STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF CORRECTIONS
GARY D. MAYNARD, DIRECTOR

Iowa Department of Corrections

Report to the Board of Corrections

Mental Health

Second in a series of reports highlighting issues contributing to corrections population growth

April 2006

Introduction

In 1999, the U.S. Bureau of Justice Statistics estimated about 16.3% of state prison inmates, and 16.0% of probationers, were mentally ill, based on offenders' self-reports.[1] In 2000, the American Psychiatric Association reported research estimates that perhaps as many as one in five prisoners were seriously mentally ill.[2] The figures for Iowa inmates cited in this report are higher still, with about one-third of offenders identified as mentally ill.

Deinstitutionalization of the mentally ill from mental health facilities beginning in the late 1950's and early 1960's – and absent the full realization of the community mental health centers that were supposed to take their place – has contributed to institutionalization of the mentally ill in local jails and state prisons.[3]

According to the Iowa Department of Human Services, the average daily population of the four state mental health institutions in Iowa during FY2005 was 236. The largest of these, in Independence, houses about 90 persons on an average day. In contrast, the Iowa prison system on June 30, 2005 held 2,902 mentally ill offenders, and operates the largest functioning mental health facility in the state: the Clinical Care Unit at the Iowa State Penitentiary, which housed 143 offenders on that day.

Psychiatric diagnoses are not readily available for all offenders under community based supervision. This report does document mentally ill offenders returning to the community via parole supervision, as one way of demonstrating the need for community mental health interventions.

This report goes beyond mere documentation of the problem. It describes how the Iowa Department of Corrections is addressing mental health issues among the offender population through the provision of treatment. All data was obtained from Iowa Corrections Offender Network (ICON) information residing in the Iowa Justice Data Warehouse, and the ICON-Medical module.

---

[1] Bureau of Justice Statistics, *Mental Health and Treatment of Inmates and Probationers* (U.S. Department of Justice, 1999), 1.

[2] American Psychiatric Association, *Psychiatric Services in Jails and Prisons, 2nd Ed.* (Washington D.C., American Psychiatric Association, 2000), p. XIX, as quoted by Human Rights Watch, http://www.hrw.org/reports/2003/usa1003/3.htm#_ftn13.

[3] Various sources. See, for example, Daniel Patrick Moynihan, *Deinstitutionlization of the mentally ill* (Congressional Record – Senate, July 12, 1999) at http://www.psychlaws.org/GeneralResources/article22.htm. Also H. Richard Lamb, M.D. and Leona L. Bachrach, Ph.D., *Some Perspectives on Deinstitutionalization* (Psychiatric Services, August 2001, American Psychiatric Association) at http://psychservices.psychiatryonline.org/cgi/content/full/52/8/1039.

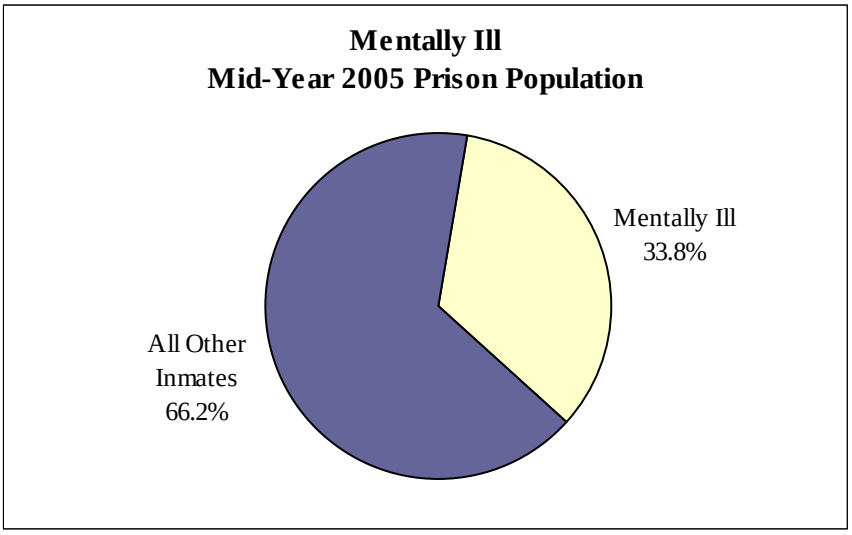
Table of Contents

Lettie Prell, Director of Research, wrote this report under the direction and consultation of Dr. Bruce Sieleni, Director of Mental Health. Statistics and charts were compiled by Sondra Holck, Management Analyst and Ms. Prell. Special thanks to Scott Musel, Paul Stageberg, Laura Roeder-Grubb and Geneva Adkins with the Division of Criminal & Juvenile Justice Planning, Iowa Department of Human Rights, for providing a number of offender data sets and analyses.

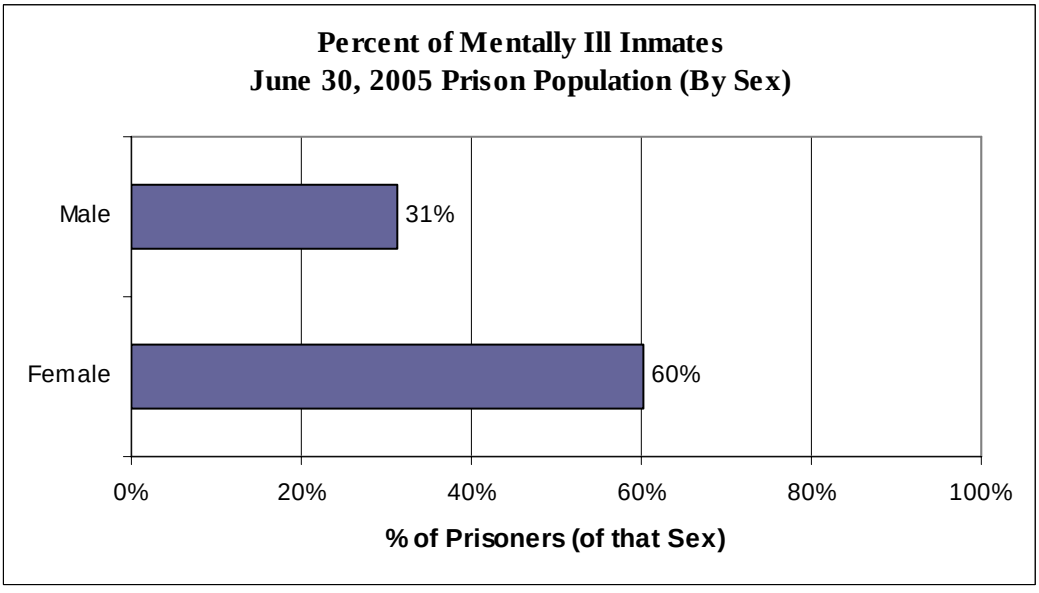
Mentally Ill Offenders in Prison

Prevalence

On June 30, 2005 Iowa's prisons held 8,578 offenders. Of these, 2,902 were mentally ill per psychiatric diagnosis.



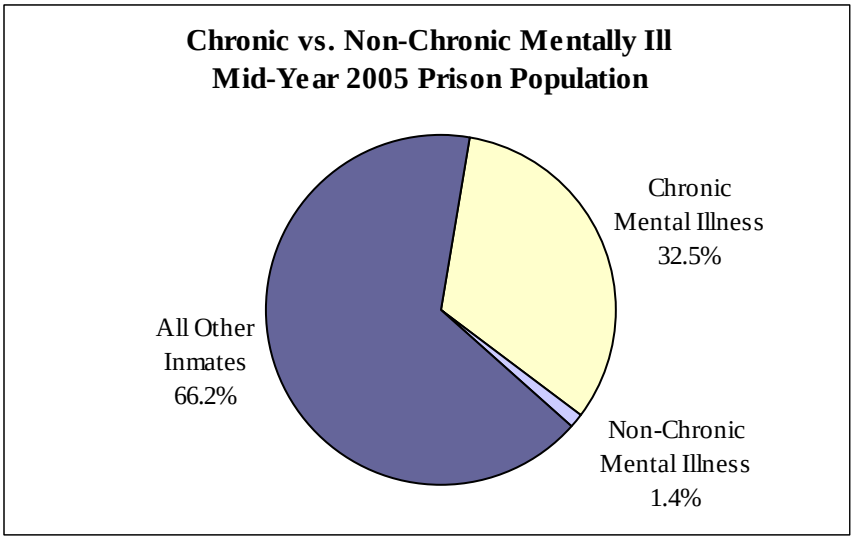
Just under one-third of male offenders, but 60% of female offenders, were diagnosed as mentally ill.



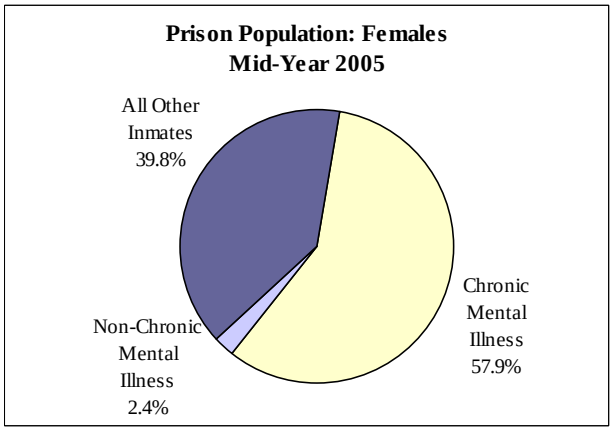
Mentally Ill Offenders in Prison

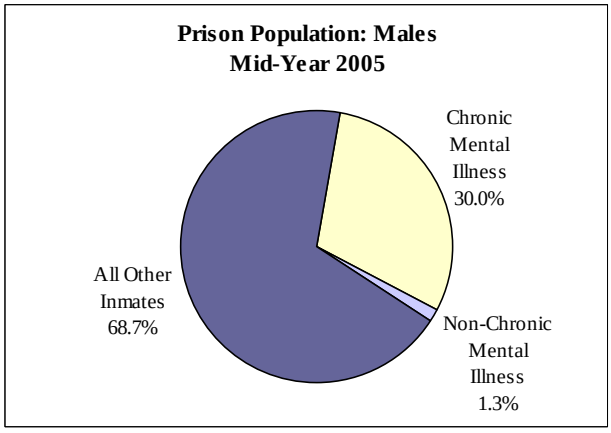
Chronic vs. Non-Chronic Conditions

Some conditions, such as depression and bipolar disorders, are chronic. That is, while the condition may not be presenting a current problem requiring psychiatric care, it cannot be cured, only managed. On June 30, 2005 there were 2,785 offenders with chronic mental illness, and 117 offenders with non-chronic mental illnesses.



There is a higher percentage of both chronic and non-chronic mental illnesses among the female offender population, compared to the male offender population.

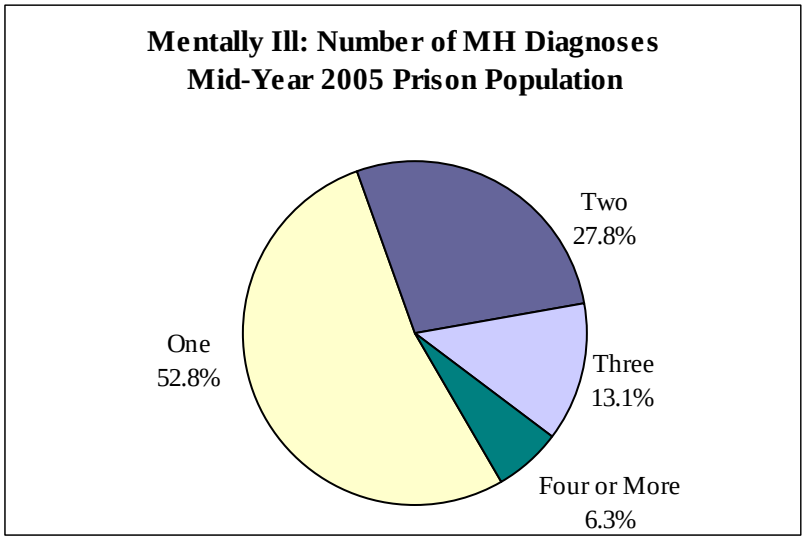




Mentally Ill Offenders in Prison

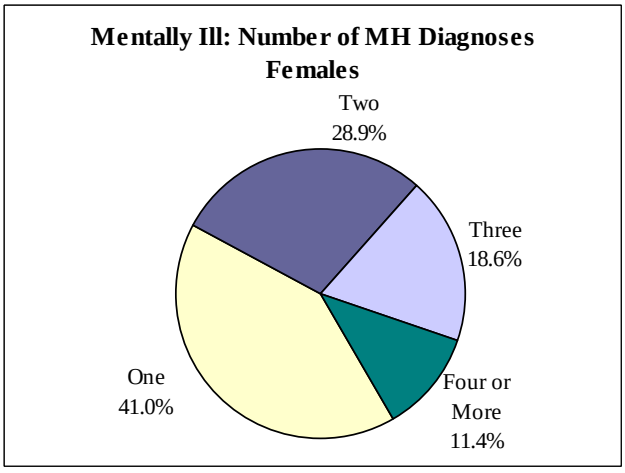
Number of Diagnoses

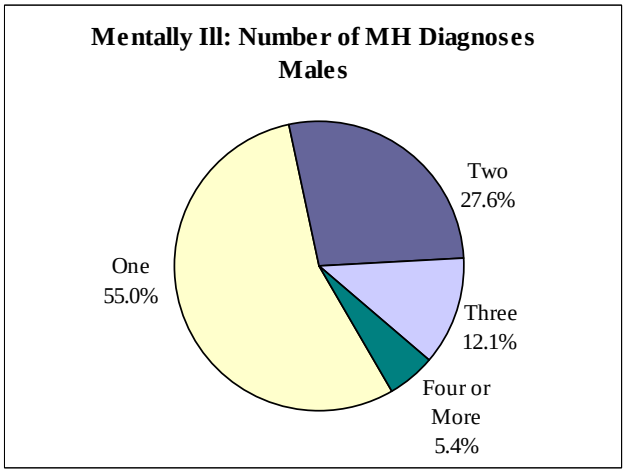
Co-occurring disorders, such as a substance use disorder combined with another diagnosis, is common among mentally ill offenders in prison. On June 30, 2005, there were 1,532 offenders with a single diagnosis of a mental illness, and 1,370 offenders with two or more mental illness diagnoses.



Includes mental illness diagnoses only.

A higher percentage of female offenders have more than one mental health diagnosis, compared to male offenders.





Includes mental illness diagnoses only.

Mentally Ill Offenders in Prison

Diagnoses by Category

Among all offenders in prison on June 30, 2005, depression, substance use disorders, and anxiety/panic disorders were the three most common categories of diagnoses. Prevalence of these among female inmates was higher when compared to males.

Female Inmates: Mental Illness Diagnoses by Category

Mental Illness Category	N Offenders	% of MI	% of Pop
Depression & major depressive disorders	271	59.4%	35.8%
Substance use disorders	135	29.6%	17.8%
Anxiety, general anxiety & panic disorders	123	27.0%	16.2%
Personality disorders	99	21.7%	13.1%
Bipolar disorders	68	14.9%	9.0%
Dysthymia/Neurotic depression	56	12.3%	7.4%
Psychosis/Psychotic disorders	40	8.8%	5.3%
Schizophrenia	25	5.5%	3.3%
Posttraumatic stress disorder (PTSD)	22	4.8%	2.9%
Other adjustment disorders (not PTSD)	15	3.3%	2.0%
Sleep, movement & eating disorders	13	2.9%	1.7%
Impulse control disorders	3	0.7%	0.4%
Dementia	3	0.7%	0.4%
Civil commitment	2	0.4%	0.3%

Male Inmates: Mental Illness Diagnoses by Category

Mental Illness Category	N Offenders	% of MI	% of Pop
Depression & major depressive disorders	1,214	48.7%	15.5%
Anxiety, general anxiety & panic disorders	632	25.4%	8.1%
Substance use disorders	543	21.8%	6.9%
Personality disorders	460	18.5%	5.9%
Dysthymia/Neurotic depression	245	9.8%	3.1%
Bipolar disorders	243	9.8%	3.1%
Schizophrenia	179	7.2%	2.3%
Psychosis/Psychotic disorders	147	5.9%	1.9%
Other adjustment disorders (not PTSD)	79	3.2%	1.0%
Impulse control disorders	46	1.8%	0.6%
Sleep, movement & eating disorders	43	1.7%	0.5%
Posttraumatic stress disorder (PTSD)	36	1.4%	0.5%
Civil commitment	34	1.4%	0.4%
Dementia	11	0.4%	0.1%
Sexual disorders/paraphelias	10	0.4%	0.1%

A given offender is counted only once per category, but may be counted in more than one category.
Data is for the June 30, 2005 prison population.

Mentally Ill Offenders in Prison

Location

Just as persons with mental illnesses are able to function well within general society if given proper community care, the majority of mentally ill offenders are appropriately managed within the general inmate population.

The Clinical Care Unit at the Iowa State Penitentiary is a 200-bed housing unit that has developed strong mental health support capabilities, and many of the most severe cases are housed there (about one-third of this population is schizophrenic, and this is the most common diagnosis category among those residing in the Unit). The most severe mentally ill female offenders are housed at the Iowa Medical and Classification Center.

A 100-bed unit for women at the Mount Pleasant Correctional Facility houses mentally ill offenders as well as those who are behaviorally challenged, such as persons with profound developmental disabilities. Likewise, the 23-bed East Unit at the Iowa Medical and Classification Center, and the 178-bed "special needs" unit to be opened in FY2007 or FY2008 houses a mix of mentally ill and behaviorally challenged offenders. The 23-bed West Unit also houses psychiatric cases; however, over time there has been an increase in the number of patients from The Iowa Department of Human Services Mental Health Institutions and county pretrial mental health evaluations in these beds.

Assessment of the adequacy of these and other resources for offenders who are mentally ill is a priority for the newly appointed Mental Health Director.

Mentally Ill by Facility: June 30, 2005

Facility	N Inmates	Total Pop	% of Pop
Anamosa State Penitentiary	393	1,315	29.9%
Clarinda Correctional Facility	362	954	37.9%
Fort Dodge Correctional Facility	363	1,229	29.5%
Iowa Correctional Institution for Women	340	600	56.7%
Iowa Medical & Classification Center	230	779	29.5%
Iowa State Penitentiary	236	847	27.9%
ISP-Clinical Care Unit	128	143	89.5%
Mount Pleasant Correctional Facility	374	1,035	36.1%
Newton Correctional Facility	380	1,182	32.1%
North Central Correctional Facility	96	494	19.4%
Total	**2,902**	**8,578**	**33.8%**

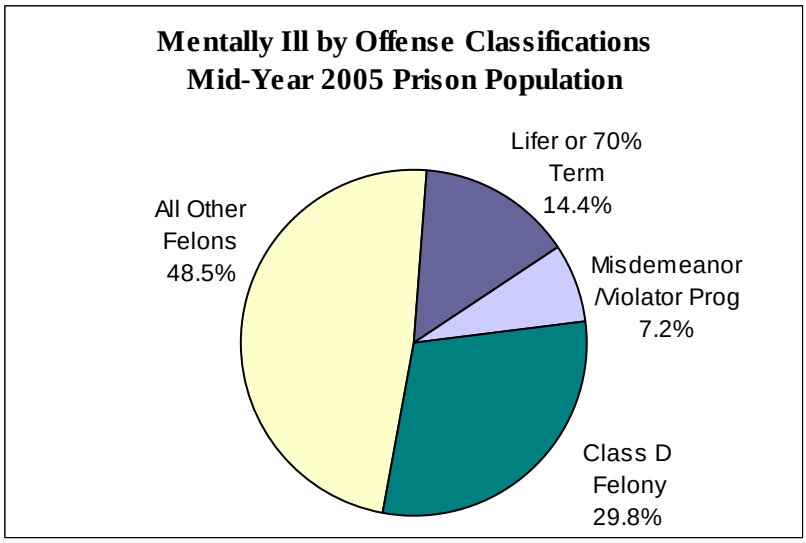
With the exception of the Clinical Care Unit, facility counts include any associated satellites. For example, the Iowa State Penitentiary counts include the John Bennett Correctional Center and the prison farms; the Newton Correctional Facility includes the Correctional Release Center; and so forth.

Mentally Ill Offenders in Prison

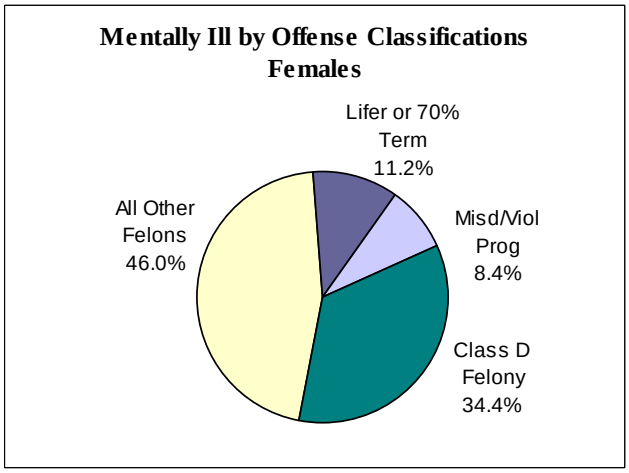
Short-Term vs. Long-Term Prison Inmates

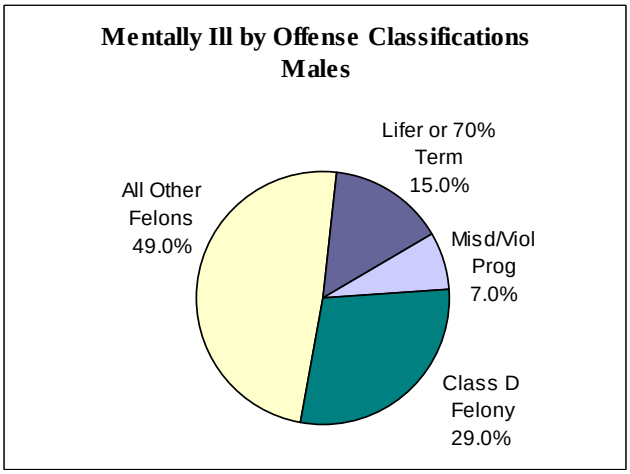
Review of mentally ill inmates by most serious offense reveals implications for offender reentry. The Misdemeanor/Violator Program and Class D Felony groups generally describe inmates with shorter lengths of stay. On June 30, 2005, there were 1,053 inmates with these short-term sentences. Another 1,378 inmates, the All Other Felons group, have generally longer expected lengths of stay in prison prior to reentry.

There are also offenders requiring long-term management of their mental illnesses in a prison setting. The Lifer/70% term group represents inmates expected to remain in prison the longest, potentially for the remainder of their lives (many 70% term offenders are expected to die in prison prior to becoming eligible for parole). On June 30, 2005 there were 410 inmates with these long sentences.



Federal, compact, safekeepers are excluded.

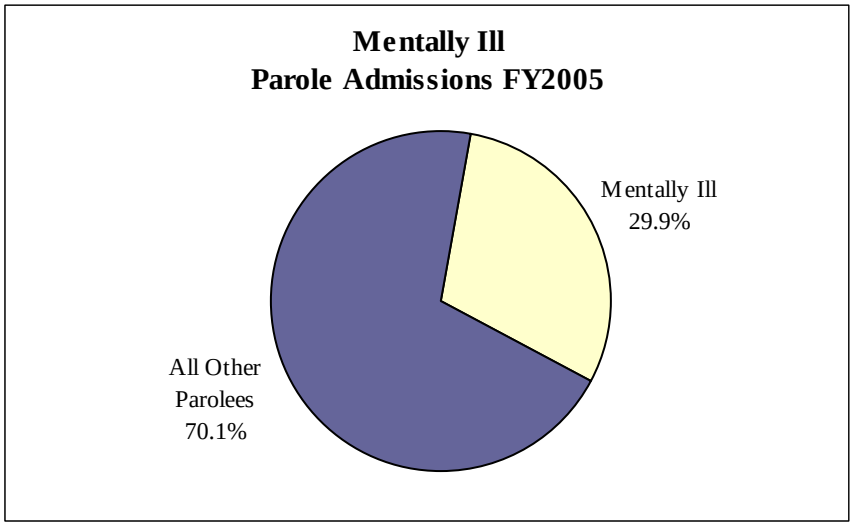




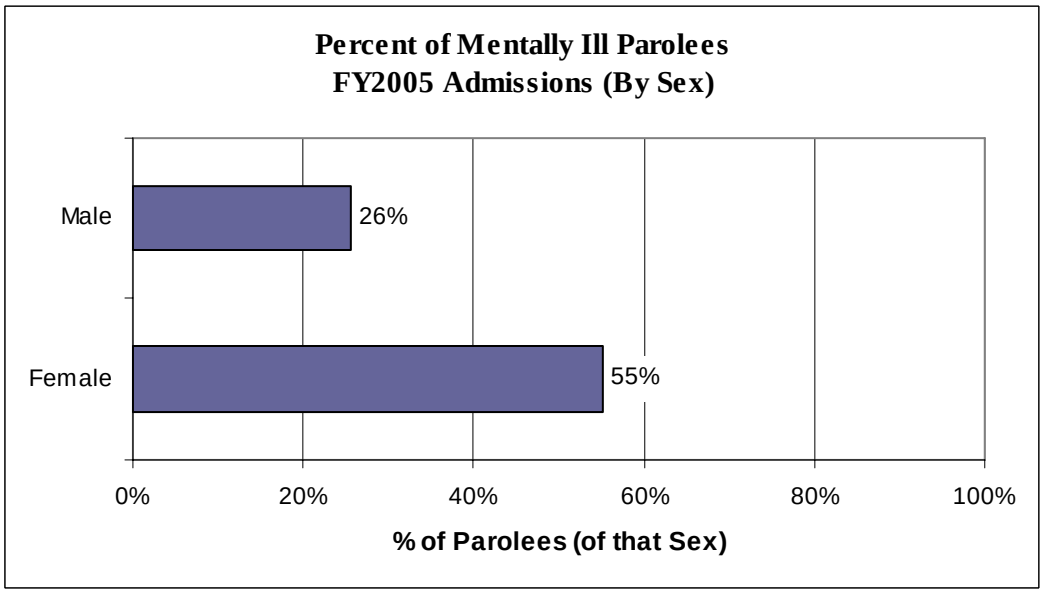
Reentry: Parole Admissions

Prevalence

During FY2005, 2,923 parolees were admitted to field supervision, either directly from prison or following a stay in a community-based work release or OWI treatment facility. Of these, 873 were mentally ill per psychiatric diagnosis.



About 26% of male offenders, but 55% of female offenders, were diagnosed as mentally ill.



Reentry: Parole Admissions

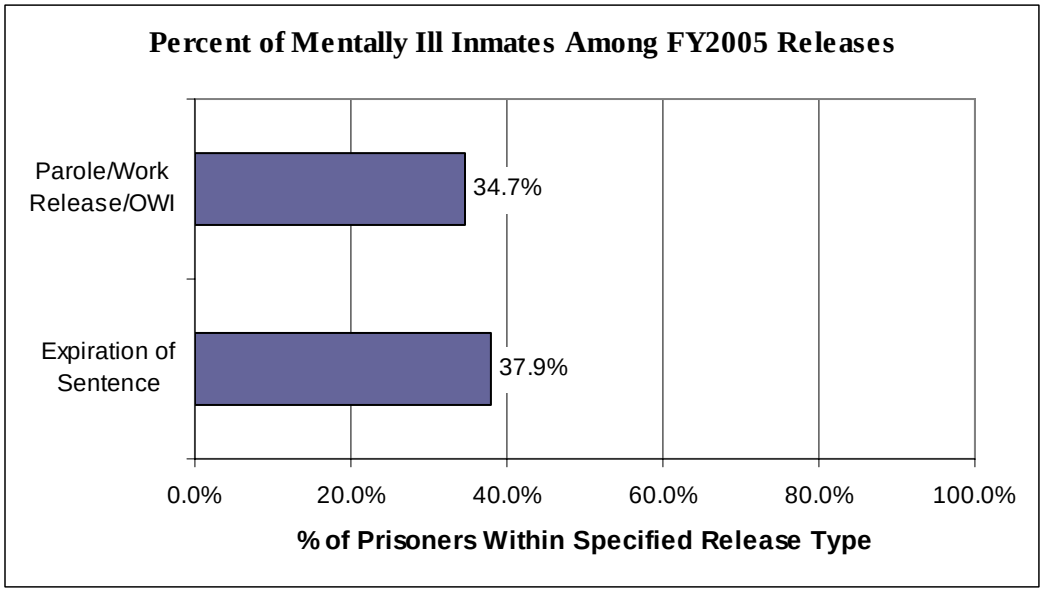
Location

Reentry of mentally ill offenders into the community is a statewide issue, with between 22.5% and 36.0% of district department of correctional services parole admissions involving persons with major mental health issues.

Parole Admissions FY2005			
Region	N MI	Total Admits	MI as % of Admits
1JD	136	442	30.8%
2JD	91	311	29.3%
3JD	71	215	33.0%
4JD	27	120	22.5%
5JD	272	911	29.9%
6JD	71	265	26.8%
7JD	94	351	26.8%
8JD	111	308	36.0%
Total Admissions	**873**	**2,923**	**29.9%**

Reentry: Release from Prison to Supervision vs. No Supervision

A slightly higher percent of offenders who expire their sentences in prison and receive no post-release supervision are mentally ill, compared with those receiving parole, or placement in community-based work release or OWI treatment facilities. However, this difference is not statistically significant, according to an analysis by the Division of Criminal and Juvenile Justice Planning.



Effective Identification & Treatment of the Mentally Ill

Four inmate suicides at the Critical Care Unit (CCU), Iowa State Penitentiary, between January 1, 2003 and November 1, 2004 brought to the fore the need to improve delivery of mental health services within Iowa's prison system. Dr. Thomas White, a consultant provided by the National Institute of Corrections, reviewed the incidents at the CCU as well as mental health services throughout the prison system. Dr. White's report contained many recommendations for change, which the Iowa Department of Corrections has worked to implement.[4] Examples of areas improved include:

- Suicide prevention procedures.
- Mental Health Training for all staff.
- A Mental Health Director to provide overall statewide oversight of DOC Mental Health Programs.
- A clear mission statement and a more therapeutic environment for the CCU.
- Intake and release process to ensure continuity of care and appropriate placement.
- Increased out of cell time to include work, and expanded recreation, hobby craft and education activities for offenders in the CCU.
- Physical changes to the CCU.

There is a tendency for mentally ill offenders to be isolated in prison settings, which is not the best environment, particularly for persons who are depressed. The overall goal of the newly appointed Director of Mental Health for the Iowa Department of Corrections is to parallel community standards in terms of a graduated mental health program. Such a program would contain the following elements:

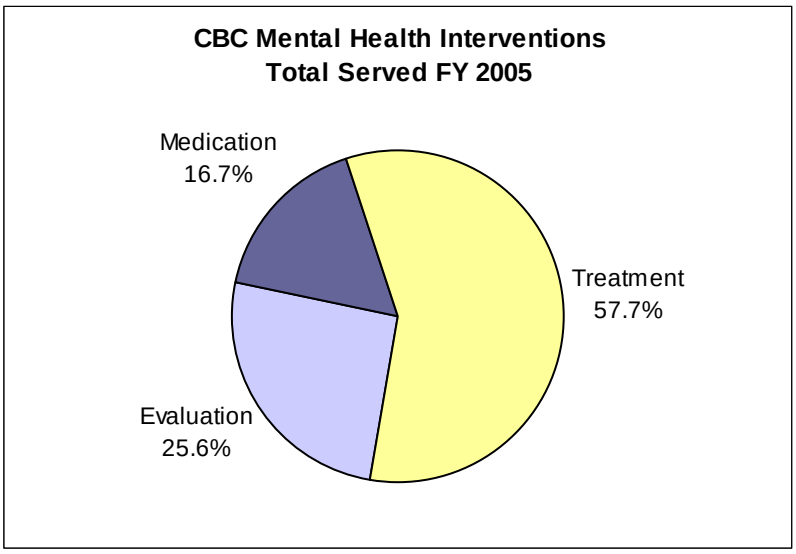
- Continuity of care.
- A continuum of care, with criteria for where a particular offender should be placed based on clinical assessment.
- A formalized acute unit as part of the continuum.
- Programming appropriate to each level of the continuum.

[4] Dr. White's complete report may be found on the Iowa Department of Corrections website at http://www.doc.state.ia.us/publications.asp (see *Mental Health Consultant Report by Dr. Thomas White*).

Mental Health Interventions

Community-Based Corrections

As used in this report, "total served" refers to offenders in the intervention at the beginning of the year, plus new admissions into the intervention. During FY2005, a total of 2,655 offenders under community-based corrections supervision received a mental health intervention (this is "total served"). **Please note these are primarily higher risk offenders; by policy, low risk offenders are not assessed for needs or assigned to interventions. It is also likely for some offenders to see their own psychiatrists/psychologists, and therefore not have a documented intervention on ICON for mental health treatment.**



The majority of mental health treatment is psychiatric or psychological services. However, in recent years, comprehensive programs have been developed that address mental health needs as one component. These include the first judicial district's day program and reentry court program, and the fifth judicial district's Going Home: KEYS Reentry Program. Not represented in the above counts are offenders in the third judicial district's mental health court, because this program is a diversion for lower level misdemeanants. The mental health court focuses on the needs of the mentally ill in an intensive & collaborative manner, by means of suspended disposition or at least jail time with the agreement the individual will participate in community programming.

In addition to mental health interventions, dual diagnosis interventions are available in five out of the eight judicial districts. The largest of these, and the first to get started, is the Waterloo Dual Diagnosis Program, which received the "Exemplary Offender Program" award from the American Correctional Association in 2004. During FY2005, a total of 252 offenders were served in dual diagnosis interventions statewide.

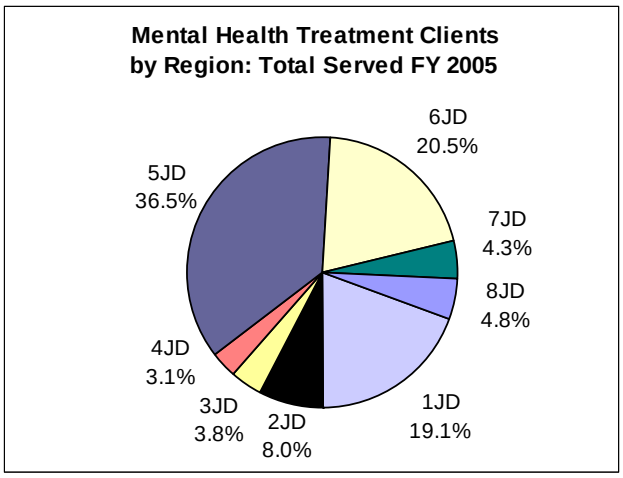
The following pages describe the types of offenders served by mental health treatment and dual diagnosis interventions in FY2005.

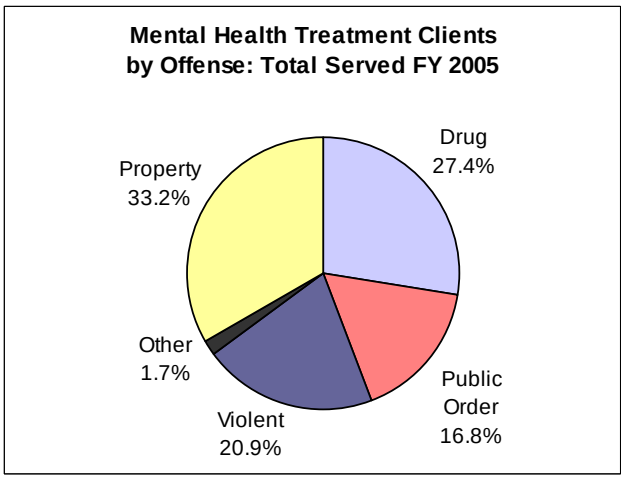
Mental Health Treatment

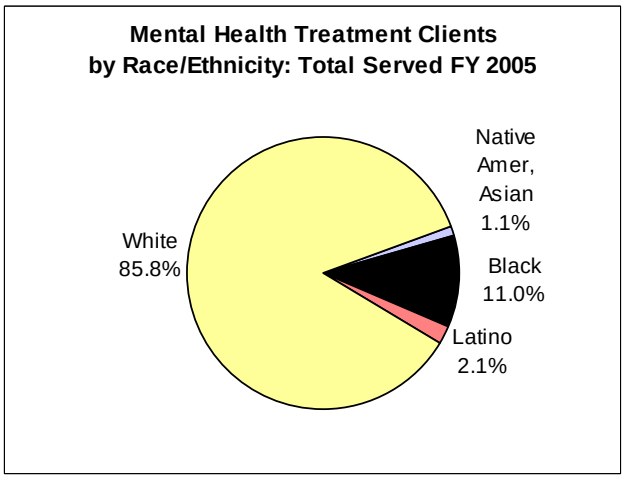
Community-Based Corrections

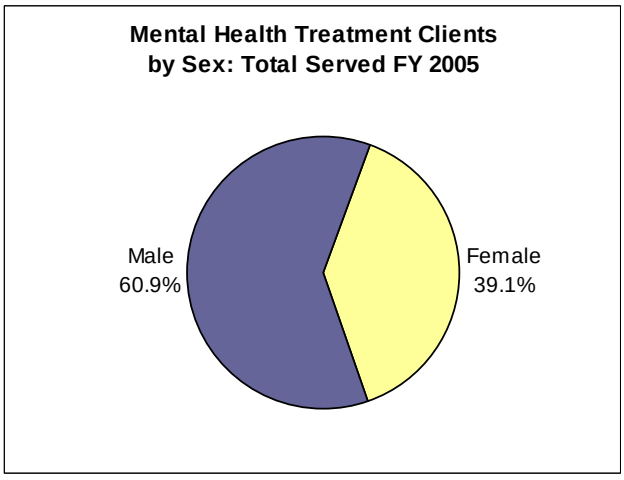
During FY2005, a total of 1,533 offenders under community-based corrections supervision received mental health treatment, usually psychiatric or psychological services. **Please note these are interventions documented on ICON, and likely under-represent the numbers of offenders receiving mental health treatment while under supervision.**

Treatment clients represented a range of offenses, and were mostly Caucasian. A large portion (39.1%) was female.







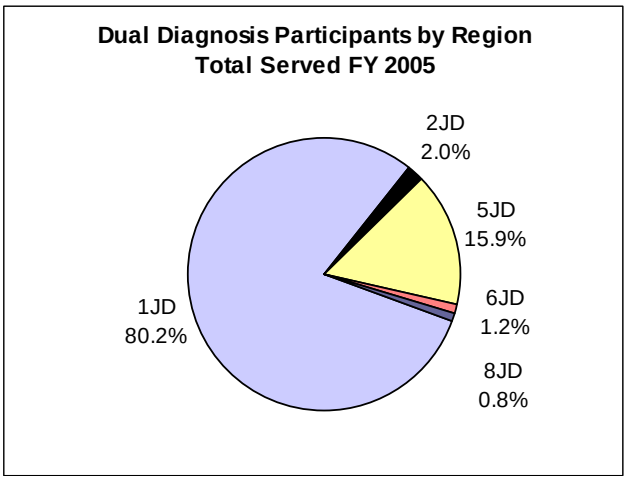


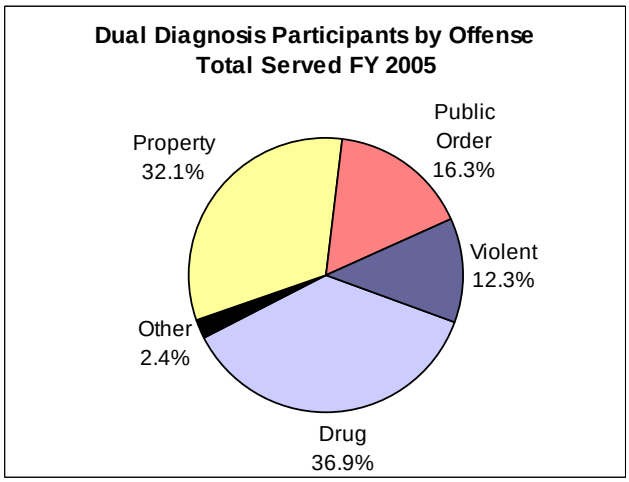
Dual Diagnosis Interventions

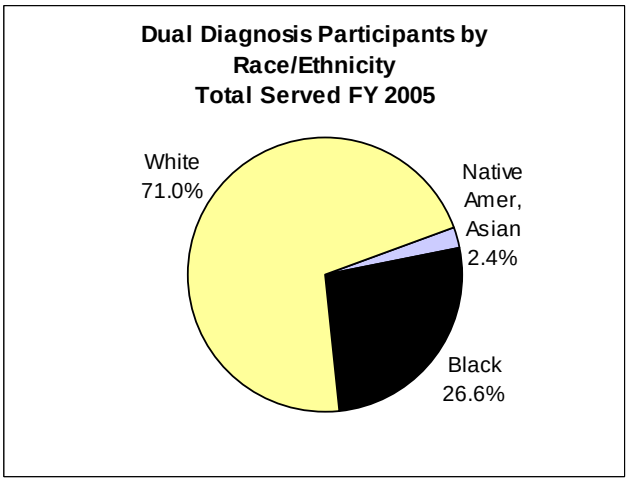
A dual disorder occurs when an individual is affected by both chemical dependency and mental illness. According to a report published by the *Journal of the American Medical Association*:

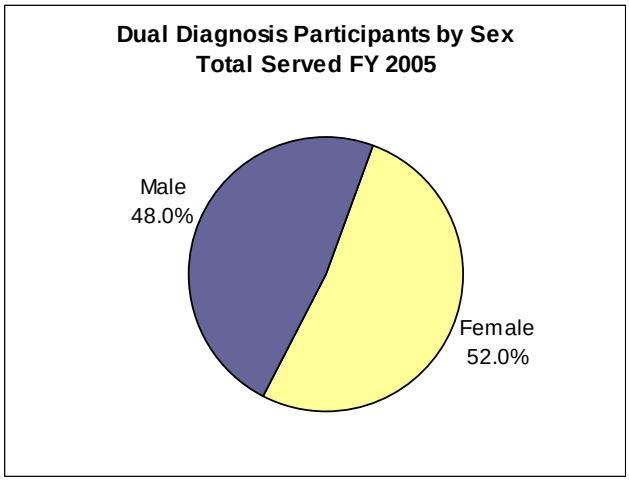
- 37% of alcohol abusers and 53% of drug abusers have at least one serious mental illness.
- Of all people diagnosed as mentally ill, 29% abuse either alcohol or drugs.[5]

Dual diagnosis interventions represent a comprehensive approach to addressing both these issues. During FY2005, a total of 252 offenders under community-based corrections supervision received dual diagnosis interventions, with most participating in the first judicial district's program. Participants represented a range of offenses, and a comparatively large portion was African-American. Female offenders made up the majority of participants.









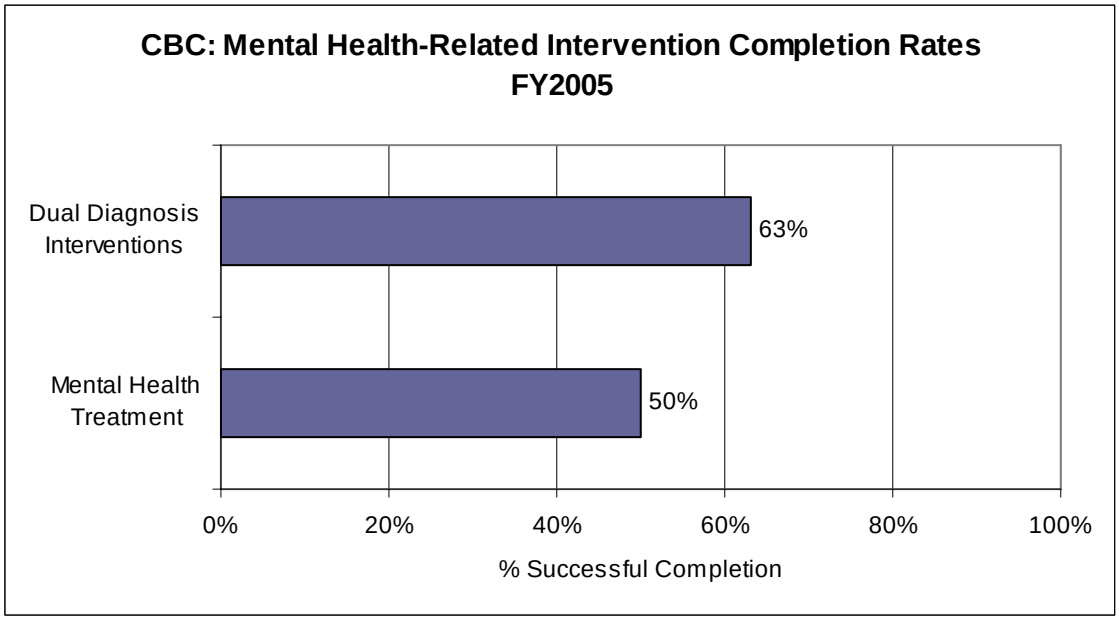
[5] As quoted in National Mental Health Association, *Substance Abuse – Dual Diagnosis* (April 2003) at http://www.nmha.org/infoctr/factsheets/03.cfm.

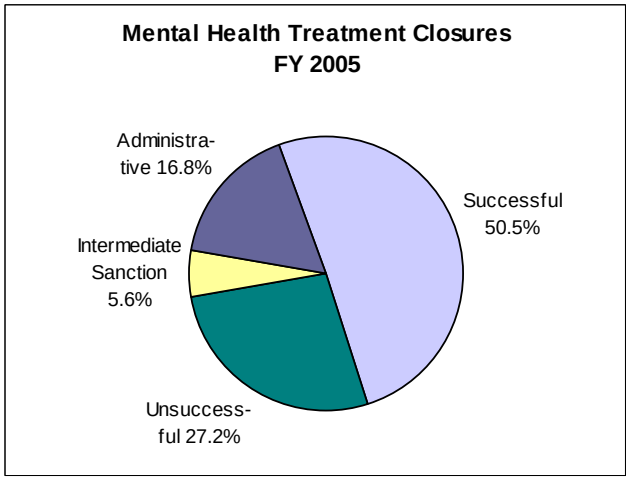
Outcomes: Intervention Completion Rates

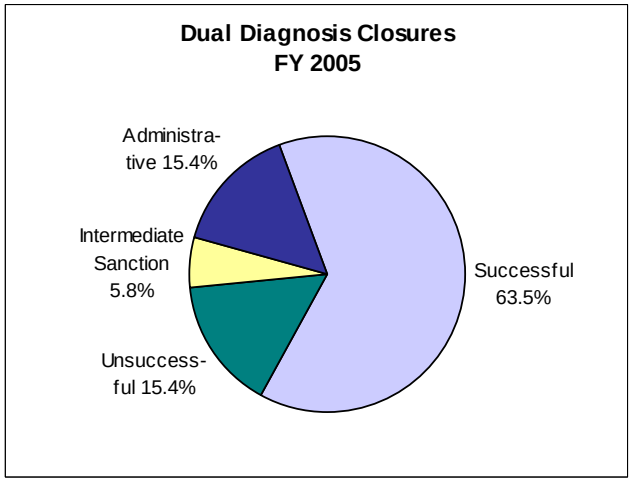
Community-Based Corrections

Treatment providers endeavor to ensure the success of offender participants, including keeping participants in the program wherever possible. Rates of successful completion are one way to assess how well programs are performing their mission. However, other factors such as the risk levels of offenders being served by a particular program also affect completion rates. Because offender risk may vary from program to program, outcome evaluations are an important way to assess whether a particular program is effective.

Rates of successful completion do not mean that the other half were unsuccessfully discharged. Administrative closures (such as transfer to another jurisdiction) and the use of intermediate sanctions to address violating behaviors short of revocation to prison represent other types of closures.







Mental Health Interventions & Treatment

Prisons

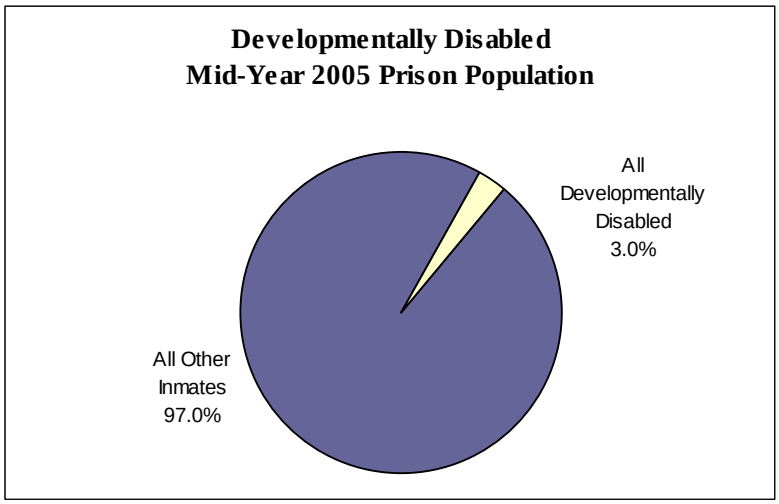
There is limited documentation on ICON describing mental health interventions in institutions. Health Services staff, including psychiatrists and psychologists, have been generally transitioning to the ICON-Medical module to document mental health appointments. Mental health-related appointments in ICON-Medical are mixed with medical appointments, and are not currently readily distinguishable from medical matters. Once this transition is complete, reports will be available from ICON-Medical to describe mental health services provided to institution offenders.

Prison-based interventions for the mentally ill are primarily psychiatric and psychological services, with proper medication where indicated. There is also a special program at the Mt. Pleasant Women's Unit, called STEPPS (Systems Training for Emotional Predictability and Problem-Solving) for offenders with borderline personality disorders.

Under the direction of the Iowa Department of Corrections' new Director of Mental Health, changes will occur to further strengthen the provision of mental health services within the prison system.

Offenders with Developmental Disabilities in Prison

Persons with developmental disabilities may also pose challenges with regard to behavior management, and need for specialized services. On June 30, 2005 Iowa's prisons held 8,578 offenders. Of these, 256 had developmental disabilities per psychiatric diagnosis. **These numbers may under-represent the true number of offenders with developmental disabilities because currently not all inmates receive IQ and development testing.**



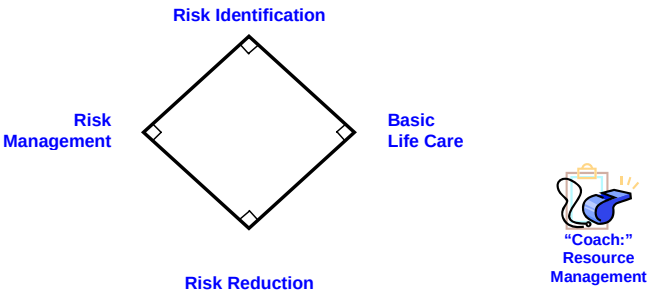
The most common documented developmental disability is attention deficit disorder, with hyperactivity; 203 or about 79% of the 256 offenders in prison who had developmental disabilities had this diagnosis.

Developmental Disabilities		
ICD9 Code	**ICD9 Description**	**N Inmates**
314.01	Attention deficit disorder, w/hyperactivity*	203
V62.89	Borderline intellectual functioning	43
317	Mental retardation, mild	11
315.2	Learning disorder	2
315.8	Development delay, other specified	1
314.00	Attention deficit disorder, non-hyperactive	1

A given offender may have more than one of these diagnoses.
* The Director of Mental Health is currently evaluating the validity of this apparent outlier.

Commitment to Evidence-Based Practices

The corrections system does four fundamental things. The first three, basic life care for offenders, risk identification and risk management, cover the bases of managing offenders. However, only risk reduction "hits a home run" to significantly affect offender outcomes and community safety, and improve the state's return on investment in corrections spending.



The Iowa Department of Corrections is committed to providing mental health interventions to those in need wherever possible, for offenders under community-based supervision and in prison. Mental health care, including the provision of proper medication where indicated, is part of basic life care – so fundamental we cannot get to "first base" without it.

At the same time, we cannot overlook that proper assessment, management and treatment of offenders with mental illnesses and/or developmental disabilities are keys to ensuring successful offender reentry for these individuals. As new mental health programs and protocols are implemented, appropriate outcome studies will be conducted to determine whether or not the program has been successful at achieving risk reduction for offenders.