BACKGROUND AND QUESTIONS RELATED TO READING OF ELIZABETH FORD'S BOOK,

AMAZING THINGS HAPPEN: HEARTBREAK AND HOPE ON THE BELLEVUE HOSPITAL PSYCHIATRIC PRISON WARD (FORD 2017)

INTRODUCTION

Elizabeth Ford's book celebrates the "amazing things" that happened during her work at Bellevue's forensic psychiatric unit. As extraordinary as they were, the "amazing things" are all the more remarkable given the limitations under which she worked and the difficult mental health environment generally prevailing in prisons throughout this country. The numbers are stunning. As Elizabeth Ford points out, the New York City jail system houses more people with mental illness "than in all the inpatient psychiatric units in the NYC public hospital system combined" (Ford 2017). In the United States today, some 400,000 people with mental illness are in prisons and jails, but only about 35,000 in state psychiatric hospitals (Guice 2016).

MENTAL HEALTH IN NORTH CAROLINA PRISONS

Here in North Carolina as of 2016, the Department of Public Safety (DPS) provided mental health treatment for 14% of 37,000 prisoners with serious and persistent mental illness, up from 9.8% in 2007 (Guice 2016, Catlett and Lassiter 2014; Jarvis 2014). There is good reason to think many NC prisoners remain untreated or inadequately treated. Contrast the percentage of those treated in North Carolina prisons versus the percentage treated in California state prisons. In California, 45 percent of prisoners, nearly four times the percentage in NC, received treatment for severe mental illness over 12 months in 2013-2014 (Steinberg et al 2014, 1). In addition to those incarcerated, among the 105,000 offenders on Community Supervision in North Carolina, approximately 31,000 have been diagnosed with some type of mental illness (Guice 2016).

CHALLENGES OF PROVIDING MENTAL HEALTH TREATMENT IN PRISONS

The challenges Elizabeth Ford describes mirror the problems the NC Department of Public Safety cites:

- Disorderly prisoners who refuse to comply with treatment strategies,
- The large number of prisoners in control status, especially long-term restrictive housing ,
- Violence and aggressive behavior by the mentally ill,
- Inadequate staffing, both in number and lack of training, and
- The unsuitable setting of prison as a treatment site (Catlett and Lassiter 2014).

In regard to the prison as a treatment site, the psychologist Craig Haney states, "Premised on punitive forms of social control, prisons are not remotely compatible with the kind of supportive therapeutic milieus that the mentally ill require. They are austere and intimidating environments that are painful and difficult for even the strongest and most resilient prisoners to withstand. The pains of imprisonment -- severe material deprivations, highly restricted movement and liberty,

lack of meaningful activity, a nearly total absence of personal privacy, high levels of interpersonal uncertainty, danger, and fear – are powerful psychological stressors that can adversely impact a prisoner's well-being" (Steinberg et al 2014, 7).

NORTH CAROLINA'S DEPARTMENT OF PUBLIC SAFETY INITIATIVES

Concerned to provide more adequate mental health services, in 2014 the NC Department of Public Safety (DPS) recommended a major budget increase of $28.4 million to hire 448 staff for mental health services. Although the NC legislature only partially funded the DPS proposal, the DPS has recently made significant strides. In 2015, DPS appointed two new highly experienced mental health professionals, Dr. Karen Steinour as the new Health Services Compliance Officer and Dr. Gary Junker as the new Director of Behavioral Health (NCDPS 2015). For entering prisoners, the DPS has instituted a more rigorous diagnostic protocol and a systematic care program for those diagnosed with mental illness. At Central Prison, DPS has developed a "treatment mall," an area where patients meet staff to participate in approximately 20 hours of out-of-cell structure activity each week. DPS has opened eight Therapeutic Diversion Units (TDUs) to provide intensive out-of-cell programming as an alternative to restrictive housing or solitary confinement. The legislature has also funded 66 staff to operate fully the 72 bed mental health unit in Central Prison. A significant number of mentally ill prisoners benefit from work programs, both in prison and on work-release outside prison (Guice 2016).

MENTAL HEALTH IN PRISONS AS PART OF A MORE GENERAL PROBLEM

It is instructive to consider the problems Elizabeth Ford encountered at Bellevue in the context of mental health problems throughout the United States.

THE UNITED STATES IS EXPERIENCING AN EPIDEMIC OF MENTAL ILLNESS:

- Bi-polar (Manic-depressive) from 1996 to 2004 increased 56%, albeit with an expansion of the diagnosis (Whitaker 2015, 181)
- The number of mentally ill children under 18 years of age increased by a factor of 35, from 16,200 in 1987 to 561,569 in 2007 (Whitaker 2015, 8).
- The Number of SSI and SSDI recipients under age 65 disabled by mental illness increased from about 1.2 million in 1987 to 3.6 million in 2015 (Whitaker 2015, 8 and Social Security Administration Statistical Reports 2015).
- A 20-year-old receiving disability today will receive an estimated $1 million over the course of his lifetime (Whitaker 2015, 10). Can we afford this cost?

LOW RECOVERY RATES:

Recovery rates from schizophrenia and other related psychoses are poor: Using the criteria of sustained clinical and psychosocial recovery (clinical remission and good social functioning that persisted at least two years), a recent study found the median proportion of patients who met those recovery criteria was only 14%. (Jaaskelainen 2013).

LOW QUALITY OF LIFE FOR MANY YEARS: Because the onset of schizophrenia is typically early in adulthood, the disability and diminished quality of life in the disorder takes an enormous toll on affected individuals and caregivers (O'Donnell 2016).

HIGH MORTALITY: Schizophrenia is associated with a two to three-fold increase in mortality rates. Compared to the general population, life expectancy is reduced by up to 20 years (Saha 2007, Chwastiak 2009, Kisely 2010, Laursen 2011, Laursen 2014).

ENCOURAGING APPROACHES IN MENTAL HEALTH TREATMENT

In contrast to the negative picture of mental illness painted above, a number of treatment initiatives merit attention. One in particular is the monumental study by John Kane et al. That nationwide study of 34 mental health clinics, including the UNC Step Clinic, demonstrated over two years that a comprehensive approach with multiple interventions had far more salutary benefits than the common approach limited almost entirely to medication. The successful comprehensive approach demonstrated by Kane et al for schizophrenic cases included 1) medications, 2) talk therapy, 3) involvement with the patient's family, and 4) education and/or supported employment (Kane, 2015). Independently, in a recent meta-analysis of ten studies, John Firth found that a fifth intervention of cardio-vascular exercise is effective (Firth 2016). O'Donnell and Whitaker discuss other promising interventions (O'Donnell 2016, Whitaker 2015).

Past experience in North Carolina and other states provides good reason to think that the initiatives instituted and proposed by the DPS can make a major difference. Unquestionably additional, well-trained staff can give more effective treatment to more prisoners. But the effective treatment DPS has instituted and proposed go far beyond efficient administration of medications. The DPS anticipates offering more comprehensive "out of cell" treatment based on best practices. Evidence based programs have shown that psychosocial programming with prisoners in groups and removing the mentally ill from isolation into improved step-up housing can help reduce violence, help the mentally ill stay out of the hospital, return to the general prison population, and save money. We cite some of the evidence below:

- **North Carolina:** At Brown Creek Correctional Institution, the Social Skills Day Training Program treated 700 mentally ill prisoners over ten years through an empirically validated program to teach illness management, social and coping skills. In 2002 alone, the program successfully discharged 81% of 63 participants to the regular prison population or to the community (MacKain and Messer 2004).

- **Mississippi** established a new objective prisoner classification system based on objective criteria: serious infractions, high-level members of a gang, and prior escapes or attempts to escape. Using that classification system, Mississippi housed prisoners in an intermediate or step down unit with an upper tier for those requiring separation and a lower tier for those who had proved they were able to interact with others. As Deputy Commissioner Emmitt Sparkman explained, "Once prisoners saw the incentives they could get, every week we saw inmates progress to the next level" (Kupers 2009). The result was a dramatic decrease in violence, far less stress on staff, less need for escorts, fewer restraints, and fewer searches. And reducing segregation saved money (Kupers 2009).

- **Maine** dramatically reduced solitary confinement of the mentally ill by using alternative methods of discipline: Short-term confinement within the general population unit, temporary loss of work privileges or contact visits, and limiting approved visitors (Heiden 2013, 31).

- In three **New York** prisons, psychosocial rehabilitation reduced serious rules infractions, hospitalization, crisis care, seclusion, and suicide attempts (Condelli et al 1994).

- **Washington** state achieved significant reductions in staff assaults, infractions, and use of expensive resources, as well as higher rates of work and school participation through treatment of mentally ill male prisoners through psychosocial rehabilitation (Lovell et al 2001). In keeping with that success, Washington state now has a step down program, the Intensive Management Unit Progressive Program "oriented towards providing offenders the pro-social skills to successfully live in the general prison population and be safe productive citizens in the community. Offenders learn to meet their needs non-violently in the following areas: physically, emotionally, mentally, socially, spiritually" (Washington Department of Correction 2013).

- Other proven initiatives include Britain's Close Supervision Centres (Gawande 2009), the ManAlive Program (Manalive Placer County 2015; Schwartz 2009), and the Alternatives to Violence Project (AVPUSA website; Garver and Reitan 1995, Walrath 2001).

QUESTIONS SPECIFIC TO ELIZABETH FORD'S BOOK

1. AUTHOR'S NOTE, P. VII,

"I have come to see my success as a doctor not by how well I treat mental illness but by how well I respect and honor my patients' humanity, no matter where they are or what they have done." Give examples of this occurring in the book. Can you share examples from your own life when you were able to honor the humanity in someone when you were frightened or upset? What about experiences when you were unable to do this and you wish that you could have?

2. CHAPTER 33, "HIGHER POWER", P. 230

"Jarvan's faith in a higher power will help him make it through the rest of his imprisoned life with restful nights. My doctoring skills don't come close to his belief in God." What do you think about this statement?

3. CHAPTER 36, "BEYOND BELLEVUE", P. 240

"If Bellevue can help a man like Jamel, with incredible doctors who love what they do and officers who have accepted the safety of respect and kindness, it doesn't need me anymore."

What do you think about this idea: the safety of respect and kindness? Can you think of examples of this in the book?

4. THE NATURE OF TREATMENT

Elizabeth Ford achieved amazing things in a setting where treatment options were limited. Given the study by John Kane et al demonstrating the effectiveness of a comprehensive approach and the treatment initiatives in North Carolina and other states, what treatment initiatives in hindsight were lacking in Bellevue and what if any initiatives might you wish have been tried?

5. PRIVATE PRACTICE VERSUS WORK AT BELLEVUE

Elizabeth Ford had a small private practice she gave up in favor or focusing on her work at Bellevue and later at Rikers Island. Discuss why she made that decision.

Questions submitted by Tom Ludlow and Hank Elkins

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Hank Elkins and Tom Ludlow, November 8, 2017