. That given the appropriate medication and therapy, which can be difficult to identify and in many cases requires an extended period of time to become fully effective, recovery in the majority of cases is possible. However, just as important as medication and other treatment, the personal interactions of all of us with whom they have contact are also key elements in the recovery process. In reality, our reaction in such situations is the first step in their recovery process. If handled properly, recovery will be much quicker, assuming the individual has access to the appropriate treatment. My hope is that in the future, you will react accordingly when you encounter someone with a mental illness, whether at home, on the job or in your community.

I consider it an honor to have been given the opportunity to speak to you via the Indiana Bar Association's Open Court publication and truly appreciate that you have taken the time to give these matters your thoughtful consideration. Thank you.