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S. HRG. 108–372

AN EXAMINATION OF S. 1194, THE MENTALLY ILL OFFENDER TREATMENT AND CRIME REDUCTION ACT OF 2003

HEARING

BEFORE THE

COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

JULY 30, 2003

Serial No. J–108–32

Printed for the use of the Committee on the Judiciary

U.S. GOVERNMENT PRINTING OFFICE

91–830 PDF WASHINGTON : 2004

For sale by the Superintendent of Documents, U.S. Government Printing Office
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AN EXAMINATION OF S. 1194, THE MENTALLY ILL OFFENDER TREATMENT AND CRIME REDUCTION ACT OF 2003

WEDNESDAY, JULY 30, 2003

UNITED STATES SENATE,
COMMITTEE ON THE JUDICIARY,
Washington, D.C.

The Committee met, pursuant to notice, at 2:08 p.m., in room SD–226, Dirksen Senate Office Building, Hon. Mike DeWine presiding.

Present: Senators DeWine, Leahy, and Durbin.

OPENING STATEMENT OF HON. MIKE DEWINE, A U.S. SENATORFROM THE STATE OF OHIO

Senator DEWINE. Welcome to the Judiciary Committee hearing on Senate bill 1194, the Mentally Ill Offender Treatment and Crime Reduction Act of 2003. Let me thank the Chairman of the Judiciary Committee, Senator Hatch, for scheduling this important hearing today, as well as cosponsoring this legislation.

Let me also thank the Ranking Member of the Judiciary Committee, Senator Leahy, for all of his hard work and for his leadership in this area, and also for his cosponsorship of the bill and for his hard work in preparing for our hearing today. Let me also thank our original cosponsors, Senator Grassley, Senator Domenici, and Senator Cantwell, for their efforts and their hard work.

Those who suffer from mental illness face great challenges in their lives, and when those with mental illness come into contact with our criminal justice system, the challenges become even greater. I learned this firsthand approximately 30 years ago when I was a county prosecuting attorney in Greene County, Ohio. I learned how important it is that our mental health community and our law enforcement community work together to deal with mentally ill offenders.

This kind of coordination is vital because people afflicted with mental illness are incarcerated at significantly higher rates than the general population. Specifically, approximately 5 percent of the American population has a mental illness, but about 16 percent of the State prison population in this country has such an illness. The Los Angeles County Jail, for example, at any one time typically has more mentally ill inmates than any hospital in the country.

Unfortunately, however, the reality of our criminal justice system is that jails and prisons are not equipped to provide a therapeutic environment for the mentally ill. In fact, mentally ill inmates often

become even sicker in jail. Once released from jail or prison, many mentally ill people end up on the streets. With limited resources and little or no ability to handle their illness alone, they often commit additional offenses, resulting in their re-arrest and re-incarceration. This revolving door is costly and is disruptive for all involved, worst of all for the person suffering from a mental illness and his or her family.

Although these problems manifest themselves most clearly within the prison system, the problem is also rooted in the mental health system and its failure to provide sufficient community-based treatment solutions. Accordingly, the key to any solution of these problems will be collaboration—collaboration between the mental health system and the criminal justice system.

In fact, because many mentally ill offenders have a drug or alcohol problem, in addition to their mental illness, solving this problem also will require greater collaboration between the substance abuse treatment and mental health treatment communities. That, in a nutshell, is what our bill does.

The entire goal of the mentally ill offender treatment bill is to foster exactly this type of collaboration at the Federal level, the State level, and most particularly at the local level. The bill provides funding for the criminal justice system, for the juvenile system, and for the mental health and substance abuse treatment systems all to work together at each level of government to establish a network of services for offenders with mental illness.

The bill would promote public safety by helping decrease the number of repeat offenders, and also would promote public health by ensuring that those with a serious mental illness are treated as soon as possible and as efficiently and effectively as possible.

The way this bill works is that it sets up a grant program, establishing a pool of money which would be used to fund State and local programs to address the problem of mentally ill offenders. Most importantly, to ensure that these programs are collaborative, the bill would require that two organizations, such as sheriff's office and a mental health care agency, would have to jointly submit a single grant application on behalf of their community. So the bill would require that you would have to have a mental health organization as well as a law enforcement organization both applying together for the grant.

These funds could be used for a variety of purposes as long as the program would further the goal of collaboration to help the mentally ill. For example, grant funds may be used to establish courts with specialized dockets for offenders who have a serious mental illness or a co-occurring mental illness and drug or alcohol problem.

Funds could be used also, for example, to enhance training of mental health and criminal justice system personnel so that they could better handle situations that might arise with a mentally ill offender. Funds also could be devoted to programs that would divert non-violent offenders into treatment instead of prison, or correctional facilities could use grant funds to promote the treatment of mentally ill inmates and ease their transition back into the community upon release from jail or prison.

Now, some of this may sound a little bit familiar to some of you because this legislation does, in fact, build on legislation that I introduced two years ago with my friend and colleague from Ohio, Congressman Ted Strickland. That bill, which many of my colleagues on this Committee joined with me in working on, did, in fact, become law and it authorized the establishment of more mental health courts.

I have long supported mental health courts, which enable the criminal justice system to provide an individualized treatment solution for a mentally ill offender, while also requiring accountability of the offender. The legislation we are discussing today builds on that law and would make possible the creation or expansion of mental health courts. It also would promote the funding of treatment services that support such courts.

There are a number of other important provisions in our legislation and we will discuss them today, but the real essence of this bill is that it would provide the funding and the incentive for law enforcement and mental health providers to work together to provide real help to those who are suffering from mental illness. The bill would help advance the community interest in promoting public safety and the human interest that we all have in helping people suffering from mental illness.

Now, let me turn to my friend and my colleague on this Committee, Senator Leahy.

STATEMENT OF HON. PATRICK J. LEAHY, A U.S. SENATOR FROM THE STATE OF VERMONT

Senator LEAHY. Thank you very much, Mr. Chairman, and before we even start I want to commend your longstanding and well-demonstrated support of this concept. Like me, you have had experience as a prosecutor. And, of course, you have seen it from State government as lieutenant governor, so you know how important it is. It is not something that we talk about out of the abstract.

This is a good, bipartisan bill. There are far more examples than not of legislation in this Congress that are put together by members on both sides of the aisle, and not surprisingly they are the ones that have the best chance of being passed.

It is a good bill. It is going to help State and local governments with a problem that sometimes is overlooked—the extent to which mentally ill individuals commit crimes and then they are sent out again without ever receiving appropriate attention from the mental health, law enforcement, or correction systems, and commit crimes again.

I welcome all the witnesses today, and I hope none of you among the witnesses will feel at all slighted if I give a special welcome to my fellow Vermonter, Senator John Campbell, who is here. He is going to testify about how our State has worked on this.

Senator Campbell is the majority leader of our Vermont Senate. He is a member of the Judiciary Committee. He is a former law enforcement officer. But even more importantly, of the things that we share—we are both Vermonters, both been in law enforcement—we both married nurses and that is the best part of our lives. In his work as a legislator, as a lawyer, and as a law enforce-

ment officer, he has seen this issue from policy perspectives, but also right up close and personal, as so many of you have.

Too often, people with mental illness rotate repeatedly; they go back and forth between the criminal justice system and the streets of our communities. They go back on the streets and they commit a number of crimes. Yet, we have fewer law enforcement officers available to deal with this. They are being occupied by very important things, very urgent things, but they get diverted many times by lesser offenders.

Then these offenders find themselves in jails or elsewhere, where there is no attempt made to take care of the mental illness problems they have. So what we are trying to do is give the State and local governments a tool to break the cycle. If we do, it helps law enforcement, it helps corrections officers, it helps the safety of all of us, but it also helps those who are mentally ill. It really is a win-win-win-win.

When I held a Judiciary hearing last June, we heard from the members of the criminal justice system. We heard from State mental health officials, law enforcement officers, corrections officials, and representatives of counties around our Nation, and they all agreed that people with untreated mental illness are more likely to commit crimes and that our State mental health systems, prisons and jails don't have the resources they need to treat the mentally ill and prevent recidivism.

We know that more than 16 percent of adults in U.S. jails and prisons have a mental illness, that about 20 percent of the youth in our juvenile justice system have serious mental health problems, and that up to 40 percent of adults who suffer from a serious mental illness are going to come in contact with the American criminal justice system at some point in their lives. We know all these things, but we have done very little to help at the Federal level. This bill could change all that.

It is not a one-size-fits-all approach. It gives grantees the ability to use the funds authorized under the bill for mental health courts or other court-based programs, for training mental health system personnel for mental health treatment. It makes a real difference in funding—$100 million authorized each year for the next two years. Actually spending this money could save a great deal of money in the long run.

I am glad—and, Mr. Chairman, you have seen this from all the people you have talked with, as I have—that it brings the mental health experts together with law enforcement, something where they both see a chance to win. So I applaud you for holding the hearing, and I am hoping this is something that we can get out and get passed.

[The prepared statement of Senator Leahy appears as a submission for the record.]

Senator DEWINE. Senator Leahy, thank you very much.

Let me introduce the panel very briefly.

Mr. Ron Honberg is the National Director of Policy and Legal Affairs for NAMI, the National Alliance for the Mentally Ill. He has worked extensively to promote diversion programs and improve treatment for people with mental illness.

Sheriff Donald Eslinger is the Sheriff of Seminole County, Florida. He has worked in the Seminole County Sheriff's Office for the past 25 years. For 12 of those years, he has served as the sheriff. Additionally, the sheriff has worked with Florida's Behavioral Health Services Integration Work Group.

Senator John Campbell is the majority leader in the Vermont Legislature. In addition to his work in the Vermont Legislature, he is a former law enforcement officer and has been practicing law for the past 20 years.

Dr. Reggie Wilkinson is the Director of the Ohio Department of Rehabilitation and Correction, and has been with the Department since 1973. He was first appointed Director in 1991 by then–Governor George Voinovich. He was reappointed eight years later by current Government Robert Taft. The Department oversees more than 30 prisons and is responsible for 45,000 inmates.

Rhonda Atkins is from Sarasota, Florida. She has firsthand experience as a mother of a mentally ill child. Her daughter got involved in a criminal justice system that was inadequately prepared to offer her the services that she needed.

Justice Evelyn Stratton, of the Ohio Supreme Court, chairs the Supreme Court Advisory Committee on the Mentally Ill in the Courts in Ohio. This committee has been instrumental in providing training for law enforcement officers to better handle mentally ill offenders in the justice system.

Mr. Honberg, you will be the first witness. Let me say that we will set the clock at five minutes for each one of you. We have your written testimony, which we appreciate and will be made a part of the record. When you see the yellow light, that means you are down for a minute. We would like for you to conclude your comments then, and that will enable us to have some time, we hope, for some questions.

You may begin.

STATEMENT OF RON HONBERG, LEGAL DIRECTOR, NATIONAL ALLIANCE FOR THE MENTALLY ILL, ARLINGTON, VIRGINIA, ON BEHALF OF THE CAMPAIGN FOR MENTAL HEALTH REFORM

Mr. HONBERG. Thank you. Senator DeWine, Senator Leahy, I am deeply honored to have this opportunity to testify at this very important hearing. My name is Ron Honberg and I am the Legal Director for NAMI, the National Alliance for the Mentally Ill. But I am also here testifying today on behalf of the Campaign for Mental Health Reform, which is a collaboration among 15 leading national mental health organizations, including consumers, family members, providers, and other advocates.

The recent report that was released by President Bush's new Freedom Commission on Mental Health emphasizes what certainly the two of you know so well that our Nation's jails and prisons have become de facto psychiatric treatment facilities. Having been in many of those facilities myself, I know that they are not treatment facilities at all, that they are environments that are not at all conducive to treating people who are experiencing severe psychiatric symptoms.

Sheriffs and police officers throughout the country, as I am sure you will hear today, will tell you that they frequently respond to people who are experiencing psychiatric crises. In view of this, the impressive line-up at this hearing, present witness excluded, reflects the reality that the criminal justice community has become the strongest ally of the mental health field, and in some cases, frankly, the leaders behind efforts to promote better mental health treatment and programs to reduce unnecessary criminalization of people with mental illnesses.

The landmark Criminal Justice/Mental Health Consensus Project, which was convened by the Council of State Governments, is an illustration of just how important these issues have become. While compassion for a particularly vulnerable segment of our society is certainly evident in these efforts, the significant involvement of the criminal justice community reflects something more—recognition that reducing involvement of people with mental illnesses with criminal justice systems benefits not only those individuals themselves, but the criminal justice systems and society as a whole.

Most people with mental illnesses who come into contact with law enforcement or criminal justice are not violent criminals. Most would never have ended up in these systems at all if they had received appropriate treatment in the first place.

Yet, mental illness is the leading cause of disability in the world, but fewer than half of all people with these illnesses have access to even minimally adequate treatment and services. I want to emphasize that with treatment, recovery is very, very possible, but without treatment, the consequences are frequently horrendous.

It is frankly unfair and very poor public policy to saddle criminal justice systems with responsibility for responding to people with mental illnesses in crisis, but that is the reality in America today. As I said, police officers around the country spend many hours transporting people to hospitals, and sit for hours in emergency rooms, only to see the same people back out again on the streets in a matter of a few hours. The time these officers spend in doing so is time they are unable to spend fighting crime.

In 2000, this Committee demonstrated its commitment by enacting America's Law Enforcement and Mental Health Project, as Senator DeWine said, a bill that authorized funding for mental health courts, and this bill indeed represents the next logical step forward.

Senator DeWine and Senator Leahy, we applaud you for scheduling a hearing to tackle these troubling problems. Senator DeWine, we are deeply grateful for your introduction of the legislation and, Senator Leahy, for your cosponsorship, that provides an important approach to badly needed community reform.

This legislation wisely recognizes that solutions will ultimately be found in communities, and what the Federal Government can do and what good legislation must do is provide support for a wide range of collaborative community programs that provide avenues for effective and appropriate treatment.

I would like to use the remaining few minutes to make the following five points.

First, it is critically important that collaboration occur among all elements of the criminal justice and mental health systems if ef-

forts to reduce criminalization of people with mental illnesses are to succeed. And I might add that this collaboration is also necessary at the Federal level between the Department of Justice, the Department of Health and Human Services, and other key Federal agencies.

Second, jail diversion and community reentry programs will succeed only when mental health services and supports are available to address the needs of individuals in these programs. A more thorough explanation of the types of services needed is contained in my written testimony.

Third, the best form of jail diversion is that which occurs prior to arrest and incarceration. For example, different approaches to pre-booking diversion have emerged, such as the nationally-renowned Memphis, Tennessee, Police Crisis Intervention Team program, which has now been replicated, I am very pleased to say, in over 50 communities across the country.

Fourth, a wide range of post-booking diversion strategies exist, tailored to local needs and systems. Most notable, of course, among these are mental health courts, which NAMI is very pleased to report have been now adopted in approximately 70 communities across the country, many in Ohio, several in Vermont. But there are other successful models, as well.

Finally, discharge planning and reentry services for individuals with mental illnesses reentering the community are critically important. Successful reintegration is frequently hampered by lack of services and the failure to restore benefits lost or suspended during incarceration. The Campaign applauds the sponsors of S. 1194 for recognizing this and ensuring that grant funds can be used to support vital community reentry services.

Once again, I thank you and am very grateful that I have had this opportunity to testify. I look forward to any questions you might have.

[The prepared statement of Mr. Honberg appears as a submission for the record.]

Senator DEWINE. Thank you very much.

Sheriff?

STATEMENT OF DONALD F. ESLINGER, SHERIFF, SEMINOLE, COUNTY, FLORIDA, SANFORD, FLORIDA

Sheriff ESLINGER. Thank you, Mr. Chairman. I, too, would like to congratulate you and commend you on your leadership concerning this very important piece of legislation.

Senator Leahy, thank you very much for your leadership as well.

I am the Sheriff of Seminole County, and based on my experience I can assure you that the provisions contained in this bill are clearly needed to stem the ever-growing tide of the mentally ill within the criminal justice system.

Ironically, it was five years ago this month that Seminole County lost Deputy Sheriff Eugene Gregory in a tragic incident that is emblematic of the crisis of untreated mental illness. Deputy Gregory, responding to a disturbance call, ended up in a confrontation with Alan Singletary, a man whose schizophrenia went untreated for years, despite his family's efforts to get him to accept treatment.

Alan killed Deputy Gregory, wounded two other deputies, and himself was killed in the ensuing 13-hour standoff.

It was that tragedy that made me recognize the inescapable conclusion that we have to shift the focus of intervention for people with untreated mental illness away from law enforcement and the criminal justice system back to professionals who are trained to provide care and treatment for individuals with severe mental illness.

The Senate bill provides critically needed resources for alternatives to incarceration, including training of law enforcement officers and mental health providers, and fostering collaboration among community stakeholders.

With these resources, we have a greater hope of accomplishing really three main goals: number one, preventing fatal encounters involving law enforcement officers and those who are suffering from mental illness, as well as preventing unnecessary injuries that often occur during these crisis situations; number two, responding to the intense fiscal pressures in our counties throughout America, as well as making better use of public safety resources by not just treating symptoms of the problem, but looking at the underlying causation and addressing it.

The loss of Deputy Gregory and Alan Singletary were far from an isolated incident and is not unique to Florida. Just since that tragedy in July of 1998, at least 175 other people with mental illness and 28 law enforcement officers have been killed in altercations across this Nation, 6 in D.C. and Maryland alone. This month, five mentally ill people have been killed in encounters with law enforcement. We now know that mental illness is a factor in many police shootings. In fact, people with mental illnesses are four times more likely to be killed in these encounters than the general population.

It is critical to train officers to deescalate crisis situations. Seminole County has fully implemented the Memphis Model for CIT, a proven approach that fosters partnerships between law enforcement and the community. CIT has been shown to reduce officer injury rates five-fold.

Equally as important is to prevent these incidents from ever occurring, because even the best training is no substitute for having medical professionals handle medical crises. The most effective way to prevent these violent episodes and deadly encounters is to prevent them by providing earlier intervention and treatment. This is not only the safest approach, but it is the most cost-effective.

Lack of treatment impacts county budgets significantly in costs of personnel, incarceration, treatment within the system, emergency care, and even lawsuits. I am aware of at least seven lawsuits stemming from police shootings filed or settled since April of this year, some in excess of $1 million.

When there are no alternatives to incarceration, the mentally ill begin to swell inmate populations in local jails and prisons.

Mr. Chairman, as you alluded to, we now have over 300,000 incarcerated mentally ill in county and State prisons throughout this country, nearly six times the number in State psychiatric hospitals. These individuals are ill and most don't belong in jail.

I will abridge my comments, Mr. Chairman, for the sake of moving on. I would be delighted to answer any questions, but I must say again, to reiterate what you had conveyed, fostering community collaboration is a vital component of this bill. The deaths of Deputy Gregory and Alan Singletary inspired our community to collaborate to prevent such tragedies and improve the lives of people with severe mental illness. It is my hope that Senate bill 1194 will be a part of Gene and Alan's legacy, making certain that people with mental illness get treatment before tragedy.

Thank you, Mr. Chairman.

[The prepared statement of Sheriff Eslinger appears as a submission for the record.]

Senator DEWINE. Sheriff, thank you very much.

Senator Campbell.

STATEMENT OF HON. JOHN F. CAMPBELL, MEMBER, VERMONT STATE SENATE, QUECHEE, VERMONT

Mr. CAMPBELL. Thank you, Mr. Chairman. Let's make sure we get this on.

Senator DEWINE. You have to have those really close, is what we have learned here.

Mr. CAMPBELL. My children will like that, also.

Senator LEAHY. What happened, John, is we had too many snippets on the evening news with open mikes, everything from planning golf games to sometimes a little bit stronger. So we are being a little more careful around here.

Mr. CAMPBELL. Well, Don and I were planning our golf game before, but we will hold off until after the hearing.

Good afternoon, Mr. Chairman, Senator Leahy. My name is John Campbell. I am a member of the Vermont State Senate, where I serve as the majority leader, and also serve on the Judiciary and the Appropriations Committee.

First, I would like to thank you for inviting me here today to speak in support of S. 1194, the Mentally Offender Treatment and Crime Reduction Act of 2003. As a former law enforcement officer and attorney for over 20 years and a current State legislator, I believe I have a unique perspective on the issues that we are discussing here today.

During my time as a police officer, I frequently found myself called to scenes involving petty thefts, disturbances, and public intoxication. It was not uncommon to find the suspects of these crimes to be acting paranoid or behaving erratically.

While I was quite able to handle the criminal aspect of the situation, I was not trained to deal with the complex underlying issues of mental illness and substance abuse. Although there were times that it was necessary to arrest and incarcerate certain individuals with mental illnesses in order to protect the public, others who had committed low-level crimes, non-violent, as a result of their mental illness should have been referred to a mental health agency. Unfortunately, such care was rarely available, which left us with no other option other than to transport them to the county jail, not a fine place for someone who is suffering from mental illness.

Police officers today are better trained to recognize and deal with these situations. However, they still find the process of securing di-

agnosis and treatment extremely frustrating. They find that the treatment providers may refuse to accept an individual for several reasons—lack of health care coverage, acuity of the illness, denying responsibility for the treatment of that person's specific diagnosis.

In cases where an individual is eligible for services, the officer may find themselves waiting hours before that person is admitted. In other cases, the person is admitted for treatment, but often discharged shortly thereafter, and sometimes is back on the street before the police officer even makes it back to finish his report.

Requiring police officers to act as quasi-mental health care providers places an unreasonable burden on them, the department, and their communities. The time required to facilitate treatment for individuals keeps the officers from performing their normal patrol functions and forces departments to either hire additional personnel or expose the community to a lack of police coverage. This is especially troublesome in rural communities, such as Vermont, as reduced police presence there sometimes means the difference between having one officer and having none at all.

While the initial responsibility for finding placement for these individuals often falls upon law enforcement, a burden felt by the communities, the ones who really suffer, the ones who truly suffer are those who are afflicted, and also their families. They simply have no place to go.

This disjoined spectrum of responsibility is never more evident than when dealing with co-occurrence disorder. Individuals who suffer from co-occurrence find themselves the proverbial hot potato, tossed among the mental health agencies, substance abuse facilities, and the criminal justice system.

These agencies and organizations have good intentions. All of them seek to break that cycle. However, unless there is a collaborative effort, it is inevitable that the individual will find themselves interacting with the criminal justice system.

The systemic dysfunction is not isolated to any one area. From large urban areas to small communities such as my own in Quechee, Vermont, people are in dire need of integrated services. I often represent families in crisis, and in the majority of these cases you will find an underlying mental health problem.

It is extremely frustrating to search for a solution for these families. Too often, we come up short as a result of fragmented and insufficient resources to deal with the issues. It is devastating to watch families implode over issues that, if treated, could be managed. Mothers and fathers have to stand by as their children self-medicate themselves with alcohol and drugs in order to escape the personal horrors of their mental illness.

Passage of S. 1194 will promote the types of integrated treatment and collaborative efforts between the criminal justice system and the mental health organizations that could spare many of these families those agonies.

As an elected official, I appreciate more than ever the fiscal implications of the existing problem. Having to provide mental health treatment in an incarcerated setting is neither cost-effective nor clinically sound. A community-based approach would provide more complex services at a far greater service to the taxpayers.

Many States have implemented programs for just these reasons. Vermont is one of them. One of our more effective programs is taking place in two of our largest communities, Burlington and Brattleboro. It is called the Co–Occurring Disorders Treatment Project, which promotes public safety and health by offering comprehensive, integrated mental health and substance abuse services to those individuals with both psychiatric and substance abuse disorders and who have ongoing involvement in the criminal justice system.

Quite simply, as everyone has said so far, we can't do this without you. There is no way that we are going to bring collaborative services to our communities without your help, and therefore I would ask that anything we can do to help you support and pass S. 1194.

If there are any questions, I would be more than happy to answer them later.

[The prepared statement of Mr. Campbell appears as a submission for the record.]

Senator DEWINE. Senator, thank you very much.

Director Wilkinson.

STATEMENT OF REGINALD A. WILKINSON, DIRECTOR, OHIO DEPARTMENT OF REHABILITATION AND CORRECTION, COLUMBUS, OHIO, ON BEHALF OF THE ASSOCIATION OF STATE CORRECTIONAL ADMINISTRATORS

Mr. WILKINSON. Good afternoon. Thank you, Senator DeWine, Chairman Hatch, and Ranking Member Leahy, for inviting me to testify regarding Senate bill 1194. My name is Reggie Wilkinson and I am the Director of the Ohio Department of Rehabilitation and Correction. ODRC comprises more than 30 prisons and on any given day our agency supervises 45,000 prisoners housed in our correctional institutions. Moreover, we supervise another 30,000 persons on parole and probation.

Today, I not only represent the great State of Ohio that is so ably represented by Senator DeWine, but also the Association of State Correctional Administrators. ASCA is the national organization that represents persons who serve in my position in each of the 50 States and several other jurisdictions in this country. I am the current president of ASCA.

I would also like to provide testimony on behalf of the Council of State Governments. They recently undertook a major initiative dealing with the mentally ill offender. Their work culminated in the publishing of a landmark report entitled "Criminal Justice/Mental Health Consensus Project." This bipartisan initiative brought together 100 leading law enforcement and mental health officials in the United States.

A brief history. In 1993, following a prison riot at the Southern Ohio Correctional Facility where one correctional officer and nine inmates were killed, a Federal lawsuit was filed in Ohio entitled *Dunn* v. *Voinovich*, challenging the constitutionality of Ohio's mental health delivery system in our prisons.

We agreed, however, to a five-year consent decree in 1995 and decided to concentrate on, with the oversight of the Federal court, improving our mental health services for the mentally ill prisoner.

Throughout the life of this lawsuit—the case was terminated per the settlement in the year 2000—all parties, including the plaintiff's counsel, the court monitor, State's attorneys, correctional administrators, and health care administrators, agreed to manage points of contention privately.

Consequently, I am extremely proud of the mental health delivery system that currently exists in the State of Ohio. I consider the current system to be a national benchmark as it relates to prison mental health care. However, I know that it is very difficult, with the budget constraints, that we continue along the current path that I am so proud of today.

I think this legislation, Senate bill 1194, can be the single most important positive legislative development for correction and mental health workers to occur in Congress in recent memory. It is gratifying to see a group of leaders in the Senate rally as they have under Senator DeWine's and others' leadership around a bill that practitioners and policymakers alike will agree can save lives, increase public safety, and reduce State and local government spending.

First, save lives. Our Nation's prisons, where more than 1.3 million persons are incarcerated on any given day, and our jails, which book about 10 million people annually, house more people with mental illness than do our country's mental health institutions. In fact, I often claim that correctional administrators are de facto mental health directors. That is enormously frustrating for us in the corrections community. Our principal job is to incapacitate and rehabilitate persons who are dangerous to the community, not to hospitalize sick people.

Although we believe criminals with a mental illness should be punished, we also know that a correctional environment is hardly conducive to recovery for a person with mental health problems, especially a seriously mentally ill person or a person with an Axis 1 diagnosis. Not surprisingly, inmates with untreated mental illness are at a high risk of committing suicide or being victimized by predatory inmates.

Public safety. The growing involvement of persons with mental illness in the criminal justice system has enormous public safety implications. Many offenders with mental illness have committed a crime that makes their incarceration necessary and appropriate. Still, nearly all inmates with a mental illness will be released from prison at some point.

Unless we provide these offenders with the services and treatment they need while they are incarcerated, we are virtually guaranteeing that they will commit new crimes when they return to the community. Nevertheless, few corrections systems are able to prepare inmates for adequate release following their incarceration. Not surprisingly, studies have shown that rates of recidivism for persons with a mental illness should concern all elected officials.

Senate bill 1194 can promote effective reentry planning for persons with a mental illness through efforts such as encouraging mental health providers to come into correctional facilities and connect with the offender prior to release and ensuring inmates have an adequate supply of medication upon their release. Typically, two

weeks of psychotropic medication is provided to offenders once they are released from our custody.

Reduced spending. Nearly every State in the Nation now knows that it is extremely expensive to manage persons with a mental illness. We have found out in the corrections business that we are no longer recession-proof, that we have enormous responsibilities and great fiscal burdens. Speaking on behalf of persons in my capacity, we are hoping that Senate bill 1194 will continue with its current path in due speed.

[The prepared statement of Mr. Wilkinson appears as a submission for the record.]

Senator DEWINE. Thank you very much.

Ms. Atkins.

STATEMENT OF RHONDA ATKINS, SARASOTA, FLORIDA

Ms. ATKINS. Chairman DeWine, I am very grateful to be here today in support of Senate bill 1194, the Mentally Ill Offender Treatment and Crime Reduction Act of 2003.

My name is Rhonda Atkins. I am the mother of a 25-year-old mentally ill daughter from Sarasota, Florida. My daughter would have been spared a great deal of torment, as well as our entire family, had these things been in place ten years ago.

My daughter suffers from a severe mental illness, bipolar disorder, and for much of these last ten years she has cycled in and out of psychiatric hospitals—rather, ping-ponged from psychiatric hospitals to substance abuse treatment centers—inconsistent treatment, and her condition has steadily grown worse over the years. She is presently in treatment, after struggling for literally most of these last ten years to have her in long-term treatment.

I will never forget what it is like when she is not in treatment. When she is not on her proper medication, she becomes very symptomatic, with mania. Some of the symptoms of that would be extreme irrationality, hyper speech to the point where she can hardly be understood. She doesn't think the way that you or I do when she is suffering from one of these episodes.

She can become paranoid, thinking that those of us who are trying to help her, who love her, who want to get assistance for her, are trying to make her think that she is crazy, that it is we who have the problem and she is fine. She becomes delusional, very poor judgment, very dangerous to herself.

There have been many, many nights, countless nights when I have not known where my beautiful daughter was, sometimes for a night, sometimes for a week, up to three months at one time. Like many people with mental illness, she sometimes doesn't think that she is ill and doesn't want to take her medication. She had not been consistently in treatment long enough to really gain the insight to understand that she indeed is ill and it would behoove her to stay in treatment or stay on medication.

Like so many other people with mental illness, she has tried to calm the chatter in her own mind with substance-abusing, which only makes her symptoms worse and the situation worse. She has often been uncontrollable and we have many times been afraid of what she would do to herself. She has indeed tried to harm herself

on numerous occasions by wrist-cutting, overdosing, and things like that.

When someone gets that sick and when the mental health system doesn't respond, usually the first line of recourse is the police. There have been numerous times when we have had to have police officers come to our home. Some have been educated enough to know how to deescalate a situation.

There were others. I will never forget the one who very roughly handled her and said that if you were my daughter, I would knock you across the room. As you can imagine, that can throw fire upon a very tense situation already and cause problems that would not have been necessary, They might have deescalated a situation and gotten her into a safe situation had they been better trained to deal with a mentally ill person.

The first time my daughter was arrested was for a trespassing charge. Each time she brushed with the law, we would hope that then would be the moment that we would get some assistance that we needed to get her into treatment that we knew she needed.

Sometimes, when we would get into a situation, there were no services for her to be diverted to, or if there were services, there were waiting lists for those services. Waiting lists are just—when you need the treatment, you need it now. Six months from now doesn't serve someone who desperately needs to be in safe care in the moment.

She has been arrested on a drug charge, which isn't surprising because when she is self-medicating, it will just often lead to that. There was one occasion when she was arrested on a drug charge and actually went through a drug court, but even then there was no real understanding or integration of services for substance abuse and mentally ill offenders.

So rather than having an integrated approach to working with my daughter, she was just in the drug treatment program. Actually, a social worker in the program had discouraged her from taking her medication, which was lithium, which resulted in her deescalating, becoming manic again, and an a series of hospitalizations occurred after that.

I believe in a 3-year period, there were, I think, 20, 21 hospitalizations, which is very costly to the State. My statements to those in charge were it would be so much less expensive if you treated this on the front end rather than the repeated hospitalizations, the jail, all of those occurrences.

The very tragic thing about so much of this is that my daughter is intelligent. She is a beautiful young woman, and while many of her friends were starting careers, getting married, having babies, my daughter spent years drifting through the streets, in and out of the jail system and emergency rooms, living among drug dealers.

Within the last three years, she was sleeping in cat feces. She weighed 81 pounds at one point. Her body was covered with sores, and still we couldn't get her in long-term care. This bill could have saved years of my daughter's life. It could have saved us a great deal of heartache and grief early on, because this is an illness that doesn't affect just the person who has the illness, but it affects the entire family.

The reality under current law is that law enforcement officers often are the ones who are the first line of response for people with mental illness. I am deeply in support of this bill to encourage what is needed on every level of working with those with mental illness in all levels of the system. Nothing can be gained by putting a person on a waiting list.

My daughter has a brain disease, and these people need help; they simply need help. I felt personally compelled to come here today to plead with you to pass this bill. There are many people suffering who will continue to suffer without its passage. I am here to speak on behalf of all of us, all the families across the State of Florida, where I am from, and across the Nation who suffer from this illness. Please pass this bill so that another mother won't have to watch her daughter or her child deteriorate the way that my daughter has. Thank you.

[The prepared statement of Ms. Atkins appears as a submission for the record.]

Senator DEWINE. Thank you very much.

Justice STRATTON.

STATEMENT OF HON. EVELYN LUNDBERG STRATTON, JUSTICE, SUPREME COURT OF OHIO, COLUMBUS, OHIO

Justice STRATTON. Thank you very much, Senator Leahy and Senator DeWine, for allowing me the privilege of coming and sharing with you.

You have heard much today about the problems that have brought us to this bill. I hope to share with you a little different focus on why this bill can be successful and why this bill can make a difference.

My own story that brought me here is that about eight years ago I received a call from the governor's office appointing me to the Ohio Supreme Court. As you can imagine, it was one of the most exciting moments of my life. That same week, my 12-year-old son ended up in a mental hospital seriously depressed and suicidal, and I went from the biggest highs during the day to the biggest lows at night, holding his hand, wondering if he was going to live.

Then I went to court and sat on the bench and looked at the defendants in front of me who had absolutely no mental health care. If they were alcoholic and drug-addicted but had a mental health problem, Drug and Alcohol wouldn't take them. If they were mentally ill but had a felony, the mental health system wouldn't take them. So I put them in jail, often more for their protection than anything else.

I felt a compelling need to do something. So two years ago I went to the chief and asked if I could establish a task force. He said we have no money. I said I will do it on my own. I called together some experts in the field and said I don't know anything about this, but I want to make a difference, help me.

We got people from Mental Health, from Drug and Alcohol, from Sheriff's, from Probation, from NAMI, from the Ohio Advocates for the Mentally Ill. We put together a statewide task force and we started to try to find solutions. We have met every month for two years now, and every meeting our goal is to come forward with

something positive, not a white paper, not a study, but something to move forward to make a difference in this State.

We have now over 20 counties that have either a mental health court or some program specifically aimed at the mentally ill in the jails. Every major city in Ohio now has a CIT program. We have over 150 law enforcement officers that came to the last NAMI convention, something totally unprecedented. We are even now going to the campus police and offering training for campus police.

Our goal is to get every single county to put together a collaborative task force. I have a waiting list a mile long of counties that want me to come, but I still have no staff, no resources. I make all my site visits myself. My law clerks type all my letters. We are doing it on our own, but we are still making a difference because collaboration is what works.

I wish to give you an example of one county where it worked. Some people came to me from Franklin County and said, we have a serious problem. We have all these mentally ill. We know you are doing something. Can you come and help us?

One of the advantages of my job is judges tend to return my phone calls. So I called some judges, I called some local people. We had ten people that met over a year-and-a-half ago, tried to put a little group together, and discovered the Department of Mental Health had funded a grant program for Franklin County, for the jails. The judges had never heard of it. We had 500 beds funded by the Community Shelter Board for the Mentally Ill and Homeless. The judges had never heard of it. We had a program that trained the mentally ill to work. The judges had never heard of it.

That committee now has 55 people on it. It has started a mental health program in the Franklin County muni court and a drug court in the common pleas court. It has received two grants. One is from your mental health bill that you passed before. They are starting two CIT programs in the city of Columbus, and that program not only deals with the mentally ill in the jails, but they have started to find so many other ways to collaborate and work together outside of the jail system and not duplicate and waste resources. So it has been a tremendous success just in one county alone.

A judge from Seneca County started this with the Juvenile Court, trying to deal with the juveniles in his court. He got together the schools, mental health, and drug and alcohol folks, and got them to work on the problem in their county. When he first met with them, they sat on opposite sides of the room, wouldn't even talk to each other, Drug and Alcohol one side, Mental Health on the other. By the fourth meeting, they were intermingling.

They are currently now having an intervention program that tries to identify kids before they even are declared a criminal defendant, before they are even arrested, to intervene and work with them. This program can further that type of collaboration. It can provide that key seed money.

I have a staff attorney and she has a sister named Sheree. Sheree had a drug and alcohol problem, a mental health problem, and had been arrested several times. Last week, Sheree died of a drug overdose. To others, she was a statistic; she was a mentally ill, drug-addicted criminal defendant. But to us, she was a sister,

a mother, a daughter, a wife. She left four children. She was 46. There was no mental health program in her community.

We were too late to help Sheree and we may be too late to help others, but we can really make a difference with this bill, with the catalyst this funding can provide, to get that collaboration going that can make such a difference.

Thank you.

[The prepared statement of Justice Stratton appears as a submission for the record.]

Senator DEWINE. Well, I want to thank all of our witnesses for some very compelling testimony.

Let me turn now to Senator Leahy.

Senator LEAHY. Thank you, Mr. Chairman. I think this has been a very good hearing. You know, there are a million things going on right now on the Hill. The Senate is in session and we are having votes and doing other things. That is why there are so few here. There are, however, a number of staff members of various Senators, key Senators on this on both sides of the aisle, and I have a feeling that a synopsis of all your testimony, the six of you, is going to be in the must-reading book for a lot of Senators tonight.

Let me ask Senator Campbell this question, and I ask this not to be parochial, but I think probably the same question can be asked in any small State or any basically rural areas.

Can you give me examples of what Federal funding provided under the Mentally Ill Offenders Treatment and Crime Reduction Act that we are talking about—what funding under that would allow a small State like Vermont to do that it wouldn't otherwise be able to do?

Mr. CAMPBELL. Senator, I think especially small States, but even some of the ones that maybe are not as far advanced in their State programs regarding mental illness—we are trying to start with the mental health court. We now have a pilot program for drug courts, and in coming up with the ideas for these programs we are following the lead of a lot of other States.

It is wonderful to start the programs, but unless we have the resources to actually treat the folks that are coming through the programs, we are not going to be successful here. Then we are just going to be again back here in a few years talking about other programs and trying to get other grants.

I believe that with the Federal funds that this bill would suggest, we would be able to make sure that the drug courts and the mental health courts not only are implemented, but they are sustained. That is really the key here, is the sustainability of the programs. In addition to that, we need to make sure that we have the resources available to have the collaborative effect that you are seeking under this bill.

So with that, with the funds that are provided here, I think we will be able to make a difference. Without them, I don't see us fiscally being able to handle it in the State budgets.

Senator LEAHY. Are there other things we see in a rural area? We have very small police departments. I suspect rural Ohio and rural Illinois, or any other State represented here also have very small police departments. Are these among the biggest problems?

We have heard Ms. Atkins talk about a police officer reacting to her daughter. We have heard the sheriff speak and others speak about how you react when you go there. Is this an insurmountable problem?

Mr. CAMPBELL. I don't think it is, but I tell you the training of police officers is so important. I can understand Ms. Atkins's dismay over something like that, and as a former law enforcement officer, I cringed when I heard that story.

Especially in rural areas like we have, as you know, the State police do a wonderful job in Vermont. However, they are spread very thin. We are right now down 40 to 45 officers. Sometimes, in the rural areas, the only people we have actually patrolling are the sheriff's department, which only has about two or three people, and most of those are part-time folks, or constables. The sheriff's department in Vermont—a lot of the sheriffs, and also the constables, are not trained in these areas specifically. So we have that problem to deal with.

In addition to that, we have an issue that when you are in such a rural area, everything is so spread out that it is very difficult to get the services and use the urban models that seem to be effective here in those rural areas because of the fact that there is not enough training.

So this bill, I believe, would effectively enable the mental health communities, the corrections and the substance abuse communities, to train the folks within these smaller communities, train the police officers, and train the constables to make sure that they are available to help in crisis situations and to continue with the wraparound services, and also to make sure that it is not just a one-time shot, that they follow them all the way through until there is some type of recovery.

Senator LEAHY. You have the obvious problem we have with juveniles; they get out and nobody does follow-up. I know it is one of the things that both Senator DeWine and I have talked about, and I would hope that this would allow us to do something in that kind of a follow-up.

Mr. CAMPBELL. If I may read, this is from the Juvenile Justice Commission report of February 2003. I couldn't sum it up better, but this kind of lets us know about how our juvenile justice is in Vermont.

"Vermont's juvenile and youth justice response represents a fragmented array of programs and interventions. There is no clearly defined, consistent, or coordinated statewide response for juveniles and young offenders, nor are efforts woven into a large continuum of care for children and families. The State Agency of Health Services, working in partnership with the judiciary, communities, and families, need to bring these efforts together and create an integrated and coordinated system of care."

That sums it up right there, and we can have wonderful programs, but unless it is a collaborative and integrated affair, then we are not going to be successful.

Senator LEAHY. Well, you know, I couldn't agree with you more from my own experience, and certainly from the things that you have done and others have done in Vermont on this, but also from some of the other testimony Senator DeWine and I have heard.

I would like to ask Dr. Wilkinson, what about law enforcement and corrections officers and mental health problems? I mean, you come from a much larger State than Senator Campbell and I do. Are they willing to work together? I am talking about law enforcement and corrections and mental health. Are there obstacles to coordinating? Are there things that could be done better? What is your general take on that?

Mr. WILKINSON. I think the obstacle that exists more so than anything else has been the fact that people have not brought folks together that need to be in the same room, like Justice Stratton is currently doing. I think that is the first thing, and a lot of the problems that we can solve can be solved without a whole lot of money, which brings us to the second problem.

Sometimes, money can't be avoided when we are talking about the need to get persons who appear to be acting out, and sometimes that behavior is criminal and sometimes it is deviant behavior as a result of a psychosis, for example. If there are not crisis centers for police to refer persons to, if there is no crisis intervention training and first responders can't adequately identify unusual behavior that might be a mental illness, then those persons are going to travel through the criminal justice system and cause taxpayers of all of our jurisdictions to spend multi-million dollars on something that could have been avoided at the very beginning of this process.

Senator LEAHY. To say nothing about the risk to others, themselves, and everybody within the system.

Mr. WILKINSON. That is exactly right, and it is very expensive once they are in the system. The cost of housing a person who is mentally ill is extremely more costly than it is to house a person without a mental illness. You take the statistic that Senator DeWine mentioned. About 16 percent of all the persons in prison have a mental illness, and half of them have an Axis 1 serious mental illness. We are talking about an awful lot of money.

But on your original question of do we work together, the answer is unequivocally, absolutely yes, and it is happening. But part of the problem that relates to that is that we don't tell those stories well enough. So I think part of the bill addresses that we not only need to give grant money to jurisdictions who apply for it; we need to dissect what is going on and share that with other jurisdictions across this country.

Senator LEAHY. Thank you. Well, I think what Judge Stratton has said, as you have mentioned, is important there.

Mr. Chairman, I will put my other questions in the record.

I just might say, Ms. Atkins, obviously all of us who are parents up here feel for what you are going through and hope that someday the best solution will come of that.

Sheriff, there is no way to bring back Deputy Gregory, but all of us, again, on this Committee share your sadness at his death.

Thank you all for taking the time. It is not easy to work out time for people to come to testify and I appreciate it.

Ms. Atkins, do you want to say something?

Ms. ATKINS. I just wanted to say that it is wonderful to be at a table in a group with a cooperative spirit of everyone working together, because as my daughter shuffled through the system it has

been so fragmented and to have everyone working together is just what I have prayed for for ten years.

Senator LEAHY. Thank you.

Senator DEWINE. Ms. Atkins, we just appreciate your testimony very much and the fact that you would come and share your story with us. I take it that your daughter is doing better today?

Ms. ATKINS. She is doing better today. She was in residential treatment for a year and she is in a therapeutic community presently, still in treatment, but a step down from where she has been. And I can honestly tell you that a year-and-a-half ago, no one thought she would be alive today. Because she has been in treatment, we have hope that she is going to continue with her recovery. She is doing better presently than she has in the last ten years.

Senator DEWINE. Good. Well, we wish her well and we wish you well.

Ms. ATKINS. Thank you.

Senator DEWINE. Sheriff, you gave in your written testimony some very alarming statistics and pointed out something, I think, that we should know and maybe we don't think enough about, and that is how very dangerous it is for the police officer and how dangerous it is for the defendant, the criminal, when that criminal has a mental problem.

You pointed out how many people just in the last month have been killed when that person had a mental problem. I mean, the sheriff or the deputy or the police officer goes in and tries to make an arrest. If that person whom he is arresting has a mental problem, that is a high-risk proposition for both of them.

I guess it just points out maybe the need for this bill, but also points out the need for training. Ms. Atkins gave some testimony that would indicate sometimes maybe we don't have enough training for those officers. I got a letter after I introduced this bill, a copy of a letter that was sent to some of my colleagues from another State from, again, a mother who had some similar experiences that Ms. Atkins had relating about her child, her experiences with officers.

I think we are doing a better job today than we were probably when I was a county prosecutor 30 years ago. But how well are we doing? How often do we have these crisis intervention teams? How many jurisdictions have crisis intervention teams? Could you just kind of reflect on that for us?

Sheriff ESLINGER. I do believe that law enforcement administrators throughout this country recognize that the mental health issue is not just a humanitarian issue or a public health issue, but it is also a public safety issue as well. I believe that a lot of agencies—and NAMI can back us—have moved to CIT and much more can be done in the area of training.

But what the bill also does, Mr. Chairman, is to provide earlier intervention. Law enforcement is called upon only during a crisis situation and we need to shift the focus of that intervention back to the mental health professionals.

In the State of Florida, law enforcement conducts 34 percent more Baker Acts, which is our involuntary examination, than DUI arrests. We average over 115 a day of Florida's Baker Act law.

That is more than aggravated assault, that is more than burglary arrests that we make, and we need to shift the burden back.

In fact, in half the counties in the State of Florida, nearly half of the counties, no mental health professional is involved in administering the Baker Act; it is law enforcement. What your bill will do is not only develop that collaboration, but it will also shift focus back to the mental health professional and provide greater assistance in community-based treatment.

Senator DURBIN. But it is a safety issue, and it is a safety issue for the officer, it is a safety issue for the person they are going to arrest, and maybe a safety issue for innocent bystanders as well.

Sheriff ESLINGER. As I mentioned earlier, Mr. Chairman, those who suffer from mental illness are four times more likely to be involved in a fatal police shooting.

Senator DEWINE. A staggering statistic.

I am going to have to move on. Let me ask Mr. Honberg and anybody else who wants to comment on what our experience has been with the mental health courts. They are of fairly recent origin. They are certainly of recent origin on the Federal level, but before our bill was enacted there were some mental health courts at the State level that had already been started. Ours didn't start it. We were trying to add to that and put kind of the Federal seal of approval on them, and we were glad to be able to do that.

What has been the experience at the local level?

Mr. HONBERG. Well, you know, they are a relatively new phenomenon.

Senator DEWINE. Yes, they are. That is why I asked.

Mr. HONBERG. Yes, despite the fact that there are over 70, so they have certainly devolved like wildfire around the country. So, you know, in terms of formal data, it is just starting to come out.

I think based on what we have heard today, first of all, the first point I would make is that it is pretty obvious that any mechanism that can link people with needed treatment and with treatment for co-occurring, for not only their mental illness but substance abuse, is good.

I would say that the early data that I have seen, at least, in places like Broward County is very favorable. For example, the court has been successful in linking people with treatment. The court has been successful in preventing recidivism. Very few people who have been under the jurisdiction of the court have re-offended.

Another intangible that is difficult to measure is sort of the experience of the individuals who have come through the court, by and large people who have reported that the experiences have been very positive. They have not been coercive. They have felt that the judge and the court were very supportive.

One other point I would make is that the judges—I have met a number of judges and the judges, as is true for Justice Stratton, have come real advocates and sort of use their bench as a bully pulpit to advocate for services that don't exist.

Again, using Broward County as an example, where there is just a lack of community mental health services, lack of housing, the judge has been able to go before the legislature and actually lobby and get resources for housing and for treatment for mental illness and substance abuse.

So, again, I would make the point that it is not the only approach, that there are a number of different approaches that need to be tried, and it is up to each community to decide to work best. Mental health courts certainly seem to me to be a very positive development and a very positive experience for those who have been through them.

Senator DEWINE. Justice Stratton?

Justice STRATTON. There are, in fact, not very many statistics because they are all relatively new, but the oldest one in Ohio is the Akron court, Judge Stormer. She had a drug court, started the mental health docket within her drug court, devoted two full days to just people who were mentally ill and also had a co-occurring disorder, helped put together the task force that started the CIT program. And not just because of the court, but because of the CIT diverting to the facility the community agreed on, her docket has dropped in half. She only has one day a week now for the people who are mentally ill.

The anecdotal stories of the physical changes in appearance, people who started getting jobs who haven't worked for years, people going back to college—the stories these judges tell of the difference in the lives of people from the first day they appeared to when they graduated from the program are just heart-warming.

Senator DEWINE. The main emphasis, frankly, of this bill is the collaborative effort, and what we require is law enforcement has to be a part of it and the mental health community has to be a part of it.

I am going to quote something that Justice Stratton wrote in her prepared testimony. She says, "Taxpayer dollars are paying for police officers to repeatedly arrest, transport, and process mentally ill defendants, as well as for jail costs associated with treatment, crisis intervention, salaries of judges, and, of course, staff prosecutors and defense attorneys and many more hidden costs. The question becomes would we rather spend these dollars to keep mentally ill citizens homeless, revolving in and out of our criminal justice system, or would we rather spend these dollars to help them become stable, productive citizens?"

I guess the question then is, you know, why aren't we doing this more? Senator Leahy asked Director Wilkinson that, and I would ask maybe some of the rest of you the question. Why haven't we in the past been doing more of these collaborative efforts and what is it that has stopped us from doing that? Is it money? Is it culture, a culture that means that law enforcement doesn't talk to treatment, treatment doesn't talk to substance abuse people? We have all kind of seen that over the years. I think we are doing better, but what is it?

Mr. WILKINSON. My first take is the squeaky wheel gets the grease. We have not squeaked loud enough, like law enforcement and like some other venues have. We are here squeaking today, Senator, that there are other ways that we can skin the public safety cat, that we can divert funds to. But we can't forget about the public safety notion that we are currently doing. It has to be a gradual process.

But probably more so than anything else, it is going to take leadership for people to have a bigger vision about tackling the mental

health problem, the co-occurring disorder problem, the problem for people who have retardation. It is going to take people who can tie all of that together and see a bigger picture of answers rather than what we have seen before. Otherwise, it is going to be business as usual.

Mr. CAMPBELL. Senator, if I could add, in fact, I was quite shocked. When I learned first about the co-occurrence about three years ago when I had a constituent that was going through this with her daughter, similar very much to Ms. Atkins, I was shocked. I couldn't believe that they weren't dealing with both issues at once. Everyone was trying to point the finger at someone else.

It was like turf wars almost and people were concerned about who was going to get what funding, and if we don't justify our position and our use here, then we are not going to get the funds. I find that to be abhorrent and I am glad that we are finally discussing it, and your bill here is going to force the States to make sure that they do work in a collaborative fashion.

Senator DEWINE. Justice Stratton?

Justice STRATTON. I think it has been a culture issue more than anything. I have found that groups just never talk to each other, like the experience I had with Franklin County. The trial courts are very isolated from the mental health community. Drug and Alcohol is very fixed with their funding.

When I brought them to the table and said let's talk together and they started talking, barriers came down and people found ways to work together. I have had almost no resistance to people working together. The Department of Corrections sits on our board, Probation sits on our board, and Mental Health. All these people started talking. That is what it makes a difference.

Senator DEWINE. Everybody is well-intended, everybody wants to do the right thing. It is just that when you get up in the morning, that is not what you do. I mean, you just don't work with the other group. You just go about and do your own business. I mean, we have all been in courthouses. We know how things work. You know, the mental health folks are over here and substance abuse is over here, and we are doing our thing—as a prosecutor, we did our thing in criminal justice and we just didn't necessarily work together.

Justice STRATTON. But where your bill can really make a difference is that sometimes funding is a galvanizing force; it is a catalyst. When communities say, okay, there is some funding available, but we have got to put a task force together and we have got to communicate and we have got to collaborate before we can get the funding, it is the catalyst that can get that to happen. So in that sense, it can really be important.

Senator DEWINE. That is the idea.

Senator Durbin.

STATEMENT OF HON. RICHARD J. DURBIN, A U.S. SENATOR FROM THE STATE OF ILLINOIS

Senator DURBIN. Thank you, Mr. Chairman. Thank you for this hearing and this important legislation. I would be honored if you would add me as a cosponsor of this bill.

Senator DEWINE. We appreciate that. Thank you very much.

Senator DURBIN. Let me also thank the panel for your contributions. Though I wasn't here for your actual testimony, I have reviewed your statements and I appreciate what you have added to this record.

I also would like to note for the record that our former colleague, Paul Simon, now at Southern Illinois University in Carbondale, last year held a meeting with former Surgeon General David Satcher on this issue and wrote us all a letter. Obviously, if you didn't get the letter, you were inspired by your own means, but I am glad to be able to tell Paul that—

Senator DEWINE. Paul has been a real leader in this area. Paul really gets it, gets the whole problem.

Senator DURBIN. If it is permitted, I would like to add to the record the findings of his conference last year, which is relevant.

Senator DEWINE. It will be made a part of the record.

Senator DURBIN. I would like to ask a few questions based on some of his findings which I think might be interesting if this panel could address.

Senator Simon as a result of this asked, or at least requested that all those incarcerated be screened for mental illness, developmental disabilities, and learning disabilities as part of the initial processing as they enter the correctional system.

Is that done now or is that something that may or may not emerge during the entire criminal process and may, in fact, emerge later in some instances where it finally is realized that we are dealing with a situation with mental illness?

Justice STRATTON. It is something that is not done. I don't know about the prison system, but at the local jail system it is frequently not done and it is part of why we have very poor statistics. One of the things we urge in our collaboration effort is an intake process that even asks some basic questions about what mental health illnesses or treatment they have had to even help us identify it.

That is one of the things we hope to have funding for. That is one of the things that does require funding, is somebody who can be trained, ask the questions, and deal with the intake process, because we just don't even have any statistics because there is very little done. That is one of the things we are trying to put into the whole collaborative process.

I know that the Department of Correction has done some things on that and I would like Reggie to speak to that.

Senator DURBIN. Before Dr. Wilkinson or others respond, I am tempted to divert my questioning into another line as to how a person can go through a criminal trial, when one of us learned in law school that one of the first questions you asked is whether they had the criminal intent or whether they were capable of forming that criminal intent. If that person is, in fact, seriously mentally ill and it is not even discovered at the point when they are incarcerated, it appears to me that the important question was not asked at an earlier stage that might have related to the guilt of the defendant.

Justice STRATTON. I can explain how that works.

Senator DURBIN. Maybe that is for another hearing. I don't know.

Justice STRATTON. I can explain briefly how that works. At the felony level, most of the time you do catch them when they are screened. It is at the municipal level where they don't. If you have

a defendant and you know he has a mental problem, you can plead him out and get him three days and he is out of jail. Do you do that or do you let him go into the process, 30, 60, 90 days before he even gets a hearing and a psychiatric evaluation, sits in jail now 30, 60, 90 days?

A lot of the criminal defense attorneys that I talked to said I think it is my duty to get him out of jail as quickly as possible. The problem is it doesn't get at the underlying illness. So they often ignore the mental health problem, or they may be acting competent at that exact moment, but may not have been when they were arrested.

There are a lot of factors, but the basic thing is a lot of them consider it better to move them through the system quickly than get them caught up in the mental health process.

Senator DURBIN. Dr. Wilkinson?

Mr. WILKINSON. Senator, there is an awful lot of mental health assessment taking place. We think we do it well. However, that varies across the country in both prisons and jails regarding how well it is done. It is not cheap to do initial assessments of thousands of people who come in and out of your correctional facilities on an annual basis.

So we in some cases depend an awful lot on the sentencing courts to give us that information in pre-sentence investigation reports so that we don't have to go back and do our own investigations regarding the pasts of these persons who are coming. Benchmark programs can help resolve that in a significant way.

The other thing that we don't do well, including in our system, is detecting those persons who either have a mental illness and deteriorate while they are in prison or the people who develop a mental illness while they are incarcerated.

Senator DURBIN. So let me take it to the next step. Let's now talk about the population that has now been discovered to be suffering from some form of mental illness and they are incarcerated, and that, I think, has been suggested 16 percent serious mental illness. At least that is our benchmark figure for this discussion.

What percentage of those receive medication and treatment during incarceration? Does anyone know?

Mr. WILKINSON. Senator, of the 16 percent, we guesstimate about half of those have a serious mental illness, which means that they require a lot more supervision, they require medication, they require in some cases hospitalization. Hospitalization is sometimes short. What we do is have intermediary housing areas where we can take the persons who have a very visible mental illness.

A lot of people in our correctional institutions with a mental illness, you don't know it if they are on their medication because they can behave normally with medication. But at least half of that 16 percent is on some sort of psychopharmacology.

Mr. HONBERG. Senator, if I just could quickly add, I know that in Ohio, in particular, Reggie Wilkinson has done some marvelous things in creating programs. But I have tell you, around the country, the way that people with mental illnesses who are incarcerated in jails and prisons are treated is frequently deplorable.

I mean, people may have access to medication if they are overtly psychotic, at least for as long as they are psychotic. But I have seen

it many times. People with mental illnesses tend to get sent to the worst units in the prison. There is excessive use of solitary confinement, there is excessive use of seclusion and restraints. It is a nightmare and it is oftentimes in circumstances that are only going to make the symptoms worse.

That is why it is so important to have legislation like this and to have a movement like this that is designed to get at least low-level offenders out of these facilities and into community treatment.

Senator DURBIN. I want to get to two more questions and I don't know how much time I have remaining.

Senator DEWINE. You have plenty of time.

Senator DURBIN. Thank you.

In the situation where you have someone who is mentally ill and incarcerated and has been diagnosed and is now being treated, who pays for the treatment?

Mr. WILKINSON. The taxpayers of that State, sir.

Senator DURBIN. Is the Federal Government involved at all?

Mr. WILKINSON. No.

Senator DURBIN. No Medicaid, no Medicare?

Mr. WILKINSON. No. In fact, the law excludes persons who are in detention from receiving any Medicaid funds whatsoever.

Senator DURBIN. Justice Stratton?

Justice STRATTON. One of the problems we are struggling with in Ohio is if you are in jail, just even jail for a shorter-term sentence, after 30 days your Medicaid is cut off. That means now they have to go get a psychiatrist to do a new evaluation to give medications which may be different than what they are used to.

If they get out of jail in 60 days, they may not even get the new medication by the time their other 30 days are up. The door is open, they walk out. Now, they have to re-apply for Medicaid. It may be months before they get it. They decompensate and they are back in prison before they ever get back on Medicaid. So it is a re-entry problem that we are really having a struggle with as well.

Senator DURBIN. You have taken me, Justice, to the point I wanted to get to, and this goes back to Senator Simon's conference which he held. He recommended something which I hope Senator DeWine will consider as part of his legislation. He believes that there is a missing link in the current system which you have just noted—access to medication after mentally ill offenders are released.

I would like to ask anyone on the panel to discuss the merits of providing Medicaid presumptive eligibility for mentally ill offenders upon release from incarceration. Under presumptive eligibility, mental health and health care providers would be able to grant mentally ill offenders immediate short-term Medicaid eligibility while a formal determination is being made. This presumptive eligibility would be intended to provide immediate access to mental health and health care services such as psychotherapy, medication, and rehab.

I think you have just identified the problem. You have someone who, after a long period of time, is finally receiving some medication. Now, they are released, and that should be good news, but it may be the worst news because, being released, they are released

without medication or help. Then they have to, if they can ever figure the process out, get into it, make application, and hope that they receive their medication in time before they do something that is harmful to themselves or others.

Justice STRATTON. One of the things we are working on through both the reentry court and through my committee is trying to set up a process that hooks up a defendant before his sentence ends with the Medicaid process, get the applications in, and get the approval before he steps out the door because most of them—you know, they may be given a two-week supply and they are out the door.

They don't even know how to get to a Medicaid office. They don't even know what a Medicaid office is, as you said, to even go through the process. So there is a huge link in there that is fixable. It is very fixable. It is a matter of finding the process to make it work and starting it before they walk out that door.

I am delighted to hear you say that because my committee has been struggling with this issue and I am so excited to hear some focus on it because it is a huge problem we have all across the country.

Senator DURBIN. I want to give my friend, Senator Simon, credit for it.

I hope we can consider adding this as part of our conversation on this.

If I could ask one last question, and that is it appears to me—I spoke to our Illinois Director of Corrections a couple of years ago about what he was challenged with and he was telling me about the over-crowding situation and the complexity of the inmates, the challenges that they brought, and so forth and so on, and he talked about this issue of mental illness and what to do with it. It struck me that our profile of the qualifications of a corrections officer doesn't reflect the reality of what the Department of Corrections faced today.

When we talk about mental illness in the corrections system, for those who can address it, are there people who are being trained and recruited to deal with this new phenomenon so they can recognize the potential mental illness with an early screening or a developing situation and protect those inmates who may be potential suicide victims or victims themselves within the institution? Are we developing that expertise at a time when many States are saying we are out of money, we can barely house the people that are being sent to us, let alone provide any kind of special services?

Dr. Wilkinson?

Mr. WILKINSON. Senator, it is a great question. The issue relates to basic training for corrections officers. If the corrections system does not do training for first-line personnel such as a corrections officer and others regarding how to detect unusual behaviors—we are not wanting them to be clinicians. We just want them to be able to detect behavior that is unusual so that they can refer that to the proper staff person.

A third-shift officer, for example, doesn't have on his or her shift a person that they can immediately get to, other than maybe a third-shift nurse. But that is woefully inadequate when we are

talking about a person who has got a serious psychiatric problem and that problem is manifesting itself in a security concern.

So if we aren't doing it—and some jurisdictions do it very adequately—if we aren't doing it, then the Federal courts are going to intervene because it is going to manifest itself in a lot of other problems that we don't want to deal with.

Senator DURBIN. I want to thank the panel and thank you, Mr. Chairman.

Senator DEWINE. Senator Durbin, thank you very much for very constructive comments.

Let me thank our panel. This has been, I think, an excellent hearing. I appreciate the fact that you all are here.

Ms. Atkins, thank you very much for coming here notice.

Ms. ATKINS. Thank you. My pleasure.

Senator DEWINE. We appreciate your making time to come here and we wish you and your daughter well.

We have two statements that need to be entered into the record, which I am going to do. The statement of Chairman Hatch will be made a part of the record. Also, I would like to enter into this record of this hearing a letter from the Chairman of President Bush's New Freedom Commission on Mental Health, Dr. Mike Hogan. Attached to Dr. Hogan's letter are several pages from the commission's July 2003 report that are directly relevant to S. 1194.

Again, let me thank all of our witnesses. I would also like on a personal note to thank Evelyn Fortier, who is a member of my staff, who I know has been in contact with all of you. Unfortunately for me, at least, and I think for Congress, Evelyn will be leaving us, I hope, on a temporary basis, but she will be leaving us at the end of the week. We would not be here today on this hearing, and I don't think we would be here with this bill without Evelyn's help.

So, Evelyn, thank you very much for your hard work. We appreciate it very much.

[Applause.]

Senator DEWINE. We hope Evelyn will be back with us in the not too distant future.

Let me again thank all of you very much for your very, very good testimony. I think it has been an excellent panel, excellent testimony, and we hope to move this bill forward.

Thank you very much.

[Whereupon, at 3:37 p.m., the Committee was adjourned.]

[Questions and answers and submissions for the record follow.]

QUESTIONS AND ANSWERS

Questions for Dr. Reggie Wilkinson from Sen. Richard Durbin

1. ***The current screening process identifies only 37 percent of those with acute mental health disorders. Other than increased funding, how can we improve the screening process? Are there opportunities to improve it before offenders enter correctional facilities?***

A. National Overview

The absence of effective and uniform screening is one of the main reasons that corrections administrators are unable to state with certainty the number of offenders with a mental illness. There are a number of recommendations that correctional systems can adopt to improve screening at their facilities. These include adopting an effective screening instrument, ensuring uniform usage of the instrument, training personnel on effective use of the screening instrument, and ensuring access to other available information.

Currently there is no nationally recognized screening instrument that is considered the gold standard in the field. However, the National Institute of Justice, in conjunction with the University of Maryland, has recently begun the process of developing such a screening instrument. While this standardized instrument is in the development stage, correctional systems should take steps to ensure that all their facilities utilize the single best screening instrument that they have available. Periodic evaluations of the existing screening instruments are a simple and cost effective way to achieve this goal. Staff can compare the outcomes of screening performed with different measures, determine the rates at which screening positively or negatively identified a mental health problem, and engage in interdisciplinary communication (between mental health and custody staff) about the screening process.

In addition, correctional administrators can ensure consistency of the screening protocols within their correctional system by using the same screening instrument at all facilities statewide. This is important because uniformity in screening procedures allows for increased input into that procedure and assists in tracking trends within the system. New York State, for example, has developed the Suicide Prevention Screening Guidelines Tool (SPSG). The SPSG is part of a multifaceted program designed to facilitate the identification and treatment of offenders who are suicidal and /or seriously mentally ill. Following a period of training and technical assistance, this program has been implemented in every county in New York State.

A screening instrument, even when uniformly applied, is only as efficient as the people using it. The extent to which the relevant staff implement the screening procedures effectively, depends in large part on whether they understand their responsibilities and execute them properly. These staff should include mental health providers in the community, whose efforts may allow

individuals with mental illness to be identified before they enter the criminal justice system. Training on issues such as the screening protocol, the appropriate use of information gathered, confidentiality issues, and cultural and gender sensitivity issues is key. As such, the strategies discussed in questions two and four, regarding information links and cultural competency, will improve the accuracy of the screening process.

B. Ohio Activity

The Ohio correctional mental health system has a two-tier process to identify offenders with a mental illness upon admission to the prison system. Within 24 hours of admission, the medical nurse meets with the offender and conducts a screening to determine their medical needs, whether the offender was receiving mental health services prior to incarceration, and the type of services (including mental health medication prescribed). A second screening is done within 14 days of admission by a member of the mental health staff to determine the current mental health status of the inmate, to review the offender's mental health history, and to assess their mental health needs. Both screening forms, the initial one used to screen in the first 24 hours, and the more detailed one used within 14 days, are standardized forms developed by the Bureau of Mental Health Services (BOMHS) within the Ohio Department of Rehabilitation and Correction (ODRC), as required by ODRC policy. The administering staff are trained to understand and utilize the screenings.

In addition, all offenders who received services prior to incarceration are asked to sign a release of information form during the detailed screening process in order to obtain a summary of previous community mental health services and treatment history, thereby ensuring continuity of care.

2. ***This week, the Department of Justice's National Institute of Justice held its Annual Conference on Criminal Justice Research and Evaluation. One of the presenters at this Conference recommended that jails and prisons link their management information systems to local mental health facilities. In doing so, these community mental health centers might be able to re-establish connections with offenders who were previously receiving mental health assistance but had dropped out of the system.***
Is this something that is happening in Ohio or other states? If so, is it successful and how can we encourage these links?

A. National Overview

There are enormous benefits to information-sharing between mental health agencies and corrections systems. However, the various state and federal regulations protecting patient privacy make it unlikely that a completely integrated mental health records system could be created for correctional officers

and mental health agencies to simultaneously access. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandates a national floor of privacy protections for patients, and individual states and local governments have enacted their own, often more restrictive, laws.

Nevertheless, some jurisdictions have been able to implement information-sharing protocols that both adhere to these federal, state, and local regulations and contribute to continuity of care and effective use of resources. For example, the Maricopa County (AZ) jail provides a daily list of people incarcerated to the local and regional mental health providers; the providers are then able to cross-check this list against their own rosters and the appropriate case managers can communicate with the jails to ensure continuity of care for patients under their care. Likewise in Connecticut the judicial marshals send a list of the people in custody to the mental health diversion staff. The staff accesses its own database to determine whether any of the people in custody is a past or current user of their services and visits that person to determine their eligibility for diversion. If the person is deemed eligible, the mental health diversion staff requests an authorization for the release of information that specifies what information will be released and who will receive this information. Based on the authorization for the release of information the mental health diversion staff member is then able to coordinate appropriate services for the person in custody.

It is equally important to ensure that continuity of care is maintained when an individual with mental illness transitions back into the community. In Massachusetts, the Department of Mental Health's Forensic Transition Team ensures that program participants (adult and juvenile offenders with mental illness) preparing for release from incarceration sign a release that allows open communication between mental health providers and parole staff. Parole and treatment staff work together closely to ensure effective oversight and compliance with treatment as a condition of release.

B. Ohio Activity

The Ohio Department of Mental Health (ODMH) has a management information system called MACSIS for Medicaid community mental health clients. The Ohio Department of Rehabilitation and Correction works with ODMH community linkage staff assigned to the prisons to complete community linkage packets that include the offender's course of treatment while incarcerated, and a listing of psychotropic medications the offender will be prescribed upon release. The community mental health system takes these packets and cross-references the information using MACSIS to determine whether the offender was previously served in their system and the type of services they received. This serves to re-establish connections with the individual's service provider previous to incarceration.

3. ***When asked, prisoners in a study reported the following psychiatric concerns: 28.6 percent reported sleeping problems; 21.6 percent reported depression; and 20.1 percent reported anxiety. However, only 13.2 percent of these prisoners requested psychiatric services.***

How do we encourage offenders who need mental health services to seek those services? Are mentally ill offenders stigmatized within correctional institutions? If so, how can we address that problem?

A. National Overview

The issue of identifying and treating incarcerated offenders with a mental illness is a pressing one that can be addressed both through screening (as addressed in question one above), and through subsequent assessment. Some inmates, concerned about the stigma associated with mental illness, may conceal symptoms of their disease; mental illness may manifest itself as the distorted belief that staff intend to harm, rather than help. In addition, inmates with mental illness may have personal safety concerns, given that inmates with a perceived "weakness" are often preyed upon by other inmates. The peculiar and sometimes inappropriate behavior of individuals with mental illness can also create tension with other inmates leading to verbal and/or physical altercations. Yet not all of these issues may be apparent at intake. Inmates may not present symptoms of mental illness until they have been incarcerated for some time. In other cases, an inmate's mental status can change dramatically during the course of incarceration.

Correctional mental health staff should be able to incorporate regular, informal mental health assessments into existing practices without burdening the service delivery system, and all correctional staff should be trained to recognize the signs and symptoms of a mental illness and be able to make targeted referrals for follow-up. Corrections administrators should also consider establishing a system to code the mental health status (and risk of exhibiting signs of mental illness) of all inmates. They should institute effective mechanisms through which inmates can refer themselves for confidential mental health assessments, and educate staff regarding mental illness in order to reduce the stigma surrounding such illness. Inmates with mental illness would be encouraged to self-identify by more educated and receptive staff members. They could also benefit from direct education about mental illness. These recommendations should work hand in hand with the information-sharing recommendations in question two above.

B. Ohio Activity

The Ohio Department of Rehabilitation and Correction's goal is to mainstream offenders with a mental illness whenever possible and to ensure that this population has access to all the services and privileges within the prison that are available to offenders without a mental illness. Offenders with a mental illness are only identified as such on a need-to-know basis, so that they are not

unnecessarily stigmatized. This identification will primarily involve corrections officers and medical staff. Offenders with a serious mental illness who need intensive mental health services are referred to our residential treatment unit (RTU) until their condition has stabilized, and are then returned to general population. However there are some offenders (approximately 25-30% of the RTU population) who may require RTU treatment during their entire incarceration period. In addition, staff training is essential to address the needs of offenders with a mental illness, as well as understanding the problems related to stigma for those offenders receiving mental health services.

4. ***Studies also note that women are more likely to seek needed mental health services then men and African American males access mental health services with less frequency than white or Hispanic males because of cultural differences.***

How can we address these gender and cultural differences to encourage men – and African-American men in particular – who need mental health services to seek those services?

A. National Overview

The consistently disproportionate rates of minorities and of men incarcerated in U.S. jails and prisons make the problem of the relative reluctance of these groups to seek treatment particularly pressing. Data contained in the recently released Justice Department report on prison populations shows that an African American male has about a 1 in 3 chance of going to prison during his lifetime. For a Hispanic male the rate is 1 in 6, compared to 1 in 17 for white males. While a general approach to destigmatizing mental illness, as described in question three above, may make some inroads into the problem, it is critical that corrections systems work to achieve cultural competency and gender equity in treatment. Effective strategies include recruiting members of minority communities for clinical and administrative positions where there is contact with consumers; providing a culturally informed training curriculum for mental health staff; and developing outreach programs that target members of minority communities. In California, the behavioral health services provider Pacific Clinics has made a priority of ensuring that their sites include Spanish-speaking staff and follow practices sensitive to both Latino and Asian cultures that predominant in their areas of service. In Cambridge, Massachusetts, the Haitian Mental Health Clinic incorporates culturally and linguistically appropriate practices throughout its service offerings. While these models are drawn from the clinical setting, we believe that corrections administrators can glean from them to improve cultural competency in their institutions.

B. Ohio Activity

The Ohio Department of Rehabilitation and Corrections is planning to administer an assessment tool to determine the level of cultural competency in its correctional mental health system. The goal is to improve access to mental health services by minority populations who may not be accessing services. The assessment is designed to evaluate leadership, vision, mission, staff composition, work climate, policies, procedures, service delivery, staff training, and other indicators that promote a culturally competent system.

5. ***At the NIJ Conference a presenter noted that the pharmacological formularies in many prisons and jails are not up-to-date. For example, a schizophrenic offender may have been taking newer anti-psychotic drugs at the time s/he was incarcerated, but if those drugs are not part of the prison or jail formularies, they would not be available to the offender.***

Do you believe this is a problem? If so, how are Ohio jails and prisons addressing it? How can we raise awareness and encourage jails and prisons to maintain updated pharmacological formularies?

A. National Overview

Cost concerns, the slow dissemination of current research through the corrections system, and lack of communication between community and correctional mental health providers, can result in the disruption of treatment plans for individuals with mental illness who enter the justice system. Because inmates are usually prohibited from bringing their own medications into jail, offenders with a mental illness often go without medication for some time after arrest, sometimes causing them to decompensate and requiring expensive crisis care. If the medications prescribed by their primary physician are not available, or the reasons for which they have been prescribed certain specific medications are not known, inmates may be forced to switch to ill-suited alternatives, resulting in further decompensation or severe side effects, or in refusal by inmates to adhere to their treatment plans.

One way to address this problem is by educating corrections administrators and personnel about the cost-effectiveness of facilitating access to medication that is medically appropriate to each inmate's condition. In order to ensure quality and objectivity, correctional agencies should enlist the services of a licensed pharmacist to review policies and procedures, and to assist in a review of the use of medications in the facilities. Additionally, state correctional agency officials can work with leaders in the mental health system to develop and adopt jointly standardized clinical decision protocols (i.e., algorithms) that are based upon research conducted on a national level. This would enable consistency in the application of psychotropic medications, and would help to manage pharmacy costs. One example of the thoughtful application of these principles is the Texas Medication Algorithm Project (TMAP). TMAP is a collaborative effort designed

to improve the best possible patient outcome by establishing a treatment philosophy for medication management. TMAP developed and instituted a set of algorithms to illustrate the order and method in which to use various psychotropic medications. The graphic presentations of algorithms and explanatory physicians' manuals are accessible through the TMAP website,

http://www.mhmr.state.tx.us/centraloffice/medicaldirector/TMAPtoc.html.

B. Ohio Activity

The Ohio Department of Rehabilitation and Correction has a restricted formulary that includes some of the new generation psychotropics including Risperdal and Geodon and some of the newer SSRI's such as Prozac. However, offenders admitted to the Ohio prison system and medicated with a new generation psychotropic that is not on the formulary are allowed to continue on that medication as long as they are responding well. When an offender is not doing well on that previously prescribed medication, the psychiatrist will look at options from the formulary. In the event an offender does not respond to any of the medications on the formulary, the prescribing psychiatrists will contact the Department's Chief Psychiatrist to request permission to prescribe medications outside the formulary. To approve medications outside the formulary, the Chief Psychiatrist uses a procedure that emulates the process of an algorithm.

Given that each facility operates independently and budgets vary, training regarding best practices interventions is the primary method to demonstrate the cost efficiency of utilizing the new medications and to therefore create change. Availability of information regarding positive outcomes in the form of increased compliance and decreased management issues should encourage the availability of new generation psychotropics on formularies.

6. ***Senator Paul Simon's Southern Illinois University Public Policy Institute issued working group recommendations on mental health and prisons. One of the top recommendations was that "correctional mental health systems should adequately address mental health issues relevant to female inmates, which include parenting issues, post traumatic stress disorders, and depression." This need was echoed by the President's New Freedom Commission on Mental Health, which noted that "Gender-specific services and gender-responsive programs are in increasing demand but are rarely present in correctional facilities designed for men."***

A recent study of Illinois state prisons also determined that 85 percent of female inmates had at least one child and that 28 percent had four or more children.

Are you aware of any successful programs specifically designed to meet the needs of female offenders—and mothers in particular—who are mentally ill? If so, how can we encourage such programs?

A. National Overview

As this question recognizes, the need to address the complex, gender-specific issues of women within the justice system has become increasingly urgent as the number of female inmates continues to grow. A large majority of these women have themselves been victimized. In response to their identified need, the Substance Abuse and Mental Health Services Administration (SAMHSA) has funded an extensive Women, Co-Occurring Disorders, and Violence study, now in its third year, through which programs around the country are supported in the development and delivery of evidence-based services for women with a wide range of risks and needs. The National GAINS Center for People with Co-Occurring Disorders in the Justice System is coordinating the study, and expects to publish results by fall 2003. The study will assuredly shed light on the specific population of female inmates who do have mental illness, though it is important not to conflate these inmates with all female inmates who have a history of trauma.

Among the study's participating programs is Maryland's Trauma, Addictions, Mental Health and Recovery (TAMAR) Project, one of a spectrum of model programs initiated under the leadership of the Maryland Department of Health and Mental Hygiene. The TAMAR Project provides integrated services for women who have interrelated trauma, substance abuse, and mental health issues, including both clinical and peer-to-peer supports. A related program, Tamar's Children, provides services specifically to pregnant and postpartum women with mental illness in the criminal justice system and their infants, providing an integrated system of care through community agencies, substance abuse counseling, and mental health treatment. In Rhode Island, the Women's Discovery Program and Safe Release Program provides case management to female inmates with mental illness, including helping them to locate community-based substance abuse and mental health services, housing, employment, and other services upon release. Raising awareness of the efficacy of such programs, and demonstrating and disseminating positive outcomes, is the primary way by which their establishment elsewhere can be encouraged.

B. Ohio Activity

The philosophy of Unit management incorporated into all Ohio prisons assists mental health staff by ensuring that offenders receive mental health services in a timely manner. The Department also has several innovative programs for women including a nursery program at the Ohio Reformatory for Women in Marysville that allows non-violent pregnant offenders to maintain custody of their infants after they are born. This program, approximately 2 years old, works in partnership with the federal Supplemental Food Program for Women, Infants, and Children (WIC) and includes parenting classes. Each participant has an individualized treatment plan to address any problems, including mental health issues, that may have contributed to her incarceration. If

the female inmate is already on the mental health caseload, further psychological testing and assessment is completed to assure the safety of the offender's unborn child, the offender, and other participants of the program. Further, after the birth of the child, mental health staff may be asked to intervene in situations where post-partum depression may be evident, or any time that it is determined that further services might be needed.

Female offenders who are on the mental health caseload have access to all programs, including the nursery program, if it is determined that they will be able to maintain in the program and they meet the specific criteria of the particular program. An offender cannot be excluded from programming based on the sole fact that she is on the mental health caseload.

7. ***There is anecdotal evidence that parole boards have a bias against paroling mentally ill offenders. Do you find that to be true? If so, how can we address this issue?***

A. National Overview

In the roughly two-thirds of states that retain programs for discretionary release, parole boards face the difficult task of predicting the best outcome for society in regards to a particular inmate. There is some evidence that, absent services that can enable an offender with a mental illness to reenter society while ensuring the public safety, parole boards are reluctant to grant conditional release to members of this offender population. In Pennsylvania, for example, a year 2000 study found that inmates with a serious mental illness were three times more likely to serve their maximum sentence as other inmates. The result of this difficulty is to extend the sentences and incarceration costs for offenders who could otherwise be supervised in the community. Another serious implication is that, upon an offender's eventual release at the end of his or her maximum sentence, the offender is released into the community with no supervision whatsoever.

Recently, some jurisdictions have begun to explore a range of effective ways to address this concern. In Missouri, for example, the Parole Board applies the expertise of independent mental health assessment services to release decisions by contracting with them to identify the risk associated with the release of people with a mental illness. In Utah, the Forensic Mental Health Coordinating Council brings together into one body the information and resources of the Department of Corrections, mental health organizations, and the parole agency to maximize access to services and placement options for offenders with a mental illness. In Texas, the Council on Offenders with Mental Impairments (TCOMI) is part of a special panel that considers special realistic, relevant, and research-based release conditions for offenders with a mental illness. And in Pennsylvania, the identification of the discrepancy in sentence service led to the development of a program by the Department of Corrections, in conjunction with the Pennsylvania

Board of Probation and Parole and the Pennsylvania Community Providers Association, that provides comprehensive transition services including, in some instances, housing for up to 60 days. The success of these programs, combined with coordinated information-sharing and training, will likely do much to assist parole boards in other jurisdictions in balancing concern over lengthy and costly incarcerations and public safety needs.

B. Ohio Activity

The Ohio parole board has no such bias against paroling offenders with a mental illness. Rather, in many cases, offenders with mental illness were paroled but not released due to a lack of appropriate housing to meet their needs. As a result, the Bureau of Mental Health Services has been working with the Ohio Department of Mental Health, community providers, and with the community at large to increase the number of housing options and service mix for this population. In addition, the Department is exploring the possibility of requiring mental health services for offenders with a serious mental illness as a condition of parole for a small portion of the caseload. One example would include those who have gone through a due process hearing for mandated medications within the correctional institution, and mandating continuation of the forced medication decision upon release. Another example would involve offenders referred to an assertive community treatment (ACT) team. The goal is to ensure continuity of care and decrease the likelihood of a return to prison that is related to the offender's mental illness.

Written Questions for the Honorable Eve Stratton
From July 30, 2003 Hearing:
Mentally Ill Offender Treatment and Crime Reduction Act
Sen. Richard J. Durbin

NOTES:

(1) Justice Stratton forwarded these questions to the Advisory Committee on Mentally Ill in the Courts, which she chairs at the Supreme Court of Ohio, for their ideas. Remarks from committee members are identified by their name, title, and organization. To obtain additional information on a particular idea or to speak directly to a member of the Advisory Committee, please refer to the attached committee roster for contact information. **Attachment A** – Advisory Committee Roster.

(2) Please refer also to responses from the Ohio Department of Rehabilitation and Correction, Director Reginald Wilkinson, who did an excellent job of describing both national and Ohio efforts. However, please bear in mind that Director Wilkinson's remarks are primarily limited to programming in Ohio's prisons. Many of the gaps in services exist in jails at the local level in Ohio's 88 counties.

(3) The opinions and information in this document reflect the opinions of various members of the Supreme Court of Ohio Advisory Committee on Mentally Ill in the Courts, and do not necessarily reflect the positions of the Advisory Committee itself.

1.) The current screening process identifies only 37 percent of those with acute mental health disorders. Other than increased funding, how can we improve the screening process? Are there opportunities to improve it before offenders enter correctional facilities?

Justice Evelyn Lundberg Stratton, Supreme Court of Ohio:

- Screen at intake after arrest.
- There are several 5-10 question screening tools that can be used. Key questions for intake officer could include:
  - Are you on medications?
  - Have you ever been on any medication?
  - Have you ever been hospitalized?
  - Do you have a treatment plan?
  - Do you have a case worker or case manager?
- If offender has signs of mental illness or other disabilities this should trigger a referral to more highly trained mental health screener.

- **Attachment B -** "The Prevalence of Mental Illness in Jails: A Summary of the Licking County Jail Pilot Study"

- If intake officer(s) identifies problem, alert judge, prosecutor, defense attorney to deal with, put into mental health track, etc.

- Attach note to file so information follows offender into jail, prison, probation, etc., and alerts everyone to the issue.

Patrick Boyle, Substance Abuse/Mental Illness (SAMI) Coordinating Center of Excellence

- Provide basic cross-training to all intake officers to identify mental health, substance use problems.

- Is the problem one of insufficient staffing, i.e., too rushed to do a thorough assessment due to volume or multiple duties?

Terry Russell, Executive Director, NAMI-Ohio

Everything mentioned above is important. But, until there is a fundamental change in community mental health, the situation can only get worse. In the early 1960s, the community mental health center model was created. For over 40 years has seen little change. The community mental health center model is a clinical model which emphasizes counseling. The President's Freedom Commission recognizes the need to shift to a recovery "community support model" which emphasizes psychiatric evaluation, medications, housing, vocational rehabilitation and assertive case management. The severely mentally disabled individual who becomes involved with the criminal justice system can be diverted into the community if those supports just mentioned are available.

With funding from the Mentally Ill Offenders' Treatment and Crime Reduction Act, Ohio could be a leader in developing a pilot project directed toward this specific population emphasizing community supports. This pilot project could then be the catalyst of restructuring an outdated system that is failing the severely mentally disabled and their families.

Magistrate Gary Hauter, Seneca County Juvenile Court

With regard to "screening," we have employed the use of the MAYSI-2 as an initial screening tool to identify those juveniles who may have mental health disorders. MAYSI-2 stands for Massachusetts Youth Screening Instrument and was developed by Thomas Grisso and Richard Barnum. It is geared to juveniles and is a self-reporting test. It screens in the areas of alcohol/drug use, anger-irritability, anxiety, depression, fighting, somatic complaints, suicidal ideation, thought disturbances and traumatic experiences. It is academically-based and it is **free** for use in juvenile justice agencies or by mental health professionals nationally, without costs, if prior approval is obtained from the authors. (It is

copyrighted by the authors.) It is updated by feedback from the participating juvenile agencies and mental health professionals, who are registered users.

The MAYSI-2 is administered to each of our juveniles who are admitted to our Youth Center. It is available on computer software, which includes the test of 52 questions and an automatic scoring component. It takes only about 8-10 minutes to complete. Our goal is to screen all juveniles (alleged delinquent, unruly, traffic offenders, etc.) as they come into our court.

We like the MAYSI-2 because it is free, it is simple, and we can do it ourselves as it essentially requires no professional to administer or interpret the test/results. Follow-up then can be referred to the proper professional, if warranted. I am currently not aware of such a screening tool for adults, but there must certainly be one. This solution can be accomplished without further funding or additional personnel.

2.) This week, the Department of Justice's National Institute of Justice held its Annual Conference on Criminal Justice Research and Evaluation. One of the presenters at this Conference recommended that jails and prisons link their management information systems to local mental health facilities. In doing so, these community mental health centers might be able to re-establish connections with offenders who were previously receiving mental health assistance but had dropped out of the system.

Is this something that is happening in Ohio or other states? If so, is it successful and how can we encourage these links?

Joe Krake, Manager, Mental Health Diversion Alternatives, Office of Forensic Services, Ohio Department of Mental Health
&
Sandra Cannon, Chief, Office of Forensic Services, Ohio Department of Mental Health
There are no formal electronic links, however, several communities in Ohio have established a process whereby the jail faxes list of bookings to the mental health provider, so the treatment people know who has been detained and will need treatment.

Dr. Mark Munetz, Chief Clinical Officer, Summit County ADM Board
In Summit County we have been able to access jail data and cross match with the mental health data base. This allows us to recognize which of our clients are in the jail and the Board can then alert the mental health staff at the jail as to the presence of such individuals, in case they are missed in routine screening. However, privacy concerns, even more so with the implementation of HIPAA, make this very difficult. Privacy concerns essentially allow information to only flow in one direction, from corrections to mental health; unless you have the

same providers in the community and the jail, the matching of databases may still not allow for sharing of critical information.

Dr. Lisa Shoaf, Researcher, Ohio Office of Criminal Justice Services
Akron's primary outpatient treatment provider has on staff a 'court liaison' whose role is to attend the municipal court sessions, obtain a list of arrestees on the docket, and match their names up with a list of present or past clients. She uses a palm pilot to gain access to the list. Anyone who shows up as a mental health client she may interview. Also, she has some counseling background, so if she comes across an arrestee in court whose outward appearance leads her to think he/she may have a mental health issue, she may interview that person as well. Ultimately she does this work to find clients for the Akron Mental Health Court, but it also allows her to inform caseworkers that one of their clients has been arrested. The last I talked to the court liaison, I think she said that not all treatment providers in the area are willing to release such information as whether a person has ever been to their facility, even if that is all she wants to know. She said without a release some agencies are not willing to divulge any information about a person's involvement in a mental health facility.

Justice Evelyn Lundberg Stratton, Supreme Court of Ohio

- Encouraging more of this type of interaction could really help identify the offender on intake & give us a history. It could allow us to reconnect the offender with prior treatment, social worker, encourage that reconnection.

- CAVEAT- Beware of "labeling." Someone who might have had issues with mental illness in the past, but who is now well (but may still be committing crimes) being labeled mentally ill. Stigma issues.

- HIPPA privacy issues in sharing information may require legislative changes to HIPPA by Congress.

Joe Krake, Manager, Mental Health Diversion Alternatives, Office of Forensic Services, Ohio Department of Mental Health
I agree that stigma is a big problem. Often, jails distribute medication in what is referred to as the "bug line" and other stigmatizing practices. We need to remember that the jail and prison populations are not the most understanding, aware, or progressive humanistic people.

Terry Russell, Executive Director, NAMI-Ohio
Currently, it is to the mental health system's advantage for the offender to drop out of the mental health system. There is not enough capacity to meet the demand. One of our major problems with our diversion programs is the lack of

community supports that will be required for success. We can use technology to enhance our ability to meet the growing numbers of offenders entering into the system. As referred to in Question #1, this could be an intricate part of a pilot project that restructures the system.

S.R. Thorward, M.D., Twin Valley Behavioral Healthcare
The ideas on direct linking of information between jail and mental health centers should at least address HIPPA privacy issues and how they can be successfully addressed. This will probably take some research to address. It is likely the biggest barrier to be resolved to allow information sharing to occur.

Magistrate Michael J. Lawson, Sandusky County Common Pleas, Probate & Juvenile Court
Re: the concerns raised that federal HIPAA regulations make the sharing of protected health information difficult may be a misunderstanding of the regulation. Attached is a copy of 45 CFR 164.512 (one of the many voluminous HIPAA Privacy & Security Regulations) which addresses those circumstances in which a person's (patient's) authorization to allow a covered entity "CE" (community mental health center, hospital, etc.) to disclosed protected health information "PHI" is **NOT NECESSARY**. There are only two problems with the HIPAA regulation which impede the ability of a correctional facility to obtain information. Both of these could be solved at the state level legislatively or administratively. **See the relevant HIPAA regulation with highlighted sections, which carves out specific exceptions for "specialized governmental functions" including" correctional institutions and other law enforcement custodial situations."**

First, 45 CFR 164.512 throughout uses the word "**may**" in reference to a CE disclosing information. This would appear to leave the decision to disclose, at the discretion of the CE. My experience in court so far is that CE's since April 14, 2003, (effective date of the HIPAA privacy regs.) upon advice of their attorney's are, choosing to interpret the HIPAA regulations conservatively and not disclose anything without an "authorization" or release of information, signed by the patient. It is clear that HIPAA did carve out exceptions to the requirement for a signed authorization. However, HIPAA does not mandate the disclosure of PHI by a CE when these exceptions apply.

Second, HIPAA is **preempted** by state confidentiality and/or privilege statutes/regulations where the protections afforded by the state provisions are "**more stringent**." The term "**more stringent**" is not defined in HIPAA. The real problem, in several Ohio provisions, e.g.., Ohio Administrative Code OAC 5122:2-1-02 (D)(13) Client right of confidentiality; OAC 3701-84-07(A)(4) Patient Care Policies and Record Confidentiality; O.R.C. Section 3793.14 Civil Rights of Drug and Alcohol Patients Confidentiality to name a few, clearly preempt the

federal regs and prevent the practical utilization of the more liberal HIPAA regulation. The Ohio legislature however, could amend the relevant Ohio statutes or the more restrictive administrative regulations could be changed. The possibility of these state level changes may be more realistic than amending federal privacy regulations. The Ohio patient-physician evidentiary privilege could be maintained while relaxing the confidentiality statutory and regulatory provisions.

If the Ohio legislature and/or departments can amend relevant Ohio statutes and regulations to permit the disclosure as allowed by HIPAA, there would be another hurdle regarding the confidentiality patient records/information for those patients with drug and alcohol diagnoses. Although the Ohio regulations could be amended, there are specific federal regulations 42 CFR Part 2, outside of the HIPAA privacy regulations, which prevent federally funded agencies (those that accept funds in any federal program, Medicare, Medicaid) from disclosing information without patient authorization. This federal regulation is not so liberal as HIPAA when it comes to correctional facilities and law enforcement entities. As we are all aware, the number of consumers which have either a D&A diagnosis or have a co-occurring disorder is not insignificant. Thus, it would seem that the 42 CFR Part 2 D&A Confidentiality regulation may be the real problem when it comes to sharing relevant clinical information for effective intervention. This particular regulation is not relevant to those patients with strictly mental health diagnoses.

3.) When asked, prisoners in a study reported the following psychiatric concerns: 28.6 percent reported sleeping problems; 21.6 percent reported depression; and 20.1 percent reported anxiety. However, only 13.2 percent of these prisoners requested psychiatric services.

How do we encourage offenders who need mental health services to seek those services? Are mentally ill offenders stigmatized within correctional institutions? If so, how can we address that problem?

Justice Evelyn Lundberg Stratton, Supreme Court of Ohio

- Prisons/jails must develop a good MH system – often low contract pay gets inferior doctors or doctors who give less time than contract requires.
- Stigma is big issue. If offender complains, they may be considered difficult, disciplined, and put in solitary confinement.
- More education & training is needed. Better training of prison guards and front line workers to recognize mental issues or signs of developmental disabilities. Plus, many prison guards feel prisoners feign symptoms to get out of work, get into hospital setting, etc. Better education is needed to be able to weed out illegitimate mental illness claims.

- Responsive system – not one medicine or treatment fits all. Side-effects must be taken into account. Must listen and adjust meds if warranted.

- Formulary. Often monies are budgeted only for the cheapest, oldest medications – that often have severe side-effects. Need to mandate better, newer medications and monitoring.

- Keep mental health complaints confidential to avoid stigma with other prisoners, or mistreatment.

- Recent Columbus Dispatch article highlights the issue of the quality of prison medical care, particularly as cost factors drive many issues.
    - See Columbus Dispatch articles:
      Attachment C -Critical Care, 8/24/03
      Attachment D- Prison Doctors Aren't Top Shelf; Some Come With Big Problems, 8/24/03
      Attachment E- Lives Lost and Damaged, 8/25/03
      Attachment F- When Co-Pay Plan Started, Clinic Visits Started Falling, 8/25/03
      Attachment G- Costs of Inadequate Care, 8/25/03
      Attachment H- Medical Care in Ohio's Prisons, 8/25/03
      Attachment I – Taft Focuses on Inmate Care, 8/28/03
      Attachment J- Panel to Review Health Care for Inmates, 9/5/03

Sandra Cannon, Chief, Office of Forensic Services, ODMH
Better mental health service standards for jails/prisons should be developed.

Patrick Boyle, Substance Abuse/ Mental Illness (SAMI) Coordinating Center of Excellence
Mental health services need to be offered in a welcoming manner; training needs to be "sold" in light of how accurate recognition will lessen the burden on guards and other staff if medication and counseling are offered.

Terry Russell, Executive Director, NAMI-Ohio
This question emphasizes the need for education. 28.6 percent report sleeping problems; 21.6 percent report depression; and 20.1 percent report anxiety. These numbers mean nothing. They're in prison. They are going to have depression and anxiety. But, I can assure you that those suffering from schizophrenia, bipolar illness, and major depression are not the 13.2 percent requesting psychiatric services. They are the ones forced into treatment or, more likely, are the prisoners who end up in trouble and/or in isolation.

When the Ohio Department of Rehabilitation and Correction was under a federal court order to provide quality mental health care, over 70 million dollars was allocated. Families throughout Ohio stated that the mental health treatment offered in the prisons was superior to that offered in the community. We now see erosion in the revenue and quality in the prison's mental health programs.

4.) Studies also note that women are more likely to seek needed mental health services than men and African-American males access mental health services with less frequency than white or Hispanic males because of cultural differences. How can we address these gender and cultural differences to encourage men—and African-American men in particular—who need mental health services to seek those services?

Justice Evelyn Lundberg Stratton, Supreme Court of Ohio

- Increase cultural diversity of screeners and doctors.
- Education of guards and mental health workers. Need to train them in cultural issues and encourage them to encourage offenders to seek treatment and work to reduce stigma.

Patrick Boyle, Substance Abuse/ Mental Illness (SAMI) Coordinating Center of Excellence
Consider roles for recently released peer involvement throughout the screening and counseling process (if not already provided) thus helping to reduce stigma.

Terry Russell, Executive Director, NAMI-Ohio
There has been a tremendous amount of work done in the area of cultural competency. The Ohio Department of Mental Health has developed a significant amount of information concerning this issue.

Gary Hauter, Seneca County Juvenile Court Magistrate
We in the "system" need to develop and employ personnel who can develop empathy for those with mental health issues on a daily basis. A good mental health system is only as good as the devotion and empathy of those who work in that system.

5.) At the NIJ Conference, a presenter noted that the pharmacological formularies in many prisons and jails are not up-to-date. For example, a schizophrenic offender may have been taking newer anti-psychotic drugs at the time he/she was incarcerated, but if those drugs are not part of the prison or jail formularies, they would not be available to the offender.

Do you believe this is a problem? If so, how are Ohio jails and prisons addressing it? How can we raise awareness and encourage jails and prisons to maintain updated pharmacological formularies?

Justice Evelyn Lundberg Stratton, Supreme Court of Ohio

- Cost is a big issue, but with improved medication and better follow up with community providers, recidivism will likely decrease.
- Sometimes due to budget concerns, the caliber of doctors in jails and prisons is lacking.
- Further, due to budget restraints, many are not up-to date in training.
- Rigidity of jail/prison requirements – only approve certain drugs which are sometimes out of date. Whoever sets formulary needs to allow for newer drugs or continue what the person is on when enters jail/prison.
- In Ohio, our Advisory Committee is working on a bench sheet for judges to give them a quick reference guide for medications & symptoms.
- In addition, we will provide training on this bench sheet at an upcoming judicial seminar.

Scott Blough, formerly, Chief, Bureau of Adult Detention, Ohio Department of Rehabilitation and Correction; currently, Professor, Tiffin University

With regard to ODRC, the formulary is established by the ODRC Pharmacy & Therapeutics Committee which is chaired by the ODRC pharmacy consultant. Members include ODRC medical and psychiatry chief physicians, and representative institutional physicians, psychiatrists and pharmacists. The formulary is updated on as needed basis as new medications & generics become available and new treatment regimens become standards of care. If my memory serves me well, I think both the medical and mental health components were both updated within the past couple of years.

Joe Krake, Manager, Mental Health Diversion Alternatives, Office of Forensic Services, Ohio Department of Mental Health
&
Sandra Cannon, Chief, Office of Forensic Services, Ohio Department of Mental Health

Re: cost of medications- Several jails in Ohio are working with ODMH Central Pharmacy and the ADAMHS boards to reduce the cost and increase the availability of the newer psychotropic medications. Ohio has one agency, ODMH, to order medications in bulk through its Central Pharmacy, for all state institutions, therefore saving money.

Terry Russell, Executive Director, NAMI-Ohio
As recent headlines have appeared in The Columbus Dispatch, general healthcare is a significant problem in our prison system. Mental health care was assisted by the federal lawsuit. However, the use of the new atypical medications in our prisons and jails is deplorable. Formularies for these medications to the general Medicaid population of our state have exempted mental health drugs. This is not the procedure used in our prisons and jails. Formularies are followed (or administrative edict) and often the most successful medications are not used due to cost. Many times in our jails all medications are withdrawn and anti-psychotic medications are not available at all. This may be the single biggest problem in mental health care in our prisons and jails.

Dr. Mark Munetz, Chief Clinical Officer, Summit County ADM Board
This is a huge problem in Ohio, as it is around the country. Many correctional systems require a "fail first" approach; in such a system people must be prescribed the older, less well tolerated and sometimes less effective medications before being permitted the newer generation antipsychotic and antidepressant medications.
Some jails in Ohio have been able to use the ODMH Central Pharmacy program to reduce the cost of medications.
The jail in Cuyahoga County actually started its own pharmacy, again in an effort to control costs.
I think there is a bigger problem with access to physicians in jails and prisons, rather than the quality. In large part this is a budget issue; not enough funds to pay for adequate staff.
Regarding jails, there is a big issue with who is responsible to pay for the mental health care and psychotropic drugs: the sheriff who runs the jail or the local mental health board. Neither can afford to fund adequate services, especially given that services (including meds) are not Medicaid reimbursable in correctional settings.

6.) Senator Paul Simon's Southern Illinois University Public Policy Institute issued working group recommendations on mental health and prisons. One of the top recommendations was that "correctional mental health systems should adequately address mental health issues particularly relevant to female inmates, which include parenting issues, post traumatic stress disorders, and depression." This need was echoed by the President's New Freedom Commission on Mental Health, which noted that "Gender-specific services and gender-responsive programs are in increasing demand but are rarely present in correctional facilities designed for men."

A recent study of Illinois state prisons also determined that 85 percent of female inmates had at least one child and that 28 percent had four or more children.

Are you aware of any successful programs specifically designed to meet the needs of female offenders—and mothers in particular—who are mentally ill? If so, how can we encourage such programs?

Justice Evelyn Lundberg Stratton, Supreme Court of Ohio
See the following:
Attachment K- Women, Girls & Criminal Justice, June/July 2002
Attachment L- Alternative Interventions for Women, Summary of Services
Attachment M – Art for a Child's Safe America Foundation, 2003 Fact Sheet
Attachment N – Art for a Child's Safe America, Resiliency Through The Arts: Turning Nothing into Something.

Terry Russell, Executive Director, NAMI-Ohio
There is a tremendous parenting program for female offenders at the Marysville Reformatory for Women. With or without a mental health problem, prevention programming to this population is mandated.

Sandra Cannon, Chief, Office of Forensic Services, Ohio Department of Mental Health
Ohio Reformatory for Women has a specialized program.

Note: See Director Reginald Wilkinson's responses from the Ohio Department of Rehabilitation and Correction for greater detail.

Patrick Boyle, Substance Abuse/ Mental Illness (SAMI) Coordinating Center of Excellence
Women make up only about 7% of the prison population, but their needs are great. When there are female only prisons, there are more services available, but when women have to compete with men for services, men usually win out because there are more of them and because male prisoners are less compliant/more violent than women, in general.

One of the most important principles in working with women in prison is that of integrated dual disorders treatment. Since the majority of women in prison have drugs/alcohol problems as part of their profiles, the need for treatment is great. Programs in prisons are just as fragmented as they are on the outside. The majority of women who need mental health care also need substance abuse treatment. By dual disorder treatment we are talking about more than schizophrenic women - depression, PTSD, anxiety, etc. are common diagnoses among women in prison,

but don't necessarily get treated. There are also high levels of sexual victimization among female prisoners and often this untreated trauma leads to continued drug/alcohol abuse. It's a huge and ugly cycle.

There could be some innovative programming done in Cleveland at the state correctional facility since many of the women there are from Cleveland. Some energy could be placed there. WREN (Women's RENtry) runs some groups there, but nothing that really addresses the comprehensive needs of re-building families. If the task force wants to do something concrete, there is a place to do it. WREN, the shelter programs, county welfare, etc. could be partners and develop a program to prepare families and mothers for re-entry providing mental health, AODA and counseling services (housing is a big problem). Services for mothers are rare. Even rarer are programs for families (moms and their kids together). Continued contact between families is almost impossible when the mother is sent to prison far from home. Bedford Hills Prison in New York usually has progressive programs as do some of the prisons in Oregon for future reference.

Take seriously the fact that the majority of women re-enter the prison system because of parole/probation violations; get serious about screening for mental health problems, treatment and re-entry. Take the stance that hospital discharge planners used to: at admission ask yourself - What will this client need when she leaves here? and then act on it. This means that prisons take on more rehabilitation than correction yet there are those in society who are opposed to that. In order to make these things happen we need much more cooperation at a budget/planning level among state agencies and not just pilot programs. It is a daunting task, but I think the real danger lies in not doing it.

7.) There is anecdotal evidence that some parole boards have a bias against paroling mentally ill offenders. Do you find that to be true? If so, how can we address this issue?

Justice Evelyn Lundberg Stratton, Supreme Court of Ohio
Yes, some experts estimate that mentally ill offenders often serve 1/3 longer sentence for the same crime as do non-mentally ill offenders. The parole board is fearful of mental issues and is concerned, and rightfully so sometimes, that they will get flack if the mentally ill offender they release re-offends.

Solutions:

- Need education.
- Need assurance of safety net in community if person is released to reduce risk of re-offending.

Sandra Cannon, Chief, Office of Forensic Services, Ohio Department of Mental Health

Many times, the appropriate level of mental health and supportive services is not available such as Assertive Community Treatment (ACT), supported housing, and supported employment. Need more intensive levels of services and supports such as ACT, housing and employment.

Patrick Boyle, Substance Abuse/ Mental Illness (SAMI) Coordinating Center of Excellence

- Safety net must be adequate – need best practices promulgated so that parole board has better outcomes in their community.

Joe Krake, Manager, Mental Health Diversion Alternatives, Office of Forensic Services, Ohio Department of Mental Health

Ohio has a linkage program for people leaving prison and in need of community mental health services. Several of the ODMH diversion programs also have a linkage component. These programs help reduce the risk to public safety by improving the opportunity for successful re-entry.

Terry Russell, Executive Director, NAMI-Ohio

The above response "need assurance of safety net in community if person is released to reduce risk of re-offending" is directly related to the response in Question #1. Today there is no safety net. According to the Ohio CORE Grant, of the offenders leaving prison in 1996, 41% from Cuyahoga County and 38% from Franklin County were returned to prison within three years. Without a restructured system, this number will only increase.

I believe that this is an opportunity for Ohio to receive federal funding to stimulate the changes needed in the community mental health system. These changes will break the cycle that currently exists for the mentally ill individual involved in the criminal justice system.

Dr. Mark Munetz, Chief Clinical Officer, Summit County ADM Board

Many community mental health systems are also biased against serving offenders. Lacking service, these high risk individuals are likely to reoffend. Once they reoffend there is no responsibility for the mental health system to serve them. In other words there are no incentives for the mental health system to make offenders/parolees high priority and there may even be a perverse incentive not to serve these people.

Lisa Shoaf, Researcher, Ohio Office of Criminal Justice Services

The following link is to an article by the Bureau of Justice Statistics called "Mental Health and Treatment of Inmates and Probationers," by Paula Ditton.
http://www.ojp.usdoj.gov/bjs/pub/pdf/mhtip.pdf

The Supreme Court of Ohio

Advisory Committee on Mentally Ill in the Courts

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A SUMMARY OF THE PREVALENCE OF MENTAL ILLNESS IN JAILS: LICKING COUNTY JAIL PILOT STUDY

I. The Methodology

The purpose of the pilot study was to answer two research questions: 1) what is the prevalence rate of mental illness among persons incarcerated within the Licking County Jail between March 1, 2001 and March 31, 2001? And, 2) what is the mental health diagnosis of those individuals identified as being mentally ill in the Licking County Jail between March 1, 2001 and March 31, 2001?

This research is an example of a quantitative study. The research design included collecting data for thirty (30) consecutive days for a period beginning March 1, 2001 and continuing until March 31, 2001. During this sampling time frame, jail booking officers administered an eight item "trip screen" questionnaire (attachment A) to all individuals who completed the booking process. The "trip screen" questions were incorporated into the booking software currently used by the jail.

For those offenders who answered "yes" to any of the "trip screen" questions, they were referred to one of two contractors/data collectors who administered the Computerized Diagnostic Interview Schedule (C-DIS IV). The C-DIS IV produced a medical diagnosis for each person interviewed. These diagnostic classifications are recognized by the Diagnostic and Statistical Manual of Mental Disorders. Each C-DIS IV interview took approximately one hour to complete. Participation in the study was voluntary.

II. Research Findings

A total of 265 offenders were "booked into" the Licking County Jail during the month of March 2001.

- 119 offenders answered "yes" to any of the mental health "trip screen" questions.
- 50 offenders were referred to the contractors. Three offenders refused to participate in the study . Those who declined did so because "I have to talk to my lawyer first," I'm sleepy and want to go back to bed," "This type of interview isn't going to get at my real issues and, I'm hungry."
- 72 of the 119 offenders who answered "yes" to any of the mental health "trip screen" questions were not referred to the contract data collectors by the correction officers.
- Of the 47 offenders who completed the C-DIS interview the following diagnosis were found:

- 13 cases of Posttraumatic Stress Disorder
- 2 cases of Posttraumatic Stress Disorder/mild symptoms
- 1 case of Posttraumatic Stress Disorder w/Medical Condition
- 2 case of Posttraumatic Stress Disorder w/Substance Abuse
- 5 cases of Posttraumatic Stress Disorder w/delayed onset
- 6 cases of Schizophrenia
- 2 cases of Schizophreniform Disorder
- 27 cases of having experienced a Major Depressive Episode
- 1 case experienced a Dysthymic Disorder
- 17 cases of a Manic Episode
- 6 cases of Hypomania
- 27 cases of Alcohol Dependence
- 1 case of PCP Dependence
- 16 cases of Marijuana Dependence
- 12 cases of Amphetamine Dependence
- 14 cases of Cocaine Dependence
- 7 cases of Sedative Dependence
- 2 cases of Inhalant Dependence
- 4cases of Hallucinogen Dependence
- 8 cases of Opiate Dependence

- Of the 47 individuals who answered completed the C-DIS interview:

  - 42 were white
  - 1 was black
  - 1 were hispanic
  - 3 were unknown
  - 39 were male
  - 7 were female
  - 1 were unknown
  - 26 were single
  - 11 were married
  - 7 were divorced
  - 3 were unknown
  - The mean age was 30.8
  - The mode age was 18 (4)
  - The youngest was 18 (4)
  - The oldest was 56 (1)

- Of the 47 individuals who completed the C-DIS the following **arrest** data was reported:

  - Probation Violation 31.9%
    Driving Under the Influence 6.4%
    Driving Under Suspension 4.3%
    Comtempt 4.3%
    Endag. Child 4.3%
    Theft 4.3%
    Theft 4.3%
    Drug Abuse 4.3%
    Domestic Violence 2.1%
    Non-support 2.1%
    Assault 2.1%
    Extortion 2.1%
    Violation of a Protection Order 2.1%
    Agg. Burglary 2.1%
    Burglary 2.1%
    Breaking and Entering 2.1%
    Criminal Trespassing 2.1%
    Reckless Operation 2.1%
    Hit Skip 2.1%
    Domestic Violence 2.1%
    Theft of Drugs 2.1%
    Holder-Warrant 2.1%
    Reconvey 2.1%
    Other 6.4%

III. Cost for the Study

Department of Rehabilitation and Correction

3 software C-DIS Licenses	$900.00	
Training Materials	$500.00	
Contractors/Data Collectors	$3,050.00	($8,800.00 had been encumbered)
Total	**$4,450.00**	

Department of Mental Health

C-DIS Training	$1,000.00
Total	**$1,000.00**

Total Combined Cost for the Pilot Study $5,450.00

IV. Process Summary Notes

- **Training:** Jon has more clinical experience as a clinical interviewer and therefore took to the training more quickly. It took Eric a little longer to come up to speed, and he evidenced more difficulties in the live subject interview as well as the pilot subjects' interviews. Jon was also more familiar working with laptop computers than Eric.

- **Tracking and Referral Sheets:** Interviewer tracking sheets were not utilized well by the interviewers. Eric kept records of how many subjects were referred and who declined from 3/1 through 3/20, but failed to keep them the last week of the pilot. Jon did not maintain a tracking sheet at all. From the electronic and written records, it appears as through 32 subjects were referred to Eric and 18 were referred to Jon.

- **Problems with Laptops and Software:** Laptop problems that arose during training included the "jumpiness" of the built-in cursor pad, which was a huge problem for Eric – he was even shocked near the end of the first day's training. The mouse seemed to help Eric quite a lot. There were additional problems with "skipping" questions and getting "stuck" on returns to previous questions. We were eventually able to get around these problems in the field application, but the solutions were somewhat cumbersome. Generally speaking, the laptops slowed down the longer they were in use. Software problems generally involved being unable to enter certain values related to age.

- **Security Issues:** Both contractors received three days of safety and security training at the jail (provided by jail staff). Jon and Eric expressed concern that building renovation knocked out the jail's electronic security, rendering their "beeper pens" useless. However, neither interviewer made any remarks about feeling unsafe with subject inmates. The interviewers reported that the jail staff were friendly and helpful. Midway through the study this author contacted the Major at the jail, who reported that the study was going well, and they were not aware of the presence of the two contractors.

V. Recommendations

- Future contractors/data collectors should be comfortable working with laptops and have experience working with seriously mentally ill populations.

- Data collectors/contractors should visit the jail each morning to review the results from the eight item "trip screen" trip screen questionnaire, and follow up with all offenders who answer "yes" to any of the questions. This will reduce the role of the booking officers and ensure that all possible subjects are captured.

- Carol Carstens, ODMH researcher will consult with the Washington University in St. Louis – School of Medicine regarding some of the difficulties with the software particularly in the area of entering number (ages).

- It is recommended that the state-wide study be completed. However, in order to adopt the second recommendation, the number of jails included will need to be "scaled back" to ensure that the work can be completed within the total budget of $221,300.00 (Byrne Memorial Grant). The multi-agency planning group believes that this can be accomplished while maintaining a representative sample.

SUBMISSIONS FOR THE RECORD

Written Testimony for the Record of
the American Psychological Association
Regarding the
U.S. Senate Committee on the Judiciary
Hearing on S.1194, "the Mentally Ill Offender Treatment
and Crime Reduction Act of 2003"
Wednesday, July 30, 2003
Submitted Wednesday, August 6, 2003

Chairman Hatch, Senator DeWine, Senator Leahy, and Members of the Committee:

The American Psychological Association (APA), the largest membership association of psychologists with 150,000 members and affiliates engaged in the study, research, and practice of psychology, appreciates the opportunity to submit this written testimony regarding the Mentally Ill Offender Treatment Act and Crime Reduction Act of 2003 (S.1194). We applaud Senator DeWine and Senator Leahy, as well as your partner in the House of Representatives, Representative Strickland, for your bipartisan efforts and leadership in introducing this legislation to improve the lives and care of criminal offenders with mental disorders. Building upon the foundation of this Committee's original mental health courts pilot program, "America's Law Enforcement and Mental Health Project," enacted with broad bipartisan support in 2000, this legislation will provide much needed resources to improve treatment for offenders with mental disorders. It also will foster greater collaboration and innovation between the criminal justice, juvenile justice, and mental health systems.

Moreover, the emphasis in S.1194 on diversion and re-entry programs is consistent with the recently released report of President Bush's New Freedom Commission on Mental Health, which found that "[t]oo often, the criminal justice system unnecessarily becomes a primary source for mental health care." As the Commission concluded, many non-violent offenders with mental disorders could be diverted to more appropriate and typically less expensive supervised community care, such as diversion programs: "With appropriate diversion and re-entry programs, these consumers could be successfully living in and contributing to their communities." President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America,* at 43 (July 22, 2003).

The APA recognizes that mental disorders are widespread among both juvenile and adult criminal offenders. Many of these individuals have conditions that can be treated successfully with access to appropriate mental health care. S.1194 offers a comprehensive and much needed approach to improving the lives of one of our nation's most underserved populations. By promoting the use of alternatives to prosecution, additional training for both criminal justice system and mental health treatment personnel, 'wrap around' services in such areas as housing and job training/placement, and important re-entry services, this legislation seeks to expand upon the mental health courts program in sensible and effective ways.

One of the more subtle, yet important, ways S.1194 appropriately builds upon the foundation laid by the earlier mental health courts law is that it employs the same definition of "mental illness." Specifically, both S.1194 and the mental health courts law define "mental illness" as:

> [A] diagnosable mental, behavioral, or emotional disorder (A) of sufficient duration to meet diagnostic criteria within the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; and (B) that has resulted in functional impairment that substantially interferes with or limits 1 or more major life activities.
>
> S.1194, §4(a); America's Law Enforcement and Mental Health Project, Pub. L. No. 106-515 § 2202(1) (2000) (codified at 42 U.S. 3796ii).

This definition of mental illness appropriately turns on the concept of "functional impairment." Functional impairment is required not only under the mental health courts law, but also has its origins in many other areas of Federal law and regulation as well, such as the Substance Abuse and Mental Health Services Administration's (SAMHSA) block grant program for community mental health services. 58 Fed. Reg. 29422, 29424-425 (1993). *See also* Children's Health Act, Pub. L. No. 106-310 §3107 (2000) (codified at 42 U.S.C. §290bb-35(e)(1) (2003). The APA fully supports usage of this already well established definition of mental illness for adults.

The APA does, however, raise two technical concerns with the bill as presently drafted. First, we are concerned that the bill's definition of mental illness is an imprecise fit for children, and may render many emotionally disturbed juvenile offenders ineligible for the programs offered by this bill, the very programs intended to help these juvenile offenders. SAMHSA employs separate and distinct, yet parallel definitions for adults and children. Accordingly, the APA recommends that S.1194 be amended to mirror the existing SAMHSA regulation, 58 Fed. Reg. at 29425. The parallel definition for children, based on the SAMHSA regulation, would state:

> Anyone, from birth up to age 18, who currently or at any time during the past year has had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria within the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities.

The APA would be happy to work with you and the Committee's staff to include this additional provision.

Second, we are concerned that the bill's definition of a "preliminarily qualified offender" draws an unprecedented and overly narrow nexus between the criminal act and the

offender's mental illness. Specifically, in order to be eligible for diversion as a preliminarily qualified offender under Section 4(a) of the bill, a finding is required that "the commission of the offense is *the product of* the person's mental illness (emphasis added)." This language assumes the ability to identify specific causation as to what led to the criminal act.

The APA understands the objective of limiting eligibility for diversion to cases where there is a connection between the mental disorder and the crime alleged. However, the requirement that the crime be a product of the person's mental illness goes beyond connection to causation, a far more difficult standard to meet. This standard is so narrowly drawn that it could eliminate from eligibility many worthy candidates for diversion programs.

Consistent with Department of Justice (DOJ) policy for the mental health courts project, the APA would like to propose that part (B) of the definition of "preliminarily qualified offender" be amended to require connection – not causation – between the offender and the criminal act, as follows:

> "has faced or is facing criminal charges and is deemed eligible by a designated pretrial screening and diversion process, or by a magistrate or judge, on the ground that *the mental illness or co-occurring mental illness and substance abuse disorders likely contributed to the commission of the crime (emphasis added)."*

This language is based on DOJ's competitive grant announcement for the mental health courts project, which requires a showing that a demonstrable mental illness or disability of defendants "likely contributed" to their crimes (see attached).

In conclusion, the APA again commends you Mr. Chairman, Senator DeWine, Senator Leahy, and the members of the Committee for your efforts to expand upon the original mental health courts pilot project with your introduction of S.1194, and by holding this hearing. This bill will promote the diversion and re-entry programs that we know are greatly needed by both adult and juvenile offenders with mental disorders. The APA is ready to work with you to see this legislation enacted.

Respectfully submitted by,

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STATEMENT OF JUDGE MAURICE H. RICHARDSON (Ret.),
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IN SUPPORT OF SENATE BILL 1194

My name is Maurice H. Richardson, of Brookline, Massachusetts, and I am pleased to have this opportunity to provide a statement in support of Senate Bill 1194. I am a retired Massachusetts trial judge, and I served as a justice in the Dedham District Court for 24 years prior to my retirement in May of 1998. For many years I was a member, and later chairman, of the District Court Committee on Mental Health and Retardation, and I became very much concerned with the plight of mentally ill persons, who caught up in the criminal justice system and often inappropriately incarcerated. In this regard I developed an "ad hoc" process in my own court, which allowed us to divert defendants with mental illness, who were charged with non-serious offenses, out of the criminal justice system and into appropriate treatment. In a great many of these cases, the defendants had co-occurring problems of drug or alcohol addiction which required us to seek a broader range of treatments to meet their several needs.

Following my retirement, I joined the Law & Psychiatry Program at the University of Massachusetts Medical School, Department of Psychiatry, to pursue further my interest in issues relating to the mentally ill criminal defendant. Beginning in 2001, our group established the Massachusetts Mental Health Diversion Program (MMHDP) of which I currently serve as Director. The MMHDP is dedicated to advocating for and developing programs in Massachusetts that will assist in diverting mentally ill persons out of the criminal justice system and into effective treatment.

To date, our Program has focused on three key areas of diversion:

- Training police officers in Boston, Worcester and other communities to deal effectively with mentally ill persons in crisis, which includes identifying signs and symptoms of mental illness, crisis de-escalation techniques, and learning what community treatment alternatives are available in lieu of arrest;

- Working with the Boston Municipal Court and the Framingham District Court in developing new strategies to utilize the authority of the Court to motivate criminal defendants suffering with mental illness and/or substance abuse, who have been charged with non-serious crimes, to engage in appropriate treatment options. This is very much in line with the Bill's provision regarding the authority of the court in "leveraging justice sanctions to encourage compliance with treatment," which has been proven effective based on over 12 years of Drug Treatment Court data.[1]

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[1] Hora, PF (2002). A dozen years of drug treatment courts: Uncovering our theoretical foundation and construction of a mainstream paradigm. Substance Abuse & Misuse, 37(12-13), 1469-1487.

- Convening diversion taskforces, both in Boston and Worcester, comprised of key criminal justice officials (police and court personnel), health and social service providers, consumer advocates, as well as the state mental health, mental retardation, and public health agencies, to work collaboratively to develop and implement appropriate diversion options for this population. These collaborations, have already proven highly effective in promoting communication across and among treatment and criminal justice systems. In Boston,our Diversion Consortium is developing plans for a Crisis Triage Unit (CTU) that would provide police officers with an effective and efficient treatment access point for persons experiencing a mental health crisis, and which would be able to triage the mental health, substance abuse, and housing needs of this often marginalized population.

The problem in many states, including Massachusetts, is that there is a growing backlog of persons with serious mental illness who are sorely in need of case management within the mental health system. A sluggish economy and falling revenues has resulted in even further cuts in needed treatment options. As a result, unprecedented numbers of persons with mental illness are being inappropriately channeled through the criminal justice system. Increasing numbers of persons with mental illness and developmental disabilities are being arrested while experiencing behavioral and emotional difficulties. Police officers, with no specific training in identifying mental health issues are called upon to evaluate these behaviors and determine what action should be taken in order to maintain public safety. As a result, many such individuals are arrested, often as a last resort, and are brought to courts or jails that neither have the knowledge or capacity to deal with the mental illness involved nor are able to deal with the co-occurring drug or alcohol abuse that often further complicate the picture.

In recognition of the gravity of the situation, a number of jurisdictions around the country have established different types of police, court, or jail diversion programs which channel offenders charged with non-serious crimes away from the criminal justice system and into mental health treatment programs. Designed to focus on support rather than punishment, these initiatives prescribe two key strategies: (1) diversion of persons with serious mental illness from the criminal justice system; and (2) the bridging of existing mental health and social service programs to provide a seamless network of support capable of stabilizing and sustaining the mental health of this population.

These programs have proven effective in preventing criminal recidivism, and in connecting (or re-connecting) these persons to much needed mental health services. It is of the greatest significance that this approach is gaining a broad coalition of supporters from many different fields and backgrounds. In 1999 the American Public Health Association acknowledged the success of such programs nationwide. It is also important to note that it was Senator DeWine who co-sponsored and this Committee which strongly supported the enactment in the 106th Congress of the *America's Law*

Enforcement and Mental Health Project [P.L.106-515], an Act which has gone a long way in addressing the need for the coordination of service delivery among law enforcement, the judiciary, and mental health services and in providing for the creation of many additional Mental Health Courts.

In this context, it is clear that the time to enact passage of S.1194 has come. It would certainly be a great help by providing sorely-needed funding to develop new diversion programs to address treatment needs of offenders. More importantly, however, is the broad purpose it sets forth as a mandate for state and local governments:"...to increase public safety by facilitating collaboration among the criminal justice, juvenile justice, mental health and substance abuse systems." If enacted, S.1194 would provide a very important step in creating the ability of the criminal justice system to work in partnership with those agencies of government that provide the mental heath and addiction services that are so desperately needed to rehabilitate many minor offenders.

Senator DeWine is to be commended for proposing this important bill to promote the coordinated efforts of state and local agencies working together to solve this growing public safety and public health issue. We strongly support S.1194, and respectfully urge the Senate Committee on the Judiciary to grant it favorable consideration.

Judge Maurice H. Richardson (Ret.)
Director, Massachusetts Mental Health
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"Nurturing the creative spirit~ inspiring positive choices"

Art for a Child's Safe America Foundation
2003 Fact Sheet

Art for a Child's Safe America Foundation (ArtSafe) was incorporated as a 501 C-3 to provide opportunities for communities to use the arts to create safe, nurturing environments for children, youth and adults. ArtSafe creates, develops, and implements programs that promote productivity, positive outlook, and a sense of community through encouraging participants to discover, value, and use their innate talents and individual interests. Creating programs and products that provide meaningful alternatives to violence is ArtSafe's highest priority.

ArtSafe's Programs include:

- **InSide Out:** This artist-in-residency program for incarcerated youth is in its third year of implementation. Program goals include life skills development, character education, restorative justice, and mentorship with professional artists. Each goal is in support of healing, community service, and successful reentry into society. Through substantive roles in planning and creating individual and group projects, participants learn to think creatively, problem solve, and work cooperatively.

The project's success include: measured improvements in behavior and attitude, high school English and Fine Arts credit, the publication ***InSide Looking Out,*** and music CD ***MACI: Men Acquiring Courage and Intelligence.***

> James Garbarino, Ph.D., Professor of Human Development at Cornell University and author of *Lost Boys: Why Our Sons Turn Violent and How We Can Save Them*, says:
>
> "**InSide Looking Out** *gives voice to these youths and affirms their humanity-in all its complexity. It invites the reader to be sympathetic to the challenges they face, the strength they possess, and the goodness that can lie behind the tough and troubled façade".*

- **Resiliency through the Arts:** Incarcerated young adults participating in this nine month multi-disciplinary program develop positive communication and leadership skills via the group art process. They explore values and attitudes that affect their coping strategies, discipline, responsibility and personal strengths. Participants' build resiliency and self-esteem in a nurturing environment of commitment of purpose, hope, and integrity. The program utilizes arts modalities including creative writing, visual arts, and music.

The project's success include: ***A Caged Bird,*** a publication compiling the participants writings and artwork; increased communication, problem-solving, team work skills; and improved community service performance.

> Alvin F. Poussaint, MD, Professor of Psychiatry at Harvard Medical School, says:
>
> "**A Caged Bird** *is eye-opening; it will dispel the stereotypes we often hold about teenage prisoners. The passionate voices of these young women express despair about their past experiences, yet, they express optimism about their personal growth and hopes for the future".*

▫ **Arts Empowerment**: Preventing and intervening with young people before they become involved with the criminal justice system is key to building resilient children and strong communities. Arts Empowerment programming synthesizes the curriculum and successes of **InSide Out** and **Resiliency through the Arts**.

Programming is offered in multiple community and institutional settings. It provides a safe, structured platform in which to explore current coping strategies, and the consequences of behaviors and actions. The learning experiences utilize writing and arts modalities; skill development includes team work, sharing, and relationship building around life experiences. **Arts Empowerment** is offered in flexible program segments between one and nine months in duration.

> Marci Sutherland, Ohio Department of Youth Services Administrator says:
>
> *"When anxiety and stressors abound, this project brought a sense of brightness and growth that was felt by all with whom I spoke. Teachers commended the positive educational impact and personal growth of the youth (even those who are challenging to work with). JCOs found the experience rewarding as the youths involvement and developed insight reduced the issuance of conduct reports and behavioral outbursts."*

Art for a Child's Safe America Foundation
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- The **Memorial to Our Lost Children** is a touring interactive violence prevention program. Built by prison inmates in the form of a house ripped apart, the structure symbolizes a family torn apart. The walk-through exhibit displays photos, precious belongings, and stories honoring the lives of children killed by violence. Since 1996 the program has partnered with schools and communities as an art and education effort - empowering participants to change attitudes and behaviors towards violence by motivating young people and adults to help build safe, nurturing environments.

The Memorial's outcomes include a 47% change in attitude toward handling weapons and; a 42% shift in children's feelings from not being able to make a difference, to commitments of involvement and non-violence. Memorials are on tour in the Central Ohio and Greater Cincinnati areas.

- **Restoring the Faith: Restorative Justice Through The Arts:** In 2000, ArtSafe, in cooperation with Children Writing for Children, created a restorative justice and violence prevention program for inmates in the Ohio Department of Rehabilitation and Correction. The objective was for participants to share their stories about the personal costs and consequences of violence and abuse. In two, 12-week writer's workshops, incarcerated participants learned writing techniques that enabled them to share their thoughts, ideas, and feelings with each other and their readers.

The project's success includes *UnLived Lives,* a book of writings and original art created by adult inmates at Orient Correctional Institution. These authentic stories are aimed at young people, motivating them to consider the costs and consequences of violence and abuse and to make positive life choices.

Art for a Child's Safe America Foundation

Resiliency Through The Arts: Turning Nothing into Something

Executive Summary

Background behind the scope and focus of the Resiliency Program Model

The Resiliency Program has been a core aspect of the juvenile programs at Madison Correctional Institution and the Ohio Reformatory for Women since January 1988. The success and value of this program has been recognized by a variety of individuals, such as Mrs. Hope Taft, First Lady of Ohio, Ms. Susan Zellman, Superintendent of the Ohio Department of Education, Mr. Carl Upchurch, author of "Convicted in the Womb", Mr. Mark Wallace, Producer of Court TV.

Stephen J. Wolin, M.D. and Sybil Wolin, Ph.D., founders of the Project Resilience Foundation and authors of several books and articles about resiliency, recently identified their vision of the "next step" of the Resiliency program, at the recent "The Struggle to be Strong" workshop on July 12, 1999, at the Ohio Department of Commerce. They have recognized, as have the leaders of the Resiliency Program at both institutions, the need for the "written story". Although the Resiliency Program assists the inmate in identifying and owning their individual assets, by building their self-esteem and positive ego strength, there is little direction of how to explore and write their "life story". The "Life story" which is a written story that tells of the growth from negative choices and consequences to identifying assets and creating success, is a factor in the Resiliency Program. Through it they discover personal assets, they learn how to make positive choices and they recognize their strengths, which become positive personal and community future. The inmates have discussed having the desire to find a way to make a difference for others and to stop the criminal pattern within them. These inmates are looking for:

- A structured platform for purposeful reflection
- A group format to reflect on their behavior, actions and consequences
- A place to explore future focused ideas and actions to restore justice, mend the consequences of their behavior and prevent further negative behaviors

- Ways to assist in the prevention of other's following in similar footsteps.

A series of 12-week workshops has been designed to prepare inmates for entry into the community, provide opportunities for restorative justice work, decrease disciplinary problems while incarcerated and recidivism by: strengthening the already existing Resiliency Program, providing an environment for the inmates to gain life knowledge and understating while exploring their stories, through structured experimental exercises. Physiological theorists suggest that individual behaviors are a result of environmental conditioning, and that these behaviors are often reactive rather than reflective. These experts further suggest that action oriented purposeful activities, such as art and education provide these individuals with insightful tools for reflections and change.

How the arts can partner with the Resiliency Program Model

The design of the arts workshops:
"*With time, the imaginative energy that drives playing is channeled into shaping or making art. In adolescence, many resilient survivors dabble in writing, music, painting, or dance to break the constraints of their troubled families and their own hurt feelings...related resiliencies, creativity and humor are tangible proof that you have stopped the course of destruction and have emerged whole from shattering experiences*"
(Wolin and Wolin, The Resilient Self, 1993, Villard-New York, p. 163).

The purpose of the arts workshop is to provide a group setting offered one time per week that offers arts based learning experiences, skills development, and expressive outlets in order for the inmate to better gain knowledge and understanding of their resiliency's and their choices. Through the process of creative arts expression, group participants can in effect reverse a bitter reality (Wolin and Wolin, 1993) and turn:

- Struggles into strengths
- Pain into pleasure
- Defeat into triumph
- Irrelevance into significance
- Something into nothing and nothing into something

What the arts workshops will offer the inmate participants:
"*Resilience is the capacity to shape your awful experiences at home into art and convert a victim's posture into a proud and beautiful stance. In adolescence, many survivors turn to writing, music, art, sports, or dance to express their inner turmoil and to bring order out of confusion. By imposing the discipline of creativity on despair, resilient survivors heal an injured self*"

(Wolin and Wolin, 1993, p. 173).

Participants in the resiliency through the arts program will be afforded the chance to develop positive communication and leadership skills via the group art process including team work, sharing, and relationship building around like life experiences and interests. They will explore values and their attitudes that affect their coping strategies, discipline, responsibility and assets. This series of workshops will enhance their assets and self-esteem, by providing a commitment of purpose, hope, and integrity. These learning experiences will utilize a various arts modalities including the involvement of creative writing, visual arts, music and other creative arts avenues in combination to provide a structured platform to explore behaviors, current coping strategies and the consequences of behaviors and actions.

The resiliency through the arts program will provide the inmates, not capable of verbal introspective reflection on their lives and behaviors, with a means of active engagement in personal changes, insights and decisions through the use of various art making experiences. These art-based groups will address and aid in communication and listening skills development to include such themes as: cooperation, trust, conflict resolution, teamwork, patience and forgiveness. These themes will be addressed through the art of storytelling through mural creation and other creative visual experiences. By engaging in a variety of experimental processes each participant will have the opportunity to connect aspects of their past experiences in a way that will give the past meaning for the present and potential hope for the future. In effect, it is the goal of the resiliency through the arts program to offer the following resiliency based tenants or areas of awareness and self-exploration for group participants:

- *Authenticity in the self – getting down to the bare essentials; wholeness.*
- *Freedom – achieving trust in self*
- *Beauty – the compelling need to create beauty not ugliness*
- *Power – creating one's own world and awareness of one's own power and not staying trapped in opposite messages from the past*
- *Connectedness- telling one's story through art can touch other people and help one learn they are not alone and share feelings alike with others*
- *Control – when the art surface (canvas, page) limits the size of an individual's problems, the hurt will never get big enough to overtake that individual*
- *Morality – the obligation to be all that one can be*
- *Joy – learning to achieve an emotion that once seemed unattainable*

(Wolin and Wolin, 1993)

Sites and Populations Makeup:

- Madison Correctional Institution
  - Males, Ages 15-20
  - 50% African-American
  - 40% Caucasian
  - 1% Hispanic
  - 1% Asian

- Ohio Reformatory for Women
  - Females, Ages 15-20
  - 50% African-American
  - 40% Caucasian
  - 1% Hispanic
  - 1% Asian

Project Period Continuation Dates:

July 1, 2002 to June 30, 2003

THE MENTALLY ILL OFFENDER TREATMENT AND CRIME REDUCTION ACT OF 2003
S. 1194

Senate Judiciary Committee
July 30, 2003

Rhonda Atkins
Sarasota, Florida

I am grateful for the opportunity to testify in support of S. 1194, The Mentally Ill Offender Treatment and Crime Reduction Act of 2003. My name is Rhonda Atkins and I am a mother from Sarasota Florida whose daughter might have been spared years of torment if S. 1194 were already enacted. Instead, she saw the inside of a jail cell several times before she even turned 22 years old.

My 25-year-old daughter was diagnosed with bipolar disorder, a severe mental illness, ten years ago. For much of those ten years, she was not being treated and her condition steadily deteriorated. She is finally in treatment now, but I can never forget what it is like when she is not. When she is symptomatic she experiences severe mania, which at its worst, means that she can go days without sleeping. Her speech gets so rapid and pressured that I can't understand her. She becomes extremely irrational – she doesn't see the world the way we do. She can be very paranoid, thinking that those of us who love her are trying to make her think she's crazy. Her paranoia caused her to run away many times and there have been too many nights when I did not know where my beautiful and vulnerable daughter was. Like so many other people with mental illnesses, my daughter tried to calm the storm in her head and began abusing substances. That only made her symptoms and her situation worse.

She was often uncontrollable and I was afraid of what she might do to herself. When things get that bad, the mental health system doesn't respond. When things get that bad, the only recourse is to call the police. I can't even count how many times they had to come. While many of the law enforcement officers were compassionate and appreciated

my daughter's illness, engrained in my memory are the law enforcement officers who were rough and could have escalated her symptoms to the point where she or they might have been hurt. One officer told her "if you were my daughter, I would knock you across the room."

The first time my daughter was arrested, it was for a trespassing charge. It was an opportunity to get her into treatment, but there were no services to divert her to. There were only waiting lists for services. Later, she was arrested on a drug charge, not surprising since she was self-medicating at that point. Unlike her earlier arrest, this time we had hope. She was diverted to a drug court, but our hopes were dashed because even in the drug court, they had no understanding of mental illness. Not only did the court fail to integrate treatment of substance abuse and mental illness, a social worker in the court actually discouraged it. The result was predictable – when my daughter stopped taking her medication, she spiraled into a mania that resulted in her repeated hospitalization. One time she went directly from the state hospital to a jail cell – from treatment to no treatment because they didn't give her medication in jail.

While her friends were in college, getting married, and having babies, my sweet daughter spent years bounding through the streets, jails, emergency rooms and living with drug dealers. Three years ago, she was sleeping in urine, weighed 81 pounds, had sores all over her body.

This bill could have saved my daughter years of her life and made all of us safer. The reality is that law enforcement officers provide the crisis response for people with mental illness. Without training, their ignorance of mental illness can too easily exacerbate an already tenuous situation. But, an awareness of mental illness allows an officer to facilitate an outcome that can save everyone time, expense and suffering.

Proper training will allow law enforcement officers to recognize opportunities to divert people to treatment rather than incarceration. But, there must be a coordinated system of treatment and services to divert people to. Nothing can be gained by diverting a person to a waiting list. This bill will provide the resources necessary to accomplish that goal. And nothing can be gained by diverting people to services they do not understand they need. My daughter suffers from a brain disease, one that makes her unable to recognize that she needs treatment. She would have benefited from the mental health court that we now have in Sarasota, because the court provides the oversight needed to help people like my daughter stay in treatment. Another vital provision of this bill that would have saved my daughter so much torment is the integration of mental illness and substance abuse treatment.

I felt personally compelled to travel here to day to plead with you to pass S. 1194. We can't let another mother helplessly watch her daughter deteriorate through the revolving door of the criminal justice system.

Testimony of John F. Campbell
U.S. Senate Committee on the Judiciary
"An Examination of S.1194, The Mentally Ill Offender Treatment and Crime Reduction Act of 2003"
July 30, 2003

Good afternoon Mr. Chairman, Senator Leahy, and other distinguished members of the Committee. My name is John Campbell. I am a member of the Vermont State Senate where I serve as Majority Leader and also serve on the Judiciary and the Appropriations Committees.

I would like to thank you for inviting me here to speak in support of S. 1194, *The Mentally Ill Offender Treatment and Crime Reduction Act of 2003*
As a former law enforcement officer, an attorney for over twenty years, and a current State Legislator, I believe I have a unique perspective on this issue that I hope will be able to assist the Committee in its deliberations.

During my time as a police officer, I frequently found myself called to scenes involving petty thefts, disturbances and public intoxication. It was not uncommon to find the suspect of these crimes to be acting paranoid and behaving erratically.

Though I was quite able to handle the criminal aspect of the situation, my background and training did not prepare me to understand or respond to the suspect's behavior. Quite simply, I was not equipped to handle the complex underlying issues of mental illness and substance abuse.

Obviously, it was necessary to arrest and incarcerate certain individuals with mental illness in order to protect the public; however, others who committed low level, non-violent crimes that were simply a manifestation of untreated mental illness should have been referred to a mental health treatment provider. Unfortunately, such care was rarely available, which left us with no other option than to transport them to the county jail – not an appropriate place for someone who is mentally ill.

Times have not changed much in twenty years. Police officers today are better trained

to recognize and deal with these situations. However, they still find the process of securing diagnosis and treatment to be extremely frustrating.
Treatment providers may refuse to accept the individual, noting that he or she does not have health care coverage, is not acutely ill, or has a primary diagnosis that is not their responsibility.

In cases where the individual is eligible for services, the officer may have to wait hours before that person is admitted. In other cases, the person is accepted for treatment, then discharged shortly thereafter - sometimes back on the street and the subject of another complaint before the officer even finishes his report on the initial incident.

Requiring police officers to act as quasi-mental health care providers places an unreasonable burden on them, the department, and the community as a whole. The time required to facilitate treatment for the individual keeps the officers from performing their normal patrol functions. This forces departments to either hire additional personnel or to expose the community to a lack of police coverage.

This is especially troublesome in rural communities, like those in Vermont, as reduced police presence sometimes means the difference between having one officer on patrol and having none at all.

While the initial responsibility for finding placement for individuals often falls upon law enforcement – a burden felt by the communities, the ones who truly suffer are those afflicted and their families. They simply have no place to go. This disjointed spectrum of responsibility is never more evident than when dealing with dual diagnosis, or what is commonly referred to as co-occurrening disorder.

Individuals suffering from co-occurrence find themselves the proverbial hot potato - tossed among the mental health agencies, substance abuse facilities, and the criminal justice system. The current service system is unable to effectively engage these individuals in treatment or to coordinate among the various service providers. Due to these problems, these individuals are often arrested or rearrested for non-violent property or behavior crimes.

If they are fortunate enough to find treatment, all too often it is directed at just part of their disorder. Consequently, it will inevitably fail, and that individual will recycle within the system.

Mental health agencies, substance abuse facilities, and the justice system have good intentions. They are all seeking to break the cycle. However, as laudable as their attempts may be, unless there is a collaborative effort, they will continue to fail.

This systemic dysfunction is not isolated to any one area. From large, urban areas to small communities such as my own in Quechee, Vermont, people are in dire need of integrated services. I often represent families in crisis, and in a majority of these cases, you will find underlying mental health problems. It is extremely frustrating to search for a solution for these families. Too often, we come up short - a result of fragmented and insufficient resources to deal with the issues.

It is devastating to watch families implode over issues that, if treated, could be managed. Mothers and fathers stand by as their children self medicate themselves with illegal drugs and alcohol in order to escape the personal horrors of their mental illness.

Passage of S-1194 would promote the types of integrated treatment and collaborative efforts between criminal justice and mental health organizations that could spare many of these families from this agony.

As an elected official, I appreciate more than ever the fiscal implications of the existing problem. Having to provide mental health treatment in an incarcerated setting is neither cost effective nor clinically sound. A community based approached would provide more complete services at a far greater savings to the taxpayers. Many states have implemented programs for just these reasons - I am proud to say that Vermont is one of them.

One of our more effective programs is taking place in two of our larger communities, Burlington and Brattleboro. In collaboration with our Department of Corrections, Mental Health and Substance Abuse agencies the Howard Center for Human Services and Health Care & Rehabilitation Services have developed the Co-occurring Disorders

Treatment Project. It promotes public safety and health by offering comprehensive, integrated mental health and substance abuse services to those individuals with both psychiatric and substance abuse disorders, and who have ongoing involvement in the criminal justice system.

We are also currently piloting drug courts in four communities. However, the effectiveness of these courts to divert people from the criminal justice system depends directly on the existence of a treatment system with enough capacity to accept and treat referrals from court.

Vermont's existing programs, as well those in other states, while effective, are significantly under-resourced. This is why passage of S.1194 is so important. It will provide the resources necessary to implement collaborative programs – ones that have proven to work; ones that will effectively and humanely deal with a problem that afflicts hundreds of thousands of Americans.

Once again, I would like to thank the Committee for inviting me to testify. I hope my testimony will be useful.

John F. Campbell

CRITICAL CARE

Wrongful deaths. Inadequate care. Questionable doctors. . . . Health care in Ohio's 33 prisons is plagued with serious, deadly problems.

Sunday, August 24, 2003

Randy Ludlow
THE COLUMBUS DISPATCH

At age 19, Sean Schwamberger was tired of being a punk. Cashing two forged checks for $777.32 cost him 11 months, and the small-time con just wanted to return to Toledo for the go-straight lifestyle of a house painter.

But rather than the celebration of redemption envisioned in his prison journal, Schwamberger's homecoming was one of second-chances lost.

He died as inmate A 436969 on April 29 amid a prison staph outbreak — perhaps for want of a $10 diagnostic test and a different antibiotic.

The drug-resistant staph infection that overwhelmed Schwamberger and his prescribed penicillin was not detected until he fell mortally ill in the yard of Pickaway Correctional Institution.

His death is a symptom of serious flaws — sometimes fatal — that regularly beset the health-care system in Ohio prisons.

A three-month investigation by The Dispatch and WBNS-TV (Channel 10) found that the medical care provided to 45,402 inmates in 33 prisons is riddled with hidden problems and costs.

Reginald Wilkinson, director of the state prison system since 1991, said the investigation's findings are aberrations that do not present an accurate portrayal of prison medicine.

"I think the department has an excellent medical system, and I think we are actually a model for the rest of the nation from a number of points of view," he said. "We know what we are doing, and we do it well."

A review of thousands of pages of records from the Ohio Department of Rehabilitation and Correction from the past three years and dozens of interviews reveal:

• Taxpayers, who underwrite annual spending of more than $122 million on correctional health care, also footed more than $1 million in bills to pay wrongfuldeath and medical-negligence claims filed by inmates and their families.

• Critically ill inmates died at hospitals after waiting nearly an hour for ambulances, and prisoners with chest pains died of heart attacks within minutes of being seen and released from clinics.

"This is a pathetic situation in Ohio, and it needs to be addressed promptly. . . . It's reflective of a systemic problem.

" ALPHONSE GERHARDSTEIN a Cincinnati lawyer and president of the Prison Reform Advocacy Center

SCHWAMBERGER FAMILY PHOTO

Sean Schwamberger, 19, who died

• Some prisoners waited up to 16 months for surgery while their ailments worsened, with the waiting list once backlogged with 100 inmates.

• Inmates, including the mentally ill, went days without receiving their prescribed medicine and without seeing doctors, while officials fretted about fielding enough nurses to staff prison clinics.

• Medical professionals working in state prisons included a doctor under a 35-count felony indictment, a physician who lied about his criminal background and others with a history of disciplinary action.

• In a flood of e-mails between prisons and the Office of Correctional Health Care in Columbus, administrators regularly complain about the poor performance of contractor-provided physicians and dentists.

Some prisons have gone months without medical directors while revolving-door rosters of doctors work too few hours to fulfill contracts requiring that ill inmates be seen within two days.

Amid long-lingering state budget woes, a medical system has evolved in which contractors are paid less to care for more inmates, with one contractor lamenting a corresponding drop in the caliber of physicians.

Meanwhile, the state continues to rehire contractors with checkered histories while some physicians ousted because of concern about the quality of their care later resurface to work in other institutions.

''We don't profess that we're perfect. We profess to operate a constitutional health-care operation, and we do. But we're also very cognizant of the fact that if there are quirks . . . we want to fix them," Wilkinson said.

'Systemic problem'

Alphonse Gerhardstein, president of the Prison Reform Advocacy Center and a Cincinnati lawyer who won a 1995 settlement to improve psychiatric care for mentally ill inmates, disputes Wilkinson's description of ''quirks."

After reviewing the findings of The Dispatch and Channel 10, Gerhardstein diagnosed Ohio's prison medical system as ''in crisis."

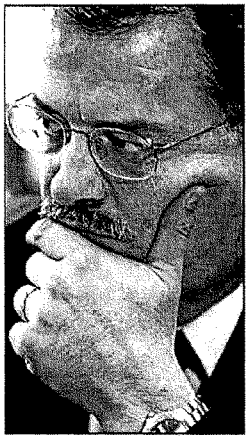
''This is a pathetic situation in Ohio, and it needs to be addressed promptly....It'sreflective of a systemic problem," Gerhardstein said.

Medical care tops the list of inmate complaints to the Prison Reform Advocacy Center. In 2002, prison officials found merit to 85 of 562 inmate grievances claiming improper care or delays in care or medication.

''Back in the late 1700s, when we passed the Constitution, we knew that we were supposed to treat inmates in a way that wasn't cruel and unusual, and here we're doing it. And that's terrible in the year 2003," Gerhardstein said.

Within the past three years, the state has paid five wrongful-death claims filed by relatives of deceased inmates — and more lawsuits are pending.

from a massive staph infection, clowns for the camera in a photograph shown at his funeral in Toledo. He was an inmate at Pickaway Correctional Institution at Orient.



"You will find no perfect system, but I think we do an excellent job meeting . . . the increasing demands with the limited resources.

" DR. BRUCE MARTIN medical director for the Ohio Department of Rehabilitation and Correction

"They didn't die because they weren't receiving treatment; they didn't die because they were being ignored," said prisons spokeswoman Andrea Dean. "Just like unfortunate deaths occur in hospitals . . . there are unfortunate deaths that occur in the Department of Rehabilitation and Correction."

Dr. Bruce Martin, the prison system's medical director, defends the system and its handling of unhealthy inmates.

"You will find no perfect system, but I think we do an excellent job meeting the challenges — meeting the increasing demands — with the limited resources," Martin said.

Increased costs

Prison clinics form the front line of the health-care system. Inmates who need skilled-nursing care are housed at the Frazier Health Center at Pickaway Correctional or in Columbus at the Corrections Medical Center, which includes a hospice.

Those who need hospitalization or surgery are treated in a prison wing at Ohio State University Medical Center, which is paid $26 million annually by the state.

Wilkinson describes Ohio's specialized in-house medical facilities, and the relationship with Ohio State, as rare among state prison systems. "We actually save lives." Many prisoners have left the state system with "prolonged lives" because of the care received while serving their time, he said.

Aside from the millions in taxes Ohioans provide, they have a significant stake in the quality of the prison medical system.

"Tens of thousands of inmates are being released into the community every year with undiagnosed or untreated communicable disease, chronic disease and mental illness," said a report by the National Institute of Justice in conjunction with the National Commission on Correctional Health Care.

With an average sentence of 33 months in Ohio, the state released 25,635 inmates last year from a system that is at 123 percent of capacity.

Ineffective care also escalates public spending as the health of freed ex-convicts with no insurance worsens and they seek treatment at taxpayer expense for conditions not diagnosed or treated appropriately behind bars.

"The quality of (prison) care is not as high as it might be, resulting in unnecessary morbidity, premature mortality and increased costs," the institute report found.

Mourning the premature death of her son, Schwamberger's mother thinks he was "not given the medical attention he deserved as a human being."

"He wanted to come home and do things right," Karen Bollett Neal said. "Sean was not a bad person. He did some bad things."

Bob Schwamberger remains in near-denial over his son's death. "It's

Death behind bars

A total of 120 inmates died in 2001 and 118 died in 2002. Through the end of July, 56 inmates have died this year. Prison officials point out that patients die at the best hospitals and note that many inmates enter prison in poor health. Here are some examples of how inmates died while under the care of the prison medical staffs:

CLIFFORD GRIFFIN, 47

Died: April 11, 2000
Cause of death: heart attack
Sentence: four to 15 years for attempted rape (Morrow County)

After complaining of chest pains at Madison Correctional Institution near London, he collapsed while walking to a van to be taken to the hospital. An ambulance was summoned, and he died at the hospital.

VINCE PELPHREY, 33

Died: May 23, 2000
Cause of death: cardiac arrest
Sentence: 11 months for drug trafficking (Shelby County)

He developed chest pains after running 300 yards at his own pace during an exercise program at Montgomery Education and Pre-Release Center in Dayton. He was treated at the infirmary and died at a hospital. The exercise, which records say was required but officials later said was voluntary, was eliminated after his death.

DONALD PURKEYPILE, 48

Died: June 6, 2000
Cause of death: heart attack
Sentence: nine to 25 years for felonious sexual penetration (Cuyahoga County)

While working, he complained of dizziness and was taken to the infirmary at Allen Correctional Institution near Lima. He was waiting to be seen when he slumped over and lost consciousness.

LEO CASON, 41

unbelievable. I thought he would be safer there.

"They didn't take care of my son. He was there under state custody. He should have been protected by the state instead of allowed to lay there and get sicker and sicker and sicker."

Burned out

While in Pickaway Correctional at Orient, 15 miles southwest of Columbus, Schwamberger was under the care of Dr. Adil Yamour, a 66-year-old Washington Court House resident who has worked in prisons for more than nine years.

After eight years at London Correctional Institution, Yamour was described in mid-2002 as experiencing "burnout" by Vicki Ware, the prison's health-care administrator, who requested he be replaced.

"He orders ibuprofen for everything, regardless of the diagnosis," Ware wrote to the Rehabilitation and Correction Department's central office. "He takes off without notifying me. . . . 95-98 percent of my daily . . . complaints are regarding the doctor."

Yamour, a native of Iraq, said he lost his job at London because of discrimination and that he gave good care to inmates despite being asked to see "an unheard of" number of inmates — 70 to 93 in an eight-hour shift.

The physician, criticized by Ware for telling inmates he was not allowed to order certain procedures or medicines because of a lack of funding, said that what he told prisoners was true.

After he was removed as medical director at London, Yamour was reassigned as a physician at Pickaway, which receives its physicians under a state contract with Columbus-based Clinicare.

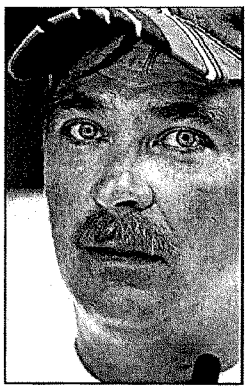
Despite an outbreak of at least 26 staph cases among inmates in two months at Pickaway, no cul- ture tests were taken to learn whether the infections were the easily treated common strain or the potentially deadly, drug-resistant form.

State health officials were alarmed by the lack of culture tests — which now are standard procedure in the wake of Schwamberger's death — when prison administrators summoned them for help the day before he died.

Within the next month, the recommended tests detected 15 other inmates with methicillin-resistant Staphylococcus aureus infections. No other prisoners died during the staph outbreak, which officials attributed to shared tattoo needles after first suspecting spider bites.

Eight more Pickaway inmates have been infected with drugresistant staph since, with the latest case reported to public-health officials on Tuesday.

In a Feb. 28 e-mail, medical director Martin wrote that it was his "best guess" the wounds were being cultured, but added: "I would recommend only doing cultures if there is a nonresponsive wound."



"He was there under state custody. He should have been protected by the state instead of allowed to lay there and get sicker and sicker and sicker.

" BOB SCHWAMBERGER father of inmate Sean Schwamberger, who died of a staph infection while in prison

TIM REVELL | DISPATCH

Karen Bollett Neal cries while viewing photographs of her 19-year-old son, Sean Schwamberger. "Every day, I wake up. I miss him," she said. "He's with me still. In my heart, he's not dead."

PRISON MEDICINE
COSTLY DECISIONS, DIRE CONSEQUENCES

Martin also later expressed concerns that Yamour was lancing and draining lesions to create open sores that could worsen infections. Yamour defended his practice, calling it a "medical must" to drain infections.

Complaining of back and shoulder pain, Schwamberger refused to go to OSU Medical Center on April 23. But he relented the next day and was checked at the Columbus hospital and "sent back, nothing wrong with him," Yamour said.

Both Yamour and Martin defended Schwamberger's care, saying he appeared to be responding to treatment until he collapsed from toxic shock and was hospitalized at OSU on April 26, three days before he died.

Ohio State officials said they could not comment on Schwamberger's treatment because of medical-privacy laws.

"If we could turn the clock back and do something different to save his life, we would be happy to do it," Wilkinson said. "I have not seen anything definitive at this point that he died because of negligence."

Higher standard

Although federal court precedents require states to provide "reasonably adequate" health care, Ohio's system bills itself as demanding a higher "community standard of care" for its prisoners.

The care inmates receive within prison walls is expected to be the same quality Ohioans receive on the outside from their personal doctors, dentists, pharmacists and optometrists.

But without the option of choosing another provider, a few examples — among dozens — illustrate the substandard treatment some inmates have received:

• An inmate at the Ohio Reformatory for Women at Marysville bled profusely and was in "excruciating pain" because of improper anesthesia after a physician's assistant performed a surgical incision on her vaginal lip on Jan. 21. Robert Kessack, who officials say performed the procedure outside the scope of his duties and without supervision, was fired by his employer, West Edge Medical Care Inc.

• Incidents at the "super-max" Ohio State Penitentiary included an inmate in cardiac distress who waited five days for heart surgery and a prisoner with a lump on his shoulder that grew to larger than a billiard ball. He spent 16 months on a surgery waiting list before its removal. State officials agreed in court in mid-2002 to improve the quality of care and other conditions at the Youngstown prison.

• Inmates at Lima Correctional Institution went as many as five days without prescribed medications after the prison pharmacy was unstaffed for six days during a twoweek period in late 2001. Prime Care, the pharmacy contractor, sent a pharmacist to replace one who resigned, but his license once had been revoked and he was rejected by prison officials. Failure to give medications to inmates in a timely manner is an ongoing problem.

An investigation by *The Dispatch* and WBNS-10TV resulted in a series of stories appearing today and Monday:

TODAY
Inadequate care costs lives and money.

► Low standards for prison doctors | A8

► Inmates who died behind bars | A8

► At 11 p.m., Eve Mueller examines the cost of medical negligence.

DISPATCH.COM
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MONDAY
Budget cuts slice medical care

• Despite the 1995 settlement of a class-action lawsuit to secure improved care for mentally ill inmates, prisons continue to encounter problems. The prison system has a separate, $67 million annual budget for mental-health services.

In June, officials at Lorain Correctional Institution warned that prisoners were running out of medication, and psychiatrists were not evaluating enough inmates. Records show delays of up to a week in obtaining psychotropic medicine for the mentally ill at prisons and backlogs of inmate assessments.

Dr. Shura Hegde, a contract psychiatrist at Lorain, was ousted in 2001 after prison officials found he gave "full mental-health evaluations" in 10 minutes and gave the same assessment scores to 30 of 31 inmates, "some of whom were psychotic." Lorain officials complained Hegde played ping-pong on duty and billed for half-hour lunches for four years and was overpaid $36,864. He denied the charges.

Ongoing complaints

In a quest to improve care, the Department of Rehabilitation and Correction abandoned the direct employment of doctors and dentists more than 15 years ago in favor of hiring contractors, at first paying per-hour rates and then later soliciting lump-sum bids.

The partnership between the public agency and private-sector companies has not always been effective, with ongoing complaints from the department about some contractors failing to provide contractually required care to inmates.

Prison officials have insisted on the removal and replacement of numerous problem physicians, but no company providing doctors has ever lost a contract because of substandard performance.

TIM REVELL | DISPATCH

A shackled inmate awaits examination at the Corrections Medical Center on the South Side. The prison hospital houses ill inmates in need of long-term care and operates on an annual budget of about $13.9 million.

"I will readily admit" problems with contractors, Wilkinson said. "Typically, we'll find something wrong and fix it. Unfortunately, sometimes issues and problems slip through the crack. We are very intent on trying to fix problems that occur."

Records show ongoing prison complaints about staff provided —or not provided, in some instances — by Annashae Corp., a staffing management company in Cleveland.

For years, health-care administrators have complained about Annashae's failure to consistently provide medical directors and about physicians who fail to see enough inmates or otherwise prove troublesome.

The prison department's concerns spiked late last year when some Annashae physicians threatened to quit because the company had not paid them for months because of cash-flow problems. The company said all physicians were paid.

Annashae has continued to receive state contracts because it has met state guidelines and standards and addressed prison concerns, said Dean, the prison spokeswoman.

Christopher Pasiadis, Annashae's chief operating officer, said there is turnover among the firm's physicians, but the company always has honored its contracts and its physicians have provided quality clinical care.

Bidding on medical contracts has become a losing proposal because of the state's unwillingness to pay enough

money to attract first-rate physicians to work in prisons, he said.

Some Ohio prison officials have been displeased with the physicians assigned to treat inmates at their institutions and periodically have begged for replacements.

Angered by an Annashae-provided physician at Madison Correctional Institution near London in February, the prison's health-care administrator penned a plea to higher-ups in Columbus.

"We need to do something immediately or we're gonna get sued. One inmate was told he needed to pray to God. That may be, but a doctor usually takes a more proactive approach to medicine."

WBNS-10 TV reporter Eve Mueller, researcher Joel Chow and intern Kristen Orlando contributed to this story.

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Prison doctors aren't top shelf; some come with big problems

Sunday, August 24, 2003

Randy Ludlow
THE COLUMBUS DISPATCH

The prison doctor was a candidate to bunk with the felons he treated.

Unknown to prison officials — because they never bothered to check — a prescription-peddling physician strolled into the razorwire enclosures of two of Ohio's most-secure institutions for more than a year.

Dr. Ayman Kader was under a 35-count felony indictment while working in the close-security Lorain Correctional Institution and the ''super-max" Ohio State Penitentiary at Youngstown.

His history did not catch up to him until Jan. 6, when officials at the Mansfield Correctional Institution finally followed state policy and conducted a criminal-background check of their newly arrived medical director.

Banished from Mansfield, Kader was convicted a month later of five counts each of drug trafficking and illegal processing of drug documents for writing bogus prescriptions for amphetamines in Tuscarawas County.

The 49-year-old Kader received a suspended three-year prison sentence and a $40,000 fine when he pleaded no contest Feb. 6. His Ohio medical license was permanently revoked.

Kader is not the only contractorprovided medical professional with a spotty past to work in Ohio prisons, according to state records:

• Dr. Brett Toward was approved to work in Grafton Correctional Institution despite falsifying state forms on which he did not disclose that he was a two-time drunkendriving offender and had been convicted of a firearms offense.

• Dr. Frederick Ho-A-Lim, assigned to the Toledo Correctional Institution, improperly practiced without a license at a Toledo hospital in 2001 during a 23-day suspension of his license for failure to pay child support.

• Dr. Naba Goswami, who worked in Belmont Correctional Institution in 2001, had trouble gaining an Ohio medical license in 1995 because he had been denied a South Dakota license in 1984 for copying another's answers during an exam.

Dr. Brett Toward failed to disclose his criminal background before working in a state prison.

Dr. Frederick Ho-A-Lim was removed from one prison for poor performance but now works in another.

Dr. Ayman Kader worked in two state prisons while under a 35-count felony indictment.

• Dr. Steven Friday, a podiatrist in Chillicothe, Ross and Southeastern correctional institutions, lost his license in 1995, before working in prisons, because of alcohol dependency and three DUI convictions. He was granted a probationary license in 1998 and remained on probation until April.

• Dr. Lenzy Southall, medical director at North Central Correctional Institution in Marion, twice had his license suspended and has faced hundreds of dollars in liens for failure to pay state and federal taxes.

• Dr. Judson Wynkoop, a Hocking Correctional Institution dentist, was cited last year for violating standards of care.

• Dr. Thomas Fellner, a dentist at Mansfield and Richland prisons, spent one year on probation through mid-1999 for infectioncontrol and X-ray violations.

• Richard Sweet, a pharmacist at Lorain and Grafton prisons, lost his license for one year for drug abuse and stealing drugs before receiving a five-year probationary license in 1996. He faces an Oct. 14 unprofessional-conduct hearing before the State Board of Pharmacy on allegations of verbal abuse of a nonprison customer.

"We do have to tolerate a different standard sometimes because it's hard to get people to come and work in the prisons to provide medical care," said Andrea Dean, spokeswoman for the Ohio Department of Rehabilitation and Correction.

"You're not going to get the valedictorians of the class from Ohio State University knocking on the door to work at the Pickaway institution as medical director. . . . You're not going to find doctors who can go get jobs at Riverside (Hospital) knocking down the doors to come and work at Chillicothe Correctional Institution."

Still, Dean conceded, the Egyptian-born and educated Kader never should have been allowed to set foot inside a state prison while under felony indictment.

"They didn't do the job," she said of the failure of officials at the Ohio State Penitentiary and Lorain Correctional to run departmentrequired criminal-background and security-clearance checks on Kader.

The institutional inspectors and two deputy wardens at both prisons were reprimanded and underwent "corrective counseling" for their failure to check on the physician.

On March 21, 2001, seven months before he began working in prison, Kader was indicted for repeatedly writing medically unnecessary weight-loss prescriptions for undercover agents between mid-1999 and early 2001.

He transferred from the "supermax" prison to Lorain Correctional in December 2001 after officials threatened to revoke Annashae Corp.'s $435,000-a-year contract unless it assigned a permanent physician to oversee inmate care. Annashae had touted Kader as "one of our most valued, cooperative physicians."

Christopher Pasiadis, Annashae's chief operating officer, said the company checked Kader's medical credentials, but was unaware he was under indictment because the prison system is supposed to do criminal background checks.

"People do not go to medical school dreaming of some day working in a maximum-security prison," he said.

Kader could not be located for comment. He is being investigated in New York for obtaining a medical license in March 2002 and failing to disclose his indictment. He briefly worked in Bath, N.Y., before his license was suspended. Pennsylvania authorities also are moving to revoke his license in that state.

In Toward's case, officials were unaware he did not disclose his criminal convictions on state forms. But they learned through a background check that he had two convictions for driving under the influence and a misdemeanor conviction for improper use of a firearm in a motor vehicle. Prison officials debated whether he should work in prison, but cleared him.

Prison officials were unaware Toward had failed to disclose his convictions until the falsified forms were discovered by The Dispatch and WBNS-TV (Channel 10). Toward declined to comment.

"Did we know that going in? No. Had we known he falsified his application, we would have not have allowed him to continue to provide a service for us," Dean said.

Toward worked in Grafton as a probationary contractual employee from Clinicare for about three months during the summer of 2002 before he left amid complaints that he was not working enough hours seeing patients, records show.

Misdemeanor and traffic convictions do not forbid employment in state prisons, but felons are disallowed, Dean said.

Officials realize some prison physicians are not top-drawer.

''We just have some poor-quality physicians that either have left our other institutions voluntarily or have gotten the boot, and I can help to make sure you don't unknowingly get (one) of those," Beth Ferguson, a prisons contract administrator, wrote to a deputy warden last year.

But not all prisons succeed in sidestepping departed doctors.

Ho-A-Lim, who now works in the Toledo Correctional Institution, is one of at least three physicians who lost their behind-bars jobs, only to later surface in another prison.

The doctor said he stopped working at the Northeast Pre-Release Center in Cleveland because he had tired of the commute from his Toledo-area home. ''I told them to replace me. They begged me to stay. They said I was one of the best doctors they had," Ho-A-Lim said.

Asked about continuing to practice medicine during the suspension of his license, Ho-A-Lim ended the conversation.

Last summer, officials at the Northeast Pre-Release Center appeared frantic to rid themselves of Ho-A-Lim, who attracted complaints of working only two hours during a scheduled 10-hour day and not showing up another day.

''I cannot tolerate such inadequate coverage," wrote the prison's healthcare administrator. ''We had a female that was injured this morning (and) in a wheelchair since 8:45 a.m. waiting to see him. Nearly four hours!!! What are we to do with this man?"

WBNS - 10 TV reporter Eve Mueller and researcher Joel Chow contributed to this story .

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LIVES LOST AND DAMAGED

Cost of inadequate care is measured in human terms and millions of dollars

Monday, August 25, 2003

Randy Ludlow
THE COLUMBUS DISPATCH

William Reynolds Sr. died after his pneumonia was diagnosed but treated only with Pepto-Bismol.

David Thiessen died after a nurse waited 40 minutes to call an ambulance as he suffered epileptic seizures.

And Terri Lynn Luckel underwent emergency surgery for internal bleeding and fell into a coma for more than two weeks after her blood-thinning medication was doubled.

Atop the cost of lives lost and damaged, Ohio taxpayers have parted with $1.1 million during the past three years to settle claims of medical negligence and wrongful deaths within state prisons.

The payments, mostly to prisoners or their estates, were spawned by a problematic prison health-care system that crit denounce as long on mistreatment of inmates and short on cash and accountability.

The Dispatch and WBNS-TV (Channel 10) conducted a threemonth investigation, including a review of thousands of pages of state records, and found:

• Per-inmate spending on health care has edged up 9 percent since 2000, while medical costs outside prison have increased twice as much. The state credits efficient practices; critics call it a prescription for poor care.

• Prison administrators and doctors are pressured to contain medical costs, with central-office approval required for certain surgeries, tests and drugs. Doctors have been scolded for "liberal" referrals of inmates to specialists.

• Spending limits on medical contracts progressively have ratcheted down costs, with caps set at the amount paid to l bidders the prior year. One contractor says the practice yields lower-paid, less-trained prison physicians.

• State assessments of the quality of care provided to inmates by physicians and other medical providers are secret an what critics portray as a neartotal lack of accountability and outside review.

In response to the findings of the investigation, the state senator in charge of a prison-oversight committee plans an examination of health care behind bars, and the prisons director wants to identify and correct problems.

"It's gotten to the point where I think they (prison officials) feel they can do whatever they want. I think that's been a real problem for the past couple of years," said Sen. Mark Mallory, a Cincinnati Democrat and chairman of the committee.

"The reality is, we are talking about human beings, and we're talking about the expenditure of public money and the accountability of public money, and those things should really be of concern to everybody in the state," he said.

Mallory said he will assign the staff of the joint House-Senate committee to examine the quality of health care in Ohi prisons and report back to lawmakers.

"We need to get into the issues of medical care inside the institutions and again make sure it is provided in a timely r

Prisons director Reginald Wilkinson said he would welcome any legislative review, and will talk with prison officials seek solutions.

"Where situations can be remedied, that's what I want."

Hidden costs

Pending lawsuits against the Ohio Department of Rehabilitation and Correction alleging that inmates died because of boost one of the hidden costs of health care behind bars.

"Certainly, there are unfortunate incidents. But even when you look at the grim side of what happens when people di the average population in Ohio," Wilkinson said.

Lawyer Alphonse Gerhardstein, president of the Prison Reform Advocacy Center of Cincinnati, said of inmate claims cheap. The number is tiny compared to the problem."

The state paid Barbara Slade-Lanier $20,000 in May to settle the wrongfuldeath suit she filed over her son's lack of c "As far as I'm concerned, they got away with murder."

Slade-Lanier, called "Love" by her first-born, David, still wells with tears and anger while reading letters he sent hor Orient Correctional Institution, southwest of Columbus.

Hi, Love. ... Every night, I just pray I'll make it out of here alive. I'm very sorry for what I've done, but I'm not ready not getting them down here.

The 27-year-old robber died Sept. 22, 2001, of a toxic overload of iron that was not adequately flushed from his body required by his anemia disorder.

"They knew what he needed to survive, and they said they gave it to him. But if they did, then he'd be here," she

Shrinking budgets

The amount taxpayers pay for prison medical care will top $122 million this fiscal year. The 2000-01 medical budget $14 million (11 percent) cut and has yet to return to the same level.

From paying $6.79 per inmate per day in 2000, the department now spends $7.40, a hike of 9 percent during the same Consumer Price Index rose 19 percent.

Dr. Robert Greifinger, former medical director of New York Department of Corrections, warns of the price for inadec

"The budgets for health care for inmates have to keep pace with medical-care inflation. If they do not, not only will t will suffer with greater ultimate costs to the taxpayers," he said.

For the current fiscal year, the medical budget grew by $4.2 million, or 3.4 percent, but the health-care budgets of 25 than a year ago — were cut an average of 11 percent.

Prison officials say the institutional reductions are largely attributable to retaining $10.8 million to directly distribute funds between accounts.

Ohio Department of Rehabilitation and Correction records show ongoing pressure to contain costs, with the medical c certain medicines or authorize certain procedures for inmates, including hernia operations.

Prison physicians have grumbled about what they apparently view as limits on the care they prescribe.

In a memo to prison health-care administrators on March 29, 2002, Kay Northrup, director of the correctional health-
be instructed to alter the message some were giving inmates.

''Please discuss this issue with your physician, dentist, etc., to be sure they are citing clinical reasons, not budgetary r
have a problem with any of your clinicians on this issue, please let us know," she wrote.

In a 2001 e-mail, Northrup instructed prison officials to tell podiatrists they were ''no longer in the boot business" an
inmates with feet hobbled by stiff state shoes.

''There has been some discussion about the need to improve the state shoes . . . (as) these may contribute to foot prob
alternative footwear should be strictly limited to true medical need — diabetics who develop foot ulcers due to the sti

Dr. Bruce Martin, medical director of Ohio's prison system, says the quality of health services has not been comprom
as administrators admittedly work to restrict spending.

The system's nationally recognized telemedicine program, which allows inmates at far-flung prisons to be ''seen" by
line on costs along with increased use of generic drugs and effective, but less costly, alternative medical practices, M

Wilkinson observed: ''Even Ohio State and Grant hospitals are doing things to save costs. The costs we are saving ar
The mission here is to not spend more taxpayer dollars than we absolutely have to."

Gerhardstein, who won a legal bid to improve prison psychiatric care, replied: ''It's a short-sighted reduction in today
time. Certainly, the need for medical care has not been cut.

''If you're going to try to provide 44,000 prisoners with adequate medical care, plus make a decent profit for a privat
necessary for that medical care, it's not going to happen. The inmates are going to lose."

Compromising quality

The prison system has reduced medical costs by using contract caps to gradually pay less to the companies providing
in prison clinics.

For example, the contract cap for physicians at the Lebanon and Warren prisons northeast of Cincinnati was $260,00
coming in at $198,000 — the amount at which the cap was set for this year.

One provider cautions that the spending limits placed on prison medical-care contracts — while demanding more wo
are a classic example of getting what you pay for.

''The financial constraints the state is experiencing . . . has inhibited the ability of our system to provide better health
Pasiadis, chief operating officer of Annashae Corp. of Cleveland.

''One thing that suffocated us in our ability to recruit and retain better medical professionals" for prisons is the contra
physicians have been a constant source of complaints from prison officials.

''If you're offering less than a doctor could make at a private clinic or emergency room, how are going to sell that ph
security or medium-security inmates in a remote area of Ohio?"

The result is ''a lesser-caliber physician, maybe a lesser-trained physician" working in prisons, Pasiadis said.

Before paying lump-sum amounts for physician services starting in 2001, the state paid hourly rates that equaled $16
directors and $145,600 for full-time physicians, a total of $312,000 for the typical prison.

The Department of Rehabilitation and Correction this year is paying $175,000 — $137,000 less — for both a medical

Southern Ohio Correctional Facility near Lucasville.

The department must offer competitive salaries to improve the quality of physicians, as it did to attract better psychia

"They're getting the dregs, and there's no reason for it," he said.

Martin disputes that there are inferior prison physicians because of the falling contract caps, which he calls a "good p

"I do not believe it impacts quality at all. It has forced us to use available resources in a much more proficient manne got working," he said.

At the same time, when asked if decreased spending improves the quality of health care, Martin replied: "The answe mission."

Hidden records

Without the option of turning to other medical providers, inmates who feel they receive inadequate care can only file seeking reviews of their health-care complaints.

A 2001 report by a consultant hired by prison officials suggested revamping medical-grievance procedures to provide professionals. Prison officials discussed creating a task force to examine the issue but never followed through.

Gerhardstein said the medicalgrievance system lacks accountability.

"The medical grievance goes to a bureaucrat, the bureaucrat then sends it to the medical staff, who then say, 'We're about?' Then they send the grievance back and deny it.

"If they aren't going to provide grievance systems that actually look at medical problems, then they're going to be st the lawyer said.

Beyond accreditation from the American Correctional Association every three years, when out-of-state corrections of visits, there are no outside checks on the quality of medical care.

In fact, prison officials' assessments of the quality of care behind bars are secret — with fines possible for disclosure

The department maintains a long checklist to evaluate physicians and others monthly to ensure they are meeting patie but the documents are confidential.

"The notion here was not to prevent any public-records inspection, but more so to protect the medical records of inm

The Correctional Institution Inspection Committee, consisting of Mallory and seven other lawmakers appointed to ov toothless the past two years.

While records show that the committee's staff periodically persuaded prison officials to address inmates' health conc for two years amid the state-budget crunch.

However, beginning July 1, legislators provided $200,000 — less than half the committee's prior budget — to hire a complaints and keeping check on prisons.

At this point, Ohio should gather "an independent, outside team of correctional medical experts" to review prison me medical director of Illinois prisons and a correctional health-care consultant.

"If the concerns are serious, the state should want to know. Is it getting a bang for its buck, or is it creating liability?"

''Health care has been an afterthought in corrections," Shansky said. ''People don't care unless they have relatives lo this society.

''A society is judged by how it deals with prisoners. If you deal brutally with your most alienated population, that say

WBNS - 10 TV reporter Eve Mueller , researcher Joel Chow and intern Kristen Orlando contributed to this st

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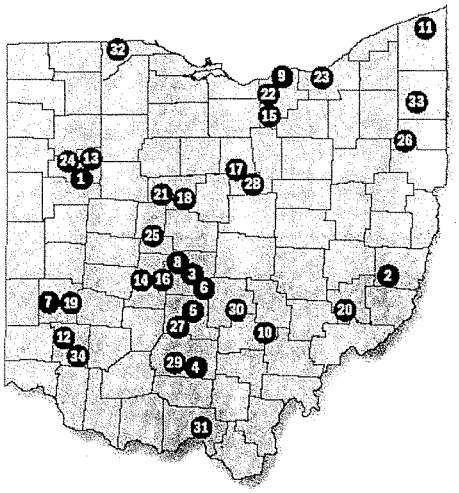
Medical care in Ohio's prisons

The Ohio Department of Rehabilitation and Correction will spend about $122.6 million on medical care for prisoners during the fiscal year ending June 30, 2004. The health-care budgets of 25 prisons were cut an average of 11 percent to hold back $10.8 million for distribution as needed. Despite a 19 percent increase in the medical-care component of the Consumer Price Index since 2000, health-care spending per prisoner has risen just 9 percent, from $6.79 per day to $7.40.



Source: Ohio Department of Rehabilitation and Correction

PRISON	INMATES (CHANGE*)	CURRENT MEDICAL BUDGET (CHANGE**)	PRISON
1. Allen Correctional Institution Lima	1,227 (5%)	$1.9 million (-23%)	**18. Marion Correctional Institution** Marion
2. Belmont Correctional Institution St. Clairsville	2,120 (2%)	$2.4 million (-7%)	**19. Montgomery Education and Pre-Release Center** Dayton
3. Office of Correctional Health Care Columbus		$39.2 million (40%)***	**20. Noble Correctional Institution** Caldwell
4. Chillicothe Correctional Institution Chillicothe	2,579 (14%)	$3.5 million (-8%)	**21. North Central Correctional Institution** Marion
5. Correctional Reception Center Orient	1,916 (3%)	$2.4 million (-15%)	**22. North Coast Correctional Treatment Facility** Grafton
6. Corrections Medical Center Columbus	112 (9%)	$13.8 million (-3%)	**23. Northeast Pre-Release Center** Cleveland (females)
7. Dayton Correctional Institution Dayton	459 (-3%)	$1.2 million (-12%)	**24. Oakwood Correctional Facility** Lima
8. Franklin Pre-Release Center Columbus (females)	457 (-2%)	$828,960 (-19%)	**25. Ohio Reformatory for Women** Marysville
9. Grafton Correctional Institution Grafton	1,346 (1%)	$1.8 million (-3%)	**26. Ohio State Penitentiary** Youngstown
10. Hocking Correctional Facility Nelsonville	447 (6%)	$1.7 million (-9%)	**27. Pickaway Correctional Institutio** (Includes Frazier Health Center) O
11. Lake Erie Correctional Facility Conneaut	1,388 (1%)	Privately operated/ figure unavailable	**28. Richland Correctional Institutio** Mansfield
12. Lebanon Correctional Institution Lebanon	1,728 (6%)	$2.7 million (-9%)	**29. Ross Correctional Institution** Chillicothe
13. Lima Correctional Institution Lima (scheduled to be closed)	496 (-68%)	$671,024 (-49%)	**30. Southeastern Correctional Institution** Lancaster
14. London Correctional Institution London	2,027 (12%)	$1.9 million (-5%)	**31. Southern Ohio Correctional Faci** Lucasville
15. Lorain Correctional Institution Grafton	1,954 (20%)	$3.8 million (-4%)	**32. Toledo Correctional Institution** Toledo
16. Madison Correctional Institution London	2,110 (2%)	$3.0 million (-8%)	**33. Trumbull Correctional Institution** Leavittsburg
17. Mansfield Correctional Institution Mansfield	2,373 (4%)	$3.6 million (-8%)	**34. Warren Correctional Institution** Lebanon

* Change in inmate population from July 2002 to July 2003 ** Change in budget from fiscal year 2003 to 2004

*** Budget includes $27.5 million for inmate care at Ohio State University Medical Center and $10.8 million in medical contingency funds for prisons.

When co-pay plan started, clinic visits started falling

Critics: Charging for medical care discourages early treatment Proponents: Fee cuts d faking ailments

Monday, August 25, 2003

Randy Ludlow
THE COLUMBUS DISPATCH

Three times, Dan Cahill paid $3 a visit in futile hopes he could get past the screening nurse to see a prison doctor about his severe bronchitis.

Cahill abandoned his quest for care, concluding that he no longer could part with the $3 co-pay charged inmates for self-initiated clinic visits.

"It cost me $9. That was half my state pay. I just couldn't afford it anymore," said Cahill, who earned $18 a month as a kitchen worker and porter at the now-closed Orient Correctional Institution.

"Out of that money, you had to buy your toothpaste, toiletries, writing paper, stamped envelopes, whatever," said the convicted burglar and drug trafficker who was paroled in 1999.

Enacted in March 1998, the co-pay is credited by prison officials with weeding out malingerers who signed up for clinic visits in hopes of landing a "lay-in" — an excused absence from work assignments due to illness.

The $3 per-visit co-pay approved by Ohio lawmakers almost immediately cut "sickcall" clinic visits by nearly half, from 626 to 345 a day.

Some suggest the co-pay discourages inmates from seeking early care for seemingly minor ailments that could infect inmates and staff, or later develop into serious illnesses.

"A fee-for-service program ignores the significance of full and unimpeded access to sick call and the importance of preventive care," says the National Commission on Correctional Health Care in its position statement on prison co-pays.

More than 35 state prison systems now charge inmates a co-pay for medical and dental visits they initiate.

In Ohio's 33 prisons, physician visits, follow-up care, mental-health treatment, intake and periodic physical exams, chronic-care clinics, hospitalization and infectious-disease testing are free. Indigent inmates, those who have earned or received less than $9 during the 30 days before a sick-call visit, also are exempt from the $3 co-pay.

Officials at Pickaway and Belmont correctional institutions recently suspended the co-pay and offered "free clinics" to prisoners to help deal with outbreaks of staph infections.

"I don't think it has been a deterrent to good health care," Reginald Wilkinson, director of the Ohio Department of Rehabilitation and Correction, said of the co-pay.

"Now inmates are thinking twice about manufacturing different kinds of ailments for the sake of getting out of work or any other reason," he said. "It sends the message: We're not going to waste the time of our

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doctors and nurses."

Alphonse Gerhardstein, a lawyer and president of the Prison Reform Advocacy Center of Cincinnati, countered: "Th of nickeling-anddiming inmates in order to intimidate them from seeking medical care."

Three dollars does not sound like much to most Ohioans, but critics contend that it is a burden to inmates who do not friends and only earn $18 to $24 a month from their prison jobs.

Taxpayers, of course, pay for inmates' housing, food, clothing and other needs, but in percentage terms, the $3 co-pa $594 to an averageincome Ohio household earning $47,521 a year.

The inmate co-pay has brought in $1.7 million since 1998, with annual collections dropping 28 percent from $408,55 $295,978 in the fiscal year ending June 30.

Of the $1.7 million collected, the prison system still has $1 million in an account dedicated to improving inmate healt to purchase big-ticket items such as kidney dialysis machines.

Dr. Bruce Martin, medical director of the state prison system, was surprised when told the amount of the balance. "I' money," he said.

The National Commission on Correctional Health Care says charging inmates a copay "should be contingent on evid to care. Such evidence might consist of increased infection rates, delayed diagnosis and treatment of medical problem

The Department of Rehabilitation and Correction never has formally studied the impact of the co-pay on access but h compromised the health of inmates, said Kay Northrup, director of the Office of Correctional Health Care.

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About the project

After the death of 19-year-old Inmate Sean Schwamberger in April, *The Dispatch* and WBNS-TV (Channel 10) assigned members of their staffs to determine the quality of health care behind bars. Working together, reporters from the two organizations reviewed thousands of pages of state documents, examined every inmate death from the past three years and conducted dozens of interviews as part of a three-month investigation of prison medicine.

RANDY LUDLOW is a state desk reporter for *The Dispatch*. He joined the newspaper one year ago after 19 years with *The Cincinnati Post*. Ludlow covered state prisons and corrections issues during a decade as *The Post's* statehouse bureau chief in Columbus.

TIM REVELL joined *The Dispatch* as a photographer in 1979. He was named Best Photographer in Ohio by the Associated Press for a collection of work shot in 2001.

EVE MUELLER covers state government for WBNS-TV (Channel 10). She joined the station in 1993. She won an Emmy for her work on the public-affairs program *Capitol Agenda* and a national Edward R. Murrow award for her reporting on black mold in school buildings.

JOEL CHOW ha been a researche WBNS-TV (Chan 10) since 2001. works with the s tion's investigati unit and the "Co sumer 10 Hotlin which receives a many as 600 cal month. Chow is p ident of the Oh Associated Pres Broadcasters.

From: Libby, Shannon
Sent: Friday, September 05, 2003 3:29 PM
To: Hawk, Kristina
Subject: Here you go, Kris. Enjoy your weekend. -Shannon

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Terms: **taft and inmate and date geq (08/05/2003)** (Edit Search)

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Columbus Dispatch (Ohio) August 28, 2003 Thursday, Home Final Edition

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Columbus Dispatch (Ohio)

August 28, 2003 Thursday, Home Final Edition

SECTION: NEWS; Pg. 01A

LENGTH: 658 words

HEADLINE: TAFT FOCUSES ON INMATE CARE ;
After 'Dispatch' stories, governor orders in-depth review of prisons' medical system

BYLINE: Randy Ludlow, THE COLUMBUS DISPATCH

BODY:
Gov. Bob Taft instructed the state prisons director yesterday to hire an outside expert to review prison health care and to recommend ways to improve it.

Taft ordered a far-reaching and comprehensive assessment of prison medicine after an investigation by The Dispatch and WBNS-10TV disclosed a pattern of wrongful deaths, inadequate care and questionable doctors.

"Certainly, the information in those stories was very troubling," the second-term Republican said in an interview.

The state has a humanitarian, constitutional and legal responsibility to meet prisoners' health-care needs, Taft said, adding that Ohio provides "a good quality of care to the vast majority of inmates."

Still, the governor expressed alarm about numerous cases in which inmates did not receive prompt or appropriate medical care and concern about the dubious backgrounds of some physicians working in state prisons.

"As this investigation disclosed, we have not had the kind of standard of care, or the kind of competence in certain of the personnel in the system, that we should expect and that we should strive to accomplish," he said.

Taft also asked Reginald Wilkinson, director of the Ohio Department of Rehabilitation and Correction, to appoint an in-house team to review health-care operations and to implement the recommendations of the outside expert.

The veteran prisons director said an internal health-care review group would be formed within three weeks, and an outside correctional health-care expert should be hired within six weeks.

"I want somebody who is good and who understands corrections," said Wilkinson, who has pledged to identify and correct problems with inmate care.

Taft signaled a willingness to work with lawmakers to increase annual spending on inmates' health care, now at $122 million, if warranted.

"It is true you get what you pay for. ... Is there adequate funding to recruit and retain competent physicians? If we need to invest more in certain areas to make sure there is good care, then that would be the route in which we would have to move."

Taft seemed particularly troubled by physicians with criminal backgrounds or histories of disciplinary problems working in prisons. He wrote Wilkinson that he wanted his assurances that checks will be conducted on every physician.

"In some cases, obviously, there were people who were in these prisons' health-care systems that simply shouldn't have been there," he said.

Taft also wants reviews of the quality of nurse screenings and access to prescriptions.

The $3 co-pay charged to inmates for self-initiated clinic visits also should be examined to ensure it "does not have negative, unintended consequences."

The governor offered condolences without commenting on specific inmate deaths, such as that of 19-year-old Sean Schwamberger, a Toledo inmate who died in late April of an undetected drug-resistant staph infection.

"Certainly, where inadequate care was provided, if that was the case, we deeply regret that and express our apologies to the families of those persons," he said.

The state has paid damages in five wrongful-death cases filed by deceased inmates' families in the past three years.

Alphonse Gerhardstein, a Cincinnati lawyer who has won several lawsuits against the state prison system, described Taft's call for an outside review of prison medicine as "a start."

"But political promises are not enough," said Gerhardstein, who also serves as president of the Prison Reform Advocacy Center.

The lawyer said the state should join the group in agreeing in court to specific health-care reforms. "That would have greater staying power than a political promise.

"Inmates will always slink back into the shadows except for the few times when somebody points a bright light at them. It's critical we honor our constitutional commitment when the

public does not have the issue on the front burner."

rludlow@dispatch.com

GRAPHIC: Photo, DIPTI VAIDYA DISPATCH,, Gov. Bob Taft said the state has a legal and humanitarian responsibility to, meet prisoners' health-care needs.

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The Columbus Dispatch

PANEL TO REVIEW HEALTH CARE FOR *INMATES*

Corrections chief wants recommendations for improvements in care by end of year

Friday, September 5, 2003
NEWS 03B

By Randy Ludlow
THE COLUMBUS DISPATCH

Ohio's prisons director predicts the quality of ***inmate*** health care will improve markedly after an in-house team and an outside expert prescribe fixes for problems.

"We're confident the issues that need to be fixed will be," Reginald Wilkinson said yesterday after naming a 14-member team to examine how Ohio manages prison medicine.

"It doesn't mean things will be perfect. But we're certainly confident the system will be much better off," said the director of the Department of Rehabilitation and Correction.

Gov. Bob Taft requested an internal review and the hiring of a correctional health-care consultant after an investigation by The Dispatch and WBNS-10TV unveiled a host of problems with health care behind bars.

The investigation disclosed prison physicians with questionable backgrounds, cases of wrongful death and ongoing failures to quickly or appropriately treat ill or injured ***inmates***.

While saying most ***inmates*** receive good care, Taft called the findings of the probe "very troubling."

Wilkinson directed the health-care review team, led by deputy director Tom Stickrath, to produce a report by year's end detailing ways to improve care for 44,000-plus prisoners.

In a memo to team members, the director said the review should include staffing levels and address the quality of contractor-provided medical professionals. He also directed the team to study the impact of the $3 ***inmate*** co-pay as well as access to care, the ***inmate*** grievance system and other areas.

Team members

Fourteen Ohio Department of Rehabilitation and Correction officials have been appointed to review the prison-medicine system and submit recommendations to improve ***inmate*** health care.

* Tom Stickrath, deputy department director (chairman)

* Toni Brooks, north regional director, Office of Prisons

* Greg Bucholtz, assistant chief, Chief Inspector's Office

* Annette Chambers, deputy warden of special services, Ohio Reformatory for Women, Marysville

* Brian Eastman, chief, Bureau of Budgets and Analysis

* Michelle Eberlin, deputy

Officials have identified the prison-medicine expert they want to hire to review clinical care, but have not yet reached a contract agreement with the consultant, Wilkinson said.

The prisons department may be forced to "rob Peter to pay Paul" or request more money from lawmakers to pay for improvements recommended by the expert and in-house team, Wilkinson said.

"We're anticipating it will cost some dollars to fix some of the problems," he said.

"But we're not throwing in the towel on money at this point" because the reviews also could identify measures to save costs within the annual $122 million medical budget, Wilkinson said.

State Sen. Mark Mallory, chairman of the Correctional Institution Inspection Committee, will meet with Wilkinson soon to discuss the health-care review.

"This is one of those situations where we have to honestly identify the problems and correct them and not concern ourselves with saving face," said the Democrat from Cincinnati.

Mallory said he was most alarmed by "the variety of problems" The Dispatch and WBNS-10TV identified. "We're not talking about an isolated situation here and there, but numerous cases where we could have done a lot better.

"There's a very serious problem. It's going to take quite a bit of time and effort to straighten it out."

rludlow@dispatch.com

warden of special services, Belmont Correctional Institution, St. Clairsville

* Kathy Ehrle, legal counsel

* Michelle Gray, registered nurse, Corrections Medical Center, Columbus

* Tammy Hartzler, warden, Corrections Medical Center

* Cindy Lawson, health-care administrator, Lebanon Correctional Institution

* Denise Mance, licensed practical nurse, Corrections Reception Center, Orient

* Kay Northrup, deputy director, Office of Correctional Health Care

* Julie Riley, chief, Bureau of Internal Audits and Standards Compliance

* Karen Stanforth, health-care administrator, Pickaway Correctional Institution, Orient

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THE MENTALLY ILL OFFENDER TREATMENT AND CRIME REDUCTION ACT OF 2003
S 1194

SENATE JUDICIARY COMMITTEE
JULY 30, 2003

DONALD F. ESLINGER

SHERIFF, SEMINOLE COUNTY FLORIDA

PAST PRESIDENT, FLORIDA SHERIFFS ASSOCIATION

PAST STATE DIRECTOR, FLORIDA PARTNERS IN CRISIS

Thank you for inviting me to testify today in support of S. 1194, The Mentally Ill Offender Treatment and Crime Reduction Act of 2003. I commend Senator DeWine's leadership along with the other sponsors of this bill.

I am the Sheriff of Seminole County, Florida. Based on my experience, I can assure you that the provisions contained in this bill are clearly needed to stem the ever-growing tide of the mentally ill in the criminal justice system.

Ironically, it was five years ago this month that Seminole County lost Deputy Eugene Gregory in a tragic incident that is emblematic of the crisis of untreated mental illness. Deputy Gregory, responding to a disturbance call, ended up in a confrontation with Alan Singletary, a man whose schizophrenia went untreated for years despite his family's efforts to get him to accept treatment. Alan Singletary killed Deputy Gregory, wounded two other deputies, and was himself killed in the ensuing 13-hour standoff.

It was that tragedy that made me recognize the inescapable conclusion – we have to shift the locus of intervention for people with untreated mental illnesses away from law enforcement and the criminal justice system back to professionals who are trained to provide care and treatment for individuals with severe mental illnesses.

S. 1194 provides critically needed resources for alternatives to incarceration, including training law enforcement and mental health providers and fostering collaboration among community stakeholders. With these resources we have a greater hope of accomplishing three goals:

- Preventing unnecessary injuries and deaths to law enforcement officers and people with mental illnesses;
- Responding to intense fiscal pressures on counties; and

- Making better use of public safety resources.

Preventing unnecessary injuries and deaths to law enforcement officers and people with mental illnesses

The loss of Deputy Gregory and Alan Singletary was far from an isolated incident and is not unique to Florida. Just since that tragedy in July 1998, at least 175 other people with mental illnesses and 28 law enforcement officers have been killed in altercations across this nation – six in DC and Maryland alone. This month alone, 5 mentally ill people have been killed in encounters with law enforcement. We now know that mental illness is a factor in many police shootings, that in fact, people with mental illnesses are four times more likely to be killed in these encounters than the general population.

It is critical to train officers to de-escalate these crisis situations. Seminole County has fully implemented the Memphis Model for Crisis Intervention Teams, a proven approach that fosters a partnership between law enforcement and the community. CIT has been shown to reduce officer injury rates 5 fold.

Equally as important is to prevent these incidences from occurring – because even the best training is no substitute for having a medical professional handle a medical crisis.

Responding to intense fiscal pressures on counties

The most effective way to prevent violent and deadly altercations between people with mental illnesses and law enforcement officers is to prevent these altercations

altogether by providing early intervention and treatment. This is not only the safest approach; it is the most cost-effective approach.

Lack of treatment impacts county budgets many times over – in costs of personnel, incarceration and treatment within the system, emergency care, and even lawsuits. I am aware of at least 7 lawsuits stemming from police shootings filed or settled since April this year, some in excess of $1 million against local governments around the country.

When there is no alternative to incarceration, the mentally ill begin to swell inmate populations in local jails and prisons. In 1999, the Department of Justice estimated that 16% of the inmates in the nation's jails and prisons are mentally ill. Based on the new inmate statistics released this week, there are now *more* than 300,000 incarcerated mentally ill in this country, nearly 6 times the number in state psychiatric hospitals. These are individuals who are ill and most don't belong in jail.

It can cost as much as 50% more to incarcerate a person with mental illness than other inmates. The increasing costs of medications alone are staggering. Fresno County, CA recently reported a 268% increase in psychiatric medications costs over the last 4 years. Not only are costs greater overall for counties, but there is no federal assistance – when the mentally ill are in jail, there is no federal Medicaid reimbursement and the counties bear the full burden of these escalating costs.

Revolving door patients take their toll on everyone's budgets. One person in New York cost the state and federal government $95,075 in one year, mostly for emergency inpatient stays after he stopped taking medication. Last year in Florida, one individual

had 41 emergency psychiatric evaluations at an approximate cost of $81,000 - not including court costs, law enforcement resources, and long-term treatment.

Making better use of public safety resources

There is no question that law enforcement officers increasingly bear the responsibility for responding to people with severe mental illness who are in crisis. A 1999 survey of sheriffs in Virginia disclosed that virtually all survey participants had encountered arrestees with psychiatric illnesses. And the number of police responses to complaints about "emotionally disturbed persons" in New York City rose over 300 percent from 1980 to 1998.

Several factors have contributed to the expansion of law enforcement responsibility for the untreated mentally ill. The initial wave of moving individuals from state psychiatric hospitals to the community during the 1960s to 1980s, known as "deinstitutionalization," failed to adequately invest in community services.

Legal reforms in the 1970s also contributed significantly to the increased need for law enforcement response to people with severe mental illnesses. Treatment laws across the country were changed to require that someone be dangerous to themselves or others before they can be treated over objection. When Pennsylvania changed its law in 1974 to require dangerousness, Philadelphia's police chief issued a directive that nondangerous people who could no longer be taken into custody under the Mental Health Act could be arrested for disorderly conduct. That practice continues today when officers find that there is no alternative for a person who is psychotic but not yet dangerous.

In Florida, law enforcement officers initiate an average of more than 100 emergency psychiatric evaluations each day. Just to put that in perspective, that is comparable to the daily number of aggravated assault arrests and *more* than the daily number of burglary arrests.

In many jurisdictions across the country, these calls take officers off the streets for hours while they wait with a patient in an emergency room. The Charlotte Observer reported this week that it cost the Lancaster County South Carolina Sheriff's department $200,000 last year to watch psychiatric patients at the local hospital. The deputies were responsible for making sure they didn't harm themselves or others.

The increasing responsibilities for crisis intervention and psychiatric services in criminal facilities are a tremendous drain on law enforcement resources that are already strained beyond comprehension responding to heightened security needs since September 11.

How this bill will help

After the deaths of Deputy Gregory and Alan Singletary, I devoted my attention and resources to better understanding and addressing the systemic failures that led to this tragedy. I chaired Florida Partners in Crisis, a statewide coalition of stakeholders in the mental illness treatment system. S. 1194 is entirely consistent with what I have learned is needed to allow mental illness to be handled in a medical context rather than a criminal one.

Training is essential so that law enforcement can properly respond to the mentally ill in crisis, but as importantly, so that mental health professionals can better understand

the plight of their clients in the criminal justice system. As a community, we respond much more effectively to the mentally ill who are in crisis because we have both highly skilled and trained officers and mental health professionals who understand each other's roles.

Fostering community collaboration is a vital component of this bill. These are multi-disciplinary problems that cannot be resolved unilaterally. Effective collaboration can lead to solutions that promote public safety, are cost-effective and preserve valuable law enforcement – and medical – resources.

Early intervention and sustained treatment are critical to keeping people with severe mental illnesses from ever encountering the criminal justice system. It is essential that this bill provide resources for communities to utilize or expand treatment programs that reduce arrests, incarceration, homelessness, victimization, and violence. It is particularly important that we address the needs of individuals who may not seek treatment because they lack awareness of their illness.

The deaths of Deputy Gregory and Alan Singletary inspired our community to collaborate to prevent such tragedies and improve the lives of people with severe mental illnesses. It is my fervent hope that S. 1194 will be part of Gene and Alan's legacy – making certain that people with mental illnesses get treatment before tragedy.

Senate Committee on Judiciary
Hearing on, "An Examination of S.1194, The Mentally Ill Offender Treatment and Crime Reduction Act of 2003"
July 30, 2003

Statement of Senator Charles Grassley

Mr. Chairman, thank you for holding today's hearing on the very important issue of bridging the gap between the criminal justice system and mental health communities. The American public deserves a resolution to this important issue that directly affects their safety.

In order to effectively protect the public, the criminal justice system must have some re-enforcement in its effort to solve the problems it faces regarding the mentally ill. The Bureau of Justice Statistics reports that more than 16 percent of incarcerated adults in the U.S. are suffering from mental illness. According to the Office of Juvenile Justice and Delinquency Prevention, more than 20 percent of the youth in the juvenile system suffer serious mental illnesses. Many of the offenders with mental illnesses can

be easily treated. However, most mentally ill offenders are never treated before being released from prison. Unfortunately, often the mentally ill offenders again participate in criminal activity, and then find themselves in trouble with the law, and back in jail. This is a costly cycle for our criminal justice system.

So there is a breakdown in the mental health system's community-based treatments for those with mental health problems. Without collaboration between the criminal justice system, the mental health system, as well as the substance abuse programs, the mentally ill will continue to commit crimes and jeopardize public safety. If the mentally ill had access to treatment, there is the potential that they would not commit crimes that jeopardize the public.

It's important that Congress find a solution to this problem. I'm proud to be a co-sponsor of S. 1194, the Mentally Ill Offender Treatment and Crime Reduction Act of 2003 with Senator DeWine and others Senators on

this bill. This bi-partisan bill will help state and local governments develop programs that encourage collaboration between our criminal justice and mental health systems. It will be a huge step in keeping the mentally ill from committing crimes.

This bill provides the Attorney General with the authority necessary to administer grant money to assist communities in planning and implementing services for mentally ill offenders. The Attorney General and the Secretary of Health and Human Services will be able to establish a catalog of "best practices" for those working in the criminal justice system to use when transferring the offenders with mental illnesses from prison into a treatment program. These grants are funded for $100 million for each of the next two fiscal years, and will increase public safety by fostering collaborative efforts by criminal justice, mental health, and substance abuse agencies. I've seen these types of collaborative programs

work in Iowa, and I believe that they can work throughout the Nation.

I'm proud to say that my State of Iowa has led the way in the effort to find creative and collaborative programs to help solve the problems presented by criminals with mental health problems. If we as a Congress can work together with the criminal justice system, as well as the mental health systems and substance abuse professionals, then we will increase the safety of the American people.

Again, I thank the Chairman for scheduling this hearing, and I thank Senator DeWine for his leadership on this important issue. I encourage my colleagues in the Judiciary Committee to support this important piece of legislation, and to work together for the safety of the American people.

STATEMENT OF CHAIRMAN ORRIN G. HATCH
Before the
Senate Judiciary Committee
July 29, 2003

"An Examination of S. 1194, The Mentally Ill Offender Treatment and Crime Reduction Act of 2003."

I am grateful for Senator DeWine's continued and tireless efforts in the field of mental health. I too have long been a supporter of legislation designed to assist those afflicted with mental health problems. A few examples include cosponsoring during the 105th Congress S. 543, the Mental Health Equitable Treatment Act, to require health insurance policies to give mental health claims the same treatment given to other health related claims and during the 107th Congress S. 525, the Child Health Insurance and Lower Deficit Act, to provide for Early Periodic Screening Diagnosis and Treatment, which includes treatment for mental illnesses.

Another example of my support in this area includes favorably reporting Senator DeWine's legislation, S 1865 America's Law Enforcement and Mental Health Project, out of the Judiciary Committee during the 106th Congress which established mental health courts for nonviolent offenders with severe mental illnesses. That bill, which was signed into law by the President, provided grants to establish up to 125 mental health courts throughout the nation.

Those mental health courts permit non-violent offenders with serious mental illness to be diverted from jails and placed into appropriate community programs. That law also provides specialized training for law enforcement and judicial personnel to help them identify and address the unique needs of people with serious mental illness that come into contact with the criminal justice system. That was a good step towards assisting those mentally ill who are arrested for minor criminal offenses.

I continue to support increased training for law enforcement and judicial personnel. We should continue to increase efforts designed to interdict mentally ill individuals prior to their interaction with the criminal justice system, and, for those incarcerated, appropriate

treatment of mentally ill offenders while in prison. If we can deal with mental illness issues as early and as continuously as possible, maybe we can halt the deterioration of mentally ill offenders and stop the revolving door to the prison system that so often ensnares those trapped by problems beyond their control.

We should continue working towards practical solutions for those suffering from mental illness. This hearing is a positive step in that direction. In the many years I have spent addressing mental health issues, I have come to the conclusion that the problems attendant to those suffering from mental health complications require bi-partisan action.

I look forward to hearing how these pilot programs have worked across the country. I also would like to receive the Department of Justice's views, considering the Department will play an important role in formulating the rules relating to the distribution of funds for this program. I appreciate the appearance by today's witnesses and look forward to their testimony.

STATEMENT OF RON HONBERG

ARLINGTON, VA

ON BEHALF OF THE CAMPAIGN

FOR MENTAL HEALTH REFORM

REGARDING

S. 1194, "THE MENTALLY ILL OFFENDER AND CRIME REDUCTION ACT OF 2003"

BEFORE THE SENATE JUDICIARY COMMITTEE

JULY 30, 2003

Chairman Hatch, Senator DeWine, Senator Leahy and distinguished members of the Committee, thank you for affording me this opportunity to testify at this important hearing. My name is Ron Honberg and I am Legal Director for the National Alliance for the Mentally Ill (NAMI). NAMI is the nation's leading voice on mental illness, representing individuals with mental illnesses and their families. Founded in 1979, NAMI today works to achieve equitable services and treatment for more than 15 million Americans living with severe mental illnesses. Hundreds of thousands of volunteers participate in more than one thousand local NAMI affiliates and fifty state organizations to provide education and support, combat stigma and advocate for treatment and services for people with mental illnesses of all ages.

I am also testifying on behalf of the Campaign for Mental Health Reform, a collaboration among leading mental health organizations, including the National Mental Health Association (NMHA), the Bazelon Center for Mental Health Law, the National Association of State Mental Health Program Directors (NASMHPD) and NAMI, working to advance the goals set forth in the report recently released by President Bush's New Freedom Commission on Mental Health.

The New Freedom Commission's report emphasizes what this Committee already knows – that our nation's jails and prisons have become "de-facto" psychiatric treatment facilities. In 1999, the U.S. Department of Justice released a report estimating that 16% of all inmates in our nation's jails and prisons suffer from serious mental illnesses – schizophrenia, bipolar disorder, major depression and other serious psychiatric disorders. (1) And, sheriffs and police officers throughout the country will tell you that they regularly respond to people who are experiencing psychiatric crises in their jobs.

In view of this, the lineup of impressive leaders in the criminal justice field on this panel reflects the reality that the criminal justice community has become our strongest ally – and, in some cases, the leader – behind efforts to promote better mental health treatment and programs to reduce the unnecessary criminalization of people with mental illnesses. The landmark Criminal Justice/Mental Health Consensus Project, convened by the Council of State Governments and participated in by national leaders in law enforcement, corrections, courts, and mental health, is an illustration of just how important these issues have become. (2) And, while compassion for a particularly vulnerable segment of our

population is certainly evident in these efforts, the significant involvement of the criminal justice community in efforts to promote jail diversion, better treatment in facilities, and community reentry services for offenders with mental illnesses reflects something more – recognition that reducing the involvement of individuals with mental illnesses in criminal justice systems benefits not only those individuals but criminal justice systems and society as a whole.

Most individuals with mental illnesses who come into contact with law enforcement or criminal justice systems are not violent criminals. Most are charged with non-violent crimes or engaged in non-violent but bizarre behaviors that have attracted the attention of law enforcement officers. And, most of these individuals did not have access to the treatment and services they needed that very likely would have prevented their involvement with the criminal justice system.

Mental illness is the leading cause of disability in the world and in American society. (3,4) Yet sadly, fewer than half of all people with these illnesses have access to even minimally adequate treatment and services. (5) With treatment, recovery is very possible and most people with these illnesses can live productive and meaningful lives. Without treatment, the consequences are frequently horrendous – homelessness, dependence on families and/or public benefits, suicides – or involvement with criminal justice systems.

It is frankly unfair – and very poor public policy – to saddle criminal justice systems with responsibility for responding to people with mental illnesses in crisis. Police officers around the country spend many hours transporting people to hospitals – and sitting for hours in emergency rooms – only to see the same people back out in the streets again the next day engaging in the same behaviors that attracted the attention of law enforcement in the first place. The hours these officers spend in responding to people with mental illness are hours that they are unable to spend fighting crime.

Criminal justice systems and personnel are also unequipped to respond to people with serious psychiatric needs. Traditional correctional responses to individuals unable to follow the rules of the system – such as administrative segregation, solitary confinement or use of restraints – tend to exacerbate severe psychiatric symptoms. Yet, jails and prisons are not set up to provide psychiatric treatment.

In 2000, this Committee demonstrated its commitment to the cause of reducing the unnecessary criminalization of people with mental illnesses by enacting "America's Law Enforcement and Mental Health Project," a bill that authorized funding for Mental Health Courts. This bill represents the next logical step forward.

Mr. Chairman, we applaud you for scheduling a hearing to tackle this troubling problem. We are also deeply grateful to Senator DeWine for introducing legislation that provides an important approach to badly needed community reform. This legislation wisely recognizes that solutions to the problem of criminalization of people with mental illnesses will ultimately be found in communities across this country. They will be solutions that take account of the strengths and the weaknesses in the local mental health systems, the criminal and juvenile justice systems, and often other systems as well. No two communities will necessarily bring the same needs, resources, capabilities, and vision to those problems. But what the federal government can do – and what good legislation must do – is to provide support for a wide range of collaborative community programs to ensure that low-level offenders with mental illnesses avoid unnecessary detention and incarceration, and provide avenues for effective and appropriate treatment.

The Campaign is gratified by the Committee's continuing interest in addressing the needs of people with mental illnesses who come into contact with criminal justice systems. With key elements listed below in mind, we are eager to continue working with you to advance this important initiative and, once it is enacted, secure needed funding. I would like to use the remainder of my time to highlight principles of particular importance to the mental health community.

Diverting individuals with mental illnesses from our jails and prisons requires a collaborative effort by criminal justice and mental health systems.

A very strong feature of S. 1194 is that grant recipients would be required to engage in comprehensive planning and develop partnerships between mental health, criminal justice and other key systems in states or communities that would receive grants. Without collaborative efforts of this kind, the most creative approaches to addressing the mental health needs of non-violent juvenile or adult offenders with mental illnesses will not

succeed. The Campaign therefore applauds the sponsors of this legislation for recognizing, and proposing a framework for fostering collaborative partnerships in grantee communities.

Jail diversion and community reentry programs will succeed only when mental health services and supports are available to address the needs of individuals who are diverted.

As stated above, the growing numbers of individuals with mental illnesses in criminal justice systems frequently reflect lack of available mental health services and supports in communities. A critical component of any successful approach to jail diversion or community reentry therefore must include access to treatment and services such as medications, case management services, housing and rehabilitative services. Children and adolescents with mental disorders who come in contact with the juvenile justice system must also have access to appropriate educational services.

The best type of jail diversion is that which occurs prior to arrest and incarceration.

Many approaches have emerged around the country to divert low level, non-violent offenders with mental illnesses into treatment. Some of these are "pre-booking" programs, i.e. programs that link people with services before they ever get caught up with criminal justice or court systems. Others are "post-booking" programs, i.e. programs that link people with services after they are arrested. While both of these approaches have proven very effective, it is always best to link people with services before they are arrested or fall under the jurisdiction of the Courts.

For example, the nationally renowned Memphis Police Crisis Intervention Team (CIT) program is designed to link people with treatment in lieu of arrests. This program has been so successful that it has been replicated in scores of communities around the country. Key to the success of this program is the collaboration between the police and the mental health system. In Memphis, police receive extensive training in recognizing the signs and symptoms of mental illnesses and in crisis intervention techniques. They know how to respond to these individuals in ways that defuse rather than escalate these crises. Whenever possible (i.e. when the individual in question has not committed a serious crime), the police transport the individual to a specially designed psychiatric emergency room at a local hospital, rather than arrest and charge him/her with a crime.

The Memphis CIT program has achieved remarkable results. Research shows that this program, first implemented in 1988, has resulted in:

- Fewer arrests of individuals with mental illnesses;
- Lower injury rates for individuals with mental illnesses at the hands of the police;
- Lower injury rates for police officers responding to people with mental illnesses in crisis;
- Decreased use of expensive tactical intervention units and SWAT teams; and
- Increased officer satisfaction, confidence in their ability to respond to people with mental illnesses, and knowledge that the mental health system will respond effectively to individuals diverted to treatment instead of incarceration.

Communities should be encouraged to employ an array of post-booking diversion strategies, tailored to local needs and systems.

A wide range of models exists for responding to low-level offenders after they have been arrested. For example, Mental Health Courts have been established in more than 70 communities in the country.

As with other forms of diversion, the effectiveness of these Courts is very much dependent upon the availability of mental health services and supports. For example, many of the individuals under the jurisdiction of the Broward County (Ft. Lauderdale) Mental Health Court in Florida are homeless. The Court has struggled to link individuals with community placement options. Using her position as political leverage, the Judge who presides over the Court successfully appealed to the Florida state legislature for funding for a three year program to develop a residential treatment facility, resources for intensive case management, and independent housing options for individuals within the jurisdiction of the Court.

The Federal Government can provide important help to communities that have invested in jail diversion strategies by continuing the progress that has been made in addressing chronic homelessness. The work that Senator DeWine and Senator Bond have done in pushing HUD to develop more permanent supportive housing and President Bush's Samaritan Initiative are important steps forward.

Mental Health Courts are not the only effective means for providing court-based jail diversion services. Other approaches place less responsibility for supervision with judges and more responsibility with mental health or other systems. Programs such as CASES in New York involve collaborations between parole and probation and mental health providers to coordinate mental health treatment, substance abuse treatment, and other vital services for individuals with mental illness who violate parole for reasons related to their illnesses. (6)

The importance of discharge planning and reentry services.

The successful reintegration of individuals with mental illnesses back into communities following incarceration is frequently hampered by lack of services upon reentry. This is particularly unfortunate because lack of services is frequently what led to involvement with the criminal justice system.

S. 1194 attempts to address this crucial problem by allowing grantees to use funds "for transitional, re-entry programs for those released from any penal or correctional institution." (Sect. 4, Part HH, (b)(5)(I)(iv)). The Campaign applauds the Sponsors of this legislation for recognizing this need and making provisions for the use of grant funds to support these vital services.

We would like to emphasize two particularly important components of discharge planning and reentry services – the first is the need to initiate these services prior to discharge, the second is the importance of restoring vital income supports and medical benefits to individuals upon their discharge. Restoration of Medicaid or comparable medical benefits is particularly important so that individuals will be able to pay for medications and other important mental health services.

Conclusion:

NAMI and the Campaign greatly appreciate this opportunity to testify on this important issue. Enactment of legislation and appropriation of funds to give those on the front lines vitally needed new tools to avert the needless criminalization of juveniles and adults with mental illnesses who are not violent criminals offer the promise of both saving lives and improving the quality of life in our communities. As the President's New

Freedom Commission on Mental Health has underscored, our country can and must do a better job of helping people across the country who require treatment. With that powerful report as a call to action, this Committee has an extraordinary opportunity to help communities establish alternatives to incarceration.

We stand ready to be partners in working with the committee to move legislation to make that hope a reality.

Respectively Submitted,

Ron Honberg

Endnotes

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2. Council of State Governments, *Criminal Justice/Mental Health Consensus Project,* 2002 (available at www.consensusproject.org).

3. World Health Organization, *The World Health Organization 2001, Mental Health: New Understanding, New Hope*, 2002.

4. President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America,* 2003.

5. U.S. Public Health Service Office of the Surgeon General, *Mental Health: A Report of the Surgeon General,* (1999).

6. See Program Examples Database on website established by the Council of State Government's Criminal Justice/Mental Health Consensus Project, www.consensusproject.org.

Statement
United States Senate Committee on the Judiciary
An Examination of S. 1194, The Mentally Ill Offender Treatment and Crime Reduction Act of 2003.
July 30, 2003

The Honorable Patrick Leahy
United States Senator , Vermont

Statement of Senator Patrick Leahy
Ranking Member, Senate Judiciary Committee
Hearing on "An Examination of S. 1194, The Mentally Ill Offender Treatment and Crime Reduction Act of 2003"
July 30, 2003

We hold a hearing today on The Mentally Ill Offender Treatment and Crime Reduction Act, which Senator DeWine and I introduced last month. This is a good bipartisan bill that would help state and local governments deal effectively with an often overlooked problem – the extent to which mentally ill individuals commit crimes and recidivate without ever receiving appropriate attention from the mental health, law enforcement, or corrections systems. I welcome all of our witnesses today, and would like to offer a special welcome to Vermont State Senator John Campbell, who will testify today about efforts in our state to address this problem, and how this bill could help. Senator Campbell is the Majority Leader and a member of the Judiciary Committee, and he is also a former law enforcement officer. As a result, he has seen this issue from both an individual perspective and a broader policy perspective, and I look forward to hearing his insights today.

All too often, people with mental illness rotate repeatedly between the criminal justice system and the streets of our communities, committing a series of minor offenses. The ever scarcer time of our law enforcement officers is being occupied by these offenders, who divert them from more urgent responsibilities. Meanwhile, offenders find themselves in prisons or jails, where little or no appropriate medical care is available for them. This bill gives state and local governments the tools to break this cycle, for the good of law enforcement, corrections officers, the public safety, and mentally ill offenders themselves.

I held a Judiciary Committee hearing last June on the criminal justice system and mentally ill offenders. At that hearing, we heard from state mental health officials, law enforcement officers, corrections officials, and the representative of counties around our nation. All of our witnesses agreed that people with untreated mental illness are more likely to commit crimes, and that our state mental health systems, prisons and jails do not have the resources they need to treat the mentally ill, and prevent crime and recidivism. -We know that more than 16 percent of adults incarcerated in U.S. jails and prisons have a mental illness, that about 20 percent of youth in the juvenile justice system have serious mental health problems, and that up to 40 percent of adults who suffer from a serious mental illness will come into contact with the American criminal justice system at some point in their lives. We know these things, but we have not done enough about them at the Federal level, and our state and local officials need our help.

The bill does not mandate a "one size fits all" approach to addressing this issue. Rather, it allows grantees to use the funding authorized under the bill for mental health courts or other court-based programs, for training for criminal justice and mental health system personnel, and for better mental health treatment in our communities and within the corrections system. The funding is also generous enough to make a real difference, with $100 million authorized for each of the next two fiscal years. This is an area where government spending can not only do good but can also save money in the long run – a dollar spent today to get mentally ill offenders effective medical care can save many dollars in law enforcement costs in the long run.

Indeed, this bill has brought law enforcement officers and mental health professionals together, as one can see from our witnesses today. I hope that we hear today and in the coming weeks about any improvements that we should make to this bill so that it truly addresses this issue in a way that is both compassionate and effective. Thank you and I look forward to hearing from our witnesses.

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July 30, 2003

Senator R. Michael DeWine
U.S. Senate
140 Russell Senate Office Bldg.
Washington, D.C. 20510

Dear Senator DeWine:

We appreciate your continued leadership on criminal justice and mental health issues, and the hearing you will conduct on S. 1194, the Mentally Ill Offender Treatment and Crime Reduction Act of 2003. This legislation is a targeted and effective way to reduce crime and also ensure compassionate care for individuals with mental illness. As you know, often people with a mental illness may be involved in crime—often minor property offenses—because they have not been adequately connected to care. The collaboration that your legislation would foster will increase effective connections between mental health, law enforcement, and the criminal justice system, to address this problem.

As you know, I had the honor of serving as Chair of the President's New Freedom Commission on Mental Health. President Bush established the Commission to examine the Nation's mental health service delivery system, and recommend improvements. Just last week, the Commission completed its assignment, and submitted its report (Achieving the Promise: Transforming Mental Health Care in America) to the President. I look forward to the future opportunity to brief you on this effort, as it is most relevant to your leadership responsibilities and interests.

However, I have attached for your reference several pages from the Report that are immediately relevant to S. 1194. You will see that the Commission concludes: "Too often, the criminal justice system unnecessarily becomes a primary source for mental health care" (Report, page 43). We recommend improved efforts to divert people as appropriate into mental health and substance abuse treatment programs instead of jails and prisons. Your legislation would be a significant step in this important direction.

Thank you again for your leadership on this issue and good luck with this important legislation.

Sincerely,

Michael F. Hogan, Ph.D.
Director, Ohio Department of Mental Health
Chair, President's New Freedom Commission on Mental Health

cc: Governor Bob Taft
Justice Evelyn Lundberg Stratton
Representative Ted Strickland
Administrator Charles G. Curie, SAMHSA

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THE PRESIDENT'S NEW FREEDOM
COMMISSION ON MENTAL HEALTH

Achieving the Promise:

TRANSFORMING MENTAL HEALTH CARE IN AMERICA

FINAL REPORT

JULY 2003

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GOAL 2

RECOMMENDATIONS

Mental Health Care Is Consumer and Family Driven.

2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.

2.2 Involve consumers and families fully in orienting the mental health system toward recovery.

2.3 Align relevant Federal programs to improve access and accountability for mental health services.

2.4 Create a Comprehensive State Mental Health Plan.

2.5 Protect and enhance the rights of people with mental illnesses.

Understanding the Goal

The Complex Mental Health System Overwhelms Many Consumers

Nearly every consumer of mental health services who testified before or submitted public comments to the Commission expressed the need to fully participate in his or her plan for recovery. In the case of children with serious emotional disturbances, their parents and guardians strongly echoed this sentiment. Consumers and families told the Commission that having hope and the opportunity to regain control of their lives was vital to their recovery.

Indeed, emerging research has validated that hope and self-determination are important factors contributing to recovery.[45; 46] However, understandably, consumers often feel overwhelmed and bewildered when they must access and integrate mental health care, support services, and disability benefits across multiple, disconnected programs that span Federal, State, and local agencies, as well as the private sector.

As the President said in his speech announcing the creation of the Commission, one of the major obstacles to quality mental health care is:

> "... our fragmented mental health service delivery system. Mental health centers and hospitals, homeless shelters, the justice system, and our schools all have contact with individuals suffering from mental disorders."

Consumers of mental health services must stand at the *center* of the system of care. Consumers' needs must drive the care and services that are provided. Unfortunately, the services currently available to consumers are fragmented, driven by financing rules and regulations, and restricted by bureaucratic boundaries. They defy easy description.

Program Efforts Overlap

Loosely defined, the mental health care system collectively refers to the full array of programs for anyone with a mental illness. These programs exist at every level of government and throughout the private sector. They have varying missions, settings, and financing. They deliver or pay for treatments, services, or other types of supports, such as housing, employment, or disability benefits. For instance, one program's mission might be to offer treatment through medication, psychotherapy, substance abuse treatment, or counseling, while another program's purpose might be to offer rehabilitation support. The setting could be a hospital, a community clinic, a private office, a school, or a business.

> Many mainstream social welfare programs are not designed to serve people with serious mental illnesses, even though this group has become one of the largest and most severely disabled groups of beneficiaries.

A brief look at traditional funding sources for mental health services illustrates the impact of this overly complex system. The Community Mental Health Services Block Grant, funded by the U.S. Department of Health and Human Services (HHS) through the Substance Abuse and Mental Health Services Administration (SAMHSA), provides funding to the 59 States and territories. It is only one source of Federal funding that State mental health authorities manage. The funding totaled approximately $433 million in 2002,[47] or less than 3% of the revenues of these State agencies.[48]

But larger Federal programs that are not focused on mental health care play a much more substantial role in financing it. For example, through Medicare and Medicaid programs alone, HHS spends nearly $24 billion each year on beneficiaries' mental health care.[15] Moreover, the largest Federal program that supports people with mental illnesses is not even a health services program — the Social Security Administration's Supplemental Security Income (SSI) and Social Security Disability Income (SSDI) programs, with payments totaling approximately $21 billion in 2002.[49-51]

Other significant programs that are funded separately and play a role in State and local systems include:

- Housing,
- Rehabilitation,
- Education,
- Child welfare,
- Substance abuse,
- General health,
- Criminal justice, and
- Juvenile justice, among others.

Each program has its own complex, sometimes contradictory, set of rules. Many mainstream social welfare programs are not designed to serve people with serious mental illnesses, even though this group has become one of the largest and most severely disabled groups of beneficiaries.

If this current system worked well, it would function in a coordinated manner, and it would deliver the best possible treatments, services, and supports. However, as it stands, the current system often falls short. Many people with serious mental illnesses and children with serious emotional disturbances remain homeless or housed in institutions, jails, or juvenile detention centers. These individuals are unable to participate in their own communities.

Consumers and Families Do Not Control Their Own Care

In a consumer- and family-driven system, consumers choose their own programs and the providers that will help them most. Their needs and preferences drive the policy and financing decisions that affect them. Care is consumer-centered, with providers working in full partnership with the consumers they serve to develop individualized plans of care. Individualized plans of care help overcome the problems that result from fragmented or uncoordinated services and systems.

Currently, adults with serious mental illnesses and parents of children with serious emotional disturbances typically have limited influence over the care they or their children receive. Increasing opportunities for consumers to choose their providers and allowing consumers and families to have greater control over funds spent on their care and supports facilitate personal responsibility, create an economic interest in obtaining and sustaining recovery, and shift the incentives towards a system that promotes learning, self-monitoring, and accountability. Increasing choice protects individuals and encourages quality.

Individualized plans of care help overcome the problems that result from fragmented or uncoordinated services and systems.

Evidence shows that offering a full range of community-based alternatives is more effective than hospitalization and emergency room treatment.[18] Without choice and the availability of acceptable treatment options, people with mental illnesses are unlikely to engage in treatment or to participate in appropriate and timely interventions. Thus, giving consumers access to a range of effective, community-based treatment options is critical to achieving their full community participation. To ensure this access, the array of community-based treatment options must be expanded.

In particular, community-based treatment options for children and youth with serious emotional disorders must be expanded. Creating alternatives to inpatient treatment improves engagement in community-based treatment and reduces unnecessary institutionalization. These young people are too often placed in out-of-state treatment facilities, hours away from their families and communities. Further segregating these children from their families and communities can impede effective treatment.

Emerging evidence shows that a major Federal program to establish comprehensive, community-based systems of care for children with serious emotional disturbances has successfully reduced costly out-of-state placements and generated positive clinical and functional outcomes. Clinically, youth in systems of care sites showed an increase in behavioral and emotional strengths and a reduction in mental health problems. For these children, residential stability improved, school attendance and school performance improved, law enforcement contacts were reduced, and substance use decreased.[52]

Consumers Need Employment and Income Supports

The low rate of employment for adults with mental illnesses is alarming. People with mental illnesses have one of the lowest rates of employment of any group with disabilities — only about 1 in 3 is employed.[53] The loss of productivity and human potential is costly to society and tragically unnecessary. High unemployment occurs despite surveys that show the majority of adults with serious mental illnesses want to work — and that many *could* work with help.[54; 55]

Many individuals with serious mental illnesses qualify for and receive either SSI or SSDI benefits. SSI is a means-tested, income-assistance program; SSDI is a social insurance program with benefits based on past earnings. A sizable proportion of adults with mental illnesses who receive either form of income support live at, or below, the poverty level. For more than a decade, the number of SSI and SSDI beneficiaries with psychiatric disabilities has increased at rates higher than each program's overall growth rate. Individuals with serious mental illnesses represent the single largest diagnostic group (35%) on the SSI rolls, while representing over a quarter (28%) of all SSDI recipients.[49; 51]

People with mental illnesses have one of the lowest levels of employment of any group with disabilities – only about 1 in 3 is employed.

Though living in poverty, SSI recipients paradoxically find that returning to work makes them even poorer, primarily because employment results in losing Medicaid coverage, which is vital in covering the cost of medications and other

treatments. According to a large, eight-State study, only 8% of those returning to full time jobs had mental health coverage.[56]

Recent Federal legislation has tried to address the loss of Medicaid and other disincentives to employment. For instance, the "Medicaid Buy-In" legislation allows States to extend Medicaid to disabled individuals who exit the SSI/SSDI rolls to resume employment, but many States cannot afford to implement Medicaid Buy-In. The Balanced Budget Act of 1997 allows States to extend Medicaid coverage to disabled individuals whose earned income is low, but still above the Federal Poverty Guidelines.

Another statutory reform — The Ticket to Work and Work Incentives Improvement Act (TWWIIA) of 1999 — is problematic because its rules do not give vocational rehabilitation providers enough incentives to take on clients who have serious mental illnesses. Rather, these programs are more inclined to serve the least disabled — a process called *creaming*, in reference to the legislation's unintentional incentives for vocational rehabilitation providers to serve less disabled people rather than more disabled ones (the latter most commonly people with serious mental illnesses). One large study found that only 23% of people with schizophrenia received any kind of vocational services.[6] Since TWWIIA rewards only those providers who help their clients earn enough to no longer qualify for SSI, the bottom line is that most people with serious mental illnesses do not receive any vocational rehabilitation services at all.

Because they cannot work in the current climate, many consumers with serious mental illnesses continue to rely on Federal assistance payments in order to have health care coverage, even when they have a strong desire to be employed. Regrettably, a financial disincentive to achieve full employment exists because consumers lose Federal benefits if they become employed. Adding to the problem is the fact that most jobs open to these individuals have no mental health care coverage, so consumers must choose between employment and coverage. Consequently, they depend on a combination of disability income and Medicaid (or Medicare), all the while preferring work and independence.

For youth with serious emotional disturbances, the employment outlook is also bleak. A national study found that only 18% of these youth were employed full time, while another 21% worked part-time for one to two years after they left high school. This group had work experiences characterized by greater instability than all other disability groups.[57]

Other financial disincentives to employment exist as well, including potential loss of housing and transportation subsidies.

Over the next ten years, the U.S. economy is projected to grow by 22 million jobs, many in occupations that require on-the-job training.[58] With appropriate forms of support, people with mental illnesses could actively contribute to that economic growth, as well as to their own independence. They could fully participate in their communities. Instead, they are trapped into long-term dependence on disability income supports that leave them living below the poverty level.

A Shortage of Affordable Housing Exists

The lack of decent, safe, affordable, and integrated housing is one of the most significant barriers to full participation in community life for people with serious mental illnesses. Today, millions of people with serious mental illnesses lack housing that meets their needs.

The shortage of affordable housing and accompanying support services causes people with serious mental illnesses to cycle among jails, institutions, shelters, and the streets; to remain unnecessarily in institutions; or to live in seriously substandard housing.[59] People with serious mental illnesses also represent a large percentage of those who are repeatedly homeless or who are homeless for long periods of time.[60]

In fact, people with serious mental illnesses are over-represented among the homeless, especially among the chronically homeless. Of the more than two million adults in the U.S. who have at least one episode of homelessness in a given year, 46% report having had a mental health problem within the previous year, either by itself or in combination with

substance abuse.[59] Chronically homeless people with mental illnesses are likely to:

- Have acute and chronic physical health problems;
- Use alcohol and drugs;
- Have escalating, ongoing psychiatric symptoms; and
- Become victimized and incarcerated.[61]

A recent study shows that people who rely solely on SSI benefits — as many people with serious mental illnesses do — have incomes equal to only 18% of the median income and cannot afford decent housing in any of the 2,703 housing market areas defined by the U.S. Department of Housing and Urban Development (HUD).[62] HUD reports to Congress show that as many as 1.4 million adults with disabilities who receive SSI benefits — including many with serious mental illnesses — pay more than 50% of their income for housing.[63]

Affordable housing programs are extremely complex, highly competitive, and difficult to access. Federal public housing policies can make it difficult for people with poor tenant histories, substance use disorder problems, and criminal records — all problems common to many people with serious mental illnesses — to qualify for Section 8 vouchers and public housing units. Those who do receive Section 8 housing vouchers often cannot use them because:

- The cost of available rental units may exceed voucher program guidelines, particularly in tight housing markets;
- Available rental units do not meet Federal Housing Quality Standards for the voucher program;
- Private landlords often refuse to accept vouchers; and
- Housing search assistance is often unavailable to consumers.

The lack of decent, safe, affordable, and integrated housing is one of the most significant barriers to full participation in community life for people with serious mental illnesses.

Tragically, many housing providers discriminate against people with mental illnesses. Too many communities are unwilling to have supportive housing programs in their neighborhoods. Since the 1980s, the Federal government has had the legal tools to address these problems, yet has failed to use them effectively. Between 1989 and 2000, HUD's fair housing enforcement activities diminished, despite growing demand. The average age of complaints at their closure in FY 2000 was nearly five times the 100-day period that Congress set as a benchmark.[64]

Just as the U.S. Supreme Court's *Olmstead* decision has increased the demand for integrated and affordable housing for people with serious mental illnesses, public housing is less available. Since 1992, approximately 75,000 units of HUD public housing have been converted to "elderly only" housing and more units are being converted every year, leaving fewer units for people with disabilities.[65]

Too few mental health systems dedicate resources to ensuring that people with mental illnesses have adequate housing with supports. These systems often lack staff who are knowledgeable about public housing programs and issues. Partnerships and collaborations between public housing authorities and mental health systems are far too rare. Highly categorical Federal funding streams (*silos*) for mental health, housing, substance abuse, and other health and social welfare programs greatly contribute to the fragmentation and failure to comprehensively address the multiple service needs of many people with serious mental illnesses.

Limited Mental Health Services Are Available in Correctional Facilities

In the U.S., approximately 1.3 million people are in State and Federal prisons, and 4.6 million are under correctional supervision in the community.[66; 67] Remarkably, approximately 13 million people are jailed every year, with about 631,000 inmates serving in jail at one time. The rate of serious mental illnesses for this population is about three to four times that of the general U.S. population.[68] This means that about 7% of all incarcerated people have a current serious mental illness; the proportion with a less serious form of mental illness is substantially higher.[68]

People with serious mental illnesses who come into contact with the criminal justice system are often:

- Poor,
- Uninsured,
- Disproportionately members of minority groups,
- Homeless, and
- Living with co-occurring substance abuse and mental disorders.

They are likely to continually recycle through the mental health, substance abuse, and criminal justice systems.[69]

> As a shrinking public health care system limits access to services, many poor and racial or ethnic minority youth with serious emotional disorders fall through the cracks into the juvenile justice system.

When they are put in jail, people with mental illnesses frequently do not receive appropriate mental health services. Many lose their eligibility for income supports and health insurance benefits that they need to re-enter and re-integrate into the community after they are discharged.

Women are a dramatically growing presence in all parts of the criminal justice system. Current statistics reveal that women comprise 11% of the total jail population,[70] 6% of prison inmates,[71] 22% of adult probationers, and 12% of parolees.[72] Many women entering jails have been victims of violence and present multiple problems in addition to mental and substance abuse disorders, including child-rearing and parenting difficulties, health problems, histories of violence, sexual abuse, and trauma.[73] Gender-specific services and gender-responsive programs are in increasing demand but are rarely present in correctional facilities designed for men. Early needs assessment, screening for mental and substance abuse disorders, and identification of other needs relating to self or family are critical to effectively plan treatment for incarcerated women.

More than 106,000 teens are in custody in juvenile justice facilities.[74] As a shrinking public health care system limits access to services, many poor and racial or ethnic minority youth with serious emotional disorders fall through the cracks into the juvenile justice system. (*See Goal 4 for a broader discussion of mental health screening.*)

Recent research shows a high prevalence of mental disorders in children within the juvenile justice system. A large-scale, four-year, Chicago-based study found that 66% of boys and nearly 75% of girls in juvenile detention have at least one psychiatric disorder. About 50% of these youth abused or were addicted to drugs and more than 40% had either oppositional defiant or conduct disorders.

The study also found high rates of depression and dysthymia: 17% of boys; 26% of detained girls.[75] As youth progressed further into the formal juvenile justice system, rates of mental disorder also increased: 46% of youth on probation met criteria for a serious emotional disorder compared to 67% of youth in a correctional setting.[76] Appropriate treatment and diversion should be provided in juvenile justice settings followed by routine and periodic screening.

Fragmentation Is a Serious Problem at the State Level

State mental health authorities have enormous responsibility to deliver mental health care and support services, yet they have limited influence over many of the programs consumers and families need. Most resources for people with serious mental illnesses (e.g., Medicaid) are not typically within the direct control or accountability of the administrator of the State mental health system. For example, depending on the State and how the budget is prepared, Medicaid may be administered by a separate agency with limited mental health expertise. Separate entities also administer criminal justice, housing, and education programs, contributing to fragmented services.

A Comprehensive State Mental Health Plan would create a new partnership among the Federal, State, and local governments and must include consumers and families.

The development of a Comprehensive State Mental Health Plan would create a new partnership among the Federal, State, and local governments and must include consumers and families. To be effective, the plan must reach beyond the traditional State mental health agency and the block grant to address the full range of treatment and support service programs that mental health consumers and their families should have. The planning process should support a respectful, collaborative dialogue among stakeholders, resulting in an extensive, coordinated State system of services and supports.

As States accept increased responsibility for coordinating mental health care, they should have greater flexibility in spending Federal resources to meet these needs. Using a performance partnership model, the Federal government and the State will negotiate an agreement on outcomes. This shift will then give States the flexibility to determine how they will achieve the desired outcomes outlined in their plans.

Aligning relevant Federal programs to support Comprehensive State Mental Health Plans can have the powerful impact of fostering consumers' independence and their ability to live, work, learn, and participate fully in their communities. (*See Recommendations 2.3 and 2.4.*)

Consumers and Families Need Community-based Care

In the 1999 *Olmstead v. L.C.* decision, the U.S. Supreme Court held that the unnecessary institutionalization of people with disabilities is discrimination under the Americans with Disabilities Act.[77] The Court found that:

> "...confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."

President Bush urged promptly implementing the *Olmstead* decision in his 2001 Executive Order 13217, mobilizing Federal resources in support of *Olmstead*. However, many adults and children remain in institutions instead of in more appropriate community-based settings.

On a separate topic, the General Accounting Office (GAO) recently issued a report that illustrates the tragic and unacceptable circumstances that result in thousands of parents being forced to place their children into the child welfare or juvenile justice systems each year so that they may obtain the mental health services they need. Loving and responsible parents who have exhausted their savings and health insurance face the wrenching decision of surrendering their parental rights and tearing apart their families to secure mental health treatment for their troubled children. The GAO report estimates that, in 2001, parents were forced to place more than 12,700 children in the child welfare or juvenile justice systems as the last resort for those children to receive needed mental health care treatment. Moreover, these numbers are actually an undercount because 32 states, including the five

largest, were unable to provide data on the number of children affected.[78]

According to the report, several factors contribute to the consequence of "trading custody for services," including:

- Limitations of both public and private health insurance,
- Inadequate supply of mental health services,
- Limited availability of services through mental health agencies and schools, and
- Difficulties meeting eligibility rules for services.

When parents cede their rights in order to place their children in foster care or in a program for delinquent youth, they may also be inadvertently placing their children at risk for abuse or neglect.[79] These placements also increase the financial burden on State child welfare and juvenile justice authorities. A more family-friendly policy must be found to remedy this situation.

Consumers Face Difficulty in Finding Quality Employment

Only about one-third of people with mental illnesses are employed, and many of them are under-employed.[53] For example, about 70% of people with serious mental illnesses with college degrees earned less than $10 per hour.[80] Overall, people with psychiatric disabilities earned a median wage of only about $6 per hour versus $9 per hour for the general population.[53]

Problems begin long before consumers enter the work force. Many individuals with serious mental illnesses lack the necessary high school and post-secondary education or training vital to building careers. A major study found that youth with emotional disturbances have the highest percentage of high school non-completion and failing grades compared with other disabled groups.[81]

Only about one-third of people with mental illnesses are employed, and many of them are under-employed.

Special education legislation — the Individuals with Disabilities Education (IDEA) Act — was designed to prepare school-aged youth to make the transition to the workplace, but its promise remains largely unfulfilled. Similarly, the Americans with Disabilities Act (ADA) has not fulfilled its potential to prevent discrimination in the workplace. Workplace discrimination, either overt or covert, continues to occur. According to surveys conducted over the past five decades, employers have expressed more negative attitudes about hiring workers with psychiatric disabilities than any other group.[82; 83] Economists have found unexplained wage gaps that are evidence of discrimination against those with psychiatric disabilities.[84]

The Use of Seclusion and Restraint Creates Risks

An emerging consensus asserts that the use of seclusion and restraint in mental health treatment settings creates significant risks for adults and children with psychiatric disabilities. These risks include serious injury or death, re-traumatizing people who have a history of trauma, loss of dignity, and other psychological harm. Consequently, it is inappropriate to use seclusion and restraint for the purposes of discipline, coercion, or staff convenience.

Seclusion and restraint are safety interventions of last resort; they are not treatment interventions. In light of the potentially serious consequences, seclusion and restraint should be used only when an imminent risk of danger to the individual or others exists and no other safe, effective intervention is possible. It is also inappropriate to use these methods instead of providing adequate levels of staff or active treatment.

Rehabilitation Services Option to fund those components of supported employment that are consistent with Medicaid policy. The Commission encourages the Social Security Administration to evaluate the possibility of removing disincentives to employment in both the SSI and SSDI programs.

The Commission encourages States to use Medicaid Buy-In legislation to extend Medicaid coverage to disabled individuals who are working.

The widespread use of supported employment, coupled with the reduced disincentive to employment, could result in productive work and independence for consumers while accruing enormous cost-savings in Federal disability payments. Additionally, CMS and SSA should determine the feasibility of using savings accrued by SSA as beneficiaries go back to work to offset increased State and Federal Medicaid costs.

CMS and SSA should launch a national campaign to encourage States to use this powerful incentive to employment. The campaign should be designed to:

- Reduce barriers to implementation;
- Improve SSA and CMS communication; and
- Promote education and outreach to consumers, youth, families, vocational rehabilitation counselors, and community rehabilitation programs.

The Commission recommends developing a Federal-State interagency initiative involving all Federal agencies that are charged with addressing mental health, employment, and disability issues. Through this initiative, agencies can:

- Collaborate to inventory and assess existing Federal programs,
- Better coordinate the administration of these programs, and
- Promote interagency demonstration projects that are designed to eliminate employment barriers and increase employment opportunities for youth and adults with mental illnesses.

Make Housing with Supports Widely Available

The Commission believes it is essential to address the serious housing affordability problems of people with severe mental illnesses who have extremely low incomes. Progress toward this objective will significantly advance the goal of ending chronic homelessness and will have a great impact on the crisis of inadequate housing and homelessness for people with severe mental illnesses.

Research shows that consumers are much more responsive to accepting treatment after they have housing in place.[91] People with mental illnesses consistently report that they prefer an approach that focuses on providing housing for consumers or families first. However, affordable housing alone is insufficient. Flexible, mobile, individualized support services are also necessary to support and sustain consumers in their housing. Many consumers have troubled tenant histories and higher rates of incarceration — both of which can lead to long-term ineligibility for Federal housing programs, such as Section 8 vouchers and public housing. In addition, access to ongoing support services is limited

Research shows that consumers are much more responsive to accepting treatment after they have housing in place.

Research and demonstration programs have documented the effectiveness of the supportive housing model for people with serious mental illnesses.[92; 93] Research has also found that permanent supportive housing can be cost effective when compared to the cost of homelessness.[94] For example, a University of Pennsylvania study found that homeless people with mental illnesses who were placed in permanent supportive housing cost the public $16,282 less per person per year compared to their previous costs for mental health, corrections, Medicaid, and public institutions and shelters.[92]

The Commission recommends making affordable housing more accessible to people with serious mental illnesses and ending chronic homelessness among this population. To begin, in partnership with the Interagency Council on Homelessness (comprising 20 Federal agencies), the Department of Housing and Urban Development (HUD) should develop and implement a comprehensive plan designed to facilitate access to 150,000 units of permanent supportive housing for consumers and families who are chronically homeless. During the next ten years, this initiative should develop specific cost-effective approaches, strategies, technical assistance activities, and actions to be implemented at the Federal, State, and local levels. Expanding and ensuring a continuum of housing services would represent positive elements to include in such a plan. The Commission recommends that individuals who have a history of serious mental illnesses be given fair access to these 150,000 units of supportive housing.

The Commission recommends that States and communities commit to the goal of ending chronic homelessness and develop the means to achieve it.

The Commission recognizes that national leadership must make a concerted effort to address the problem of homelessness and lack of affordable housing among people with serious mental illnesses. The Commission urges HUD to collaborate with HHS, VA, and other relevant agencies to provide leadership to States and local communities to improve housing opportunities for this population. HUD should aggressively pursue administrative, regulatory, and statutory changes to existing mainstream housing programs; e.g., Section 811 Supportive Housing. Input from stakeholders to identify existing barriers to accessing housing should be an integral part of HUD's considerations.

Address Mental Health Problems in the Criminal Justice and Juvenile Justice Systems

Providing adequate services in correctional facilities for people with serious mental illnesses who do need to be there is both prudent and required by law. The Eighth Amendment of the U.S. Constitution protects the right to treatment for acute medical problems, including psychiatric problems, for inmates and detainees in America's prisons and jails. Professional organizations have published guidelines for mental health care in correctional settings and some States have implemented them.[69; 95-97]

All too often, people are misdiagnosed or not diagnosed with the root problem of mental illnesses. It is important to keep adults and youth with serious mental illnesses who are not criminals out of the criminal justice system. Too often, the criminal justice system unnecessarily becomes a primary source for mental health care. The potential for recovery for the offender with a mental illness is too frequently derailed by inadequate care and the superimposed stigma of a criminal record. Cost studies suggest that taxpayers can save money by placing people into mental health and substance abuse treatment programs instead of in jails and prisons.[98; 99] With the appropriate diversion and re-entry programs, these consumers could be successfully living in and contributing to their communities. Many non-violent offenders with mental illnesses could be diverted to more appropriate and typically less expensive supervised community care. Proven models exist for diversion programs operating in many areas around the country.

> Too often, the criminal justice system unnecessarily becomes a primary source for mental health care.

Unfortunately, one of the groups most isolated from society are those consumers who attempt to return to the community after being incarcerated. Linking people with serious mental illnesses to community-based services — and in the case of youth, also to educational services — when they are diverted or released from jails or prisons through re-entry transition programs is an important strategy to re-integrate consumers into their communities.

The Commission recommends widely adopting adult criminal justice and juvenile justice diversion and re-entry strategies to avoid the unnecessary criminalization and extended incarceration of non-violent adult and juvenile offenders with mental

illnesses, HHS and the Department of Justice, in consultation with the Department of Education, should provide Federal leadership to help States and local communities develop, implement, and monitor a range of adult and youth diversion and re-entry strategies.

2.4 Create a Comprehensive State Mental Health Plan.

Create Comprehensive State Mental Health Plans to Coordinate Services

The Commission envisions that developing and using Comprehensive State Mental Health Plans will greatly facilitate new partnerships among the Federal, State, and local governments to better use existing resources for people with mental illnesses. Incorporating the principles in this report, at the very least, the plan should:

- Increase the flexibility of resource use at the State and local levels, encouraging innovative uses of Federal funding and flexibility in setting eligibility requirements;
- Have State and local levels of government be more accountable for results, not solely to Federal funding agencies, but to consumers and families as well; and
- Expand the options and the array of services and supports.

To accomplish this change, the Federal government must reassess pertinent financing and eligibility policies and align reporting requirements to avoid duplication, promote consistency, and seek accountability from the States.

The underlying premise of the Commission's support for Comprehensive State Mental Health Plans is consistent with the principles of Federalism — providing incentives to States by granting increased flexibility in exchange for greater accountability and improved outcomes. For example, California's AB-34 program, designed to meet the needs of adults with mental illnesses who are homeless, demonstrates that services provided through programs that allow flexibility in financing care do, indeed, produce positive outcomes that benefit individuals, families, and society while most efficiently using resources. (*See Figure 2.3.*)

The intended outcome of Comprehensive State Mental Health Plans is to encourage States and localities to develop a comprehensive strategy to respond to the needs and preferences of consumers or families.

The Commission recommends that each State, Territory, and the District of Columbia develop a Comprehensive State Mental Health Plan. The plans will have a powerful impact on overcoming the problems of fragmentation in the system and will provide important opportunities for States to leverage resources across multiple agencies that administer both State and Federal dollars. The Office of the Governor should coordinate each plan. The planning process should support a dialogue among all stakeholders and reach beyond the traditional State mental health agency to address the full range of treatment and support service programs that consumers and families need. The final result should be an extensive and coordinated State system of services and supports that work to foster consumer independence and their ability to live, work, learn, and participate fully in their communities.

Testimony before Senate Judiciary Committee
July 30, 2003

S. 1194, The Mentally Ill Offender and Crime Reduction Act of 2003

Justice Evelyn Lundberg Stratton, Supreme Court of Ohio,
Chair, Supreme Court of Ohio Advisory Committee on Mentally Ill in the Courts

Finding effective strategies for working with mentally ill persons in the criminal justice system is important to me, both personally and professionally.

As a family member of a person who once suffered from depression, I am aware of the stigma of mental illness. It is not a popular subject, but it is one that I am passionate about. As a former trial judge, I saw first hand the effects of mental illness on the legal system. I am extremely concerned about keeping people with mental illness out of jail and diverted into appropriate mental health treatment.

The passage of S. 1194 is the right thing to do as well as a concept whose time has come. The statistics tell the story of why this bill is so needed.

- In 1955, there were 558,239 severely mentally ill patients in our nation's public psychiatric hospitals. In 1994, there were 71,619. Based on population growth, at the same per capita utilization as in 1955, estimates are that there would have been 885,010 patients in state hospitals in 1994. E. Fuller Torrey, M.D. in Out of the Shadows: Confronting America's Mental Illness Crisis, John Wiley & Sons, New York, 1997, page 8 -9

- Where have these severely mentally ill patients gone? Our jail population of people with mental illness has swelled to 285,000. According to a U.S. Department of Justice July 1999 Report, 16% of state prison inmates and 16% of those in local jails reported either a mental condition or an overnight stay in a mental hospital.
- According to that same study, half of mentally ill inmates reported 3 or more prior sentences. Among the mentally ill, 52% of state prisoners, and 54% of jail inmates reported 3 or more prior sentences to probation or incarceration.
- In fact, according to March 2000 statistics from the Ohio Department of Rehabilitation and Correction, there were 6393 mentally ill inmates, 3051 of who were classified as severely mentally disabled.
- Many of the severely mentally ill who have been released into the community through de-institutionalization, are now part of the 600,000 people in America who are homeless. Of these, it is believed that at least a third are mentally ill. U.S. Department of Health and Human Services, 1992.

A revolving door problem has developed in this country. Jails and prisons have become the de facto mental health system of our day. We must reverse this trend. Over the past few years, innovative diversion programs and other pioneering efforts across the nation have been successful in attacking this crisis. We must persevere to be able to provide community treatment for this population who were previously "warehoused," but who now are slipping through the cracks of our safety nets.

If not for altruistic reasons, this change is crucial in terms of the cost savings to the taxpayer. Mentally ill inmates require far more jail and prison resources due to treatment and crisis intervention. But this revolving door has other costs, too. Taxpayer dollars are paying for police officers to repeatedly arrest, transport and process mentally ill defendants, as well as for jail costs associated with treatment and crisis intervention, salaries of judges and court staff, prosecutors and defense attorneys, and many more hidden costs. The question becomes would we rather spend these dollars to keep mentally ill citizens homeless, revolving in and out of our criminal justice system, or would we rather spend these dollars to help them to become stable, productive citizens?

In Ohio to address this problem, we have formed the Ohio Supreme Court Advisory Committee on the Mentally Ill in the Courts, made up of representatives from the Ohio Department of Mental Health, Ohio Department of Alcohol and Drug Addiction Services, the Ohio Department of Rehabilitation and Correction, the Ohio Department of Mental Retardation and Developmental Disabilities, the Ohio Office of Criminal Justice Services, Judges, law enforcement, mediation experts, housing and treatment providers, consumer advocacy groups, and other officials from across the state. It is a collaboration effort that is the heart of this bill.

The Advisory Committee is working to establish local task forces in each local county to bring similar local representatives together to collaborate and work on the issues of the mentally ill in the criminal justice system. We encourage each

county to start a mental health specialty docket to deal with the issues, but have also found that the collaboration that results when all these groups get together goes far beyond the courtroom. The Advisory Committee provides guidance, resources, materials and information to the local task forces. We provide role models of other successful mental health court dockets, and pass on grant and other funding opportunities to the task forces.

There are three projects from our Advisory Committee that I would like to highlight to provide a sample of our progress in this area. First, in 2001, NAMI-Ohio (National Alliance for the Mentally Ill) developed a curriculum for jail and court personnel entitled, "Working with People with Mental Illness in the Criminal Justice System." Participants learn about diagnoses, treatment, symptoms, dual diagnosis (substance abuse and mental illness), psychotropic medications, crisis de-escalation, and jail suicide prevention. Jail personnel report this is some of the best training they have received in an area they feel woefully unprepared to handle.

Second, the Advisory Committee has worked to encourage Crisis Intervention Training (CIT) state-wide. CIT stands for "Crisis Intervention Team," and refers to a collaborative effort between law enforcement and the mental health community to help law enforcement officers handle incidents involving mentally ill people and to take them to a mental health facility instead of jail where appropriate. The CIT is a community-based collaboration between law enforcement NAMI (National Alliance for the Mentally Ill), mental health

consumers, mental health providers and local universities. Volunteer patrol officers receive 40 hours of training in mental illness and the local mental health system. The training is provided free of charge by the mental health community, providers, consumers and family members. The training focuses on providing practical techniques for de-escalating crises. Because our committee continually promotes CIT as a key to the collaboration effort, interest in training has exploded. We are now expanding to training parole and probation officers and even university, college, and campus police who frequently deal with troubled college students.

Third, our Advisory Committee has recently formed a subcommittee to develop jail standards for detainees with mental illness. Recently, I met an architect charged with designing jail cells for mentally ill detainees. The architect shared with me his frustration that he could find no standards for designing jail cells that would be appropriate for mentally ill, i.e., color, size, restraints etc. In response, our Advisory Committee formed a subcommittee, entitled the Jail Standards Sub-Committee to review this issue. The subcommittee has employed the advice of psychiatrists and other mental health professionals and has drafted 12 proposed standards. After reviewing this matter nationally and finding very little data available on this issue, the sub-committee plans to share these standards with other states.

Finally, I would like to share an example of how the collaboration model has worked in one county.

About a year ago, I was asked to help Franklin County start a task force. As one of the largest counties in Ohio, we had a large population of mentally ill in the local jails, and the mental health department felt very frustrated in how to deal the problem.

We had about 10 people at the first meeting - some mental health and drug and alcohol representatives and a few judges I had called. The judges were not even aware that Franklin County had received a Department of Mental Health grant to work with the mental ill in the jail. The local housing board, which had funding for over 500 beds for the homeless, had never worked with the courts, nor had a leading program to train mentally ill to work. A year later, there are over 55 community representatives on the task force, which also has active sub-committees. The mayor has approved CIT training and two classes of police officers are in training. The Municipal Court has started a mental health docket, and the Common Pleas Court has started a drug court docket that will form the structure for a mental health court docket to be included. The Franklin County courts have jointly obtained two grants, one with thanks to Senator DeWine's first mental health courts bill. The task force has expanded its collaboration effects far beyond just jails. They are finally working together.

The key to all of this is collaboration -- working together. We have discovered there are many resources out there that can be more effectively used when we join forces. S. 1194 is a key component to that effort. It provides the

seed money for that collaboration – planning money, implementation money. It is not a whole new system that needs funding but rather needs to work together with specialized funding to help that collaboration process-such as an intake officer or probation officer who is trained in mental health issues, the CIT police officer who takes a person who has stopped taking their medication, to a mental health clinic, not jail.

All the money we now spend warehousing the mentally ill in jail can be rechanneled to mental health care, job training, housing, with permanent solutions, not just a revolving door. A recent study by the Corporation for Supportive Housing found that stabilizing the homeless and mentally ill had resulted in $16,000 annual savings per year of social, mental health and jail expenses per person. In one New York study alone, the prison use by this population dropped 74% and jail use by 40%. The Corporation for Supportive Housing, June 2001 Report. Pp. 21 and 23. The end result is a reduction in crime and safer communities as well.

Senate Bill 1194, "The Mentally Ill Offender Treatment and Crime Reduction Act of 2003" sponsored by Senator DeWine is a key part of the solution for the mentally ill offender. It provides needed federal dollars for programs that could become models for duplication in other communities. The availability of federal funding is often the catalyst to spur community action and to encourage the communities to work together and collaborate, even in the act of designing a program and applying for the funds. It focuses attention on a

population that is too easy to forget-the defendant and inmate, yet a population that is mostly there because other social safety nets have already failed them. It encourages the collaboration model that Ohio has already used very successfully, but is broad enough and flexible enough to deal with the different social and political environments of each community. One program may emphasize the juvenile, another police training, a third how to integrate the mentally ill who have completed their sentence back into a community that already failed them. Each successful program becomes a model that can be duplicated elsewhere. For these reasons, and many others, I strongly urge you to consider the passage and funding of S. 1194.

In the 1800's, the greatest challenge to the mental health and criminal justice systems was to get the mentally ill out of jails and prisons and into appropriate treatment. Still today, we face the same problem. But by joining forces and working together, we are making a difference. In the end, we save money, but more importantly we save lives.

S. 1194

"Mentally Ill Offender Treatment and Crime Reduction Act of 2003"

United States Senate Judiciary Committee

testimony by

Reginald A. Wilkinson, Ed.D.

Director, Ohio Department of Rehabilitation and Correction

President, Association of State Correctional Administrators

Past President, American Correctional Association

July 30, 2003

INTRODUCTION

Good afternoon. Thank you Senator DeWine, Chairman Hatch, and Ranking Member Leahy for inviting me to testify regarding S. 1194, the "Mentally Ill Offender Treatment and Crime Reduction Act of 2003."

My name is Dr. Reginald A. Wilkinson, and I am the Director of the Department of Rehabilitation and Correction (ODRC) for the State of Ohio. ODRC comprises more than 30 prisons, and, on any given day, our agency supervises 45,000 inmates housed in our correctional institutions. We, moreover, supervise another 30,000 persons on parole and probation.

Today, I represent not only the great state of Ohio, but also the Association of State Correctional Administrators (ASCA). ASCA is the national organization that represents persons who serve in my position in each of the 50 states and several other jurisdictions. I am the current president of ASCA.

I'd also like to provide testimony on behalf of the Council of State Governments (CSG). CSG is a non-profit organization that serves the interest of governmental bodies in the United States. They recently undertook a major initiative dealing with the mentally ill offender. Their work culminated in the publishing of the landmark report: *Criminal Justice / Mental Health Consensus Project.* This bipartisan initiative (of which I was part) brought together 100 leading law enforcement officials and mental health experts. This Senate committee, at a hearing chaired by Senator Leahy, reviewed the report recommendations one year ago.

I'd first like to give you a brief history of how ODRC has dealt with problems associated with the mentally ill inmate. In 1993, following a prison riot at the Southern Ohio Correctional Facility where one correctional officer and 9 inmates were killed, a federal lawsuit was filed (*Dunn v. Voinovich*) challenging the constitutionality of ODRC's mental health delivery system in Ohio prisons. While our agency believed we met the constitutional minima to provide mental health services, the system needed repair. Therefore, rather than spending millions of tax dollars defending our previous methods we agreed to a five-year consent decree in 1995 and decided to concentrate on, with the oversight of the federal court, improving our mental health services for the mentally ill prisoner.

Throughout the life of this lawsuit (the case was terminated per the settlement in 2000), all parties, including plaintiff's counsel, the court monitor, the state's attorneys, correctional administrators, and health care professionals, agreed to manage points of contention privately. Consequently, I am personally proud of the mental health delivery system that currently exists in Ohio. I consider the current system to be a national benchmark as it relates to prison mental health care.

On behalf of all directors of state departments of correction and hundreds of thousands of correctional employees across the country, representing prisons, jails, juvenile facilities, and community corrections operations, I want to tell you this: Senator DeWine's introduction of S. 1194, together with the bipartisan support Senator Leahy and various members of the Committee have provided, has been the single most important and positive legislative development for corrections and mental health workers to occur in Congress in recent memory.

It is gratifying to see a group of leaders in the Senate rally, as they have under Senator DeWine's leadership, around a bill that practitioners and policymakers alike agree will save lives, increase public safety, and reduce state and local government spending. My testimony will review the extraordinary toll that the overrepresentation of people with mental illness in the criminal justice system is exacting on the lives of people with mental illness, public safety, and state and county budgets. My testimony will also explain how the legislation can be an unprecedented resource to state and local governments grappling with this complex problem.

I. SAVE LIVES

Our nation's prisons, where more than 1.3 million people are incarcerated on any given day, and our jails, which book about 10 million people annually, house more people with mental illness than do our country's mental health institutions. In fact, I often claim that correctional administrators are *de facto* mental health directors. That is enormously frustrating for us in the corrections community. Our principal job is to incapacitate people who are dangerous to the community, not to hospitalize sick people.

Although we believe criminals with a mental illness should be punished, we also know that a correctional environment is hardly conducive to recovery for a person with mental health problems, especially a serious mental illness or an "Axis 1" diagnosis. Not surprisingly, inmates with untreated mental illness are at a high risk of committing suicide or being victimized by predatory inmates.

Sadly, suicide is the leading cause of death in jails. The suicide rate in Ohio county jails is about 77 per 100,000 people—7 times greater than the rate in the general

population.[1] These rates are not unique to Ohio; correctional systems in other states share similar rates.

By improving procedures to screen inmates for mental illness, and training staff to identify signs of suicide risk, S. 1194 will help corrections administrators fulfill part of their core mission: ensuring safe and humane conditions for staff and inmates alike.

II. INCREASE PUBLIC SAFETY

The growing involvement of people with mental illness in the criminal justice system has enormous public safety implications. Many offenders with mental illness have committed a crime that makes their incarceration necessary and appropriate. Still, nearly all inmates with mental illness will be released from prison at some point.

Unless we provide these offenders with the services and treatment they need while they are incarcerated, we are virtually guaranteeing that they will commit new crimes when they return to the community. Nevertheless, few corrections systems are able to prepare inmates adequately for their release. For example, a study of individuals with serious mental illness leaving Washington State prisons showed that only 3 out of 10 received mental health services in the three months subsequent to their release.[2] Planning for the transition of inmates with mental illness back into the community is even more difficult in the jail context, where stays are shorter, and release dates less certain.

Not surprisingly, studies show that rates of recidivism for people with mental illness should concern all elected officials. One study showed that 72 percent of inmates

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[1] Ohio Department of Rehabilitation and Correction, Bureau of Adult Detention, *Annual Jail Report 2002*, Ohio Department of Rehabilitation and Correction, May 2003. and *www.nimh.nih.gov/research/suifact.cfm*
[2] Paul D. Peterson, David Lovell, Gregg Gagliardi, *Community Transition Study: Mentally Ill Offenders*, Washington Institute for Mental Illness Research and Training, November 2001.

with mental illness leaving the Lucas County Jail, in northwest Ohio, were re-arrested within 36 months.[3] In the same Washington State study mentioned above, 77 percent of the individuals had some post-release arrest, violation, or offense.[4]

Community safety corresponds in part to the degree to which jail and prison systems develop and implement effective transition plans for inmates with mental illness. In this regard, S. 1194 will be of enormous value. It will promote effective reentry planning for people with mental illness through efforts such as encouraging mental health providers to come into corrections facilities and connect with the offender prior to his release, and ensuring inmates have an adequate supply of medications upon their release. Typically, two weeks of psychotropic medications are provided to the offender. Without planned follow up services, this is hardly adequate for released offenders.

Correctional administrators, furthermore, support efforts by local law enforcement to help manage this dilemma. Many persons with a mental illness are arrested and sent to jail for minor infractions. A great number of these can be better served, as well as our communities, by employing crisis intervention methodologies rather than the standard justice techniques. This suggests that more and better training of police officers and the establishment of crisis centers is critical.

III. REDUCE SPENDING

In nearly every state—and, again, Ohio is no exception—we're discovering that corrections is no longer "recession proof." Funds to build, and more significantly, staff and operate prisons and jails are diminishing. State legislatures and governors are

[3] Lois A. Ventura, Charlene A. Cassel, Joseph E. Jacoby, Bu Huang, "Case Management and Recidivism of Mentally Ill Persons Released From Jail," *Psychiatric Services* 49:10, Oct. 1998, 1330-37.

ordering us to find ways to cut costs, and the only way we can realize savings of the scale they are mandating is to curb the rate of growth of our corrections systems.

We know that people with mental illness stay incarcerated much longer than the average inmate. A case in point, the Pennsylvania Department of Corrections reports that inmates with serious mental illness are three times as likely as other inmates to serve their maximum sentence.[5] One of the central reasons for this discrepancy, according to department officials, is that the lack of adequate community services makes it difficult for the parole board to develop an effective community treatment and supervision plan. The irony of this is that, when these inmates do "max out," they reenter the community with no supervision, and, usually, without effective connections to much needed services.

The lack of community-based services and supports for parolees with mental illness means that we parole inmates with mental illness far less frequently than general population inmates. Not only does that mean that they will be released without any community supervision, it also means that we spend much more money to keep them incarcerated. In this context, it is crucial to remember that it is significantly more expensive to incarcerate individuals with mental illness than other inmates. Pennsylvania estimates that an average prison inmate costs $80 per day to incarcerate, while the added costs of mental health services, medications, and additional correctional staff means that it costs approximately $140 per day to incarcerate an inmate with mental illness.[6]

The sooner we get people with mental illness who don't represent a threat to public safety out of the corrections system, and the more we can ensure people with

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[4] *Community Transition Study: Mentally Ill Offenders*, p. i.
[5] Unpublished description of Forensic Community Re-Entry and Rehabilitation for Female Prison Inmates with Mental Illness, Mental Retardation, and Co-occurring Disorders Program, courtesy of Angela Sager, grants manager, May 12, 2002.

mental illness released from prison do not violate their conditions of parole, the more likely we are to realize the savings that state officials are ordering us to find.

S. 1194 provides us with the tools needed to achieve these goals, facilitating the design and implementation of risk assessment instruments, encouraging the enrollment of ex-offenders with mental illness (of those who are eligible) in federal benefit programs, and promoting aspects of programs that prove effective in reducing recidivism.

IV. BUILDING ON OHIO'S SUCCESSES

We have recognized in Ohio that we cannot fix this problem by simply building better mental health hospitals in prison; corrections facilities are typically the largest mental health providers in many communities, and we don't want to become an even stronger magnet for sick people who haven't gained access to the community mental health system.

We also recognize that when people with mental illness are released from prison or jail their success depends largely on the extent to which they are effectively linked to community mental health services.

Dr. Mike Hogan, the Ohio Director of the Department of Mental Health, and I, along with our staffs, have worked hard to establish joint ventures that reflect this commitment to collaboration between corrections and mental health.

However, the road to success is hampered by a number of barriers that are faced by correctional jurisdictions, on both the state and local levels, that this proposed legislation addresses.

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[6] Unpublished statistic courtesy of John Shaffer, Ph.D., Pennsylvania Department of Corrections.

S. 1194 recognizes that no program or policy designed to improve the response to offenders with mental illness can be successful without such inter-agency collaboration. Accordingly, it will be an extraordinary stimulus for collaboration in those counties and states where policymakers and practitioners have yet to work together in a meaningful way. And, in states like Ohio, it will help us translate fledgling initiatives into strong, sustainable partnerships that have a credible evidence base.

For these reasons, we in the corrections community and in state government generally believe S. 1194 is a bill that should be passed immediately, and as an Ohioan, I am especially proud of the leading role my senior Senator and Congressman have taken on this issue.

DR. REGINALD A. WILKINSON

Dr. Reginald A. Wilkinson has been employed by the State of Ohio, Department of Rehabilitation and Correction (DRC) since 1973. He has served in a variety of positions including superintendent of the Corrections Training Academy, warden of the Dayton Correctional Institution, and deputy director of prisons—south region. Former Governor George Voinovich (now U.S. Senator) and Former Lt. Governor Mike DeWine (now U.S. Senator) appointed Wilkinson DRC director in February 1991. Current Ohio Governor Bob Taft reappointed him director in January 1999.

Director Wilkinson's academic background includes a B.A. degree in political science and a M.A. degree in higher education administration, both from The Ohio State University. He was also awarded a doctor of education degree (Ed.D.) from the University of Cincinnati.

Wilkinson is President of the Association of State Correctional Administrators. He is also a Past President of the nation's oldest and largest corrections organization, the American Correctional Association. Wilkinson is furthermore Vice Chair for North America of the International Corrections and Prisons Association.

Dr. Wilkinson has authored numerous articles on a variety of correctional topics. He also has chapters published in the following books: *Best Practices: Excellence in Corrections; Correctional Best Practices: Directors' Perspectives* (editor); *Ohio Crime, Ohio Justice;* and *Prison and Jail Administration: Practice and Theory.*

Director Wilkinson has received numerous awards from a variety of organizations. A few of the associations he has received honors from include the National Governors' Association, the American Correctional Association, the Association of State Correctional Administrators, the International Community Corrections Association, and the National Association of Blacks in Criminal Justice.

The Ohio Department of Rehabilitation and Correction is acknowledged nationally and internationally for its many innovative correctional programs and services in categories such as substance abuse, victims services, correctional health care, correctional education, security management, restorative justice, offender reentry, and much more. DRC is recognized as being one of only several correctional agencies in the nation that is fully accredited by the American Correctional Association.

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Vol. 3 No. 4 Pages 49-64 ISSN 1529-0689 June/July 2002

Risk Assessment

Assessing Female Offenders: Prediction Versus Explanation

by Christopher T. Lowenkamp and Edward Latessa

Introduction

Every day in the criminal justice system scores of decisions are made about what can be done with individuals who commit criminal offenses. From pre-trial release through disposition and beyond, community supervision officers, case managers, prosecutors, defense attorneys, and judges try to make decisions that will ensure public safety. The control and management of persons charged or convicted of crimes is too great and the costs to society are too high for these practitioners to make poor decisions regarding what to do with them or where to place them.

Empirical research indicates that the efficacy of decision-making is heightened by the use of empirically grounded and validated risk assessment instruments (for a review of this literature see Andrews and Bonta, 1999 and Bonta, 1996).

While the importance of empirical risk assessment is now accepted in many areas of the criminal justice system, concerns remain regarding the use of these assessments for so-called special offender population groups. For example, potential issues exist around the applicability of risk assessment instruments that are developed on male-based data and are subsequently used on women or girls. This concern is based on the assertion that the predictors of deviant behavior differ for men and women (Chesney-

See ASSESSING, page 61

Effective Advocacy Strategies

Promoting Justice in an Unjust System: Part One

by Francine T. Sherman

Introduction

Angela (a composite of many of the girls I have known over the years) entered the juvenile justice system at age four, entered foster care at age six, was separated permanently from her brother at age seven, was sexually abused beginning at age eight, lost her mother to drugs at age 12, became a prostitute at age 13, had a child at age 15, and lost her child to adoption at age 17. Along the way she lived in 15 foster homes, eight group homes, was hospitalized four times, and attended eight different schools. She had at least 15 different case workers, was found delinquent for shoplifting, prostitution and aggravated assault, and ran away from placements more than 30 times.

Angela is Latina and has long, wavy brown hair. She writes poetry and, when she is feeling good about herself, goes to church and reads spiritual books. She is very emotional and devoted to friends. She engages people easily, saying hello to passers by on the street and chatting with people everywhere she goes. When I meet with her she asks how I am doing before launching into the issue of the day. She is smart and quickly grasps everything I say and offers solid suggestions. She is disorganized and impulsive and seems to live in the moment. She quickly becomes caught up in disputes and difficulties on the street and, although she has big plans, she has difficulty following through on most things.

Above all else, Angela is resilient. Her story may sound extreme, but it is not. In fact, it is remarkably typical of girls in the justice system. Lawyers for girls around the country describe similar cases of early victimization combined with gross system failure and inconsistency beginning in the child welfare system and moving up through the delinquency and criminal justice systems. Recent research describes girls in the system with histories of multiple incidents of sexual and physical abuse, current school failure and unmet educational and mental health needs. We know that girls enter the delinquency system disproportionately for misdemeanors or misbehavior, and remain in the system due to probation and parole violations, and running away. (Justice, 2001). In its groundbreaking report, *A Call for Justice*, the American Bar Association's Juvenile Justice Center identified disposition and post-disposition practice as critical areas for lawyers representing delinquent youth. The report is clear that quality representation should extend beyond delinquency proceedings into ancillary legal matters such as special education. (Puritz, 1996). This is true for girls. Education and mental health advocacy may prevent system recidivism and offer girls the best chance of developing into healthy young women. Girls particularly

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Research Guiding Practice

Alternative Interventions for Women

by Mary Carol Melton, Mary Grace, M.Ed., M.S., Nancy Schmidtgoessling, Ph.D. and Walter S. Smitson, Ph.D.*

Introduction

In March 2001, the Alternative Interventions for Women program opened its doors in Cincinnati, Ohio as an innovative early intervention program for female offenders with co-occurring mental health and substance abuse disorders to help support criminal justice diversion and sentencing sanctions. The program, located within the Court Clinic, a community-based agency that provides mental health and forensic services for the Hamilton County Courts, was made possible through a funding partnership with The Health Foundation of Greater Cincinnati, the Hamilton County Department of Probation, the Hamilton County Department of Pretrial Services, Hamilton County TASC, and the Hamilton County Community Mental Health Board.

Background

The Alternative Interventions for Women program came to life after a needs assessment suggested relevant parameters for its services. For three years, members of the criminal justice system and community mental health leaders in Hamilton County worked together, with the support of the National Institute of Corrections (NIC), to learn about and plan alternative sanctions and services for women offenders. One result of this intersystem collaboration, which occurred when local service providers were convening to identify and discuss specific issues and, at the same time, NIC was seeking sites to help local jurisdictions improve the level and quality of services to female offenders in the criminal justice system, was the recommendation for an in-depth assessment study.

The assessment project, formally named the Women's Assessment Project, was funded by the Hamilton County Department of Probation to determine rates of psychiatric and substance abuse disorders, traumatic events, and cognitive functioning, using standardized assessment tools, in a small sample of women arraigned through the Hamilton County Municipal Court between October and December 1999. The results of that study indicated significant incidence of mental health, substance abuse and co-occurring disorders in this group. (See *The Women's Assessment Project: Final Report*, on page 53) The findings suggested that institutionalizing a system of early screening, assessment and treatment would assist the courts in determining if treatment, as an alternative to incarceration, would be beneficial for this high risk and underserved population of women offenders in Hamilton County.

As a result, the Alternative Interventions for Women program was developed to provide a continuum of assessment and treatment services for women with co-occurring mental health and substance abuse disorders including early identification, assessment and referral, treatment and community reintegration. This initiative, led by the Court Clinic, is a collaborative effort across the criminal justice, mental health and substance abuse systems.

Intersystem collaboration created an innovative early intervention program for female offenders with co-occurring mental health and substance abuse disorders.

Early Identification

The first step in the early identification, assessment and referral, treatment and community reintegration continuum of the Alternative Interventions for Women program, is a brief symptom screening of women coming through the Department of Pretrial Services in order to detect those who would likely meet criteria for co-occurring disorders. Staff administers the self-report BASIS-32 to all women coming through the Department of Pretrial Services as part of the standard pretrial assessment. Results for each client are computer scored and faxed to the Court Clinic Liaison who reviews the data and makes recommendations to pretrial staff, based on the BASIS-32 score, about seeking an in-depth assessment referral from the judge.

The court then has the option of referring a woman for the in-depth clinical assessment and, if the co-occurring disorders are confirmed, a recommendation for participation in the Alternative Interventions for Women treatment program, or other appropriate treatment could be made.

In-Depth Assessment

Women referred by the court receive an in-depth clinical assessment performed by Court Clinic assessment specialists and licensed clinical psychologists. The assessment includes the Structured Clinical Interview for DSMIV (SCID), a trauma-screening inventory, an abbreviated IQ test, and a measure of cognitive functioning. The clinical assessment determines if the woman meets criteria for co-occurring disorders and is appropriate for referral to the Alternative Interventions for Women treatment program. The examining psychologist makes a final report to the judge, including treatment recommendations.

Women deemed eligible for the program are introduced to the program with a packet of information that includes the following:

- Mission and purpose of the program,
- Consent to treatment and to collaboration with probation,
- Introduction to basic elements of the program, including group, individual, and case management, and
- Explanations of medical-somatic services, program days and times, staff,

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expectations for the participants, assessment of participant's practical needs such as childcare and transportation, and expected outcomes.

The Alternative Interventions for Women treatment program has three stages: the Core Program, Transition/ Aftercare; and Community Reintegration. The Core Program, which includes a pre-treatment group, is intensive and each woman is required to attend from 9:00 a.m. to 3:00 p.m. daily, five days/ week, for at least five weeks and up to three months.

The Core Program

Each woman starts by setting personal goals for the program and developing, with staff guidance, an individual treatment plan. It is expected that the average woman will participate in the program from 9:00 a.m. to 3:00 p.m. daily, five days a week, for at least five weeks and up to three months, with aftercare available after completion of the program. Outcomes will be assessed at the beginning and end of the program, and at the completion of the aftercare program.

Dr. Stephanie Covington's Model, *Helping Women Recover*, is at the core of the program, along with the Dartmouth/ New Hampshire model of treatment for individuals with co-occurring disorders. Additional groups that all women are expected to attend involve:

- Co-occurring disorders,
- Stages and progression of mental health and substance abuse,
- Program participation,
- Changing behavior, and
- Alcoholics/Narcotics Anonymous groups.

In addition to these core sessions, each client, in collaboration with a clinician when developing a treatment plan, will choose group sessions that are specific to her individual needs. Some options to choose from include the following:

- Anger management,
- Assertiveness,
- Anxiety management (relaxation and meditation),
- Brain functioning,
- Communication skills,
- Conflict resolution,
- Culture,
- Educational issues (GED),
- Feelings,
- Humor,
- Leisure activities,
- Medications (identifying and managing them),
- Mental Illness (bipolar, depression, panic disorder, PTSD),
- Nutrition,
- Self-esteem,
- Smoking cessation,
- Stress relief,
- Symptom management,
- Values, and
- Vocational issues.

A strong collaborative partnership between the treatment program and the community is key to the success of this initiative.

As mentioned, the women are also expected to attend community Alcoholics/Narcotics Anonymous groups as they progress through treatment. The program has an all female staff and offers a safe environment for the clients. A therapeutic lunch is provided daily, during which time women can work on socialization skills or incorporate a recent Alcoholics Anonymous meeting. Staff shares meals with the women.

Transition/ Aftercare

At the end of the five weeks, each participant's schedule is re-evaluated according to her needs. A treatment-planning meeting will take place with each woman to determine whether her continued level of care indicates one of the following:

- Continued 5 days a week attendance in the program,
- Program attendance can be reduced to three days a week, or
- Completion of the program (ready for aftercare).

At the end of five weeks, a treatment-planning meeting will take place in order for each woman to evaluate her progress in meeting her goals. Her schedule will then be adjusted according to her needs.

Community Reintegration

A critical component of the Alternative Interventions for Women program is community reintegration. Clients are at high risk for relapse as they leave the milieu of the successful treatment program where services have been delivered, connections made and community built within one program.

To address this risk, personalized community support planning for community reintegration will begin during the Core Program. These community support services will establish connections between the client and community providers, in many cases actually enrolling clients in programs, arranging jobs and assisting women in making appropriate child care plans.

A strong collaborative partnership is key to the success of this initiative and an integral component of this collaborative is the commitment to measurable outcomes. Evaluation of each woman at each step of the program is done in measurable terms, using standardized and nationally normed measurement tools. Data is reviewed in an ongoing way as part of a continuous quality management plan and these data are used to drive program modifications and establish performance standards. ■

We Want to Hear From You!

Women, Girls & Criminal Justice welcomes articles, commentaries and letters to the editor. Submissions can be sent to:

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The Women's Assessment Project: Final Report

by Mary Grace, M.Ed., M.S., Jenny O'Donnell, Psy.D., William Walters, Ph.D., Walter S. Smitson, Ph.D. and Mary Carol Melton*

Introduction

The Women's Assessment Project was undertaken as a pilot study in the fall of 1999 in collaboration with Hamilton County Probation Department, Department of Pretrial Services and Central Clinic. The objective of the study was to determine the mental health and substance abuse status of women being sent to a locked residential community assessment facility. Women could be sent to this facility from either the pre-trial or post-conviction stage of their criminal justice system involvement. Data derived from this study could identify undiagnosed mental illness and substance abuse disorders among incarcerated women, which could, in turn, suggest unmet system service needs. Based on this evidence, calls for proposals could be developed to meet these service needs. In addition, this data could be used to develop effective aftercare plans for women as they end a period of incarceration and attempt community reintegration.

Procedures

Women who were sent to the assessment facility were approached each morning by the project psychology assistant and asked to participate on a first come, first served basis. Participation was high. Over 80 percent of women approached agreed to participate in the project. The study was explained to each participant and consent obtained before the interviewing process began. Participation was voluntary for all women. No financial compensation was made for participation. Once a woman gave consent for participation, she was administered a battery of standardized self-report and interview based measures by the psychology assistant. Several days later she received an extensive diagnostic assessment from a licensed psychologist who had previously reviewed the findings from the standardized assessments.

*Mary Grace, Outcomes and Quality Management Director; Walter S. Smitson, President and CEO and Mary Carol Melton, Assistant Director are, respectively, with Central Clinic. William Walters, Assistant Director and Jenny O'Donnell, Research Assistant are, respectively, with the Court Clinic. For further information about this study, contact Mary Grace at Central Clinic, 311 Albert Sabin Way, Cincinnati, OH 45229, (513) 558-5940; (email) gracemc@uc.edu.

Measures

A battery of standardized assessments was used in this study to provide a comprehensive assessment of mental health and cognitive functioning. A brief description of each of these measures follows.

WASI. The Wechlser Abbreviated Scale of Intelligence (WASI) is an interviewer administered assessment of intelligence divided into two areas of Verbal and Performance subtests, yielding a Verbal IQ, a Performance IQ and a full scale IQ. Individual participant scores are interpreted against national norms of above average, average, low average, borderline and mentally retarded.

WRAT-3. The Wide Range Achievement Test (WRAT-3) is an interviewer-administered measure of a participant's level of academic achievement normed against the performance of other individuals in the participant's age group. Three subscales of Reading, Spelling and Arithmetic are derived and data is presented in terms of standard scores, percentiles and grade level achieved (i.e. 9th grade level).

BASIS-32. The BASIS-32, a standardized, self-report problem behavior and symptom identification assessment tool, was developed in 1987 by the McLean Hospital (Belmont, Massachusetts) Department of Mental Health Services and is currently in broad use in both the public and private mental health services arena. The tool is scored in five specific domains of mental health functioning including:

- Relationships,
- Depression and anxiety,
- Daily living skills,
- Impulsiveness and addictive behavior, and
- Psychosis.

In addition, the tool yields an Overall Impairment Score. Outpatient and inpatient norms have been established in large samples for the BASIS-32, which will allow the development and use of cutoff scores to determine likely cases of psychiatric illness.

TESI. The Traumatic Events Screening Inventory (TESI) is a self-report measure that captures the occurrence of a number of traumatic life events in the participant's life. These include:

- Sexual, physical and psychological abuse,
- Natural and man-made disasters,
- Death, and
- Injury.

Comparative data are available from patient and non-patient samples.

SCID for DSM IV. The Structured Clinical Interview for Diagnosis (SCID) was developed as a clinical interview designed to elicit the presence or absence of each of the AXIS I psychiatric disorders contained in the American Psychiatric Association's Diagnostic and Statistical Manual. Symptoms of each psychiatric disorder are investigated in a standardized way. Disorders are grouped into modules including:

- Substance abuse/dependence disorders,
- Anxiety disorders, mood disorders, and
- Psychotic disorders.

At the completion of the SCID, a comprehensive diagnostic report is electronically rendered for each client. The SCID is widely used in research studies of psychiatric disorders.

Findings

Demographic Characteristics. Forty women participated in this pilot project from October through December 1999. As noted above, this represents 80 percent of the women asked to participate. Women participants were, on average, 32 years old. Over three-quarters of these participants were African American, 90 percent were unmarried, 48 percent had less than a high school diploma, and over 67 percent had children, although only 30 percent of women with children had custody of these children. At the time of incarceration, 40 percent of the women reported working full time and an additional 32 percent reported working part time.

Forensic Status. Women in this sample were at the pre-trial or post-conviction stage of the criminal justice process in almost equal measure (42 percent v. 58 percent). Over one-half of the women were incarcerated for misdemeanor offenses. Ninety-five percent of the

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women had a prior legal history, 45 percent for misdemeanors only.

Cognitive and Psychiatric Status. Scores on the WASI IQ test indicated that only 45 percent of participants had an average IQ; 17 percent were low average, 25 percent borderline and 13 percent mentally retarded. The WRAT-3 academic achievement test indicated that 55 percent of the women had reading skills below the 9th grade level, 65 percent had spelling skills below the 9th grade level and 95 percent had arithmetic skills below the 9th grade level.

The SCID identified Axis I psychiatric disorders in 75 percent of the women participants; 38 percent of the group had combined substance abuse and at least one other Axis I psychiatric disorder. Thirty one percent of the women had only a substance abuse/dependence diagnosis. Among the women with psychiatric disorders in addition to substance abuse, 35 percent had mood disorders, 23 percent had anxiety disorders and 13 percent had PTSD.

The BASIS-32 measure of behavioral and symptom distress indicated that, while the group as a whole reported only mild symptoms of distress on average, women who had psychiatric disorders had overall distress scores at the same level as psychiatric outpatient norms reported nationally. When the total sample is divided into women without any psychiatric diagnosis, women with a substance abuse diagnosis only and women with dual diagnosis, clear differences among groups appear on the BASIS-32. Women with dual psychiatric diagnoses report over twice the impairment as those with no diagnosis. Women with substance abuse diagnosis only also report significantly less distress than women with dual diagnoses.

Trauma History. The average number of traumatic events that have occurred in these women's lives is nine. Abuse of all sorts is a common occurrence:

- Fifty-five percent report physical abuse,
- Fifty percent report sexual abuse, and
- Sixty- three percent report psychological abuse.

Discussion of Findings

Results of this pilot study reveal significant levels of psychiatric diagnoses in addition to substance abuse/dependence diagnoses in the group of women incarcerated at the assessment facility. Behavioral and symptom distress scores for those women with psychiatric disorders exceeded large, published outpatient sample scores. In addition, this study found a serious lack of intellectual capacity and educational achievement in many of the women interviewed. Numerous traumatic events, particularly sexual, physical and psychological abuse, were common. These findings, taken together, suggest the need for programming that addresses underlying psychiatric and substance abuse diagnoses, which may be contributing to women's involvement in the criminal justice system. The data also suggest that programming needs to be targeted to a woman's level of intellectual ability and readiness.

Clinical Implications and Treatment Recommendations

The population of the assessment facility would be seen as a relatively typical county jail population. The women were from a variety of situations, and varied demographically, socio-economically, and educationally. These were not women who were thought to be in need of mental health services, and certainly were not flagged to receive any mental health services while in jail. Those women who were identified as needing mental health services, such as those who are not competent to stand trial, were already on psychotropic medications, were flagrantly psychotic, and were known to be involved in the local mental health system had already been screened out of this population. Women who behaved bizarrely, self-mutilated, or acted aggressively toward others were not housed at the facility and therefore were not included in this study. However, despite the process of prescreening, this study revealed that the women at the assessment facility have significant histories of physical, sexual and emotional abuse, cognitive deficits, and mental health needs. They also exhibited problems with achieving appropriate life milestones, maintaining jobs and stable housing, managing their parental responsibilities and substance abuse.

This study allowed for a clinical assessment of a general population of incarcerated women so that future programming would meet the identified needs of this population, but it also provided an opportunity for the individuals that were evaluated to experience the potential benefits of counseling and mental health services. Several of the participants reported that they had never had an opportunity to discuss their histories, fears, and symptoms with anyone, and that they felt overwhelmed when trying to find out where and how to get appropriate services for their particular situation. Many of the women expressed a sense of relief and hopefulness at having been able to talk to mental health professionals, and were thankful for the opportunity to be heard. Several asked for information regarding community services that would be appropriate, and available to them when they were released, and how to access those services.

The women that participated in this study showed a clear need for treatment for academic underachievement and cognitive deficits, coping with histories of physical, sexual and emotional abuse and issues of grief and loss of loved ones, unmet expectations and co-occurring mental health and substance abuse.

The academic needs of this population suggest that programming should be designed for those with significantly lower academic achievement, that would particularly impact understanding written materials, being able to read without assistance, and being able to write or journal without assistance. Because of the cognitive deficits of this group, treatment planning and program design must be geared for individuals who will learn best from a model designed for their level of understanding. For example, information will be best learned in small chunks, using repetition. They will need information to be presented both verbally and visually, with repeated clarification. Regular checking with the participant for their interpretation of the information will help the facilitator recognize how much the participant has learned, and at what pace they can proceed.

This population identified several topics that could be treated through psychotherapy groups. The specific issues were sexual, physical and emotional abuse as children and adults, as well as anger management, relationship issues, and stress management. These women were often still involved in abusive relationships and were unsure how to leave the relationship or how to avoid those relationships in the future. These issues result in ongoing depression leading to continued drug use. Breaking the cycle of trauma that continues to interfere with day-to-day mood and behavior is critical.

The specific needs to be addressed with regards to parenting issues are two-

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tion. The original hardcover version of this volume was first published two years ago and the new paperback version contained an updated introduction, plus several new articles in place of others deleted from this volume. With regard to the articles covered in this review, only the article by Judy Greenspan and her colleagues is new to this volume.

In all, these articles raise a number of important concerns regarding the incarceration of women in the United States:

- Adrien Wing, a law professor at the University of Iowa College of Law and editor of *Critical Race Feminism: A Reader* (NYU Press, 1997), makes the case for taking a "critical race feminist" approach with black female gang members. Critical race feminism focuses on the concerns of women of color under the law and stresses their multiple identities and roles as women. Wing too easily accepts unverified statistical evidence on the rise of female violence, including violence by black women, and posits alternative approaches too briefly, but argues convincingly for "solutions" that "consider the African-American woman in all her roles, including gang member, girlfriend, wife, and mother."
- Joanne Belknap, a criminologist at the University of Colorado, Boulder and author of *Invisible Women* (Wadsworth, 2001), reports that women in prison need greater access to health care, especially substance abuse treatment programs.
- Juanita Díaz-Cotto, a sociologist at the State University of New York at Binghampton and the author of *Gender, Ethnicity and the State: Latina and Latino Prison Politics* (SUNYPress, 1996), briefly reviews the little more than a handful of studies that have assessed prison organization in women's prisons. She gives special attention to how these studies treated racial and ethnic interactions and discriminations, concluding that, "Mainstream social scientists studying women's prisons have tended to focus their research on emotional and sexual relationships among female prisoners to the almost total exclusion of other types of alliances. With few exceptions, studies have highlighted gender issues while ignoring the importance of racism, ethnocentrism, and class biases within prison settings. By discussing the experiences of imprisoned women as if devoid of significant influences from penal personnel, state politics, and social movements, prisoners' experiences have been portrayed as taking place within a social vacuum. As a result, social scientists have distorted the experiences not only of prisoners of color but also of white prisoners and staff." (pp. 129-130)
- Luana Ross, a sociologist at the University of Washington, Seattle and author of *Inventing the Savage: The Social Construction of Native American Criminality* (University of Texas Press, 1998) examines the denial of religious autonomy to incarcerated Native American women. She argues that the vision of Native American women—of themselves, of others, of their community—is their greatest strength.
- Judy Greenspan, a community and health organizer in the San Francisco Bay Area and a former staff member of the National Prison Project, as well as incarcerated and formerly incarcerated women from the California prison system, offer testimony from HIV and hepatitis C activists who are critically ill and dying from these diseases. This testimony challenges the quality of health care provided in the state's prisons for women.

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fold. Those women who still have custody of their children are in need of parent training and support groups that provide a safe place for them to process the frustration of parenting, and the feelings of being overwhelmed by their responsibilities. Those women who no longer have custody of their children often expressed anger, grief, hopelessness and confusion about their situation and need to be able to learn to cope with those feelings without being incapacitated or turning to substances.

Most of the individuals with co-occurring mental health and substance abuse issues were higher functioning than those in a typical SAMI program. However, these women are still in need of a dual-diagnosis treatment model that can help them balance the need for medication with abstinence from other mood altering drugs while also teaching them to live with their mental illness and the day-to-day difficulties that may entail. Several of the women may also need an evaluation for appropriateness for medication once they have detoxified from their illicit drug use and have been sober for longer than 90 days.

Clinical Implications

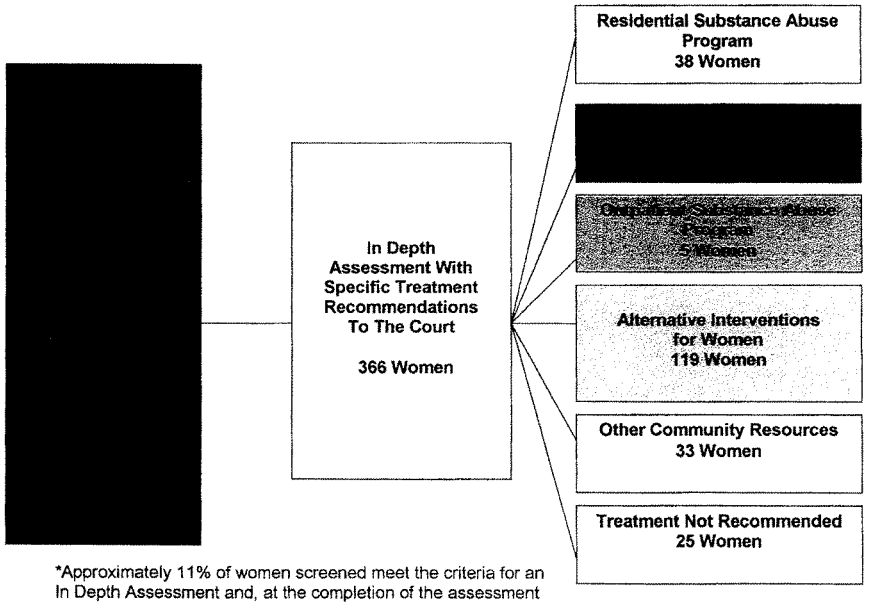
The clinical implications of this study are that we need to develop an effective assessment model that allows prescreening to explore more of the behavioral/psychological/cognitive needs of the population. Many of these needs are not apparent in a brief conversation or interview that only addresses non-clinical issues. This assessment could utilize such tools as BASIS-32 or other self-report measures (i.e. asking about special education placement) that will flag the inmates with the more difficult to detect mental health needs that we found in this population. When such women are identified, there should be some provision made for more in-depth psychological assessments, either by a clinical interview or other psychometric measures administered by trained mental health forensic personnel. There should be a dedicated team of forensic mental health professionals conducting these assessments. We found that over time, as the population became more comfortable with the project, the women were more likely to be open and more revealing with the identified staff.

Discharge Planning

Lastly, discharge planning needs to begin the moment the inmate comes into the system. The complexity of getting connected to the cluster of services, and being reconnected to the outside world is more than most of these women are capable of doing, both emotionally and cognitively. A coordinated effort among the mental health providers, the social service agencies and the criminal justice system could be embodied in a transitional case management team. That team could then facilitate connecting these women with appropriate services, and hopefully provide them with the vehicle that they need to better manage their lives. ■

Alternative Interventions for Women
Summary of Services

March 2001 – December 2002



*Approximately 11% of women screened meet the criteria for an In Depth Assessment and, at the completion of the assessment are recommended for one of the above community services.

Comprehensive Services for Women Offenders

Central Clinic / Court Clinic
Hamilton County TASC

Mary Carol Melton
Mary Grace
Kathi Strouse

Community Planning + Inter-System Collaboration

Comprehensive Services for Women Offenders With Co-Occurring Mental Health and Substance Abuse Disorders

Alternative Interventions for Women (AIW)

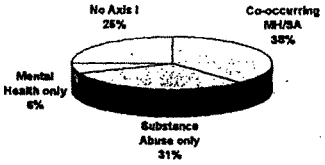
Keys to Success

- Bridge System of Stakeholders
- Needs Assessment - Build Your Case
- Continued Inter-Agency Planning & Collaboration
- Lessons Learned – Finding a 3rd Way of Doing Things

Women's Assessment Project 1999

Conducted a needs assessment to determine the mental health & substance abuse status of women incarcerated for misdemeanors or low level felonies.

Diagnoses Observed

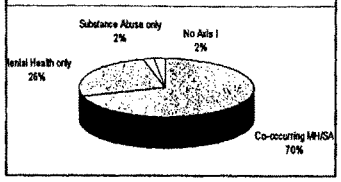


Overall AIW Program Components

- Early Identification/BASIS 32 at Pretrial
- Assessment/In-Depth Assessment
- Referral for TX to AIW or other TX services
- TASC Involvement/Drug Screening/SA Case Mgt
- Commitment to Measured Outcomes/Reports

7

Diagnoses Observed Following In-Depth Assessment



Hamilton County TASC

- Expansion of TASC Model
- Commitment to Inter-System Planning and Ongoing Communication
- Establishing of Common Language
- TASC Case Manager Member of TX Team
- Ongoing Supervision of TASC Staff

9

Lessons Learned

- Importance of ongoing dialogue
- Goals of programs can be different
- Definition of terms (MH/SA)
- Reaching common agreement

10

What Makes It Work?

A B C

- Basic elements of treatment program
  - »Individual Therapy
  - »Group Therapy
  - »Med/Somatic Services
  - »Psycho-educational Services
  - »Measured Outcomes
- Gender-specific focus on trauma & recovery Stephanie Covington Model
- Co-occurring disorder focus Dartmouth/New Hampshire Model

11

What Makes It Work?

- Child care provision
- Intensive case management to meet social/community needs
- Drug Screening
- Collaboration with Probation Officers, TASC & the Court system

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