Massachusetts Department of Correction
Luis S. Spencer, Commissioner

OPEN MENTAL HEALTH CASES IN THE MASSACHUSETTS DOC

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By
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Introduction

Mental illness is one of the most confounding and complex issues confronting our society today. In the past two decades the practice of deinstitutionalization or the systematic closing of state mental hospitals has become the norm. The closing of state psychiatric hospitals is tied to a number of factors including legal and fiscal reforms, the rise of a 'pharmaceutical optimism' due to advances in pharmacotherapy and the promise of definitive community based care for those with acute mental health needs. However, the closing of state hospitals was much easier than delivering the promise of effective community based support and treatment for those that needed it the most. Consequently, persons with severe mental illness have come into contact with the criminal justice system more so now than ever before, further adding to the mental health crisis our nation faces today by catapulting the number of mentally ill persons in our prisons and jails and contributing to rising healthcare costs. The implementation of more punitive tough-on-crime laws and austere War on Drugs legislation has also contributed to the rising number of mentally ill persons in our correctional institutions. According to a report by the Treatment Advocacy Center and National Sheriffs' Association, Americans with a severe mental illness are three times more likely to be in a correctional institution than a psychiatric hospital due to homelessness, drug addiction, or breaking the law as a physiological consequence of an untreated mental illness.[1] The paucity of specialized treatment regimens to treat those with severe mental illness has come to replace terms like 'hospitalization' with 'incarceration' and 'patient' with 'inmate.' Indeed, while there has been a deinstitutionalization in our mental health

[1] Torrey, Fuller E., Aaron D. Kennard, Don Eslinger, Richard Lamb and James Pavle. 2010. More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of States.

system, it appears there has been a very evident reinstitutionalization in our criminal justice system.[2]

Although troubling, it is no surprise that correctional institutions have become one of the largest mental health providers in the country and are increasingly acknowledged as de facto psychiatric institutions. The intertwining of the criminal justice and mental health system not only compounds the problem of overcrowding in our prisons and jails but also exacerbates symptoms of the mental illness itself due to the austerity, stress, and isolation from friends and family largely representative of correctional settings. By their very nature, correctional institutions are not designed to adequately manage and care for a growing population of persons with critical mental health needs. Persons with severe mental illness are less likely to conform to rules and more likely to break them as a result of their mental state. However, because of their recalcitrance, they are perceived to be culpable for their actions and many are disciplined and segregated much like any other disruptive inmate, often having deleterious effects on their mental condition.[3]

MA DOC Treatment and Reentry for Mentally Ill Offenders

The Massachusetts Department of Correction (MA DOC) in partnership with other state and community organizations has taken indefatigable steps to ameliorate this growing concern. A number of systemic reforms have been implemented in order to improve the quality of life of inmates with a serious mental illness currently incarcerated in a MA DOC facility. Contrary to the simplistic practice of segregating inmates with a serious mental illness that are being disruptive or exhibiting self-injurious behavioral patterns, initiatives are now in place to better serve and protect those with a serious mental illness. These recently developed therapeutic initiatives that the MAC DOC has effectuated include the implementation of a mental health classification system, the mandatory exclusion of inmates with a serious mental illness from being housed in segregation units for long periods of time, and the development of seven specialized mental health units where inmates can receive personalized mental health care and cognitive-behavioral interventions. These specialized mental health units include the Secure Treatment Program (STP), the Behavioral Management Unit (BMU), the Intensive Treatment Unit (ITU), and four Residential Treatment Units (RTU). Placement and level of intervention in these units largely depends on the level of risk the inmate presents. An inmate perceived to be "high risk" due to self-injurious behavior or maladaptive coping patterns are placed in a more structured and intensive treatment regimen. Services and treatment are specifically fostered towards an inmate's individual needs and particular learning style. Additionally, inmates awaiting placement in one of these specialized units also receive expanded mental health services, out-of-cell recreation time, and other privileges.

The Secure Treatment Program (STP) opened at the Souza-Baranowski Correctional Center in February 2008 and provides expanded and personalized mental health services to inmates diagnosed with an Axis I[4] or Axis II[5] mental illness, demonstrating significant functional

[2] Wood, Jennifer, Jeffrey Swanson, Scott Burris, and Allison Gilbert. 2011. Police Interventions with Persons Affected by Mental Illness: A critical review of global thinking and practice.

[3] Fellner, Jamie. 2006. A Corrections Quandary: Mental Illness and Prison Rules. *Harvard Civil Rights-Civil Liberties Law Review* 41: 391-412.

[4] A classification dimension used with DSM-IV, which includes major psychiatric clinical disorders and syndromes.

[5] A classification dimension used with DSM-IV, which includes personality disorders: paranoid, schizoid, schizotypal, antisocial, borderline, histrionic, narcissistic, dependent, obsessive-compulsive, and mental retardation.

impairment. Inmates placed in this 19 bed unit typically have had repeated disciplinary infractions and would otherwise serve their sanctions in the Departmental Disciplinary Unit (DDU)[6] due to being recalcitrant, violent, and failing to conform to institutional rules preventing them from benefitting from rehabilitative programming resources. The STP was designed to serve a challenging and often aggressive population diagnosed with a mental illness that significantly impairs their cognitive functioning, impulse control, and ability to adjust to environmental demands. Due to the disciplinary history of the inmates placed in this unit, the program is specifically designed to meet the mental health needs of the individual while also ensuring the safety of themselves, other inmates, and custody staff. The STP utilizes a unique interdisciplinary approach to treatment providing evidence-based psychiatric and behavioral interventions that promote pro-social coping skills, self-control, and positive social interaction.

The Behavioral Management Unit (BMU) is a ten bed unit that opened in July 2010 at MCI[7]-Cedar Junction to serve as an alternative to segregation for inmates diagnosed with a serious mental illness. The BMU consists of four program phases and provides individualized behavioral-cognitive therapy and pro-social activities for inmates with severe behavioral problems and have a reputation of being especially aggressive or disruptive. Typically inmates that are admitted to these units have been diagnosed with an Axis II personality disorder and have a history of exhibiting severely disruptive and self-injurious behavior. This interdisciplinary approach involving the close collaboration between mental health and security staff allows for the development of an individualized treatment plan that focuses on the reduction of self-injurious and recalcitrant behaviors through identifying triggers, strengthening self-control, and learning pro-social skills. The BMU utilizes a progressive phase incentive system where inmates receive incrementally better rewards for incrementally better behavior. Inmates start the program at phase one, which is the most restrictive program phase, and transfer to higher, to less restrictive phases by engaging in adaptive, pro-social behaviors. Preliminary evidence suggests that inmates discharged from the BMU have demonstrated less behavioral disciplinary infractions and violent confrontations with staff and other inmates.

The Intensive Treatment Unit (ITU) is a 32 bed unit that was opened in May 2012 at MCI-Framingham. The ITU is specially designed for female offenders and detainees perceived to be suicidal or presenting chronic disruptive or self-injurious behavior patterns. While in the ITU, females are closely monitored and receive enhanced mental health services, support groups, out-of-cell time, recreational activities, and group dining. Individualized treatment regimens are also developed to ensure female inmates receive adequate institutional programming upon release.

The Residential Treatment Units (RTU) were established for inmates that are unable to cope with the demands of daily life in a traditional general population setting due to a serious mental illness that significantly impairs cognitive processes and socially acceptable behavioral patterns. There are currently four units that serve a total capacity of 208 inmates. Inmates placed in the RTUs are often recalcitrant and resistant to taking medication and typically carry a diagnosis with an Axis I mood or thought disorder and have undergone repeated psychiatric and behavioral interventions. The primary goals of the RTUs are to change maladaptive coping strategies and

[6] A form of separation from the general population in which inmates committing serious violations of conduct regulations are confined by a disciplinary committee or authorized individual for periods of time to individual cells separated from the general population. Placement in detention may only occur after a finding rule violation at an impartial hearing and when there is not adequate alternative disposition to regulate the inmate's behavior.

[7] Massachusetts Correctional Institution (MCI)

chronic refractory behavior through behavioral management techniques and cognitive-behavioral interventions. A major component of the program includes specialized therapeutic group modules that are designed to target and alleviate symptoms of mental illness and personality disorders by promoting pro-social coping skills and behaviors that contribute to positive social interaction. As of today, preliminary evidence has shown to be promising. Recently collected data suggests that there has been an overall reduction in suicide attempts, a decrease in self-injurious behaviors among inmates discharged from these units, a decrease in the number of emergency referrals, and a decrease in the number of disciplinary infractions.

Inmates with serious mental health issues face a number of hurdles in obtaining care in the community once they are released. The MA DOC works with the Department of Mental Health (DMH) and other community organizations to provide adequate post-release treatment plans. Six months prior to release, all inmates with mental health needs are assessed for post-release treatment plans. Another valuable asset that DOC utilizes are the services offered by the Forensic Transition Team (FTT)[8] which provides eligible inmates with a DMH liaison before their release date where treatment and after care plans are devised to ensure an inmate's mental health can be monitored for up to three months after release. In addition, if an inmate is prescribed psychotropic medication while incarcerated, the MA DOC will provide a 30-day supply of prescription medication upon release.

Current Population of Mentally Ill Offenders in the MA DOC

As of July 16, 2012, the MA DOC criminally sentenced custody population[9] totaled 10,396 inmates with 2,502 identified as having an open mental health case.[10] Akin to other states, Massachusetts is not unique and continues to grapple with the problem of the steadily rising number of mentally ill persons entering the state prison system. This brief will examine and discuss the current MA DOC criminally sentenced custody population with an open mental health case as well as those identified as having a serious mental illness.

Inmates in the MA DOC Criminally Sentenced Custody Population with an Open Mental Health Case on July 16, 2012

Table 1

Open Mental Health Cases on July 16, 2012			
		Frequency	Percent
Valid	No	7,716	74.2%
	Yes	**2,502**	**24.1%**
	Total	10,218	98.3%
Missing		178	1.7%
Total		10,396	100%

Table 2

Serious Mental Illness[11] Cases on July 16, 2012			
		Frequency	Percent
Valid	No	9,391	90.3%
	Yes	**827**	**8.0%**
	Total	10,218	98.3%
Missing		178	1.7%
Total		10,396	100%

[8] The Forensic Transition Team (FTT) collaborates with other state agencies and providers to afford reentry assistance for mentally ill clients being released from prisons, jails, and detention centers.

[9] An individual is considered to be in Massachusetts DOC custody when they are being held in a Massachusetts DOC facility.

[10] However, of the 10,396 criminally sentenced offenders, 178 do not have any information regarding their mental health status, excluding them from analysis and making the final total 10,218.

[11] Inmates determined by the Department's mental health vendor to have a current diagnosis or a recent significant history (within the past year from an inpatient hospital) of any Axis I disorders, mental retardation, dementia or other cognitive disorders that are commonly characterized by breaks with reality, or perceptions of reality, that lead the individual to experience significant functional impairment involving acts of self-harm or other behaviors that have a seriously adverse effect on life or on mental or physical health.

- As illustrated in table one, 2,502 (24.5%) or approximately one in four criminally sentenced custody offenders were identified as having an open mental health case.

- Moreover, of those with an open mental health case in the criminally sentenced custody population (n=2,502), 827 or 8.0% were identified as having a serious mental illness.

- Approximately one-third of this population (n=803; 32.1%) were between the ages of 30-39 followed by the 40-49 age group with 684 (27.3%) identified as having an open mental health case.

Table 3

Open Mental Health Cases on July 16, 2012 by Age			
		Frequency	Percent
Age Categories	17-29	**523**	**20.9%**
	30-39	**803**	**32.1%**
	40-49	**684**	**27.3%**
	50-59	**369**	**14.7%**
	60-69	**100**	**4.0%**
	70+	**23**	**0.9%**
Total		**2,502**	**100%**

Gender Breakdown of Inmates in the Criminally Sentenced Custody Population with an Open Mental Health Case on July 16, 2012

Table 4

Open Mental Health Cases by Gender on July 16, 2012							
		Frequency	Percent	Frequency	Percent	Frequency	Percent
		Female		Male		Total	
Open Mental Health Case	No	163	33.82%	7553	77.58%	7716	75.51%
	Yes	**319**	**66.18%**	**2183**	**22.42%**	**2502**	**24.49%**
Total		482	100.00%	9736	100.00%	10218	100.00%

- Upon examining the gender of the inmate with an open mental health case, one can easily observe that males are driving the number of inmates with an open mental health case in the criminally sentenced custody population on July 16, 2012 and comprised 22.42% (n=2,183) of the male criminally sentenced custody population.

- Interestingly, approximately two-thirds of females (n=319; 66.18%) in the criminally sentenced custody population were identified as having an open mental health case.

Gender Breakdown of Inmates with a Serious Mental Illness in the Criminally Sentenced Custody Population on July 17, 2012

Table 5

Serious Mental Illness Cases by Gender on July 16, 2012							
		Frequency	Percent	Frequency	Percent	Frequency	Percent
		Female		Male		Total	
Serious Mental Illness	NO	362	75.10%	9029	92.74%	9391	91.91%
	YES	**120**	**24.90%**	**707**	**7.26%**	**827**	**8.09%**
Total		482	100.00%	9736	100.00%	10218	100.00%

- Males with serious mental illness comprised 7.26% (n=707) of the male criminally sentenced custody population.

- Comparatively, approximately one quarter of females (n=120; 24.90%) in the criminally sentenced custody population were identified as having serious mental illness.

Inmates in the MA DOC Criminally Sentenced Custody Population with an Open Mental Health Case by Age on July 16, 2012

Table 6

Open Mental Health Cases by Age on July 16, 2012					
			No	**Yes**	Total
Age Groups	17-29	Count	2,069	523	2,592
		% of Total	**20.2%**	**5.1%**	**25.4%**
	30-39	Count	2,289	803	3,092
		% of Total	**22.4%**	**7.9%**	**30.3%**
	40-49	Count	1,834	684	2,518
		% of Total	**17.9%**	**6.7%**	**24.6%**
	50-59	Count	1,027	369	1,396
		% of Total	**10.1%**	**3.6%**	**13.7%**
	60-69	Count	386	100	486
		% of Total	**3.8%**	**1.00%**	**4.8%**
	70+	Count	111	23	134
		% of Total	**1.1%**	**0.2%**	**1.3%**
Total		**Count**	**7,716**	**2,502**	**10,218**
		% of Total	**75.5%**	**24.5%**	**100.0%**

- Inmates between the ages of 30 and 39 had the highest proportion of open mental health cases and comprised 7.9% (n=803) of the total criminally sentenced custody population. However, this is to be expected by virtue of this age group constituting the largest proportion (30.30%) of the criminally sentenced custody population.

- Furthermore, inmates between the ages of 30 and 49 that were identified as having an open mental health case comprised 14.6% (n=1,487) of the total criminally sentenced custody population.

- The lowest proportion of inmates that were identified as having an open mental health case were between the ages of 50 and 70+ years and comprised 4.8% (n=492) of the total criminally sentenced custody population.

Conclusion

This brief attempted to provide a snapshot of those with open mental health cases and serious mental illness in the MA DOC criminally sentenced custody population. However, this brief also intended to serve as a poignant reminder of how our prisons and jails are increasingly becoming known as the new asylums. The number of mentally ill persons in our correctional systems has reached unprecedented highs and will continue to grow as a consequence of deinstitutionalization and persons with severe mental illness more frequently coming in contact with law enforcement authorities and entering the criminal justice system. By default, our nation's correctional institutions have become warehouses for mentally ill persons and have been delegated the difficult tasks of providing care to a burgeoning population with unique healthcare needs.

As of July 16, 2012, there were 2,502 (24.1%) criminally sentenced inmates in the custody population with an open mental health case and 827 (8.09%) having been clinically diagnosed with a serious mental illness. Inmates between the ages of 30 and 49 comprised the largest portion of those with an open mental health case in the criminally sentenced custody population (n= 1487; 14.6%). The males comprised the majority of this population with 2,183 (87.3%) identified as having an open mental health case. In comparison, two-thirds of females (n=319; 66.18%) in the criminally sentenced custody population had an open mental health case with approximately one in four females (n=120; 24.90%) clinically diagnosed with a serious mental illness.

The systemic initiatives and manifold reforms the MA DOC has undertaken to improve the quality of life, care, and safety for inmates with serious mental illnesses should serve as a beacon for other states to follow. Four therapeutic specialized units have been developed as alternatives to segregation for inmates acute mental health needs unable adapt and cope with the daily stressors associated with incarceration. Individualized pre-release and post-release treatment plans are carefully devised by MA DOC staff and community services that focus on the demonstrated needs of the inmate, accessibility of treatment services in the community, and fostering successful reintegration into society. However, more attention needs to be focused on evidenced-based practices, cost-effective reentry programs, and community support services for those with critical mental health needs returning to the community. In order to annul the current trend of our nation's correctional institutions becoming de facto asylums, evidence-based mental health programming and overcoming barriers to community treatment must be a priority. If reentry is to be successful for mentally ill offenders, reintegration efforts must be geared towards the continuity of care upon release. Failure to obtain the essential services to adequately manage their condition will only have inimical effects and increase the likelihood of former inmates with untreated acute mental health needs engaging in criminal behavior and once again entering our correctional institutions.

In the years to come, the disarray of the mental health system and the number of mentally ill persons in our prisons and jails will continue to worsen unless the overall problem is examined and redressed as a whole. Likewise, the incarceration of the most severely mentally ill in our correctional institutions only serves to further deteriorate an already damaging mental condition as well as create more strain for an encumbered corrections system. Instead of looking at incarceration of the mentally ill as a convenient solution to a less than adequate healthcare

system, it is time to look at it as an impetus necessary for change. Massachusetts is doing its part by galvanizing support and marshalling existing resources in attempt to put back together the remnants of a broken mental health system. The therapeutic programs and policies implemented by the MA DOC to improve the quality of care for this special population shows promise; however, it is time to reexamine this widespread social problem as a whole. As a nation, we may only be in the incipient stages of redressing this ubiquitous social problem, and it may not be a fix-all solution to a complex host of healthcare issues—but it's certainly a step in the right direction.

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