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S. HRG. 111–975

HUMAN RIGHTS AT HOME: MENTAL ILLNESS IN U.S. PRISONS AND JAILS

HEARING

BEFORE THE

SUBCOMMITTEE ON HUMAN RIGHTS AND THE LAW

OF THE

COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

SEPTEMBER 15, 2009

Serial No. J–111–45

Printed for the use of the Committee on the Judiciary



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HUMAN RIGHTS AT HOME: MENTAL ILLNESS IN U.S. PRISONS AND JAILS

TUESDAY, SEPTEMBER 15, 2009

U.S. SENATE,
SUBCOMMITTEE ON HUMAN RIGHTS AND THE LAW,
Committee on the Judiciary,
WASHINGTON, DC.

The Subcommittee met, pursuant to notice, at 9:58 a.m., in room SD–226, Dirksen Senate Office Building, Hon. Richard J. Durbin, Chairman of the Subcommittee, presiding.

Present: Senators Durbin, Franken, and Coburn.

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

Chairman DURBIN. This hearing of the Human Rights and the Law Subcommittee will come to order. The subject at today's hearing is "Human Rights at Home: Mental Illness in U.S. Prisons and Jails."

At the outset, I want to thank Judiciary Committee Chairman Pat Leahy for reestablishing this Subcommittee. This is another measure of his commitment to human rights. I also want to thank Jeff Sessions, the Committee's Ranking Member, for his support of the re-creation of this Subcommittee.

I want to express personal appreciation to my colleague Senator Tom Coburn, who not only is serving again as Ranking Member of this Subcommittee, but spoke up and said, "Why would you not have this Subcommittee?" That is a nice thing to hear from your colleague, and I think we proved in the first 2 years of our existence as a team on this Subcommittee that we could accomplish some good things.

In the 110th Congress, this Subcommittee focused and reflected on issues like genocide in Darfur, Internet censorship in China, and rape as a weapon of war in the Democratic Republic of Congo. But, in all honesty, we must also reflect on ourselves.

Today in the United States, more than 2.3 million people are imprisoned. This is, by far, the most prisoners of any country in the world and, by far, the highest per capita rate of prisoners in the world. African Americans are incarcerated at nearly six times the rate of white citizens. And many of these prisoners are non-violent drug offenders and individuals with serious and persistent mental illness.

Now, Senator Jim Webb of Virginia has introduced legislation creating a commission to examine our criminal justice system and make recommendations for reform. This comprehensive review is

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really needed. But there are critical reforms needed right now and we should not wait to address them.

Earlier this year, Senator Lindsey Graham of South Carolina and I held a hearing on the sentencing disparity between crack and powder cocaine, which leads to excessive prison sentences for many non-violent drug offenders. We are working with all the members of the Committee to try to come up with legislation to address this problem.

Today, we are going to address another aspect of the criminal justice system that raises important human rights issues: the treatment of mental illness in U.S. prisons and jails.

My late friend and mentor, former Senator Paul Simon, brought this issue to my attention many years ago. The problem has only grown worse since then.

In 2006, the Bureau of Justice Statistics found that more than half of all prison and jail inmates, including 45 percent of Federal prisoners, 56 percent of State prisoners, and 64 percent of local jail inmates suffer from a mental health problem.

In fact, the three largest mental health facilities in the United States of America are the Los Angeles County Jail, Rikers Island Jail, and the Cook County Jail.

Women and children are especially vulnerable. The Bureau of Justice Statistics found that 61 percent of females in Federal prisons have mental health problems, compared to 44 percent of males.

In a recent survey, two-thirds of boys and three-fourths of girls detained in juvenile facilities in Cook County, Illinois, have at least one mental illness. Juvenile offenders with serious mental illnesses are more likely to be abused by other juvenile offenders and have their incarceration extended because of conduct related to their mental illness.

By allowing our prisons and jails to become one of our Nation's primary providers of mental health services, we have taken a step backward in time. Two hundred years ago, people with mental illness were incarcerated in jails and prisons. By the beginning of the 20th century, we transitioned from that model to State mental institutions and hospitals. Growing public revulsion about conditions in mental hospitals led to a movement for deinstitutionalization around 40 or 50 years ago. Community mental health services were supposed to step in to replace State mental hospitals, but that did not happen. It is stunning to read that 8 years ago the GAO found that 9,000 children were surrendered by their families to the juvenile justice system so that they could receive basic mental health services.

As a result of all this, many people with mental illness cycle in and out of correctional institutions, presenting a danger to themselves, correctional officers, and the public. We have returned to the loathsome, indefensible practice of incarcerating the mentally ill. While in prison, many mentally ill prisoners have limited or no access to mental health services, and their conditions frequently deteriorate. They often have difficulty complying with prison rules and, as a result, are disproportionately represented in solitary confinement, which only makes their mental illness worse.

I am deeply troubled by reports about conditions for persons with mental illness at Tamms Correctional Center, a super-maximum

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security facility in my own home State of Illinois. Governor Pat Quinn recently ordered a review of Tamms, and I look forward to discussing this issue with one of our witnesses, Michael Randle, who heads the Illinois Department of Corrections.

I want to salute Gary Marx of the Chicago Tribune and especially George Pawlaczyk and Beth Hundsdorfer of the Belleville News-Democrat for their provocative and thorough articles on the Tamms Correctional Center.

I look forward to hearing from our witnesses about the best practices for dealing with people with mental illness in the criminal justice system, including mental health courts to divert appropriate individuals into treatment and a continuum of care for individuals from entry screening to discharge planning.

Our country was founded on the principle that all people are created equal and endowed with certain inalienable rights. This was, and still is, the promise of America. For generations, this singular idea has inspired freedom fighters, toppled ruthless dictators, and given hope to the disempowered and disenfranchised around the world. We must keep faith with our Founders by working to keep America's promises not only abroad but at home.

That is true even for, in fact especially for, the least among us—whether it is a crack addict serving a mandatory minimum sentence or a person with mental illness who cycles endlessly through shelters, hospitals, jails, and prisons. This is the right thing for us to do, but it is also the smart thing to do because it will keep police and corrections officers and the public safer and dramatically reduce costs for incarceration at a time of fiscal crisis.

Senator Coburn.

STATEMENT OF HON. TOM COBURN, A U.S. SENATOR FROM THE STATE OF OKLAHOMA

Senator COBURN. Well, thank you, Senator Durbin, and I thank our witnesses for being here. I do apologize to you in advance. I am conflicted with two other ongoing committees at the same time, and so I will be leaving in a short period of time.

As a practicing physician, I have seen over the last 25 years a significant increase in how the stressors in our country and in our lives have impacted mental health, and there is no question the greatest factor, I believe, happens to be addiction to drugs and what that does to us. And the Chairman and I both have a desire at some point in time to see a different system of incarceration for those that are addicted. We think we can do it more economically. We know we can do it more successfully, and we know that good drug treatment programs make big differences in people's lives to the tune of about 60 to 70 percent of them never walk that path again.

In terms of our hearing today, the key is recognition and prevention. If we have some incarcerated that we have not recognized a significant illness, we are asking for problems for us as well as for them. And so intake screening and thorough evaluation is a must. We understand that. Treatment also is a must, especially in some of our more significant psychoses and tougher illnesses.

The point that Senator Durbin made—I almost called you "doctor," "Dr. Durbin." The point that Senator Durbin makes about de-

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veloping mental illness in prison, it is easy to see. Depression, psychotic depression, which oftentimes those who work in our system are not prepared to understand that a psychosis is ongoing that is not the individual's normal behavior, but it is a result of psychotic depression, which I could imagine very easily anyone could fall into.

Where Senator Durbin and I differ is that, number one, I look for a constitutional role within the enumerated powers that we have the authority to fix it at the States. I am not sure we do, but the one thing I am in agreement with him on is we ought to model the absolute best practices at the Federal level, and that if we do that, lots can be learned from that, and that example can be utilized.

Oklahoma is high in its incarceration rate. We have a pretty tough justice system, and this is a problem that we experience as well.

The answer is not just more money. The answer is a great plan and set an example and let us see if we cannot markedly improve.

The final point I would make—and I appreciated the testimony from Mr. Maynard in terms of his three suggestions, which I thought were very cogent in terms of the things that we need to do:

Ensure a specific methodology at intake so that we know what we have got, know what we are doing, and make sure it is thorough.

Second, technology improvement to identification ongoing while at intake; and cross-checking data bases with past history. You know, one of the biggest problems is we do not get thorough past medical histories.

I will take just a little bit of liberty. I have a gentleman that is incarcerated today that had true manic-depressive disease, and all of his convictions are on the basis of when he was in a manic state, uncontrolled, undiagnosed, and he is now serving the minimum mandatory 15-year sentence simply because we failed. We failed to diagnose him. We failed to treat him, both inpatient and outpatient, in incarceration as well as outpatient. And so now he finds himself in a long-term situation, and he is a model prisoner because he is being controlled. His medicines are being given. He no longer has the disease. So it is a real problem, and we do not deny that. Then, finally, appropriate staffing levels in terms of mental health professionals and counseling that would go along with that.

So I am very pleased we are having—I think it is a human right to have your health care diagnosed when we are going to incarcerate you, and I think we ought to set that example at the Federal Government, and I look forward to the witnesses' testimony. I thank you all for being here.

Chairman DURBIN. Thank you, Senator Coburn.

Without objection, a statement by Senator Feingold will be entered in the record.

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

Chairman DURBIN. I yield to Senator Franken, if you would like to make an opening comment or statement.

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STATEMENT OF HON. AL FRANKEN, A U.S. SENATOR FROM THE STATE OF MINNESOTA

Senator FRANKEN. Thank you, Mr. Chairman. I would like to make just a short statement and submit a fuller statement for the record, if that is okay.

Mr. Chairman, Senator/Dr. Coburn, I appreciate the opportunity to participate in this hearing which touches on two issues that are of utmost importance to me: caring for those with mental illness and working to reform our country's deeply flawed prison system. The sheer volume of people that we imprison in this country is a crime in itself, and as a society, we are most guilty of failing the thousands of young people who, instead of receiving education, support, and treatment, are growing into adulthood behind bars, a fate which virtually dooms these children from ever becoming productive citizens.

I was very happy to hear Senator Coburn's remarks on treatment and am very encouraged by that, and I am in complete agreement with him. So I would like to hear from the witnesses, and thank you, Mr. Chairman and Senator Coburn.

Chairman DURBIN. Thank you, Senator Franken, and your opening statement will be admitted into the record at this point, without objection, and Senator Coburn's as well.

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

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

Chairman DURBIN. Now we turn to the first panel of witnesses for opening statements. They will each have 5 minutes. Their entire written testimony will be part of the record. I am going to ask them to stand, and as is the custom of the Committee, we swear in our witnesses.

Would you please raise your right hand? Do you affirm that the testimony you are about to give before the Committee is the truth, the whole truth, and nothing but the truth, so help you God?

Mr. LAPPIN. I do.

Mr. BAGENSTOS. I do.

Ms. LEARY. I do.

Chairman DURBIN. Let the record indicate that all three have answered in the affirmative and, therefore, may proceed.

Our first witness is Harley Lappin, the Director of the Federal Bureau of Prisons. He has served at BOP for 24 years, and has been the Director since 2003. Mr. Lappin is responsible for the Bureau's 114 institutions and the safety and security of over 208,000 Federal inmates. He holds a B.A. in forensic studies from Indiana University in Bloomington and an M.A. in criminal justice and correctional administration from Kent State University.

Thanks for joining us today and please proceed.

STATEMENT OF HARLEY G. LAPPIN, DIRECTOR, FEDERAL BUREAU OF PRISONS, WASHINGTON, D.C.

Mr. LAPPIN. Good morning, Chairman Durbin, Ranking Member Coburn, and members of the Subcommittee. I am pleased to appear before you today to testify on the very important topic of mental illness in correctional facilities. Inmates with mental health prob-

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lems present a host of challenges. I am well aware that the challenges we face in the Bureau of Prisons are not unique to the Federal prison system. State and local corrections systems have similar issues and often fewer resources at their disposal. I am committed to ensuring the Bureau of the Prisons does all it can to attend to this vulnerable population, but I know there are cases where individuals leave prisons with their mental illnesses untreated. We must do more if we want to prevent further criminal behavior and victimization in our communities.

Since early 2000, the National Institute of Corrections has provided support to State and local corrections in the area of mental health, including holding public hearings, sponsoring Web-based forums, and providing technical assistance both directly and through a third party. We estimate that 19 percent of the inmates admitted to the Bureau of Prisons suffer from some mental illness. As in the community, the vast majority of these inmates are treated on an outpatient basis at the institution by Psychology Services staff working in collaboration with other staff, including therapists, counselors, social workers, and either a full-time or consultant psychiatrist, as indicated. Our staff also conduct an array of forensic evaluations for the courts.

Group counseling is a very effective method for the delivery of mental health services to inmates in the Bureau of Prisons. Individual counseling is also provided at every institution to inmates with a need for more intensive services.

Inpatient psychiatric services are provided for chronic and acutely mentally ill cases, as well as for court-ordered placements. These services are provided at the Bureau of Prisons medical referral centers, each of which is accredited by the Joint Commission on Accreditation of Health Care organizations. The chronically mentally ill remain at the centers for the duration of their sentence, but acute cases are treated, stabilized, and then returned to our mainstream institutions.

All inmates coming in to the Federal prison system are screened for mental illnesses, and subsequent screenings are done during reviews of inmates in special housing units, as indicated. Treatment plans are developed for inmates found to be in need of treatment, and when necessary, inmates are transferred to different institutions.

We offer a variety of residential or intensive treatment programs for mentally ill inmates of both genders at all security levels. My written statement describes these programs in some detail.

We also operate a dual diagnosis residential drug abuse treatment program for inmates suffering from both a substance abuse disorder and a serious mental illness, and we offer this program to both male and female offenders.

The Bureau of Prisons currently has more than 450 full-time psychology treatment staff, the majority of whom are psychologists, with some psychology technicians and treatment specialists. This figure does not include the drug treatment staff.

We also have 30 full-time psychiatrists within the system. These psychiatrists are able to treat inmates at all of our institutions through the use of video technology, which is much less costly than relying on contract psychiatrist and also ensures continuity of care.

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Many individuals who suffer from mental illnesses are at the risk of committing suicide. All Bureau of Prisons staff are trained to recognize signs indicative of potential suicide, to prevent suicides, and to understand and make appropriate use of the referral process. The Bureau of Prisons uses well-trained staff, skilled clinicians, frequent referrals, prevention techniques, and extended follow-up services to manage the suicide risk by Federal inmates. While any suicide is tragic, over the past 10 years, the Bureau's suicide rate has been less than the rate for the general U.S. population.

The Bureau of Prisons works hard to ensure the smooth transition of mentally ill inmates from prison to the community through the close communication with other authorities—the United States Probation Services, the Court Services and Offender Supervision Agency, as well as treatment providers in the community, through our network of residential reentry centers.

The majority of the inmates transition through residential reentry centers—also known as community corrections centers or halfway houses—to help them to adjust to life in the community, to acquire post-release employment, and in many cases find suitable housing. The BOP's Transitional Services staff coordinate and oversee treatment of inmates housed in residential reentry centers.

Thank you for holding this hearing and bringing attention to this important topic. The mentally ill in prison are a unique population that poses real challenges for our agency. We are doing a lot, particularly given the budget restrictions we have experienced. But more can be done, particularly through collaborating with our partners around the country, State, local, and other Federal law enforcement agencies, mental health agencies, and community organizations. I think it is critically important, as Senator Coburn mentioned, that we work together to identify the presence of mental illness in offenders as early as possible in the criminal justice system, such as at arrest, and that there be a mechanism in place for that information to be passed on to those who will incarcerate that person or hold that person in the future. This will often avert harm to the offender and to others.

We should provide the resources to meet the needs of mentally ill offenders during incarceration and support them upon release as they face the challenges of reentering communities.

Finally, we should encourage jails, prisons, lock-ups, community corrections centers to seek accreditation from outside entities, thereby establishing a set of standards and expectations for staff to follow.

Chairman Durbin, this concludes my formal statement. I am pleased to answer any questions at the appropriate time. Thank you.

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

Chairman DURBIN. Thank you, Mr. Lappin.

Our next witness, Samuel Bagenstos, is Deputy Assistant Attorney General in the Civil Rights Division of the U.S. Department of Justice, an expert in disability law, taught at the University of Michigan Law School, the UCLA School of Law, Washington Uni-

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versity School of Law, and Harvard. He has a B.A. from the University of North Carolina and a J.D. from Harvard Law School.

Mr. Bagenstos, thank you for joining us, and the floor is yours.

STATEMENT OF SAMUEL BAGENSTOS, DEPUTY ASSISTANT ATTORNEY GENERAL, CIVIL RIGHTS DIVISION, U.S. DEPARTMENT OF JUSTICE, WASHINGTON, D.C.

Mr. BAGENSTOS. Thank you, Chairman Durbin and Ranking Member Coburn and members of the Committee. I am honored and pleased to be here today to testify about the enforcement of the Civil Rights of Institutionalized Persons Act and its application to protect the rights of individuals who have mental illness in prisons and jails. My name is Samuel Bagenstos, as the Chairman said, and as Deputy Assistant Attorney General for the Civil Rights Division, among my duties is supervising the Special Litigation Section, which has the responsibility for enforcing the CRIPA statute.

In the nearly three decades since the enactment of the statute, the Division has investigated more than 430 facilities across the country and has been able to improve conditions for tens of thousands of individuals in those facilities. We currently has 24 ongoing CRIPA investigations involving jails and prisons, and we are enforcing compliance with consent decrees and other agreements covering 21 correctional facilities nationwide. And I should point out that those numbers do not include our investigations of juvenile justice facilities, of which we have 17 ongoing, about three-quarters of which raise issues of mental illness and treatment of people with mental illness. And those figures also don't include our enforcement, which is a significant part of our duties, of the Supreme Court's landmark *Olmstead* case, which we are applying to ensure that people with mental disabilities are served in appropriate settings in the community.

Inadequate mental health care in the Nation's jails and prisons, which is the subject of this hearing, poses a critical problem for inmate safety and can stand in the way of real rehabilitation for those who are incarcerated and do not have access to treatment. In our CRIPA enforcement, we have uncovered systematic deficiencies in mental health care in jails and prisons across the Nation, and we have aggressively pursued reforms to ensure that inmates are afforded their constitutional rights.

I will just talk about a couple of examples, a couple of the key areas in my oral testimony, and maybe we can have questions about others.

Probably the most urgent issue that we encounter in our investigations is the lack of adequate procedures for the detection of suicide risk and the lack of measures for suicide prevention. So in our investigations, we often find that jails and prisons process and house inmates without regard to their suicidal history or their mental health history. One example was a jail that failed to take precautions even when warned by a family that an inmate was suicidal, and the inmate committed suicide within hours of his arrest.

We have found problems including the failure to remove features in jail cells that have proven conducive to suicide, like protuberances that people can hang themselves from and other situa-

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tions where individuals who are suicidal have not been adequately supervised.

Another example of our enforcement, we detected in a facility where an inmate attempted to commit suicide by cutting himself had hoarded 30 razors in his cell. Yet 4 months later, another inmate committed suicide by cutting himself with a razor. In other facilities we have found a lack of adequate safety equipment, such as cut-down tools, to quickly respond to suicide attempts. Suicide is a major part of the problems we find in the treatment of people with mental illness in prison, as Director Lappin testified.

We also frequently find that jail and prison staff use harmful methods of isolation, seclusion, or restraint as a substitute for mental health treatment, often in response to behaviors that inmates cannot control because of their mental disabilities.

In one facility we investigated, because of a lack of staff detainees were regularly placed on suicide watch, which meant they were isolated for 23 hours a day, sometimes for days or weeks at a time. They did not receive adequate assessment or treatment. They sometimes waited days for an initial evaluation, initial psychiatric evaluation, and several times detainees placed in isolation injured themselves due to psychosis-related behavior. In one instance, an individual was slamming himself against the wall of his cell while wrapped in a blanket, which protected his body somewhat. Correctional staff removed the blanket. That was their response.

We have also found that inmates with mental disabilities are subject to attack by other inmates, and jail and prison officials fail to provide proper protection. We have some examples of that in the written testimony.

And we find generally that the deficiencies that we uncover stem from two basic problems: first of all, the failure to commit sufficient resources to provide adequate care to people who are put in prison and kept away from their own opportunity to get medical care; and, second, the failure to provide adequate training to jail and prison staff.

We found one facility that had 217 detainees who received psychotropic medications, and yet there were only two part-time psychiatrists at that facility.

In other instances, when we find that staff are not trained to deal with people with mental disabilities in the prisons, they respond by using force appropriately. We have examples of people who were beat up by prison guards for engaging in conduct that was a result of their mental illness.

We have been successful in resolving the vast majority of the violations we discover through voluntary agreements, without contested litigation. We have some examples in the testimony of working cooperatively with, for example, the State of Wisconsin, with their only women's correction facility where we found significant issues relating to the constitutional rights of inmates with mental illness, but we have worked cooperatively to lay out a set of specific remedies, a detailed action plan that the State of Wisconsin has followed and that has at this point been successful. That agreement, as with all of our agreements under CRIPA, is one that we closely monitor to ensure compliance. And we find that access to mental health care is a critical need in jails and prisons across the Nation,

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so we are committed to ensuring inmates with mental illness receive adequate treatment in safe conditions.

Thank you again for the opportunity to testify before this Committee, and I look forward to your questions.

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

Chairman DURBIN. Thank you very much.

Our next witness, Mary Lou Leary, is the Deputy Assistant Attorney General for the Justice Department's Office of Justice Programs. Previously, she served as the Executive Director of the National Center for Victims of Crime, Acting Assistant Attorney General of OJP, and U.S. Attorney for the District of Columbia. She has a bachelor's degree from Syracuse University, a master's degree in education from Ohio State University, and a law degree from Northeastern University School of Law.

Ms. Leary, thank you for being here. Please proceed.

STATEMENT OF MARY LOU LEARY, DEPUTY ASSISTANT ATTORNEY GENERAL, OFFICE OF JUSTICE PROGRAMS, U.S. DEPARTMENT OF JUSTICE, WASHINGTON, D.C.

Ms. LEARY. Thank you very much, Mr. Chairman, Ranking Member Coburn, and Senator Franken. I am very happy to be here to discuss the Department of Justice's efforts to improve the response of State and local criminal justice systems to people with mental illnesses. We are very pleased that the Subcommittee is interested in this issue.

As you all are very well aware, many people entering the criminal justice system in this country have problems with mental illness. According to a report from the Council of State Governments that was funded in part by the Office of Justice Programs, 16.9 percent of the adults in a sample of local jails had mental illness, a serious mental illness. That is three to six times the rate for the general population. And also troubling is that while the rate was 14 percent for men, it was 31 percent for women. If you applied these rates to the 13 million jail admissions in 2007, the study suggests that more than 2 million bookings of persons with serious mental illness take place every year.

So to help address this issue, OJP's Bureau of Justice Assistance administers a program called the Justice and Mental Health Collaboration Program, bringing together the mental health system and the criminal justice system to work collaboratively to address these needs. And the program helps State and local governments and tribes design and implement collaborative efforts between the criminal justice system and the mental health systems. The goal is to improve access to effective treatment for people with mental illness. That improves public safety, prevents recidivism, and provides effective treatment for those who need it.

From fiscal year 2006 through 2008, BJA awarded 76 of these grants—that is a total of about $12 million—to 32 States, D.C., and Guam. Many of these programs support—many of the grants support programs for adults, but some also go to juveniles, and there are a number of grantees who are addressing both of those populations.

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Also, projects have been targeted, through the Bureau of Justice Assistance, to the National Institute of Corrections, and Council of State Governments to jointly to provide training and technical assistance to communities across this country regardless of whether they have received funding. Training and technical assistance is really critical when we talk about replicating good practices.

In just a very short period of time, we have already seen significant progress. We know that the majority of women inside prisons have mental health problems, and yet only a very few of them receive treatment while they are incarcerated.

In New Jersey, their Department of Corrections received a grant in 2008 to provide trauma-informed care and reentry life skills to women in the New Jersey State prison. This program teaches basic life skills—health, nutrition, job applications, things of that nature—but they also take part in something called "Seeking Safety," and that is a trauma-informed therapeutic program that gets at the roots of trauma and provides treatment and an outlet for women who are in this program.

In Cass County, North Dakota, in 2005 only 191 detainees were even referred for a psychological assessment, and out of these, only 92 of them actually got treatment because there just were not enough resources to provide that treatment. They received grant funding in 2008 to address these issues, and in just the first 5 months of 2009, 550 detainees received an assessment; 373 of them were referred for treatment and services, and 10 of them were actually taken for hospitalization or inpatient evaluation.

Encounters with law enforcement we know often play a very critical role in whether or not people with mental illness end up recycling in and out of the criminal justice system. In order to address this, there are many law enforcement departments that are partnering with mental health specialists around this country to make it easier from the get-go, from the first encounter with law enforcement, to refer the appropriate people for mental health services. These programs are often called "co-responder teams" or "crisis intervention teams," and these kinds of models are eligible to receive funding under the program at BJA.

Seven jurisdictions in the country have used BJA funds to start or enhance law enforcement response programs that link people with mental illness to treatment and services, and this is the best kind of diversion from the criminal justice system for people with these problems.

BJA has also partnered with the Council of State Governments and the National Association of Counties on a number of publications to help other communities learn about best practices and how to implement these models. Those publications address things like law enforcement response, mental health courts, effective reentry practices for people with mental illness, and I have included copies of these publications with my testimony, so I hope you will have a chance to look at those.

Please be assured that the Department of Justice will continue with its work and its commitment to addressing this issue. In fiscal year 2009, we will be awarding 43 grants, a total of nearly $8 million. These grants include projects in Illinois, Minnesota, Oklahoma, Pennsylvania, South Carolina, Texas, and Wisconsin. Addi-

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tional funding will support training and technical assistance efforts. Also, there are many grants under the Second Chance Prisoner Reentry Act that will specifically address mental illness and pre-release services and treatment as part of a comprehensive reentry effort.

This concludes my statement, and I am really grateful for the opportunity to testify today. I will take any questions that you have.

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

Chairman DURBIN. Thanks, Ms. Leary.

Mr. Lappin, you testified that 19 percent of incoming offenders into the Federal correctional system in 2002 and 2003 suffered from mental illness. That translates to well over 30,000, maybe 40,000 in your total population with mental illness. You testified that Bureau of Prisons psychologists conducted 37,263 individual counseling sessions in fiscal year 2008, which sounds like a large number until you consider that somewhere between 30,000 and 40,000 inmates are mentally ill.

How many inmates received individual counseling sessions during fiscal year 2008? And how frequently did these sessions take place?

Mr. LAPPIN. I am not sure that I have the actual number of individual counseling sessions that took place. I can try to gather that and provide it for the record, but it is all determined on a case-by-case basis. Obviously, as well staffed as we are—and I have to state we are probably much better staffed in the area of mental health needs than many States and locals—it is still a huge challenge to address the needs of that many individuals.

And just so you know, our definition of "mental health" is meeting the criteria of the Axis I Disorder and the Diagnostic and Statistical Manual of Mental Disorders. It does not include—as part of that Axis I, it does not include folks diagnosed with antisocial behavior or drug abuse disorders. So we have not included those in that category even though they fall within the Axis I. If we add those folks in, it would be a much higher number.

Chairman DURBIN. How many Bureau of Prisons inmates receive psychotropic medication?

Mr. LAPPIN. In excess of 16,000, and we are working on—it is a little confusing because psychotropic medication is actually provided for some disorders other than mental health issues, so we are sorting through that. We will be able to provide a more accurate number in the not too distant future. But we spent $61 million last year on medications, and $11.5 million was spent on psychotropic medication. So you can see it is a large portion of that medication that we do provide.

Chairman DURBIN. $11.5 million?

Mr. LAPPIN. $11.5 million. We only provide medications for those that have a clinical need for medication. So not all folks who suffer from mental illness get medication.

Chairman DURBIN. With 30 full-time psychiatrists at the Bureau of Prisons located primarily at your medical referral centers and other BOP facilities receiving psychiatric services via video or contract psychiatrist, this translates to roughly one psychiatrist for every 1,000 inmates with mental illness, and apparently one psy-

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chiatrist for every 530 inmates who are currently on psychotropic medication. That is an incredible caseload.

Mr. LAPPIN. There are also a number of contract psychiatrists—I can get that number—that support those 30 psychiatrists. But you are right, it is a large number. We are able to do it more efficiently because of the use of telepsychiatry in lieu of people having to travel to assess and determine appropriate medications and utilization of psychotropic medication.

But it is, it is a large number. We struggle in some locations recruiting and retaining not only psychiatrists but psychologists as well, in part because of the rural nature of some of our facilities on the one side, and, two, high cost-of-living areas. Those are our two most challenging areas.

To our benefit, which unlike States, we have the flexibility of moving those inmates to locations that have more of those staff and services available. And so I sympathize with some States that are very rural and struggle across the board, whereas we do have the ability to move the inmates who have the needs to other locations where those services can be provided.

Chairman DURBIN. The Seventh Circuit Court of Appeals at the Federal level is not known as a liberal court of appeals. They characterize the lack of an onsite psychiatrist in the Indiana State prison system as "a serious system deficiency, contributing to a finding of deliberate indifference to a serious medical need." That is a standard established by our court system, which Mr. Bagenstos has spoken to.

I would like to ask, of the inmates who are currently in the Federal Bureau of Prisons system, how many are being held in segregation or isolation?

Mr. LAPPIN. Well, that varies. There are two types of segregation: disciplinary segregation and administrative detention. And we can get an actual—it varies from day to day to day. But I know at our highest-level institution, administrative maximum security facility in Florence, of the 208,000 there are about 450 inmates there who are in controlled housing. We do not call it "solitary confinement," but they are in controlled housing. Then every facility has a segregation unit for inmates who are either misbehaving or are fearful to be on a compound or just need to be removed from the general population.

So the number varies, but we can get an actual number on a given day and provide it for the record.

Chairman DURBIN. What do you think is the impact of segregation and isolation on a mentally ill prisoner?

Mr. LAPPIN. We have not seen as a consequence of conditions of confinement of that nature a result being an increase in mental illness. So at, for example, ADX Florence, we have not seen an increase in mental illness, we believe, driven by the fact they are confined in that nature.

Now, realize although isolated or controlled, they are seen by staff daily. They interact daily. They are removed for recreation. So it is not like they are locked in a cell and there is no external contact.

We have a pretty heavy presence of medical and mental health professionals there who do ongoing assessments. There are no un-

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stable mentally ill inmates. If they become unstable, we remove them from there. We put them in a hospital until we gain their stability, at which time they would be returned to those conditions.

So there are inmates there who have mental illnesses, who came there with mental illnesses, but they are controlled and they are stable during the period of time they are there, and they are monitored very closely.

Chairman DURBIN. I am not an expert in this field. I am trying to learn.

Mr. LAPPIN. Yes.

Chairman DURBIN. In June of 2006, a bipartisan national task force, the Commission on Safety and Abuse in America's Prisons, released its recommendations after a year-long investigation. It called for ending long-term isolation of prisoners.

"Beyond about 10 days, the report noted, practically no benefits can be found and the harm is clear—not just for inmates but for the public as well. Most prisoners in long-term isolation are returned to society, after all. And evidence from a number of studies has shown that supermax conditions—in which prisoners have virtually no social interaction and are given no programmatic support—make it highly likely they will commit more crimes when they are released. Instead, the report said, we should follow preventive approaches used in [other] countries."

What I just quoted was an article entitled "Hellhole" by Dr. Atul Gawande. I do not know if you have seen it. It was published in The New Yorker on March 30, 2009. Without objection, I will enter it into the record.

[The article appears as a submission for the record.]

Chairman DURBIN. Do you disagree with the conclusion of that task force?

Mr. LAPPIN. I am going to speak to the supermax issue, and I disagree with that there is no benefit there. Let's realize there has got to be a balance here. Without question, the inmates that are housed at that supermax—and I cannot speak to the States, but my guess is they are similar. These are very violent, aggressive, challenging, difficult inmates who have decided they are not going to listen to the rules in prisons, they are not going to adhere to the direction of staff.

You cannot run safe prisons with folks like that out in the general population.

Chairman DURBIN. Is there a middle ground between isolation—23 hours in a cell, for example—and general population?

Mr. LAPPIN. I think there is, and that is when it comes to how those supermaxes are run. Is there contact with staff? Are there assessments that are done? Are there ongoing reviews? Is there a way for those folks to work their way out of those conditions of confinement? And, in fact, there are, as long as they agree to participate and abide by those rules.

So our supermaxes, I am sure like many others, have a phased program that people can work their way through and eventually work their way out. But they have got to follow the rules. And the dilemma we have is if you look at this array of inmates that happen to be housed currently, the majority of them at ADX Florence—and I am sure other supermaxes similarly—are folks that

have routinely and frequently assaulted staff and inmates in our institutions, killed inmates, sometimes killed staff.

And, again, although it is tragic and unfortunate, you cannot protect the other inmates, nor can you protect the other staff, without managing these inmates in a more controlled, more structured environment.

If people have other suggestions as to how that can be done and we still protect the other inmates and the staff who work in those facilities, I assure you that myself and the other directors of corrections around this country will be listening.

Chairman DURBIN. I will return to this, but, in fairness, Senator Franken has waited patiently. I have gone over my time.

Senator Franken.

Senator FRANKEN. Thank you, Mr. Chairman.

Mr. Lappin, how many Federal prisons are there under the Federal Bureau?

Mr. LAPPIN. We own and operate 115 Federal prisons. We contract privately with 14 large private contract facilities. They house primarily low-security criminal aliens. And then there are about 8,000 to 9,000 inmates on any given day in 250 to 300 contract residential reentry centers. These are inmates who are transitioning from prison to the community. So we contract those services with companies and organizations in local communities—for a total of 208,000 inmates.

Senator FRANKEN. Thank you. You mentioned the dual diagnosis residential drug abuse treatment program, which seems like a very worthwhile investment for prisoners who have a dual diagnosis of mental illness and chemical dependency. At how many sites does the Bureau have this program?

Mr. LAPPIN. We have this at three locations, and it is all driven on the number of inmates we see who have that dual diagnosis. If there are more inmates than we have room for, we would add more programs of that nature.

But to give you an idea, 40 percent of our inmates have a diagnosis of drug or alcohol abuse in the Federal prison system; 92 percent of those inmates are volunteering for treatment. A portion of them have been diagnosed with a dual diagnosis condition, and we place them in these three programs to deal with both their addiction to drug or alcohol as well as their mental health issues.

Senator FRANKEN. It just seems like out of all the prisons that you have, to have only three prisons with that program seems inadequate.

Mr. LAPPIN. Well, I will check and return for the record, I will tell you how many folks are in that program, how many have been diagnosed—they have to volunteer for treatment—and how long the waiting lists are, because what we do is monitor that waiting list. And if we saw the waiting list was such that we could not treat the number of folks who have that need, we would add programs. But we will provide that information for the record. We will tell you how many folks are on the waiting list and whether or not we are able to get to everybody that we diagnose with that need who volunteer for treatment.

Senator FRANKEN. Thank you.

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Mr. Bagenstos, in your testimony you describe the methods of isolation that Chairman Durbin referred to that are used to control prisoners with mental illnesses. Are these tactics used with juvenile prisoners?

Mr. BAGENSTOS. Yes, they are. So we have found in some of our juvenile investigations isolation and seclusion used as a replacement for mental health treatment in some of our investigations, even more shockingly than in some of our jail and prison investigations. So in an investigation of one set of juvenile facilities, there were individuals who violated prison rules or facility rules, were locked in a darkened room for 23 hours a day, was our finding. And so we have definitely found those sorts of problems in many juvenile facilities across the country.

Senator FRANKEN. Are there other tools that are better than putting a juvenile in isolation in a darkened room for 23 hours?

Mr. BAGENSTOS. We certainly think so. Our experts who we take on our tours certainly think so and who suggest minimum remedial measures to come into compliance with the Constitution. Often the problem in juvenile facilities is you are dealing with a population that has often undiagnosed mental illness problems, and for a variety of reasons, institutions do not provide the sorts of treatment or appropriate behavioral responses. And instead we have found in many cases seclusion restraint abuse as responses instead.

Senator FRANKEN. Let me ask you, what percentage, in your opinion or your research, are dual diagnosis, people with mental illness and substance abuse problems?

Mr. BAGENSTOS. In what class of facilities? In the juvenile facilities?

Senator FRANKEN. Just in our Federal prison system.

Mr. BAGENSTOS. Well, you know, our CRIPA enforcement authority does not extend to the Federal prison system, so I do not know that I am the best person to answer that question.

Senator FRANKEN. Okay. Let me ask you this: What type of training do prison officials receive to help them identify mental illness and defuse conflicts with mentally ill prisoners? And do you think there should be a Federal requirement for this kind of training?

Mr. BAGENSTOS. Well, it is an interesting question whether there ought to be a Federal requirement for this kind of training. We enforce the constitutional rights of inmates at facilities or residents at juvenile facilities, and what we have found contributing to violations of the Eighth Amendment and 14th Amendment is a lack of training.

So the example that I give in the written testimony of the Wisconsin State prison for women, the Taycheedah Correctional Institution, is an example where systemic deficiencies in the treatment of inmates with mental illness was related directly to a lack of training, and the remedy that we negotiated with and adopted and worked cooperatively with the State to implement includes requirements for training of the people who work at that facility, both when they come into service and then in-service training.

The lack of training is one of the essential problems that we have found contributing to constitutional violations around the country.

Senator FRANKEN. Ms. Leary, just a general question. Do you think there are just too many people in prison in this country?

Ms. LEARY. I think there are too many people in prison in this country, Senator Franken, and part of the reason is that we are not addressing appropriately the needs of many people who do end up in prison—for instance, those with mental illness. Oftentimes, they are creating a disturbance, police are called to the scene, and they just lock them up. Then they end up in prison, and it starts a cycle, and they recidivate and they never get the treatment that they need. It just becomes a lifelong process in and out. That is just one example of the type of person who is in prison who should not be there.

Senator FRANKEN. You know, I liked your testimony about the Bureau of Justice grantee program in New York City that combines mental health treatment with community service as an alternative to traditional incarceration. How much does it cost to run a program like that? And do you think that alternative programs to incarceration for the mentally ill save taxpayers money in the long run?

Ms. LEARY. I can get you the figures on the costs for actually running a program like that. I do not have them with me. But we have seen an evaluation of several of these kinds of programs; we have seen that it does save the taxpayer money because you prevent recidivism and you can reduce the costs of incarceration.

It is simply really beyond the capacity of the States to incarcerate all our problems. There are better and more cost-effective investments that we can and should be making in such things as diversion programs, mental health courts, drug courts, better reentry so that once you leave you will not be coming back. There are many ways to save taxpayer dollars and actually improve public safety outcomes. That is a lot of what we do at the Office of Justice Programs.

Senator FRANKEN. Thank you.

Thank you, Mr. Chairman.

Chairman DURBIN. Thank you, Senator Franken.

Mr. Lappin, returning to the one example you cited, when I asked you about isolation, you used the example of Florence, where you thought there were perhaps 450 inmates in isolation. Is there a resident psychiatrist at Florence?

Mr. LAPPIN. Yes.

Chairman DURBIN. One or two?

Mr. LAPPIN. There is one psychiatrist at Florence. There are about 3,000 inmates there, but he spends a great deal of his time at the administrative maximum security facility. There are also seven or eight psychologists.

Chairman DURBIN. And you indicated that if an inmate is put in isolation and there is a detection of a deteriorating mental condition, they are removed from isolation.

Mr. LAPPIN. Well, we remove them to a hospital.

Chairman DURBIN. To a hospital.

Mr. LAPPIN. To return them to a stable condition.

Chairman DURBIN. And who would make that observation of a deteriorating condition?

Mr. LAPPIN. Well, yearly we train all of our staff as to what to look for. Now, granted, our experts—our psychiatrists, our psychologists, our treatment staff—are the ones that do the diagnosis and the assessment. But an alert can come from a correctional officer, from a unit staff, from an education person, because as part of our training we train our staff what to look for and who to inform if they see an inmate acting in a certain manner. And so that report can come from anyone, and then a mental health professional would intervene and make an assessment.

Chairman DURBIN. And what is the range of isolation, in terms of days, months, years, in the Federal Bureau of Prisons?

Mr. LAPPIN. Typically very short. If you look at all the people who are in segregation as a whole, and on average, the amount of time they are there, typically their stays are short. That is our objective, to make that stay as short as possible and return them to a general population facility. So these supermaxes are the extreme only because these folks resist and they are not going to comply. And as a consequence, they end up in segregation or isolation for longer periods of time than what most inmates find themselves in those conditions that confine them.

Chairman DURBIN. There was an editorial in the Washington Post this morning about sexual violence in American prisons and sexual exploitation. What is your experience or your knowledge of the connection between mental illness and sexual exploitation in our Federal Bureau of Prisons?

Mr. LAPPIN. In general, that is a more vulnerable population, those that have mental illnesses—not only those that have mental illnesses, but the folks who come in who are young, inexperienced, do not have the wherewithal to manage in that social environment. So without a doubt, there are higher-risk groups who fall into the category of being manipulated or being taken advantage of. The mentally ill fall into that group. And it is unfortunate when, in this case, an employee violates the public trust in their capacity as a law enforcement officer and takes advantage of someone. It is unfortunate. Our policy is zero tolerance of that, and we try to aggressively identify that, investigate those incidents, and remove those folks if we have the evidence to do so.

But, without a doubt, the mentally ill are more susceptible, more risky, and more vulnerable, as are some other unique groups of inmates within our population.

Chairman DURBIN. Also, with the Bureau of Prisons, do you have a juvenile population?

Mr. LAPPIN. Very small, 141, and we contract out with local communities typically to house those offenders, unless they are of a very violent nature, and then we have a few special locations around the country where we house them. But on that issue, our challenge is finding locations that have the adequate services and support for the juveniles because, I do not disagree, a higher incidence of mental illness and emotional concerns with the juveniles. We have limited locations because when we go—we just do not dump these folks in there. We go out and we visit them. We have a contract with them. We set expectations. And it is very difficult sometimes for us to find appropriate facilities to house even as small a number as 141.

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Chairman DURBIN. So, Mr. Bagenstos, now that you have heard this discussion here and have told us that you are trying to put this in the context of the constitutional rights and legal rights of prisoners in these circumstances, what is your view of segregation and isolation, the treatment of the mentally ill in our prison system, the treatment of juveniles? Do you have a view as to whether or not there is work to be done here?

Mr. BAGENSTOS. I think there is a great deal of work to be done in the treatment of inmates with mental disabilities, psychiatric disabilities, in State jails, State prisons, juvenile facilities. You know, we do a lot of that work, and I have to——

Chairman DURBIN. Can you speak to the Federal system?

Mr. BAGENSTOS. Well, it is difficult for me to speak to the Federal system because that is not within our CRIPA enforcement responsibilities, so we have not done investigations of that. You know, when I speak to this Committee——

Chairman DURBIN. Who does?

Mr. BAGENSTOS. Well, I think Mr. Lappin could talk about that.

Mr. LAPPIN. First of all, let me just say we believe that isolation should be used very seldom for folks who are mentally ill. And so if you look at our inpatient cohort, you are going to find that we use isolation as seldom as possible for that group who have been diagnosed with that mental illness and who are exhibiting behavior that needs to be managed and controlled. So there is a combination of things, if you talk to our treatment specialists, besides isolation. There is medication in appropriate cases. There is more counseling, there are more, other ways of controlling that. So isolation is the one that we try to use the least. However, there are some cases where it is necessary.

If there are complaints about treatment of inmates in the Federal Bureau of Prisons—and those complaints can come from staff, from inmates, from the public, from whomever—all of those complaints work their way to the Office of the Inspector General, who would make a determination as to whether or not they would investigate, and they may reach out to Civil in some cases and ask them to jointly investigate a concern or a complaint that has been made. But the Office of the Inspector General takes the lead on how and where and in what fashion a complaint will be investigated and dealt with.

Chairman DURBIN. So, in addition to the court system, which is, of course, going to have the last word here, the internal mechanism is through the Inspector General's office?

Mr. LAPPIN. Yes.

Chairman DURBIN. Which we probably should have invited to this hearing, but thank you very much.

Mr. Bagenstos, we are going to hear later about the Tamms Correctional Facility in my State, a supermax facility. Have you received any complaints about Tamms?

Mr. BAGENSTOS. I cannot tell you the answer to that. I do not know whether we have received complaints about Tamms. I will certainly look into that, and, you know, we can provide that information to the Committee.

Chairman DURBIN. Ms. Leary, one of the things that you said struck me as interesting. The first intake officer for someone men-

tally ill about to enter our system is usually a policeman, and the obvious question is what skills do they have to recognize mental illness and its manifestations in contrast to simple criminal misconduct.

Ms. LEARY. I think that is a very difficult situation, and I would say probably most police officers really do not have the kind of training that they would need to recognize that this is a person with a mental disability, not just someone who is committing a criminal act.

That is where these teams come into play where you pair law enforcement officers with mental health professionals. They train as a team, and they respond as a team so that each has knowledge of the other's role at the scene, and they can assess the situation appropriately, and then if the right thing to do is to get that person some mental health treatment, instead of throwing them in jail, that should be the outcome.

When I was a prosecutor here with the U.S. Attorney's Office in D.C. in the 1980's, police officers who would encounter people with mental disabilities would just lock them up and drop them off at St. Elizabeths, and that was the end of it, or else in the D.C. Jail. And that situation is the wrong thing for everybody, and, frankly, it is dangerous. It is dangerous to the offender, and it is dangerous to the police.

Chairman DURBIN. The second intake officer, the second level of intake, is likely to be our profession: lawyers, criminal defense lawyers who interview these patients. I cannot recall a moment in law school when anyone took the time to talk to me about what you should look for to recognize mental illness.

What do you think about that?

Ms. LEARY. I do not think it is taught at law schools, although I think it certainly should be taught in places like law schools, especially if you are working in a clinic. Say you are doing a prosecution clinic or a defense clinic, or any kind of clinical work, you really should have that training, and that should be encouraged.

I think attitudes about mental illness have improved in general, in the general public in the last few years, but we still have a long, long way to go.

Chairman DURBIN. What is your opinion of the impact of segregation and isolation on the mentally ill?

Ms. LEARY. I do not have any knowledge of that. I have not, you know, researched that. Common sense would tell you that if that isolation and segregation means that the person truly is isolated from human contact, that is an aggravating circumstance that I would think has great potential to aggravate a mental illness.

Chairman DURBIN. I have many more questions, but I know we have another panel and will not be able to go much longer. It is possible that some of these will be touched on in follow-up written questions, if it would be convenient for you, if you could respond.

I would like to turn now to Senator Franken.

Senator FRANKEN. Thank you, Mr. Chairman. I just am going to do a few questions.

First of all, it seems to me, Mr. Lappin, that you are saying that when mentally ill patients are put in isolation, it is really because

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they have acted out in a way that really affects the safety of other prisoners and of the guards at the prison, right?

Mr. LAPPIN. Or themselves.

Senator FRANKEN. Or themselves, okay. And you are talking about—I hear about a ratio of psychiatrists to prisoners of one to a thousand. Is it fair to say that psychiatrists at the prisons sometimes feel a little overwhelmed?

Mr. LAPPIN. Well, let me clarify a little bit. For those that would end up in isolation, they are at medical centers. So our ratio of mental health professionals to staff is much smaller. There is going to be an abundance of——

Senator FRANKEN. You are saying that there are not mentally ill prisoners who end up in isolation in prison?

Mr. LAPPIN. In our general population facilities, it can happen. If someone becomes unstable during their period of incarceration at a general population facility, we are going to move them——

Senator FRANKEN. Are you confident that everyone——

Mr. LAPPIN.—to a location where——

Senator FRANKEN.—with a mental illness has been diagnosed?

Mr. LAPPIN. I am sorry?

Senator FRANKEN. Are you confident that everyone with mental illness has been properly diagnosed?

Mr. LAPPIN. Well, I think there is always—with that many inmates, there is always a chance there would be a missed diagnosis. I go back to the key, and that is, early diagnosis. In our intake screening, it is not only a case manager who interviews the inmate. Within 24 hours there is a psychological assessment as well as a medical assessment, and then a follow-up within 7 days.

We also have a history, the pre-sentence report if there are indications there. So our psychology staff are alerted to that. So they can begin tracking whether or not a person has a mental health condition sometimes in advance of the inmate even arriving at the institution, because in advance of the inmate, we get all the court documents. And if those court documents reflect that, they are aware of that before the offender even arrives. But once they arrive, within 24 hours there is an assessment. And if the person is displaying that behavior upon intake, there is an alert made to our psychology staff who will then respond to them immediately—their highest priority is to respond to those who are displaying behavior consistent with a mental illness.

So although it is not impossible for us to miss it, with thorough screening and competent staff and trained staff at all levels, we have a better chance of identifying those folks in advance. So if they become unstable and they end up in segregation at an institution and the psychologist there determines that I do not think this is the appropriate place for us to treat this person—sometimes they can, sometimes they cannot—they would refer them to a medical referral center. We would move that person to a location where there are more psychiatrists, more psychologists, more treatment staff. And typically that is where isolation occurs. And, again, isolation is the last resort, and we try to do it for the minimal amount of time to restore that person to the point that they are no longer a danger to themselves or somebody else. So that is how it works in our system.

Senator FRANKEN. I understand. There was one phrase you used, which was "with that many prisoners." And I had asked Ms. Leary before, Do we have too many prisoners in prison in this country? And I believe we do. And I believe that it puts a burden on everyone, including the psychiatrists in these prisons.

Mr. LAPPIN. Well, here is an example. We are going to add—just to give you an idea how it works in this system, which is probably similar to your systems. Not only are there 208,000 inmates, but we release 60,000 inmates a year. But we are going to admit this year 67,000 inmates. So we are going to add a 7,000 increment to the base, and you can assume that within that 7,000 there are 1,500 who have a mental illness. So the number continues to grow, which puts an increased burden on those in institutions.

So I go back to my original comment that early diagnosis, adequate resources in the institutions, and, as importantly, an issue we have not touched on is our inability—you are correct, most of these folks are going to release into our communities—is the inability to find contract support facilities for reentry that provide the level of services for this unique group.

So there are three groups of folks, to give you a idea: 42,000 inmates in our system released back into the streets of the United States every year; 85 percent of those released through a halfway house. We believe the most appropriate manner in which to move someone from prison to the community is through a halfway house. The three most difficult groups to place, the 15 percent we are not getting, the vast majority of them are mentally ill inmates, sex offenders, and inmates who are very violent and disruptive even toward the end of their sentence.

Let us just focus on the mentally ill. Why is it difficult? Again, because many of them are going to rural locations, where there may be a halfway house, but they do not have the wherewithal, they do not have the resources available in that halfway house to care for that individual who has unique mental health concerns, as well as the challenges we face in our more urban areas where it is very expensive. They struggle getting the resources necessary, because our contracts require that.

So here we are, we have this mentally ill inmate who is going to release, and we prefer to put them into a halfway house to transition out, acquire the services they need, whether it is for medication, whether it is for treatment or ongoing therapy, before they go to the street. But we lack the services in many of those locations. And, consequently, the inmate goes to the community.

One last issue: too many communities that continue to resist the fact that their citizens who happen to be offenders are going to return home. In some cases, we actually have to litigate to convince them to put a residential reentry center in their communities. And a consequence is these folks go directly to the street.

Now, again, I think that common sense would tell you that it is much wiser of us to transition especially these more challenging folks out through halfway houses than for us to give them $100 and a new suit and throw them on the street corner.

I can tell you, in my community I prefer to have more supervision than that. But, again, we have many communities out there that continue to resist and say not here, not in my back yard, and

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it is kind of like out of sight, out of mind, I do not want them here. And that is reality. That is tragic, but it is the truth. And it is even more complicated when you have the mentally ill, the sex offenders, and the more violent offenders who are going to go directly into our communities.

I did not mean to get off track, but that is an area we really have not touched on. But I think it is critically important, because as we have all said, most of these folks in local, State, and Federal prisons, they are going to go home at some point in the future.

Senator FRANKEN. They almost all go home.

Now, just one last thing to wrap up. Ms. Leary, the Office of Justice Programs' mission is to provide leadership and services and grant administration and criminal justice policy development to support local, State, and tribal justice strategies to achieve safer communities. That is in your testimony.

Ms. LEARY. Yes, sir.

Senator FRANKEN. So you have an overview of the whole prison system, right?

Ms. LEARY. We work with the State and the local prison systems, that is right. And we also work with the National Institute of Corrections.

Senator FRANKEN. Okay. So I am going back to this deal where we are talking—Mr. Lappin says eventually most of them get out, right?

Ms. LEARY. Right.

Senator FRANKEN. So we have got people we are putting in the system, and then they come out. In your opinion, do they come out better than they went in? And this goes, again, to my opinion that we have too many people in prison in this country. And I was struck with your talking about drug courts and mental health courts, which I was not aware of. So I guess it is—can you just respond to what you think I am getting at?

[Laughter.]

Ms. LEARY. Sure, I would be happy to. I think that there are many far better alternatives than incarceration for those who should not be incarcerated, so we are not talking about the most serious, violent offenders and those who really are big risks to public safety.

One of the things that the Office of Justice Programs works on is helping communities figure out what these alternatives are and how can we improve public safety in our communities without locking everybody up. And it runs the gamut, and you have to look at the whole spectrum from prevention to alternatives which include all the problem-solving courts that we work on, like drug courts and veterans' courts and mental health courts and so on, to provide people with the resources and the treatment they need so that they will not end up in prison, because the chances of them getting what they need while they are in prison are much slimmer than they are if you have a really effective community-based program to deal with people's issues.

Then, again, as I said, you have to look at the whole spectrum, and that is where I think reentry is so important for those who do end up incarcerated. Reentry planning has to start right from the

time of sentencing and follow all the way through your term of incarceration and back out into the community.

Senator FRANKEN. Thank you.

Thank you, Mr. Chairman.

Mr. LAPPIN. May I add to that? There are some people that belong in prison.

Senator FRANKEN. Absolutely.

Mr. LAPPIN. And we will send you some research for the record that reflects the availability of programs to focus on skills they lack result in fewer of them coming back to prison. So for those that need to be in prison, the availability of programs and opportunities to improve on the skills they lack, it is shown, results in fewer of them returning to prison—better educated, have a vocational skill, learn work skills, learn to manage this mental illness that they sometimes come to prison with, because that is probably, in part, part of the problem for this unique group. We try to put programs in place that teach them how to manage their mental illness, and there is an array of other skills they lack. And we will send the research for the record that reflects that the availability of those programs and the willingness of those to volunteer and participate typically results in fewer of them returning to prison. And that is why we have a little bit lower recidivism rate than what you are seeing on the average.

Thank you.

Chairman DURBIN. Mr. Lappin, let me thank you for that last comment and add what probably does not need to be said but will be said. The safety and security of the people who are working in our prisons is the highest priority, and I do not think anything we have said today should diminish from that commitment, which we all have, to that end. And for those correctional officers who literally risk their lives in this business, that is the first thing: to make certain that they are safe. And the safety of America at large, of course, is an equally important priority. I think we have raised some interesting and challenging questions about those who are released from prison and the likelihood that they will commit another crime, find another victim. We certainly want to diminish that as much as possible.

You mentioned during the course of your testimony that you are open to ideas. The Gawande article talks about things that are being done in Britain today as an alternative to our incarceration model. I do not know if you have had a chance to look into that, but it is at least worth a discussion, probably at another time in another setting. But I want to thank this panel, an excellent panel, for the testimony given. I am told it is extraordinary for the Department of Justice to make this kind of commitment, for several people to come forward for this kind of a hearing, and I appreciate it very much. You will receive some written questions, which I hope you can respond to in a timely fashion. Thank you all.

Chairman DURBIN. We are now going to welcome our second panel, four distinguished witnesses, who will now come to the table. If you would just remain standing for a moment, I will not have to ask you to stand up again.

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If you would please raise your right hand, do you affirm that the testimony you are about to give before the Committee will be the truth, the whole truth, and nothing but the truth, so help you God?

Mr. MAYNARD. I do.

Mr. RANDLE. I do.

Justice ZENOFF. I do.

Mr. FULLER. I do.

Chairman DURBIN. Thank you. Let the record reflect that all four witnesses answered in the affirmative.

Our first witness Gary Maynard, Secretary of the Maryland Department of Public Safety and Correctional Services, has over 30 years of experience in the field, having served as Director of Corrections in three other States—Iowa, South Carolina, and Oklahoma. He was also the President of the American Correctional Association and a member for 32 years of the Army National Guard, having served as the Adjutant General to the Oklahoma Army and Air National Guard. Mr. Maynard is a native of Oklahoma, holds a master's degree from Oklahoma State, a bachelor's degree from East Central University in Ada.

Mr. Maynard, thanks for being here. Please proceed.

STATEMENT OF GARY D. MAYNARD, SECRETARY, MARYLAND DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES, TOWSON, MARYLAND

Mr. MAYNARD. Thank you, Mr. Chairman, Senator Franken. My name is Gary Maynard. I serve as Secretary of the Maryland Department of Public Safety and Correctional Services. I have been involved in corrections for 39 years, working in five States and the Federal Bureau of Prisons. Early in my career, I served as a prison psychologist. I rose through the ranks of management, serving as warden on two occasions, and eventually serving as the head of corrections in four States. I am the Immediate Past President of the American Correctional Association, an active member of the Association of State Correctional Administrators, and have worked closely with the American Jail Association over the past several years. All three of these national recognized organizations have provided data for the testimony I will offer today.

Correctional administrators across the country have an obligation to provide effective programming for all offenders. Over the past three decades, we have witnessed an increase in the number of inmates possessing mental health issues entering the criminal justice system. Many researchers point to the depopulation of the State-operated mental hospitals in the late 1960's as one of the contributing factors to this trend.

In 1959, there were over 550,000 mentally ill patients residing in State-operated mental hospitals. This number is now less than 80,000. During this same period of time, we have seen the number of incarcerated individuals quadruple to close to 2.5 million annually.

Corrections certainly does not dispute the concept of offering comprehensive community-based services to individuals with mental health needs. However, insufficient resources have led to an increase in the incarceration of these individuals, and the resources available to us are lacking.

The American Jail Association estimates that there were over 650,000 bookings of persons with some type of mental illness in 2008. A study by the Bureau of Justice Statistics estimates that more than half of the prison population has mental health issues. This population is at higher risk of incarceration due to a number of factors, including substance abuse. Law enforcement and correctional staff lack the training and education necessary to work with this population effectively.

A study of Washington State prisons found that while only 18 percent of their inmate population was classified as mentally ill, they accounted for 41 percent of the reported infractions. Lack of training and sufficient staff to work with the population leads many correctional agencies to use disciplinary segregation as a tool to manage the population. This type of isolation sometimes proves destructive to certain members of this population.

Please understand that corrections professionals do not believe in abandoning this population and do not feel that segregation by itself is a useful practice. Though we believe strongly that the mental health system should hold the primary responsibility for this group, we understand that many of these become sentenced to our prisons and jails. We must make solid investments in working with this population.

Leadership has come from our national associations who have developed policies and standards to guide correctional administrators in the treatment of mentally ill offenders. State and local corrections have adopted a number of methods to identify and provide appropriate treatment for this population.

In Maryland, the Montgomery County Department of Corrections and Rehabilitation has served as a model in the use of a comprehensive screening and referral process that is overseen by public mental health professionals. In our department in Maryland at the State level, we have improved our methods to identify these inmates at intake. We have developed a system to share information with the Baltimore Mental Health System in order to protect our staff and prescribe appropriate treatment.

Corrections agencies across the country have invested in services to carry the inmates from incarceration to reentry back into the community. In Cook County, Illinois, the Adult Probation Department's Mental Health Unit employs officers with a mental health background to assist clients in accessing disability benefits upon release.

The Wisconsin Department of Corrections works with community advocates to assist inmates in filing applications for Medicaid benefits before release.

In Pennsylvania and Minnesota, reentry staff work with their psychologists and community providers to ensure that there is support available to returning offenders.

In Maryland, our department partnered with the Mental Health Association to pass legislation at the State level to provide 30 days' worth of medication for offenders being released in the community. Local health departments across the country have joined in release planning, staking a claim in the future of these individuals.

Each of us in the corrections profession does what we can given our respective resources, but we know that more is needed. Work

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has been done at the Federal level to assist us. In 2004, the Mentally Ill Offender Act was signed into law to provide agencies with the necessary resources to care for this population. However, due to limited funding, many corrections applications have been denied. In the period of 2006–08, only 11 percent of all applicants received funding.

Corrections agencies need funding and technical assistance to continue building collaborative relationships to properly care for this population. The corrections field needs the Federal Government to define a clear role on behalf of this population.

Specifically, we would benefit from supplemental funding for medication in prison, enhanced protocols, and proper training for our staff. We know these things exist, but working to provide a coordinated approach would greatly strengthen to serve this population.

We would encourage the Substance Abuse and Mental Health Services Administration to take the lead in working with corrections and public health agencies. We understand the complexity of this population, but we know that funding, coordination, and Federal support will be a great step forward. I know corrections leaders across the country are ready to continue to identify effective practices to support the needs of this population.

Thank you for inviting me to testify today. I would be happy to answer questions at the appropriate time.

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

Chairman DURBIN. Thanks, Mr. Maynard.

The next witness is Michael Randle, Director of the Illinois Department of Corrections, operates 28 adult correctional centers, responsible for 46,000 adult inmates; previously served for 19 years in the Ohio Corrections System, most recently as Assistant Director of the Ohio Department of Rehabilitation and Corrections; a bachelor's degree from The Ohio State University and a master's degree from Ashland University.

Mr. Randle, thanks for coming from Illinois to be with us today, and please proceed.

STATEMENT OF MICHAEL P. RANDLE, DIRECTOR, ILLINOIS DEPARTMENT OF CORRECTIONS, SPRINGFIELD, ILLINOIS

Mr. RANDLE. Thank you, Mr. Chairman, for this opportunity to speak with you. Thank you, Senator Franken.

Prior to my appointment in Illinois, I served as Assistant Director in the Ohio Department of Rehabilitation and Corrections. In conjunction with the Ohio Department of Mental Health, I had oversight responsibility over a Community Linkage Program, which was charged with providing continuity of mental health care to mentally ill persons entering and leaving the prison system.

The issue of mental illness in our prisons and jails is both complex and pervasive. In fact, a recent study conducted by the Bureau of Justice reported that up to 16 percent of the prison and jail populations are afflicted with mental illness, which is approximately four times higher for men and eight times higher for women than in the population at large. This disproportionate representation is primarily a result of policies that have shifted the emphasis from

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community-based treatment of the at-risk populations and priorities that have diverted resources away from treatment providers.

In recognition of these problems, Congress enacted the Mentally Ill Offender Treatment and Crime Reduction Act in 2004. The act required collaboration between justice and mental health program providers to help States and counties to design and implement collaborative programs within their communities regarding mental health treatment. While the Act authorized $50 million to be granted toward these efforts, only $21.5 million has been appropriated between fiscal years 2006 and 2009. Due in part to this lack of funding, coupled with record deficits, States and counties have found themselves in dire circumstances with respect to treatment and management of the mentally ill.

In 1995, the State of Ohio created the Community Linkage Program, which was designed to facilitate mental health care for persons entering or leaving the prison system by assisting in policy development, providing information sharing, monitoring outcomes, and providing assistance. In essence, this program was created as a result of recognized and demonstrated need and out of legal necessity.

At its core, the program is designed to bridge the gap between State and local criminal justice and mental health services; it provides a consistent, sustained link between these entities from the moment offenders enter the criminal justice system to the time that they are released into the community.

Like other States, Illinois prisons and jails are facing crisis levels with regards to mentally ill offenders. Recent figures indicate that between 20 to 25 percent of the inmate population in Illinois are carried on the mental health caseload, with 12 percent requiring psychotropic medication. This large caseload, along with fiscal challenges and inadequate community resources, has created difficulties with managing these offenders while incarcerated, as well as difficulty in providing reentry services.

The Illinois Department of Corrections has historically issued a 14-day supply of psychotropic drugs to offenders upon release. Unfortunately, it usually takes a few months for such offenders to acquire access to the mental health services that they need; this gap from access to services can and does lead to decompensation and often recidivism. In light of this, the department has begun to initiate a linkage program similar to that of the Ohio Linkage Program.

As director, I recognize that the challenges of providing proper care for mentally ill offenders while protecting them from themselves and the community will be ongoing. At both the national and State levels, we have made significant progress in recognizing and dealing with this issue. However, more needs to be done.

With the passage of the Mentally Ill Offender Treatment and Crime Reduction Act, we have a vehicle to help provide these resources. I respectfully ask that you fuel this vehicle and fully fund the program.

Thank you very much for allowing me to come before the Committee, and I will be obliged to answer any questions that the Committee may have.

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

Chairman DURBIN. Thank you, Director Randle.

Kathryn Zenoff is a Second District Appellate Court Judge in Illinois. She served as presiding judge of the Criminal Division and Mental Health Court in the 17th Circuit. She is the national co-chair of the Judges Leadership Initiative for Criminal Justice and Mental Health Issues. Justice Zenoff has a bachelor's degree from Stanford University and a law degree from Columbia University Law School.

Thanks for coming from Illinois. Please proceed.

STATEMENT OF KATHRYN E. ZENOFF, PRESIDING JUSTICE, ILLINOIS APPELLATE COURT, SECOND DISTRICT, ROCKFORD, ILLINOIS

Justice ZENOFF. Chairman Durbin, Senator Franken, I am grateful for opportunity to share my perspective. I hope that my experience is valuable to you. It may be somewhat unique as I can speak from the vantage points of having organized a 70-person community task force in Rockford, Illinois, to address the revolving-door syndrome of persons with mental illness being incarcerated in our jail in disproportionate numbers; of having presided for 2-plus years over a mental health court, which Senator Durbin visited a couple of years ago; of having collaborated with the Illinois Department of Human Services Division of Mental Health on a statewide mapping project to identify gaps in services for criminal justice-involved persons with mental illnesses; and of having the privilege of serving as the national co-chair of JLI.

Mental health courts—that is, specialized dockets based on therapeutic justice or approaches that address an offender's behavior and root causes—are relatively new. Long-term data on the effects of these courts on recidivism and public safety are not yet available, but the short-term reports reinforce their value and I think warrant continued, even increased, funding.

Participants seem to be positively motivated to take responsibility for their own recovery. Jail and hospital days are greatly reduced, resulting in cost savings. I recall one 50-year-old man released from jail to our therapeutic intervention program, or TIP court, who was diagnosed as schizophrenic. He believed himself to be a retired army general and barked orders at me when he came into court. In a regular courtroom, he would have been held in contempt. But in this therapeutic setting, our team of legal and mental health professionals worked with him until he steadily took his prescribed medication, participated in therapy, and was able to assume more responsibility for his own life and recovery. He is now living semi-independently and is no longer delusional. He has not had any contact with the criminal justice system in 2½ years.

This story can be repeated numbers of times in the now over 175 mental health courts in the country. Yet recent statistics still show disproportionate numbers of persons with mental illnesses in our jails. Stigma is still attached to mental illness.

We all know more needs to be done. How do we move forward? What should be our focus for study and action?

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We must continue to look for new ways to reverse the criminalization of mental illness and to improve public safety. Aware of that challenge, we have just established the Mental Health Court Association in Illinois to improve our coordination of statewide efforts. This is the first organization of its kind in the country.

We know that our jails and prisons have become the so-called "safety nets" of our unfunded and underfunded system of community mental health care in this country. Now is the time to focus our attention and our resources on continuity of care, establishing key linkages, and in funding the gaps in services. A few of my recommendations are:

First, in expanding funding for mental health courts and diversion programs, which do provide the structure for integrated treatment outside of our jails and prisons, we should focus on wrapping our returning veterans into these programs as their mental illnesses and substance abuse problems put them at risk for entering the revolving door in and out of our jails.

Second, we must improve the screening and mental health services in our jails. We know how expensive it is to house prisoners, especially those who are mentally ill. Using screening tools at booking may more readily identify those inmates. Needed medication and treatment can then be provided, resulting in earlier releases. What often happens, as we have heard today, is that inmates with mental illnesses act out due to their symptomatology and threaten guards and other inmates. Any good time they may have accumulated is taken away. Additional training for staff and separate pods may help. Sharing information between departments of human services and corrections, such as the Illinois Data Link Project, can help identify those prisoners who have a mental illness.

Best practices, SAMHSA's best practices—that is, a blend of the best research and clinical experience in the area—suggest an integrated approach to treatment of persons with mental illnesses in the criminal justice system. That includes not only medication and therapy but supported employment, supported housing, and trauma-informed services. To my knowledge, Medicaid does not cover these costs or covers them in a very fragmented way. A fresh look at this situation would be in order, along with allowing reimbursement for the case management linkage piece of release planning and diversion from our jails.

Also, funding for Centers of Excellence on a statewide or even a regional basis would be important. These centers could facilitate necessary research and examination of best practices, help coordinate efforts at cross-disciplinary training for professionals, including police officers working in the field. They could involve consumers and NAMI.

My other recommendations have been submitted to the Subcommittee in my full statement and include funding for technical staff assistance to JLI, our judges organization that has made significant contributions all across the country. Resources may be more limited than we would like, but we must persevere.

In closing, I would like to share with you some sage advice by retired Illinois Chief Justice Mary Ann McMorrow to a group of new judges. These words describe very well why I as a judge feel

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compelled to be involved and committed. Justice McMorrow offered this:

"As judges, we look beyond the legal formalities of a particular dispute, to remain aware of the human dilemma that underlies almost every case brought before us, and always within the bounds of our authority try to resolve the problems presented to us in a manner that satisfies both the legal and the human aspects of the case. Let us not forget that the law is first and foremost about human beings and their problems."

Thank you, Mr. Chairman and Senator Franken, for the honor and the privilege of being here today and assisting in this important work.

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

Chairman DURBIN. Justice Zenoff, thank you for being with us.

Our last witness, David Fuller, is an outreach and housing coordinator for the Manhattan Outreach Consortium. Previously, he worked as the Director of the Supportive Housing Program for Community Access and a peer specialist for Bellevue Hospital's psychiatric inpatient service.

Mr. Fuller is a consumer in recovery from psychiatric disability and substance abuse who spent about 20 years cycling in and out of jail. Mr. Fuller now works to improve access to services for people with mental illness. He is a member of the National Leadership Forum on Behavioral Health and Criminal Justice.

Mr. Fuller, the topic of today's hearing has affected your life like it has no other witness. Thank you for being here today and having the courage to tell your story. Please proceed.

STATEMENT OF DAVID L. FULLER, OUTREACH AND HOUSING COORDINATOR, MANHATTAN OUTREACH CONSORTIUM, BROOKLYN, NEW YORK

Mr. FULLER. Mr. Chairman, Senator Franken, I want to thank you for allowing me to testify today, and other distinguished members of the Committee that are not here today. I submitted written testimony, but there are some things I would like to talk about that are not in the written testimony.

In my trip down here, I was thinking about an occasion when I was in the Suffolk County Jail in the early 1990's, and I suffer with major depression, or I used to suffer with major depression. Today I manage it and live a very full life. But back then, things were not going so well, and I was homeless. I got arrested for petty larceny. I had stolen something to eat and some baby formula for my child at the time. I was arrested, put in Yaphank Jail, been up 3 or 4 days. I was also abusing substances at the time, wasn't very clean, depressed, preoccupied with my own death, most of the time. I viewed it as not having enough courage to actually take it out at that time.

When I got to Yaphank Jail, all through this time no one asked me did I have a mental illness or a substance abuse problem. I saw no opportunity to reach out for help to a medical professional. While I was in the holding cell going through the intake process, an officer yelled out something at me, and I was hearing voices, too. Isolation back then used to create psychotic episodes for me,

especially when I was sent to the box. And I think he had told a group of us to get up, stand up from the bench, and I didn't stand up fast enough. And one of them punched me in the head, threw me to the ground. I was handcuffed behind my back, and then one of the officers saw fit to jump off the bench into my rib cage and broke two of my ribs.

I was put in the box after this and left there. In my mind, not to be too dramatic, but I felt I was left there to die. I had no visitors. The medical personnel were not allowed to see me. I could hear them talking at the door. The officers would not let them in. I later found out when my family was looking for me, I was told, they were told I was not in the jail.

What saved me was I had a warrant for petty larceny in New York City at the time. The officers came to get me because my name was in the system. I come to find out later those New York City police officers had a hard time getting me out of Yaphank Jail. When I was finally produced, they basically looked at me and asked the Suffolk County officers, "What is this? What happened to him?" And I really do not remember what they said. All I know is they laid me down in the back seat of their car, took me to the next county, Nassau County, and I stayed in Nassau County Medical Center for another 10 days.

The first 3 days, the doctors were going back and forth of whether they would have to put a tube in my chest because my lung was collapsing at the time. Luckily, that did not happen.

The sad thing is this was not a unique experience in my time in jail. I spent 6 to 8 years cumulatively in city jails in New York City. The sad thing is that there are a lot of my peers that are not able to testify before you because they are no longer with us. They either committed suicide in jail or after they got discharged out of jail.

It is difficult to talk about this topic without thinking about the other more complicated, overlapping issues of racism, social and economic disability, cultural incompetence when it comes to getting services within the jail system. And I think that is like a sarcastic statement when I say "getting services within the jail system," because you really do not.

There is no HIPAA inside a jail. There is no privacy in your care. I put in my written testimony, I remember the first time that I got the courage up, you know, to tell people about what was going on with me, my suicidal thoughts, my complete engulfment in hopelessness, that I would put in a pen with 30 other guys, you know, officers would yell out, "Fuller, are you here to see the psychiatrist or the medical doctor?" If I wanted to see the psychiatrist, I would have to acknowledge in front of 30 or 40 people that I did not know that that is what I was doing.

When I met with the psychiatrist, it was in a little cubicle, you know, like in an office pool or something, no solid walls, no door, expected to talk about the most personal aspects of my life. I could hear other so-called medical professionals talking about previous patients and their personal information, and it scared me. I said, "Well, when I leave, are they going to be talking about my information the same way they are talking about others?" So I would kind-

ly shut my mouth and not really discuss the issues that were going on with me.

A few times I took medication in jail. It is a very embarrassing situation. In Rikers Island, when you go to medication, you are standing on a line with—I do not know—50 to 100 other inmates, other inmates going on the other side of the hall. You are taking your medication right there in front of everybody at a window. Everybody knows what you get. There are other illicit activities that go on in the medication line, you know, the selling of illicit drugs, selling of medication, things like that.

I really, you know, have to reiterate my experiences are not the worst experiences. I have been in the box three or four times. I became psychotic in the box twice. My diagnosis does not carry psychosis with it. I have not been psychotic since I have been in jail. But the isolation, combined with the depression, did create a couple of episodes for me.

I did attempt suicide in jail one time. An inmate found me and untied my neck. He did not tell the officers because just like I knew, to tell them what happened would just exacerbate the problem. I would have been put on suicide watch, which was basically the box, and isolated and probably would have felt worse, if possible, than I already did. I do not know him name today, but I always thank him for that.

What helped me was the last time I was in jail I was asked by someone did I consider treatment, and I told the person directly that if I couldn't go to some place that would address my psychiatric disability and my substance abuse, it was really a waste of time. I had graduated three long-term drug treatment programs at this time, countless rehabs and detoxes. I really can't remember how many-20, 30, 40.

It is painful. Every failed treatment episode is very painful for a person, and at this point I just could not endure another failed treatment episode. I knew what I needed. The services just were not out there for me.

This person actually said, well, we have something called a MICA program—and a MICA program stands for Mentally Ill Chemically Addicted residential program—would I be interested in that. I said yes. I sat in jail for another 2 months on a misdemeanor waiting for the service. But the good thing is when I got out, got engaged, I was able to get around people like me with similar experiences, got support, saw a doctor, got medication, got stable, decided I wanted a job, decided I wanted a family, became a father, a husband, a citizen, a man again, regained my role in the community.

For many years, the State, city, and Federal Government have been wasting their money incarcerating and paying for inadequate services for me. Through my lifetime I easily have spent a million dollars of the Government's money that did absolutely no good for me. I think it is a travesty, you know. Today, you know, I pay taxes instead of taking out of the tax coffers. I try to help people with similar experiences that I do.

But I think what is needed is, like I heard some of the other panelists talking about it, it is really about supportive housing, employment, adequate community services. Yes, there are too many

people in jail. There are too many people in jail, and I do agree that there are a small number of people that thank God there are jails. You know, I met these people. Some people really need to be in jail. But 80 percent do not. Seventy to 80 percent of the people in prisons today are either there for drug offenses or committed the offenses while under the influence of drug and alcohol. A majority of these people have underlying childhood trauma, physical and/or sexual abuse.

I think one of the things that allowed me to recover to the extent I did is that my trauma was not experienced in the home. I had great parents, loving parents. I have three siblings. All of them have post-graduate degrees, live very successful lives.

I did not respond to the violence and the racism in the 1960's as well as my siblings did. You know, I watched people beaten and killed when I was 6 and 7 years old because of the color of their skin. I went to all-white schools through elementary and high school because my parents wanted a better public education for me. I did not have the courage to tell them what names I was being called there, that, you know, I was attacked pretty regularly there and suffered injuries behind those attacks. I wanted to be a man. I wanted to stand up for myself, even as a boy.

I can recall suffering with depression ever since 10 or 11 years old because I was very hopeless in things ever changing for me. I distinctly remember when they killed Martin Luther King that I lost hope in the country, I lost hope in having a different future. And I am not saying everybody responded to things the same way. This is the way that I responded. I think, you know, I am a sensitive person by nature.

I would just like to say that we really need to focus on alternative to incarceration programs. I went through one. It changed my life. I went to MICA treatment, got around people that understood me, got on medication, went to therapy. The reason I was able to go there was because I went through a drug court that allowed me to finish my time in there, and if successfully completed, dismissed the case against me.

Chairman DURBIN. Mr. Fuller, I have given you——

Mr. FULLER. I am sorry.

Chairman DURBIN. I have given you more time than others—intentionally.

Mr. FULLER. Right. No problem.

Chairman DURBIN. You deserved it because you have a perspective on this none of us have. But I want to have a chance to ask some questions and ask you to react and others to react to your life experience.

Mr. FULLER. Sure.

Chairman DURBIN. But I really appreciate your coming. I seriously do, and I want to make sure we get everything done here before we have to wrap it up today. But thank you for coming, and sit tight, we have got some questions for you. Okay?

Mr. FULLER. Thank you.

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

Chairman DURBIN. The first question I am going to have is one that I have asked some of the experts, and you are the only one

at the table in either panel that can speak from firsthand experience. It is a real basic, open-ended question. What is the impact of isolation on the mentally ill?

Mr. FULLER. It is cruel and unusual punishment. I was shocked to hear some of the replies that the other panelists gave. Almost invariably people with mental illness in isolation get worse. I do not know many who stay stable.

Chairman DURBIN. Should there be a limit? I mean, you understand why they do it in some cases.

Mr. FULLER. I do.

Chairman DURBIN. Should there be a limit?

Mr. FULLER. I do not think it is a simple answer. I think they should never be there in the first place. Isolation does serve a purpose, a safety purpose for inmates and officers. I think the problem is that these people are being punished because they are sick, and they are in a jail that they should not have ever been in in the first place.

Mental illness is highly underreported within inmates because inmates understand the consequences by going public. So I guess my question is that—I do not have an answer to limits, but I will say it is cruel and unusual punishment, and I have not been psychotic since I got out of isolation.

Chairman DURBIN. Mr. Maynard, you were on the 2006 commission I talked about earlier that said that there should be a limit to this.

Mr. MAYNARD. Yes, sir.

Chairman DURBIN. I would like to ask you to react to the same basic question. What is the impact of isolation on the mentally ill?

Mr. MAYNARD. I think it causes deterioration with mentally ill inmates. I think it makes their conditions worse. I agree with a lot of the testimony that we in the prison system, as a need to deal with violence, inmates who would be dangerous to staff or to other inmates or to themselves and who misbehave, we put them in isolation.

I think as a rule we typically keep people longer than they should be on isolation. In some cases, they need to stay a long time just for everybody's protection. In other cases, they need to move more quickly through disciplinary and administrative segregation.

But, again, I do not think there is any question about the impact of isolation on the mentally ill. I think that is something that most corrections directors would say is something that we need some solutions in order to move away from that.

Chairman DURBIN. For the record, Mr. Randle is new to his position with a new Governor in our State, and he has been assigned a pretty tough assignment to take a look at the Tamms Correctional Facility, our supermax State facility.

According to the Belleville News-Democrat—and you can correct this report if it is wrong—54 inmates at Tamms have been held in solitary confinement for more than 10 years, including 39 who have been there since 1998 when the prison opened. George Wellborn, the first warden at Tamms, said, "I think they should have been given an opportunity to go back to a reduced security facility. It was not intended to be a place where guys would be there for 8 to 10 years."

Mr. Randle, should there be a limit on how long an inmate can be held in isolation in Tamms?

Mr. RANDLE. Thank you, Chairman. First of all, I think there should be a limit in terms of how long a person could be held in isolation. I would also add the number of 54 inmates being held at Tamms since—I believe it was 1998, that is an accurate number that comports with my review.

Chairman DURBIN. Accurate or inaccurate?

Mr. RANDLE. It is accurate.

One of the first things that Government Quinn asked me to do is do a comprehensive review of the conditions at the Tamms Correctional Facility. Even prior to my formal start as director, I began to gather information. In fact, my second day on the job, I spent about 9 hours at Tamms, walked through every cell block, talked to over 50 inmates at Tamms, spent an entire day looking at the operations in Tamms.

From that, and other research over the past 2–1/2 months of my tenure as director, I have recently submitted—in fact, just last week—a report to the Governor with a second of ten recommendations for reforms at the Tamms supermax facility. One of those recommendations involves the release or the beginnings of a step-down process for approximately 48 inmates who have been in Tamms between the 1998 and 2004 period.

So, indeed, I did have a concern about the extended stay of offenders, among several other operational things that I discovered at Tamms.

Chairman DURBIN. How many of those inmates at Tamms or any other part of the Illinois correctional system who have been held in isolation for extended periods of time—let us say beyond 1 month, for example—would you classify as mentally ill, for example, using as an objective criterion, whether they are receiving psychotropic medication?

Mr. RANDLE. On any given day, there are about 4,500 offenders in the Illinois correctional system that have a diagnosis of a mental illness. Of that population, about 12 percent of the—I am sorry, about 12 percent of the entire population, 45,000 are on psychotropic medications.

There is and continues to be times where those inmates wind up in isolation for various periods of time. I think the key for me as a director is to ensure a couple things: Number one, that we have clinicians making decisions about whether or not an offender is appropriate for isolation.

I think one of the things that sometimes gets overlooked is that there are various degrees of mental illness.

Chairman DURBIN. Well, how many staff psychiatrists do you have in the Illinois Department of Corrections?

Mr. RANDLE. There are no State-employed psychiatrists. We have a contract provider that provides psychiatric services to our entire system. Those ratios, there is at least one full-time psychiatrist assigned to every facility. Some facilities have more than one full-time psychiatrist assigned to them. It is based on full-time equivalents rather than a specific number, Chairman.

Chairman DURBIN. I am just looking here to make sure I find out how many—you have 28 facilities.

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Mr. RANDLE. Yes, sir.

Chairman DURBIN. So you are saying there are 28 full-time psychiatrists under contract to the Department of Corrections?

Mr. RANDLE. There are 28 full-time equivalent psychiatrists, yes.

Chairman DURBIN. That is what I meant, under contract.

Mr. RANDLE. Yes.

Chairman DURBIN. The same thing. I hope that is the same thing. And so that roughly means that you have—let me try to do some math here quickly –1,500 patients for every psychiatrist?

Mr. RANDLE. That potentially could sound about right.

Chairman DURBIN. It sounds like a heavy caseload.

Mr. RANDLE. Yes, it does.

Chairman DURBIN. And so let me ask you this: What is your opinion of the impact of isolation on the mentally ill?

Mr. RANDLE. I think it can cause decompensation in offenders.

Chairman DURBIN. You might define that term for us, please.

Mr. RANDLE. It can cause your mental health condition to worsen. In some cases, it could lead to suicidal tendencies. It could lead to exacerbate your mental health condition, or make it worse.

I think, though, the key, at least from my perspective, again, is to ensure that access to clinicians is available whether you are in segregation or whether you are in general population, and that does not always just mean a psychiatrist. I want to emphasize that. There are psychologists, there are licenses clinical counselors. There is an array of mental health clinicians that all provide services to the population.

Chairman DURBIN. My last question in this round, and if you do not mind, I will come back and perhaps want to ask Judge Zenoff and others some questions.

The Belleville News-Democrat found that of the over 250 inmates transferred to the Tamms Correctional Facility in the last 10 years since 1999—of the over 250 inmates—only 6 of those went through mental health screening and were placed in the prison's special treatment unit for mentally ill prisoners. That figure seems extremely low based on the 12 percent figure that you mentioned earlier for those who are receiving psychotropic medication.

Mr. RANDLE. Mr. Chairman, specifically at the Tamms Correctional Facility, historically there was a file review that would take place as part of the placement process. One of the recommendations, as part of my plan to the Governor, requires a full mental health evaluation to take place for every placement into the Tamms Correctional Facility.

Chairman DURBIN. Thank you.

Senator Franken.

Senator FRANKEN. Thank you, Mr. Chairman.

Mr. Randle, you talked about a disinvestment in community mental health services. Do you think that if we fully funded these services that we can better manage the mentally ill, incarcerate fewer of them, and end up actually saving money for the taxpayers while also making our communities safer?

Mr. RANDLE. Senator Franken, that is absolutely correct. I do believe that one of the key things, especially with our population in the State of Illinois that have a mental illness, is as part of their release process we give them about a 14-day supply of psychotropic

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medication. Unfortunately, we do not do as good of a job linking them with a community mental health provider, so in a lot of cases, these offenders, while we may do a referral, sometimes it often takes weeks or months before they are actually in to see a psychiatrist to have that medication continued.

Unfortunately, by then they have run out of medication. They have decompensated and, unfortunately, they wind up in jail and ultimately back in prison. Traditionally, these are low-level, nonviolent offenders who often are accused of theft crimes and those sorts of things, but often wind up back in the prison system.

So I think part of this charge is working collaboratively with community mental health providers and also the State Department of Mental Health in Illinois to recognize that in a lot of cases we are dealing with the same individual at different points in their life, and work together to share information and provide that sustainable linkage when they leave.

Senator FRANKEN. Thank you.

Judge Zenoff, you talked about mental health courts and they are relatively new, and that the research is new, but that you have seen real trends. And I am wondering if those correspond to results you have seen and research you have seen about drug courts.

Justice ZENOFF. I am not as familiar really with the research on drug courts. I think drug courts have been found certainly to have made a significant difference. I think one area that the researchers are looking at with respect to mental health courts is whether or not to change some of the treatment to mirror in some ways what the treatment is in drug courts—that is, to address some of the criminogenic factors that have to do with recidivism and why people commit crimes. And I think they would like to see if that will, in addition to treatment for the mental illness, help reduce recidivism and allow people to stay out of the criminal justice system.

Senator FRANKEN. Thank you.

Mr. Fuller, thank you for co ming in today and for your testimony. I am curious about this MICA program, because you said that you had been in and out of rehab, right?

Mr. FULLER. Yes.

Senator FRANKEN. What was it about the MICA program that worked for you? Was it that you were just ready at that point? Or was there something about the design of the program that made it work for you?

Mr. FULLER. Well, I think being ready is part of it, but a MICA program is a place where you can address substance abuse and traditional mental illness in the same physical setting basically at the same time. You are connected with peers that have similar experiences as you do because you can even find discrimination with "straight substance abusers" or "straight mental illness," believe it or not.

That is the unique part of it, that you are able to address the whole person. It is usually a treatment failure when you try to separate mental illness from substance abuse. Substance abuse is an Axis I diagnosis, and if you do not think it is a thought disorder, you have never known an addict before. They should be treated the same. They should be in the same category. But at this present

time, I guess for funding reasons, they are separated and have historically been separated.

Senator FRANKEN. Excuse me, but what worked for you is that the MICA program combined the discipline of mental illness treatment and drug or chemical dependency treatment?

Mr. FULLER. Yes.

Senator FRANKEN. Okay. Thank you.

Mr. Maynard, you talked about collaboration and collaborating relationships. Could you talk about the potential opportunities for collaboration between the corrections system and the Substance Abuse and Mental Health Services Administration?

Mr. MAYNARD. Yes, sir. I think, Senator Franken, that if somebody works in corrections, runs a corrections agency and they are not accustomed to collaboration, they better get used to it, because we are big agencies in the States, but we have—we have custody resources, but we have little other resources. So I think it is incumbent on us to reach out to substance abuse agencies, like in Maryland, the judge mentioned NAMI, another group that in all the States I have worked in have been an active partner in working with the mentally ill. I think SAMHSA is an organization that has the technical credibility. I think the more we can get involved with them, the more funding that might be available, the more leadership they could provide, the more protocol, I think it would be good for our organization, for our system.

I think they have the expertise. We did not come working in prisons to be mental health experts. We run the security part of it. We looked at education at the Federal level to provide educational services. They do an excellent job reaching into the prisons. I think that is a model for SAMHSA. They could do the same thing. We provide——

Senator FRANKEN. SAMHSA, once again, addresses both substance abuse and mental health at the same time.

Mr. MAYNARD. Yes, sir. And I did want to, if I might, Mr. Chairman, in talking about the segregation, the Vera Institute of Justice is doing some pilot projects with reducing segregation, and they did a pilot in the State of Mississippi and their segregation population was pretty extensive. I think they reduced it probably by one-fourth of what it was. In Maryland, we have made a request to Vera to come look at our population, because I think we have a large number on segregation. I think it just happens, if you do not go back and study it and try to figure out ways to reduce it, that it will grow. So I think that is something, if we can do some models, that might go across the country.

Senator FRANKEN. Thank you, Mr. Maynard.

Thank you, Mr. Chairman.

Chairman DURBIN. Mr. Randle, if I understand the calculation, we estimate that each prisoner at Tamms costs us $64,000 a year. Is that a rough calculation based on the budget for Tamms?

Mr. RANDLE. Mr. Chairman, that is a number that is used to describe the cost.

Chairman DURBIN. Do you think that is close? Does it sound close?

Mr. RANDLE. I think you have to look at the entire operation and the impact that just Tamms has on our entire prison system. So,

yes, if you look at Tamms in an isolated fashion, also if you look at—there are two parts to Tamms. There is a 200-bed minimum security camp that provides that support. I think that $64,000 figure is just looking at inside the C–MAX portion of that facility.

Chairman DURBIN. I see. Mr. Fuller, you can see where you can get to $1 million in a hurry with that kind of expenditure.

Judge Zenoff, to go back to an earlier question here, I do not remember the course in law school on psychology and psychiatry——

Justice ZENOFF. Nor I.

Chairman DURBIN [continuing]. And psychiatric disorders and your clients, civil and criminal. But it appears that the intake in this process of justice starts with the law enforcement officer, the attorneys, the judges, social workers, and ultimately the correctional officers. And I guess the issue, I think, Mr. Maynard just referred to was that most correctional officers focus on security. And yet if they are going to play the role that we expect them to, we need them to be more observant of other things that relate to a prisoner's well-being that may have a direct impact on security.

So when you get into this drug court atmosphere—I do not know if your background is in psychology, psychiatry, or just——

Justice ZENOFF. Not at all.

Chairman DURBIN. Do you feel that our system of justice is really equipped to deal with what we have decided as America will be our future when it comes to mental health?

I can recall, just as an aside, that in 1970, then-Lieutenant Governor Paul Simon took me, a young lawyer fresh out of law school, on an onsite visit at the Lincoln State School, 30 miles from Springfield—it was a day I will never forget as long as I live. It was in the bitter winter, and we went up to a building which housed 150 profoundly retarded adult males. It was bedlam, pure bedlam. There were two supervisors there for 150 people. There were people jumping out of the windows in their hospital gowns, people running outside in the bitter cold. It is an image I cannot forget, and now I think we have decided to replace that horrible image with one which is in many respects just as horrible: A corrections system which has decided that it will become the largest provider of mental health "services," if you can put that in quotes, in the Nation.

Is this the right thing for our system of justice? Is this a fair outcome?

Justice ZENOFF. You know, Senator Durbin, I agree with you in terms of lawyers and judges not being educated in this field. But I do think, given the problem we have before us and the job of lawyers and judges to solve human problems, we are becoming educated. We are learning to use the resources that we have to be able to address the problems.

I think Mr. Fuller's story and really all of the testimony we heard here today is the reason and are the reasons that judges are out front, that judges have become leaders in communities around the country to address this very human problem. I think that the job of judges in this particular area is actually to become educated, as I myself did. I did not have any background in psychology or psychiatry. I had a mother who had Alzheimer's, and at that point I learned a little bit about that illness at that time. But actually,

to digress 1 minute, it was because of a community mental health leader in Rockford, Illinois, who walked over to the courthouse and said, "Open your eyes. See what is happening in the Winnebago County Jail. See who is cycling in and out of your jail. See why you have an overabundance of persons with mental illnesses in jail; why your jail is overpopulated," that we started to become educated.

And I think the reason that judges have learned about this problem is, as I said, it is a very human problem. I think what we do need to do is need to use our abilities to convene stakeholders in our communities and in the country to address the problem and to bring others together to actually keep persons with mental illness, with serious mental illnesses, out of the criminal justice system so that in the end they do not end up in our prisons. We would then have at least fewer people with mental illnesses in prison. Thank you.

Chairman DURBIN. Thank you.

Mr. Fuller, I am going to ask the last question of you. In the city of Chicago, which I am honored to represent, on the west side around the United Center where the Chicago Bulls and Michael Jordan had all their glory, we have more ex-offenders than any other section of our State. They are primarily African American, and they come to this community, this area for a variety of reasons. One of them is that many of the churches there have decided to give a helping hand to ex-offenders; and, I might add, they have a Congressman, Danny Davis, who has made this his passion and his dedicated purpose for serving in Congress to deal with this whole question of ex-offenders. And I have met with him and with some of the people at the churches there, and I know what you are doing today, and I want to give you the last word on this.

What do we need to do to make sure those ex-offenders do not commit another crime, do not end up back in jail? I know the list is very long, but give me the top two or three things that your work will make a significant difference.

Mr. FULLER. Okay. First, I will say in my written testimony I included a document, "A Call to Action."

Chairman DURBIN. I read it.

Mr. FULLER. Please do. Supportive housing, supportive employment.

Chairman DURBIN. Now, do you get help when it comes from our Government in terms of that housing? I mean, there have been questions as to whether Medicaid and Medicare are there for ex-offenders, this question about housing.

Mr. FULLER. Well, the third one is mutual support, peer support, and Medicaid does not pay for those services—peer-run centers, peer support. Sixty-four thousand for jail, 23,000 for supportive housing and a beautiful apartment with onsite case managers providing services. You just do the numbers, and it makes a whole lot more sense to provide services in the community than to send people to jail.

Chairman DURBIN. Thank you.

I am going to place into the record a long list of written statements, and since there is nobody to object, it is going in.

[Laughter.]

[The information referred to appears as a submission for the record.]

Chairman DURBIN. And if there are no further comments, I want to thank this panel in particular. This Human Rights and the Law Subcommittee was created as a kind of a special and risky undertaking, and they said do not step on the Foreign Affairs Committee, and be careful that you do not intrude on others' jurisdiction.

As best we can tell, there have not been too many hearings on this subject before Congress in the last few years, and I think that, as I mentioned earlier, Senator Webb's idea of a reform commission, which I have cosponsored, is a step in the right direction. But this really is a human rights issue in our country, that we have reached this point where this is where the mentally ill find themselves more often than not, that you would have three jails as the facilities where more mental health services are offered than any place in America. We have got to open our eyes. If we were ashamed as a Nation over 100 years ago about the status of the mentally ill, what can we say today? What about our generation? What are we doing? What is the honest and effective way to give these people a chance and to keep our society safe?

I urge everyone to reflect on the question that Mr. Fuller asked in his testimony: Why do they have to be punished so severely for so long for being sick? Mr. Fuller's experience highlights the failures to provide many persons with mental illness who enter our criminal justice system with a meaningful opportunity to get well. These failures are costly in terms of lost human potential, lost years, the expense of incarceration, and the threat to public safety.

But Mr. Fuller's experience also shows that it is possible to design and implement programs that allow people to turn their lives around, and thank goodness you are here as proof of that today. I appreciate that so much. Making available the opportunities that you had to finally turn your life around has to be our goal as a Nation. This hearing is adjourned.

Thank you.

[Whereupon, at 12:13 p.m., the Subcommittee was adjourned.]

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

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U.S. Department of Justice

Office of Legislative Affairs

QUESTIONS AND ANSWERS

Office of the Assistant Attorney General

Washington, D.C. 20530

February 3, 2010

The Honorable Richard J. Durbin
Chairman
Subcommittee on Human Rights and the Law
Committee on the Judiciary
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Please find enclosed responses to questions arising from the appearance of Deputy Assistant Attorney General Samuel R. Bagenstos before the Subcommittee on September 15, 2009, at a hearing entitled "Human Rights at Home: Mental Illness in U.S. Prisons and Jails." We hope that this information is of assistance to the Subcommittee. Please do not hesitate to call upon us if we may be of additional assistance. The Office of Management and Budget has advised us that there is no objection to submission of this letter from the perspective of the Administration's program.

Sincerely,

Ronald Weich
Assistant Attorney General

Enclosure

cc: The Honorable Tom Coburn
Ranking Minority Member

Hearing before the
Subcommittee on Human Rights and the Law
Committee on the Judiciary
United States Senate

Entitled
"Human Rights at Home: Mental Illness in U.S. Prisons and Jails"

September 15, 2009

Questions for the Record
Submitted to
Samuel R. Bagenstos
Deputy Assistant Attorney General
Department of Justice

Question Submitted by Senator Coburn:

1. Mr. Bagenstos, you mention in your testimony that since the enactment of the Civil Rights of Institutionalized Persons Act (CRIPA), your Division has investigated more than 430 facilities, and that the Division currently has 24 ongoing investigations. How many of both the total past and current investigations specifically involve deficiencies in mental health care and treatment?

Answer:

Since the enactment of the Civil Rights of Institutionalized Persons Act, the Civil Rights Division has investigated more than 430 public facilities, including jails, prisons, nursing homes, juvenile detention facilities, and facilities for persons with developmental disabilities. Although our records do not enable us to generate precise numbers for past investigations, our investigations of jails and prisons have nearly always involved allegations of deficiencies in mental health care and treatment. In all but one of the 24 jails or prisons currently under investigation, we are examining alleged deficiencies in mental health care and treatment.

U.S. Department of Justice
Office of Legislative Affairs

Office of the Assistant Attorney General

Washington, D.C. 20530

October 21, 2010

The Honorable Richard J. Durbin
Chairman
Subcommittee on Human Rights and the Law
Committee on the Judiciary
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Please find enclosed responses to questions arising from the appearance of Bureau of Prisons Director Harley Lappin before the Subcommittee on September 15, 2009, at a hearing entitled "Human Rights at Home: Mental Illness in U.S. Prisons and Jails." We hope that this information is of assistance to the Subcommittee. Please do not hesitate to call upon us if we may be of additional assistance. The Office of Management and Budget has advised us that there is no objection to submission of this letter from the perspective of the Administration's program.

Sincerely,

Ronald Weich
Assistant Attorney General

Enclosure

cc: The Honorable Tom Coburn
Ranking Minority Member

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Hearing before the
Subcommittee on Human Rights and the Law
Committee on the Judiciary
United States Senate

Entitled
"Human Rights at Home: Mental Illness in U.S. Prisons and Jails"

September 15, 2009

Questions for the Record
Submitted to
Harley Lappin
Director
Federal Bureau of Prisons
Department of Justice

1. Would you agree that the Federal Bureau of Prisons (BOP) incarcerates fewer offenders overall than state prison systems?

Response: BOP incarcerates more inmates than any individual State, but fewer inmates than the combined populations of all State prisons. According to a Bureau of Justice Statistics report from December 2009, the two States incarcerating the most inmates, California and Texas, had approximately 174,000 and 173,000 inmates respectively as of December 31, 2008. BOP incarcerated almost 202,000 inmates at that time.

2. Does the Federal Bureau of Prisons have authority over or responsibility for state and local prisons and jails?

Response: No.

3. Other than the BOP's medical referral centers where it appears most of your mental health staff is located, how many mental health professionals are on staff at other institutions? How many are permanent staff, and how many are contract staff?

Response: BOP's six medical referral centers have positions for approximately 150 full-time mental health professionals. BOP's other 109 mainline institutions have positions for approximately 330 full-time mental health professionals. The bulk of mental health services are provided by full-time BOP employees, however, BOP does employ contract psychiatrists in a number of its facilities.

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a. On average, how many are assigned to each federal prison?

Response: Mental health professional staffing varies considerably based on the mission and size of the individual institution. For example, mental health professional staffing is enhanced at high security and female institutions (*see* response to question 6, infra), and at facilities with specialized treatment programs. At a minimum, the following positions are assigned to each Federal correctional institution or penitentiary: A Chief Psychologist, a Staff Psychologist, a Drug Abuse Program Coordinator (Psychologist), and a Drug Abuse Treatment Specialist. Based on the mission of the institution and size of the inmate population, additional psychologists and treatment specialists may be assigned to the facility.

Psychiatry services are available in all BOP institutions. However, the need for a full-time, BOP psychiatrist does not exist in every institution. In locations with relatively few mentally ill inmates, psychiatry services are more efficiently provided through the use of tele-psychiatry or a contract psychiatrist.

b. What is the typical education and training level of these professionals?

Response: Most BOP mental health providers are doctoral level, licensed or license eligible, clinical or counseling psychologists. Obtaining a doctorate in psychology requires approximately four years of graduate training as well as completion of a one year pre-doctoral psychology internship. In addition to psychologists, BOP employs psychiatrists, social workers, and treatment specialists. Psychiatrists complete both medical school and a three to four year residency in psychiatry. The majority of BOP social workers and treatment specialists have a master's degree in psychology or social work. At a minimum, they have a bachelor's degree in the social sciences field.

c. Other than the BOP's medical referral centers, are most mentally ill inmates concentrated at certain facilities? Is this the reason why there are not psychiatrists at every federal prison?

Response: Several factors are considered when designating a mentally ill inmate to a BOP facility. In addition to medical referral centers, BOP also preferentially designates mentally ill inmates to intensively staffed facilities based on their mental health needs. Facilities with specialized mental health programs and/or large Psychology Services departments house proportionally more mentally ill inmates.

Psychiatry services are available in all BOP institutions. However, the need for a full-time, BOP psychiatrist does not exist in every institution. In locations with relatively few mentally ill inmates, psychiatry services are more efficiently provided through the use of tele-psychiatry or a contract psychiatrist. BOP's approach to psychiatry services meets or exceeds community standards of care.

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d. If the BOP does not have mental health professionals at every institution, how do you know the needs of the mentally ill population in all federal prisons are being met?

Response: BOP has mental health professionals at every institution. If a mental health professional determines that the inmate's mental health needs exceed the institution's capacity to meet those needs, the inmate is transferred to a more appropriate facility.

4. You state in your testimony that those facilities without a full-time psychiatrist either receive services via contractual psychiatrist or via "tele-psychiatry." How effective is "tele-psychiatry?" Is it not difficult to treat and make diagnoses via a teleconference?

Response: Telemedicine, including telepsychiatry, is very effective and is increasingly utilized in a number of different fields, including dermatology, radiology, and psychiatry. Telemedicine facilitates the delivery of specialized medical assessment and treatment services in rural areas. It is often difficult to recruit specialized health care professionals to live and work in these rural locations. Telemedicine addresses this issue and ensures specialized services are available in all locations. In addition, effective tele-medicine relies on a close consultative relationship between the specialized professional and the on-site provider. With respect to telepsychiatry, an on-site physician and psychologist collaborate with the tele-psychiatrist to ensure accurate diagnosis and appropriate treatment.

a. If a facility does not have a psychiatrist on staff and tele-psychiatry is used, who administers the treatment to an inmate if it is needed?

Response: Telepsychiatry orders are issued by the telepsychiatrist in BOP's Electronic Medical Record (BEMR) where they are accessible to all Health Services staff at the institution. The orders are then administered by the medical staff at the institution – depending on the nature of the order, the staff administering the order may be nurses, physicians, psychologists, social workers, laboratory technicians, or mid-level practitioners. When mental health follow-up care is required at the institution, the bulk of this care can be provided by on-site psychologists with as needed consultation with the telepsychiatrist.

5. You state in your testimony that screening and assessment for mental illness are conducted "at initial intake, during reviews of inmates in special housing units, and as part of ongoing evaluations of mentally ill inmates."

a. How are "ongoing evaluations" conducted? Is it via rounds by mental health staff, or is it voluntary reporting by the patient or his/her cellmate?

Response: Ongoing mental health evaluations of inmates are triggered by a number of factors. Inmates classified as seriously mentally ill receive regular contacts with

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psychologists, regardless of whether they volunteer for treatment services. These clinical contacts occur at least monthly and more frequently if clinically necessary. Inmates with a history of suicidal ideation, suicide attempts, and/or the need for crisis intervention services are seen for appropriate follow up evaluation, regardless of whether they voluntarily seek treatment.

Inmates also have the opportunity to voluntarily seek mental health services through a variety of mechanisms. Psychologists are a visible presence in the institution - in the cafeteria, on the compound, and in the housing units. Admission and orientation and intake procedures ensure inmates are familiar with psychology staff upon their arrival to the institution. An inmate may speak with a psychologist during the department's weekly "open house" hours or during a psychologist's routine visits to the inmate's housing unit or the institution's cafeteria. The inmate may submit a written request for an appointment or may ask *any* staff member to contact Psychology Services to arrange an appointment. Psychology Services also receives referrals from staff members, all of whom are trained to identify potential mental health concerns. Inmates also contact Psychology Services regarding mental health concerns of their fellow inmates (e.g., cellmates or coworkers).

BOP psychologist is on-call 24 hours a day, 7 days a week, at all institutions, with a prompt response to the facility in the event of a mental health crisis.

b. How often do these "ongoing evaluations" occur?

Response: The frequency of these ongoing evaluations depends upon the individual inmate's treatment needs and general level of mental health functioning. Contacts range from daily to quarterly.

6. Some on our witness panel today have testified to the greater prevalence of mental illness in female offenders in state systems. Do you find this to be true in the federal system?

Response: Yes. We estimate that among newly committed female offenders, the overall rate of mental illness is higher than that of male offenders. For example, among newly committed female offenders who had a diagnosis of a serious mental illness, or a history of either inpatient mental health hospitalization or psychotropic medication the mental health prevalence is 26.3%. Our estimate for males is 14.4%.

a. Are programs offered to women, such as The Resolve Program and the Step-Down Program, structured differently than those offered to men? Why or why not?

Response: The structure of the programs is similar, in that services are delivered as either outpatient or residential treatment in an individual and/or group setting by psychologists, psychiatrists, and social workers. However, the content of the programs is

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gender specific. As these programs were initially developed and as they have evolved over time, the professional literature on female offenders and female offender subject matter experts were consulted extensively to ensure the programs addressed the needs of female offenders. Specifically, these programs attend to such topics as traumatic stress, resilience, assertiveness, interpersonal relationships, and co-occurring mental illness and substance use disorders.

7. You also mention several programs available to mentally ill inmates in specific federal institutions; however, only the Challenge Program is available in all penitentiaries. Are there any plans to expand other programs into additional institutions?

Response: The BOP is determining the feasibility of expanding the Step-Down and Resolve Programs to serve a larger subsection of mentally ill offenders.

a. Other than the Federal Medical Centers, how does the BOP determine when/if a federal institution should establish one of these mental health programs?

Response: Central Office and Regional Office Administrators regularly consult with the field and review mental health records to identify the mental health needs of the inmate population. In addition, large scale research projects conducted internally, as well as reviews of the professional literature, inform our decisions about program development and activation. When a need for a particular program is identified and resources are available to activate the program, the BOP's Assistant Directors and Regional Directors collaborate to identify an appropriate location for the program. At the institution level, each Chief Psychologist conducts an annual assessment of their inmate population's mental health and substance abuse treatment needs. Based on this assessment, the Chief Psychologist will implement local programming efforts, such as specialized psychotherapy groups.

b. How many of these programs are purely voluntary on the part of the inmate? Is this more effective than making some programs mandatory if the inmate is diagnosed with a mental illness?

Response: The BOP's mental health treatment programs are voluntary. The Bureau's emphasis on voluntary participation in mental health treatment is consistent with the standard of care in the community. Bureau psychologists make a concerted effort to engage inmates in treatment through the use of motivational interviewing techniques and incentives for program participation.

i. Are any programs mandatory?

Response: While mental health treatment services are voluntary, some mental health related services are mandatory. Psychologists and psychiatrists deliver clinical interventions to effectively manage mentally ill inmates in the prison setting. For

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example, these interventions may include monthly monitoring appointments or placement in a specialized housing unit or work assignment.

During a mental health emergency, psychiatric medications may be administered without first obtaining the inmate's informed consent. In non-emergency situations, informed consent is obtained and documented prior to administering medication for psychiatric symptoms or conditions. Psychiatric medication may be administered in a mental health emergency only by order of a physician, and if the inmate is at immediate risk of: bodily harm toward self or others; serious destruction of property that would immediately endanger self or others; serious disruption of the therapeutic milieu that places the inmate at risk of harm from others; or extreme deterioration of functioning secondary to a psychiatric illness.

8. How many federal inmates would you estimate have been diagnosed mentally ill?

Response: The Bureau estimates that 15.2% of newly committed Federal inmates would be diagnosed mentally ill. Diagnoses included in this estimate are limited to Schizophrenia, Schizo-affective Disorder, Bipolar Disorder and Major Depressive Disorder.

a. What definition of "mentally ill" does the BOP use in its evaluations?

Response: If evaluations refer to forensic examinations performed by Bureau psychologists for the courts, then "mentally ill" can best be thought of as a Mental Disease or Defect, as that term has been defined in statute and case law. However, in practical terms, mental health professionals (psychologists and psychiatrists) who complete evaluations, use diagnostic terms found in the DSM-IV-TR to describe mental illness.

b. Are all diagnosed inmates monitored by a mental health professional in some capacity? How often?

Response: No, inmates who are functioning reasonably well and who have no active interest in treatment may not be directly monitored by a mental health professional. This practice is consistent with the community standard, in that individuals with mild to moderate mental health symptoms are not routinely monitored or mandated to receive mental health services.

9. Is BOP aware of the innovative ideas that many states have utilized to treat this inmate population? How often does the BOP add to or update its mental health services?

Response: BOP has Regional and Central Office mental health professionals dedicated to identifying and developing evidence based treatment programs. The staff reviews the professional literature, visits programs in the community and/or State prisons, and collaborates with subject matter experts to develop more effective mental health services for BOP. BOP adds

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or updates mental health services as the needs dictate and resources permit. In Fiscal Year 2009, BOP continued to expand the Challenge Program at penitentiaries and increased the number of Resolve Programs in female institutions.

10. What type of training does correctional staff receive to enable them to recognize and appropriately react to inmates with mental illness? How often does staff receive such training?

Response: All new staff, including correctional officers, participate in a 200-hour course of training within the first year of employment. This training is offered at the local institution and at the Federal Law Enforcement Training Center in Glynco, GA. The curriculum includes specific training in managing mentally ill offenders. This subject is also addressed regularly with all staff during annual training. This component of annual training is facilitated by a doctoral level psychologist. In addition, specialized training in suicide prevention is offered semi-annually to key staff in the institution, to include health care workers, supervisory correctional officers, and unit management staff.

Due to this staff training, it would be very unusual for an inmate's mental illness to go undetected by correctional staff. Early warning signs of a mental illness are easily observed by staff working in close proximity to inmates. Psychologists regularly communicate with unit management staff, unit officers, teachers, chaplains, health care workers, recreation staff, and supervisors of inmate workers to effectively manage the care of mentally ill inmates. Staff is provided with the necessary information to assist in the monitoring of mentally ill inmates and they routinely share information and concerns with psychologists.

11. How do your correctional staff and mental health staff work together?

Response: Among the many benefits of BOP's "correctional worker first" philosophy is the strong sense of camaraderie that develops between all staff. Mental health professionals in BOP are well respected by other staff and are readily consulted regarding the management and treatment of mentally ill inmates. Correctional officers and unit management staff who work closely with inmates frequently interact with psychologists, making referrals on an almost daily basis.

a. **Would you agree that, based on their daily interaction with inmates, that the correctional staff plays a key role in monitoring inmates' mental health?**

   Response: Yes.

b. **I realize that the roles of mental health and correctional staff are very different within the prison system. Does this make it difficult to coordinate sharing of information and cooperation between these two staff groups when treating mentally ill inmates?**

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Response: As noted above, BOP's "correctional worker first" philosophy yields a collaborative, cooperative relationship across departments. In addition, a number of mechanisms are in place to enhance and encourage staff communication. Staff members communicate by e-mail, by telephone, and through in-person meetings. Psychologists identify mentally ill inmates in the population and ensure staff is aware of the special needs of these inmates. Procedures are in place to ensure that a psychologist is notified if a mentally ill inmate encounters difficulties. For example, if a mentally ill inmate engages in disruptive behavior and is placed in segregation, Psychology Services is immediately notified and the inmate is assessed.

12. Do you specifically request appropriations for mental health services for inmates? Why or why not?

Response: Funding for mental health services is included in the BOP budget request. The BOP budget structure is comprised of four decision units: Inmate Care & Programs; Institution Security & Administration; Management & Administration; and Contract Confinement. Funding for inmate mental health services is incorporated under the Inmate Care & Programs decision unit.

In FY 2011, the BOP requested $2,382,820,000 to fund all programs under the Inmate Care and Programs decision unit that includes Inmate Mental Health Treatment (Psychology, Drug Treatment, and Psychiatry). Also addressed in the decision unit are other programs (Food, Medical, Clothing, Religious Services, Recreation, Unit Management, and Receiving & Discharge). The Inmate Care & Programs Decision Unit Funding Request amount for Fiscal Year 2011 was 37% of the BOP Total FY 2011 Funding Request for the Salaries & Expenses Appropriation.

a. If not, how much is generally allocated to such services from the overall appropriations BOP receives?

Response: *See* above response.

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U.S. Department of Justice

Office of Legislative Affairs

Office of the Assistant Attorney General

Washington, D.C. 20530

February 25, 2010

The Honorable Richard J. Durbin
Chairman
Subcommittee on Human Rights and the Law
Committee on the Judiciary
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Please find enclosed responses to questions arising from the appearance of Deputy Assistant Attorney General Marylou Leary before the Subcommittee on September 15, 2009, at a hearing entitled "Human Rights at Home: Mental Illness in U.S. Prisons and Jails." We hope that this information is of assistance to the Subcommittee. Please do not hesitate to call upon us if we may be of additional assistance. The Office of Management and Budget has advised us that there is no objection to submission of this letter from the perspective of the Administration's program.

Sincerely,

Ronald Weich
Assistant Attorney General

Enclosure

cc: The Honorable Tom Coburn
Ranking Minority Member

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Hearing before the
Subcommittee on Human Rights and the Law
Committee on the Judiciary
United States Senate

Entitled
"Human Rights at Home: Mental Illness in U.S. Prisons and Jails"

September 15, 2009

Questions for the Record
Submitted to
Marylou Leary
Deputy Assistant Attorney General
Department of Justice

Questions Submitted by Senator Coburn:

1. Ms. Leary, you mention in your testimony that the JMHCP grants funded via the Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA) and other grants under the Second Chance Act are available to state and local governments to treat mentally ill offenders. Are these the only DOJ grants that can be used to further the treatment of mentally ill offenders?

Answer:

The Office of Justice Programs ("OJP") administers other grant programs that, while not directly aimed at the treatment of mentally ill offenders, do help address mental health within the criminal justice system. One such program is the Residential Substance Abuse Treatment for State Prisoners ("RSAT") Formula Grant Program. RSAT assists States and units of local government in developing and implementing residential substance abuse treatment programs in State and local correctional and detention facilities.

In addition, OJP provides grants under the Drug Court Discretionary Grant Program. This initiative provides financial and technical assistance to States, State courts, local courts, units of local government, and tribal governments to develop and implement court systems that effectively integrate substance abuse treatment, mandatory drug testing, sanctions and incentives, and transitional services in a judicially supervised court setting with jurisdiction over nonviolent, substance-abusing offenders. Drug treatment courts place nonviolent offenders in treatment, not in prison, so that the underlying cause of their criminality – addiction – can be addressed.

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OJP also administers funding under the Edward Byrne Memorial Competitive Grant Program. Byrne Competitive Grants are available to improve the functioning of the criminal justice system, to assist victims of crime (other than by providing compensation), and to fund youth mentoring initiatives. These grants help State and local communities improve the capacity of local justice systems and may be used for national efforts such as training and technical assistance. Applicants may be national, regional, State, or local public and private entities; including for-profit (commercial) and nonprofit organizations, faith-based and community organizations, institutions of higher education, tribal jurisdictions, and units of local government that support the purpose areas of this grant program.

OJP and other Justice Department components also have launched collaborative projects with the Department of Health and Human Services to find better ways to help State and local governments improve the response to people with mental illness involved in the criminal justice system. OJP's Bureau of Justice Assistance ("BJA") joined the National Institute of Corrections ("NIC") and the Substance Abuse and Mental Health Services Administration to provide technical assistance to States to build on existing efforts and replicate them statewide. These partners worked with the Council of State Governments Justice Center and the CMHS National GAINS Center to sponsor a national conference in 2009, "Smart Responses in Tough Times: Achieving Better Outcomes for People with Mental Illness Involved in the Justice System." Over 450 people attended the conference, including many representatives from our JMHCP grantees and applicants. Together, conference attendees discussed how to address homeless populations, identify those in need of specialized responses, prioritize populations with co-occurring disorders, use data to identify a target population, and implement sustainable initiatives.

a. Isn't funding also available for these purposes under the Byrne grant programs?

Yes.

b. How many grants have been awarded specifically to grantees for treating mentally ill offenders under the various Byrne grant programs?

A number of States and local jurisdiction provide some funding to this type of program as only one of their multiple priorities. Justice Assistance Grant ("JAG") funds are based on a formula and are not awarded directly for treatment of mentally ill offenders. However, justice and mental health initiatives are allowable activities under the JAG Program. States may use JAG funds to support this type of program to the extent that the issue is a priority within the State. Because these decisions are made at the State and local level and because this treatment may be supported in a larger grant project (*e.g.*, a mental health court grant), the exact number of sub-awards for mental health treatment is not known. Under the Byrne Competitive Program, a total of two awards were made in support of this purpose in fiscal year 2009.

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2. In reviewing applications for grant awards, does your staff include mental health experts to determine the viability of various collaborations proposed by grant applicants?

While JAG funds are based on a formula and are not subject to peer review, OJP is committed to having well-rounded review panels, combining subject matter experts and researchers, practitioners, and academicians for the consideration of competitive applications. When appropriate, peer review panel members are drawn from a wide geographic area and represent both urban and rural perspectives. Special attention also is paid to ensuring various backgrounds and experiences are included.

3. Does your staff require grantees to report on how they use grant funds? If not, why not? If so, what role do those results play in making future grant awards?

OJP requires award recipients to submit both financial and program reports. These reports describe the status of the funds, the status of the project, comparison of actual accomplishments to the objectives, and other pertinent information. Past performance is taken into consideration with future awards as well as at anytime when a grantee requests an extension of an award project period.

When Financial Status Reports and Progress Reports are delinquent, funds are withheld from those grants and requests for drawdown are denied. In addition, any new awards for all OJP programs will be prohibited or restricted. Also, any Grant Adjustment Notices that release funds to retire special conditions will not be approved until the grantee is in administrative/financial compliance and all financial and progress reports are current.

It is important to note that this Administration has placed a very high value on evidence-based programming, and OJP is fully committed to advancing that cause. Evidence-based programs and practices are those that have demonstrated their effectiveness through rigorous evaluation. OJP is working to improving the quantity and quality of evidence that is generated through OJP-sponsored activities. This includes generating evidence through the progression from innovative to evidence-based practices. It also includes a greater investment in highly rigorous research and evaluation.

OJP also is improving the translation of evidence into practice through improved communication strategies and training. Even as organizations have identified evidence-based practices and programs over the years, there are a number of hurdles to overcome in implementing such practices. Information about effective practices must be distilled, accessible, and comprehensible. This is one reason why OJP is developing a "crime solutions" resource center. Through the resource center, criminal justice practitioners will be able to learn about successful programs, including related research and evaluation results.

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Department of Public Safety and Correctional Services

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COMMISSION

CRIMINAL INJURIES
COMPENSATION BOARD

EMERGENCY NUMBER
SYSTEMS BOARD

SUNDRY CLAIMS BOARD

INMATE GRIEVANCE OFFICE

January 29, 2010

The Honorable Tom Coburn
U.S. Senator
172 Russell Senate Office Bldg.
Washington, DC 20510

Dear Senator Coburn:

The following information is provided in response to your questions from the United States Senate Committee on Judiciary hearing on Hearing on *"Human Rights at Home: Mental Illness in U.S. Prisons and Jails"*, which was heard on September 15, 2009.

1. What type of training does correctional staff receive in the Maryland Department of Corrections (MDOC) to enable them to recognize and appropriately react to inmates with mental illness? How often does staff receive such training?

   All incoming Maryland Division of Correction (DOC) recruits receive 5 weeks of training academy as well as one week of pre-service training. This contains a number of mental health related training modules including management of inmates in crisis, suicide awareness, cognitive intervention, and basic information about mental health issues such as depression.

   In addition, all DOC staff members are required to attend annual in-service training ranging from a total of three to five days dependant upon the institution. This training includes information related to mental health issues, particularly the methods to address suicidal inmates.

2. Does the MDOC have mental health professionals on staff at every institution? If not, why not?

   Our DOC contracts mental health services (psychiatrists, psychiatric nurses and/or nurse practitioners from an outside vendor who operates within the conditions of a contractual agreement. Additional clinical services are provided by appropriately licensed DOC personnel.

3. What changes should be made in the MDOC to improve the way it evaluates and treats mentally ill offenders?

The primary issues are access to specialized training and sufficient resources. Ideally each state would operate mental health facilities to care for the needs of mentally ill offenders. Under the current system, we would need access to sufficient training for our correctional staff. Correctional facilities are not designed to care for the specific needs of mentally ill offenders. Additionally, sufficient licensed professional staffing levels would have to be increased in order to better treat co-occurring issues in the areas of substance abuse and somatic illness that often accompany mental illness.

4. How often are new programs established to treat mentally ill offenders?

a. Are all current programs available at all institutions? If not, why not?

Recently, our DOC has implemented a system of mission specific style correctional institutions. As part of this we have identified specific institutions that are appropriate to address specific inmate needs. We have invested in the establishment of Special Needs Units to manage severe mentally ill populations and have initiated programs to address gender specific treatment.

b. In the Maryland DOC, do female offenders suffer more than male offenders from mental illness?

Our treatment team is going to more fully evaluate this issue and will respond by February 5, 2010.

c. If so, are the mental health treatment programs structured differently for women given their greater susceptibility to mental illness?

5. Does Maryland have a mental health court system? If so, have you seen a difference in the number of inmates you incarcerate since these courts were established?

Maryland does not have a mental health court system, based upon the model and suggested best practices at the national level, we would be supportive of the establishment of one in the future.

a. If not, how do you know that the needs of mentally ill inmates are being met?

It is clear that more is needed within corrections to properly care for the needs of the mentally ill offenders. If their specific illness goes untreated, it often presents itself through criminal behavior. Developing solid community resources is part of the solution as well as adequate training and sufficient resources.

b. What is the educational background of your mental health professionals?

- *Clinical psychologists have a Ph.D., and have been professionally licensed.*
- *Mental Health Professional Counselors – Master Level in Psychology and Licensed as an LCPC*
- *Psychology associates – Master Level in Psychology*

Thank you again for your leadership in advancing the issue of mental illness within the nation's correctional facilities. I would be happy to answer any follow up questions.

Sincerely,

Phil Pie
Assistant Secretary
Treatment Services

Questions for Mr. Randle

1. In your leadership positions in both the Ohio and Illinois State Departments of Corrections, you have had experience with various types of programs directed at mentally ill offenders. Which programs do you feel have been the most successful and why?

To be completely honest, we don't have "programs." We just don't have the staffing ratios to support the provision of programming beyond some individual and group therapy.

2. How often do you collaborate with other states in developing new programs for mentally ill offenders?

The IDOC Chief of Mental Health is part of a national group of Directors of Behavioral Health from state correctional systems around the country. They are in contact at least monthly but more often as needed to discuss ideas for Mental Health programming and policy.

3. Do you have mental health professionals at every institution? If not, why not? a. If not, how do you know that the needs of mentally ill inmates are being met?

Every facility other than Thomson has at least one Mental Health Professional.

b. What is the educational background of your mental health professionals?

The vast majority have at least a master's degree, either in psychology or social work. Some have a doctoral degree in psychology.

4. How does your mental health staff interact with inmates (i.e. face-to-face, through cell doors, group counseling, etc.) and how often does that occur?

The mental health staff interacts with the inmate population primarily face-to-face in individual or group therapy settings. Some "cell door contacts" are made when segregation reviews are being conducted. Most mentally ill inmates are seen monthly but stability and caseload:staffing ratios dictate whether they are seen more or less often.

5. In the Illinois DOC, do female offenders suffer more than male offenders from mental illness? a. If so, are the mental health treatment programs structured differently for women given their greater susceptibility to mental illness?

The numbers from our female prisons do not support the supposition that the female offenders in Illinois suffer from mental illness to any greater degree than do the male offenders. However, the Mental Health Professionals at the female prisons structure their services to be gender-specific where clinically appropriate.

6. How do your correctional staff and mental health staff work together? a. Would you agree that, based on their daily interaction with inmates, that the correctional staff plays a key role in monitoring inmates' mental health?

Correctional staff very definitely plays a key role and are consistently relied upon by facility MHPs to provide ancillary information on how inmates behave on a daily basis and are consulted with some frequency as to their opinion about how an inmate is doing.

b. I realize that the roles of mental health and correctional staff are very different within the prison system. Does this make it difficult to coordinate sharing of information and cooperation between these two staff groups when treating mentally ill inmates?

Not at all. The vast majority of employees appear to understand and respect one another's role in the prison and efforts to hamper information trading are rarely, if ever, seen. There are times during which an MHP's treatment direction may be challenged by another employee, but this is never done in a malicious way and is seen as a healthy interaction that ensures a check and balance system.

7. Judge Zenoff testified to the success of mental health courts in Illinois. As the director of the Illinois Department of Corrections, have you seen a decline in the number of mentally ill inmates incarcerated due to the use of the mental health court system? If not, why not?

There has not necessarily been a decrease in the number of mentally ill inmates coming into our system but nor has there been an increase and that represents a change in trends.

APPELLATE COURT OF ILLINOIS
SECOND DISTRICT

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January 28, 2010

Senator Tom Coburn, M.D.
United States Senate
Washington, D.C.

Re: Follow-up questions to testimony at hearing, "Human Rights at Home: Mental Illness in U.S. Prisons and Jails" (9/15/09)

Dear Senator Coburn:

Thank you again for the privilege of testifying at the above-mentioned hearing of the Senate Subcommittee on Human Rights last September. I am writing at this time to answer your questions which were forwarded to me by staff member, Lauren Myerscough-Mueller.

1. *Judge, you have presided over an Illinois mental health court called the Therapeutic Intervention Program (TIP). Can you tell us what you observed as the pros and cons of such a court system?*
a. *Do you believe these courts effectively divert low-level non-violent mentally ill offenders from jail? If so, why are these courts so effective?*

As the Presiding Judge of the Criminal Division of the 17th Circuit Court, and then as Chief Judge of the 24 judge circuit in northwest Illinois, I not only convened a large community task force in 2003 to address the problems of persons with mental illness involved with our criminal justice system, but also had the privilege of presiding for two and a half years over the mental health court created by the task force members, prior to my assignment to the Appellate Court in 2007. In my view, the advantages of such a problem-solving court (or specialized docket) are that it effectively addressed a number of the issues facing both the court system and persons with mental illnesses.

We had identified in our community a jail overcrowding situation. Persons with mental illnesses tended to cycle in and out of our county jail constantly – the "revolving door syndrome". Also, persons in the community with mental illnesses who acted out as a result of their illnesses were

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often arrested and taken to jail - the "criminalization of the mentally ill". Establishing a mental health court for persons with serious mental illnesses allowed intense supervision and treatment to be made available to assist persons with mental illnesses to take charge of their own recovery and break the cycle of returning to jail and involvement with the criminal justice system. The benefit is that public safety is increased, together with the quality of life for persons with mental illnesses. Statistics have demonstrated that persons who have participated in TIP return to jail less often, and are hospitalized less frequently. Thus, there is a resulting cost savings for the county and the state.

The only "con" that I can identify at this point is that a problem solving court, such as a mental health court places a strain on judicial resources. There is already a shortage of judges for the significant numbers of cases in the court system; presiding over a court that takes additional time and handles fewer defendants places an additional burden on judges. In my opinion, though, the positive outcomes merit the additional time and effort.

The structure and eligibility criteria of mental health courts varies throughout the country. In Rockford, Illinois, the criteria were developed by the task force and included misdemeanor and non-violent felony offenses. If a defendant with a serious mental illness and with a pending felony was referred and accepted, a plea of guilt was required and the program participation was part of the agreed upon sentence. But prosecution for many of the misdemeanors was deferred, and the charges dismissed upon graduation and successful completion of TIP.

Identification of those persons with mental illnesses in our jail is the first step in the process. After arrest and at booking, a questionnaire is administered to identify persons with mental illnesses. Then those persons in jail are assessed by a mental health professional and if appropriate, referred to the program. If accepted by the TIP team, and the defendant signs a consent to participate in open court, the defendant may be released from jail to participate in the structured program. The effectiveness of the program really revolves around the 11 person interdisciplinary team of mental health professionals and probation officers that works with the defendants, and the requirement that the defendants appear weekly in front of the judge for a status regarding their progress.

2. *What types of offenders qualified to appear before the mental health court?*
a. *You state in your testimony that participation in the TIP was purely voluntary. How many offenders would you estimate elected to participate?*
b. *Are inmates counseled regarding the pros/cons of choosing the TIP before deciding to participate?*

Those persons arrested who have been diagnosed with a serious mental illness (DSM-IV, Axis I: e.g. Bi-polar disorder, schizophrenia, major depression), who are charged with a misdemeanor are eligible to participate. In addition, all class 2, 3 and 4 felonies that do not involve bodily harm or threat of bodily harm or mandatory penitentiary time are eligible for TIP. Domestic violence offenses may be accepted at the discretion of the team, and with the judge's approval. All

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misdemeanor and felony domestic violence offenses must have the consent of the victim. Other felony offenses may be considered where the mental illness is a causative factor in the offense: threatening a public official; intimidation; eavesdropping. All felony offenses involving a weapon are excluded. All sex offenses are excluded, with the exception of prostitution. Certain other offenses are excluded automatically, such as driving under the influence, residential burglary, arson, and robbery.

Each defendant (whether in or out of custody) who is referred, assessed and found eligible for TIP is then screened by the team and the judge at a staffing. If accepted for the program, at the first court appearance, the judge reviews with the defendant the requirements of the program and confirms that they wish to participate. The defendants then sign a voluntary consent form and releases in open court. Prior to coming to court, their attorney, whether a private attorney or public defender, does review with them what is expected in terms of meetings with the team, court appearances, medication - if recommended by a physician, etc. It is our experience with the TIP program, that over 97 percent of those who are eligible for the program and accepted by the team, decide to participate.

3. *What methods did your mental health court employ to ensure those who actually qualified to participate in the TIP actually did so?*

When a defendant appeared in the TIP court for the first time, he or she was introduced to two team members who were assigned to work with them on a daily basis to assist with housing and securing various entitlements, as well as getting them to medical and other appointments. Each defendant was required by the court to return each week for a status report to the court on their progress. Incentives as well as sanctions were used by the judge and the team to assist in the process.

4. *Did you and/or other judges see a change in the number of cases involving mentally ill offenders in the regular court system after implementation of the TIP?*

Yes, those referred to TIP and entering the program had their cases transferred from the regular criminal dockets handled elsewhere in the courthouse. While TIP was an open court, sessions were held once a week in a courtroom separate from the other criminal dockets. A dedicated and assigned public defender and assistant state's attorney were part of the team, along with two probation officers, a nurse, family support specialist, trauma specialist, dual diagnosis specialist and two mental health professionals, as well as a jail assessor and clinical supervisor.

After TIP had been operational for just six months, we noticed that over 50 percent of the participants also had a substance abuse problem. As we did also have a drug court in our circuit, we worked to make sure that defendants were referred to the appropriate court, depending on the primary causative factor in their criminal charge– either their mental illness or their substance abuse. In addition, in my capacity as the presiding judge of the TIP Court, I convened a local summit to address the problem of the inadequacy of services for persons with mental illnesses

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with substance abuse problems. Two key agencies, Janet Wattles Center (our local community mental health center) and Rosecrance (a well known substance abuse treatment facility), collaborated with amazing dedication and sacrifice to provide an integrated, simultaneous substance abuse outpatient program for the TIP participants. This was only one example of the type of innovative collaboration exemplified by key stakeholders in our community.

5. *How much did you and your task force collaborate with other states or examine what works for mentally ill offenders in other states before establishing the TIP?*

The Winnebago County Community Mental Health Task Force did extensive research around the country in 2003, looking at models of mental health courts and diversion programs in a number of states, including Florida, Washington and California in order to assist us in planning our court. We used letters, emails and phone conferences to gather the information. A separate committee was dedicated to this process and to taking the information learned from other jurisdictions and applying it to the workings of our court system. The committee's recommendations were reviewed and accepted by the full task force, before the court became operational in February, 2005. There was also a week's training and education seminar for the team before the court opened, and a continuing education component built into TIP. In addition, at each task force meeting, I arranged for an in-service presentation to acquaint the members with issues and information in the mental health and justice fields that was pertinent to our work.

Currently, the process is made easier for jurisdictions contemplating how to address these problems, by the existence of the national Judges' Leadership Initiative for Mental Health and Criminal Justice Issues. Established in 2004, it promotes networking, information sharing and problem solving in this area. I am pleased and honored to serve as the national co-chair of JLI.

6. *How is the TIP funded? What is the share of private, state and federal resources that are contributed to TIP?*

In Illinois, there is legislation providing that counties may adopt resolutions to assess a $10. fee on criminal defendants who plead guilty or are on supervision. These monies are placed in the county's general fund to help defray the costs of mental health courts and drug courts (55 ILCS 5/5-1101 (d-5). Winnebago County has adopted such a resolution.

Winnebago County also adopted a county wide sales tax that has helped defray some of the expenses of the program. Of course, with the economic downturn, these funds have greatly diminished.

Our local community mental health center, Janet Wattles Center, contributes staff and resources to the program. It is dependent on Medicaid reimbursements.

As to federal funding, TIP submitted a number of applications to the BJA to expand the court's resources by adding essential team members. Finally on the fourth attempt, a two year expansion

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grant was awarded in 2007, enabling the program to serve additional defendants and to better meet their needs. In my view, it is vital that federal funding streams and monies continue to be available and even expanded. Many communities do not have any resources to develop programs or courts such as TIP. Yet, in the end, these programs do provide cost savings and an improvement in public safety and the quality of life for persons with serious mental illnesses.

In conclusion, I am encouraged that the Senate hearing has raised awareness with respect to mental illness and our criminal justice system. I am also hopeful that the record established can help bring additional resources to our states and communities which are in great need. I would respectfully renew my request that Congress address some of the other recommendations that I and the other panel members included in our written statements to the Subcommittee.

I am most willing to continue to assist you, Senator Durbin and your staffs as well as the Subcommittee staff on these issues. Please know that I would welcome the opportunity to dialogue and meet with you at any time. Additional details on the TIP program and its structure and operation can be made available to you if you wish to have them.

Very truly yours,

Kathryn H. Zenoff
Presiding Justice

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The American Civil Liberties Union

Written Statement
For a Joint Hearing on

Human Rights at Home: Mental Illness in U.S. Prisons and Jails

Submitted to the U.S. Senate

Committee on the Judiciary
Subcommittee on Human Rights and the Law

September 15, 2009

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I. Introduction

The American Civil Liberties Union (ACLU) commends the Senate Judiciary Committee Subcommittee on Human Rights and the Law for holding a hearing on mental illness in U.S. prisons and jails. This hearing was the Subcommittee's first hearing examining a U.S. domestic human rights issue.

The ACLU is a nationwide, non-partisan organization of more than 500,000 members dedicated to enforcing the fundamental rights of the Constitution and United States laws. The ACLU's National Prison Project ("NPP") is the only national litigation program on behalf of prisoners. Since 1972, the NPP has represented more than 100,000 men, women and children. Through litigation, community outreach, advocacy, and public education, the ACLU's Women's Rights Project ("WRP") empowers poor women, women of color, and immigrant women who have been victimized by gender bias and face pervasive barriers to equality. WRP advocates on behalf of and its clients have included incarcerated women and girls.

This statement addresses the problem of deplorable treatment of several populations of mentally ill prisoners including women, juveniles, and immigration detainees. This statement also details the successful reforms instituted at Unit 32 at Mississippi State Penitentiary (Parchman) – a model for all state and federal prisons that has produced better outcomes in terms of mental health, prison discipline, and ability to integrate back into society upon release. The ACLU urges Congress to fund Parchman-like models on the federal level and to create incentives for states to adopt Parchman-like models.

II. Rise of Mental Health Inmates in U.S. Prisons and Jails Nationwide

Between the 1970's and 1990's the U.S. prison population multiplied several times over. During that same period, the states emptied their psychiatric hospitals with the promise that patients with serious mental illness would receive better and more humane treatment in community-based treatment facilities and supported housing. Those community resources did not, however, materialize, and many thousands of people suffering from serious mental illness found themselves on the streets – and eventually in jails and prisons. As the prison population swelled around the nation, the proportion of the prison population with serious mental illness ("SMI") increased. Empirical studies across custodial settings have found that mentally disabled detainees and inmates are held for longer periods of time than persons without mental disabilities, despite the fact that providing mental health treatment services in a custodial setting is the most costly and least effective form of mental health care.[1]

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[1] See, e.g., Eve Bender, *Data Confirm MH Crisis Growing in U.S. Prisons*, 41 PSYCHIATRY NEWS 6 (2006), *available at* http://pn.psychiatryonline.org/cgi/content/full/41/20/6 ("[P]rison inmates who had a mental health problem were incarcerated for an average of five months longer than were prisoners without such a problem."); M.J. Stephey, *De-Criminalizing Mental Illness*, TIME MAG. Aug. 8, 2007, *available at* http://www.time.com/time/health/article/0,8599,1651002,00.html ("[S]tudies show that people with mental illness stay in jail eight times longer than other inmates, at seven times the cost."); *Mentally Ill Offender Treatment and Crime Reduction Act of 2003: Hearings on* S. 1194 *Before the S. Judiciary Comm.*, 108th Cong. (2003) (testimony of Dr. Reginald Wilkinson, director, Ohio Department of Rehabilitation and Correction), *available at* http://judiciary.senate.gov/hearings/testimony.cfm?id=882&wit_id=2485 ("Pennsylvania estimates that an average prison inmate 1 It 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"); Ken Jenne and Donald F.

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III. Disproportionate Impact on Incarcerated Women With Mental Illness

Women prisoners suffer especially high rates of mental illness. In many jurisdictions, rates of mental illness among women prisoners range from one quarter to one half of the population, roughly two to three times the rate seen in male prisoners.[2] Estimates of the rate of post-traumatic stress disorder among women prisoners due to sexual or physical abuse suffered prior to incarceration range from 48 percent to 88 percent.[3]

Despite the soaring rates of women's incarceration and women inmate's mental health needs, most prisons lack adequate facilities, services, and programming for women prisoners. Therapeutic counseling is rarely available.[4] As a consequence, women attempting to access mental health services are often denied care, or administered psychotropic medication without being offered psychotherapeutic treatment.[5]

IV. Effect on Juveniles with Mental Illness

About two thirds of child prisoners have at least one mental illness.[6] In its investigations of juvenile correctional institutions, the ACLU has found that this mental illness often stems from severe – often horrific – childhood sexual or physical abuse.[7] Despite high rates of mental illness, including post-traumatic stress disorder, major depression, borderline personality disorder, and bipolar disorder, children in custody are subjected to a range of abuses. For example:

Eslinger, Op-Ed., *Without reforms, problems mount*, S. FLORIDA SUN-SENTINEL, Apr. 21, 2003, *available at* http://www.psychlaws.org/GeneralResources/article122.htm ("It costs Broward County taxpayers $78 per day to house a general population inmate, but it costs $125 per day to house an inmate with a mental illness."); cf., Edward Cohen & Jane Pfeifer, COSTS OF INCARCERATING YOUTH WITH MENTAL ILLNESS – FINAL REPORT, PREPARED FOR THE CHIEF PROBATION OFFICERS OF CALIFORNIA AND THE CALIFORNIA MENTAL HEALTH DIRECTORS ASSOCIATION, at vi (2008) (finding that incarcerating "a youth with mental illness can cost at least $18,800 more than other youth....").

2*Human Rights Watch, Ill-Equipped: U.S. Prisons and Offenders with Mental Illness*, 38 (2003).

> "In New York, for example, 26 percent of incarcerated women are on the active mental health caseload (compared to 11 percent of men).[99] In Pennsylvania, 37.7 percent of female prisoners are on that state's mental health caseload.[100] In the late 1990s, the Colorado Department of Corrections estimated that 27.9 percent of the women in the Colorado Women's Correctional Facility had severe mental health needs.[101] While women made up only 5.7 percent of the state's total number of prisoners, they made up a startling 16.3 percent of the correctional system's most seriously mentally ill prisoners.[102] Georgia estimates that 33 percent of its female prisoners are mentally ill.[103] In Vermont, of the forty-five prisoners at Dale Women's Correctional Center, thirty-six were on the mental health roster as of September 2002.[104] Arkansas's deputy director of Health and Correctional Programs, Max Mobley, estimates twice as high a percentage of female prisoners are seriously mentally ill as are males.[105] In Oregon, 47 to 49 percent of female prisoners are on the mental health caseload.[106]"

3 *Amnesty International, Women in Prison: A Fact Sheet*, http://www.amnestyusa.org/women/womeninprison.html (accessed Sept. 9, 2009).

4 *Ill-Equipped*, 39; *Women in Prison Fact Sheet*.

5 *Women in Prison Fact Sheet*.

6 New York Times, *Mentally Ill Offenders Strain Juvenile System*, Aug. 9, 2009.

7 ACLU, *A Blueprint for Meeting the Needs of Girls in TYC Custody: Report and Recommendations to the Texas Youth Commission*, http://www.aclu.org/womensrights/crimjustice/29875pub20070524.html (accessed Sept. 9, 2009), 4.

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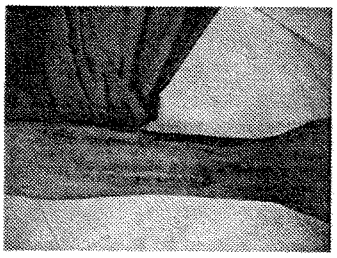
– *Children are subjected to solitary confinement and sensory deprivation for breaking prison rules, even when their mental illness or mental retardation makes it impossible for them to comply with rules.* Almost all juvenile prisons in the U.S. still implement outdated "behavior modification" programs which attempt to mold children's behavior through punishment. The high rate of mental illness among the child prisoner population renders such programs largely ineffective. Moreover, punishing children for behavior they cannot control amounts to abuse.



– *Mentally ill children, especially girls, are subjected to solitary confinement for committing self-harm or confessing their wish to hurt themselves.*[8] Adhering to a punitive culture, and lacking counseling and other mental health resources, many youth prisons punish self-harm and other manifestations of mental illness. The ACLU found the isolation of girls in crisis to be rampant in Texas youth prisons. Girls subjected to such re-traumatization commit further self-mutilation, including self-cutting, banging their head and limbs against cell walls, and self-strangling with pieces of clothing.



8 *ACLU/Human Rights Watch, Custody and Control: Conditions of Confinement in New York's Juvenile Prisons for Girls*, (2006), 100-01; *TYC Blueprint*, 10-11.

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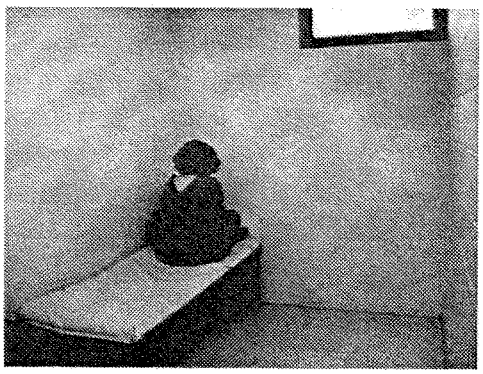
- *Mentally ill children are overmedicated, wrongly medicated, and prescribed drugs to sedate rather than treat them.*[9] Even when youth prisons attempt to address the mental health needs of incarcerated children, they do so by administering powerful psychotropic medications, often in lieu of therapeutic counseling. Medication is often administered when unnecessary, and their effectiveness and side effects are insufficiently monitored. At other times, multiple medications are used without attention to their potential interaction. Children are frequently medicated without the informed consent of the children or their guardians. And in some instances, medication is administered to make the child complaint; thus constituting a "chemical restraint" in violation of domestic and international law.



V. The Particular Plight of Immigrants Facing Detention and Deportation

68 percent of immigration detainees are held in U.S. prisons and jails that contract with ICE,[10] and in 2008 the Division of Immigration Health Services ("DIHS") estimated that 15 percent of immigration detainees are mentally ill and that the percentage of mentally ill detainees is rising.[11] This is likely a low estimate because many detainees decline to report mental health symptoms for fear of being placed in segregation.[12] The relatively high proportion of mentally ill immigration detainees should come as no surprise given that the detained immigrant population

9 *TYC Blueprint*, 6; US Department of Justice, Civil Rights Division, Special Litigation Unit, letter of Aug. 14, 2009 to New York Governor David Patterson, 19-23.

10 Kerwin, Donald and Serena Yi-Ying Lin. "Immigration Detention: Can ICE Meet Its Legal Imperatives and Case Management Responsibilities?" Migration Policy Institute. September 2009, p. 9. http://www.migrationpolicy.org/pubs/detentionreportSept1009.pdf.

11 "Careless Detention, Suicides Point to Gaps in Treatment: Errors in Psychiatric Diagnoses and Drugs Plague Strained Immigration System," Dana Priest and Amy Goldstein, May 13, 2008, available at http://www.washingtonpost.com/wp-srv/nation/specials/immigration/cwc_d3p1.html .

12 Testimony of Homer D. Venters, M.D., Attending Physician, Bellevue/NYU Program for Survivors of Torture, Public Health Fellow, New York University, House Judiciary Committee's Subcommittee on Immigration, Citizenship, Refugees, Border Security, and International Law, Hearing on Problems with Immigration Detainee Medical Care, June 4, 2008, available at http://judiciary.house.gov/hearings/pdf/Venters080604.pdf .

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contains survivors of trauma and torture awaiting credible fear interviews, who, according to a 2003 study by Physicians for Human Rights and the Bellevue/NYU Program for Survivors of Torture, face "extremely high symptom levels of anxiety, depression and post-traumatic stress disorder (PTSD),"[13] as well as long-term permanent residents and other non-citizens who end up in the criminal justice system because of chronic psychiatric illnesses, from where they are transferred to immigration custody.

The Department of Homeland Security Immigration and Customs Enforcement ("ICE")'s current policies and practices lack adequate safeguards for non-citizens suffering from mental disabilities or other mental health conditions. First, initial decisions by ICE to detain mentally ill immigrants vary immensely and are seemingly arbitrary. Insufficient screening of detainees for mental health concerns leads to inappropriate and often prolonged detention and mental deterioration of detainees with psychiatric illnesses and other mental health conditions. Although reliable and cost-effective alternatives to detention exist, they are too rarely utilized for those with mental health concerns. Detention facilities, including prisons and jails, lack the adequate personnel and accommodations to properly care for detainees with mental health concerns. As a result, detainees are often provided with erratic, inappropriate or insufficient medicine, diagnoses, and treatment.

As Dana Priest and Amy Goldstein noted in their 2008 Pulitzer Prize-nominated *Washington Post* piece, "Suicidal detainees can go undetected or unmonitored. Psychological problems are mistaken for physical maladies or a lack of coping skills . . . Some get help only when cellmates force guards and medical staff to pay attention. And some are labeled psychotic when they are not; all they need are interpreters so they can explain themselves."[14] According to numerous reports, the already fragile psychological health of immigrant detainees worsens with continued detention.[15] For example, in some cases, the mental health of several non-citizen detainees has deteriorated to the point of creating a danger, forcing facility custodians to get state court orders for involuntary treatment of 90 days each. The ACLU joins advocates in encouraging a DHS Office of Inspector General audit regarding ICE detainees with mental health concerns.[16] Unlike criminal defendants facing incarceration, immigrants facing detention and deportation are not afforded the right to government-appointed counsel. Mentally ill detainees who are unable to find or afford to retain their own attorneys, are particularly vulnerable. The lack of counsel for mentally incompetent immigration detainees serves to prolong their confinement in situations where they receive inadequate mental health attention. Immigration judges do not have adequate

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13 "From Persecution to Prison: The Health Consequences of Detention for Asylum Seekers," Physicians for Human Rights and The Bellevue/NYU Program for Survivors of Torture, June 2003, see footnote 3, Executive Summary pg. 2.

14 "Careless Detention, Suicides Point to Gaps in Treatment: Errors in Psychiatric Diagnoses and Drugs Plague Strained Immigration System," Dana Priest and Amy Goldstein, May 13, 2008, available at http://www.washingtonpost.com/wp-srv/nation/specials/immigration/cwc_d3p1.html .

15 "From Persecution to Prison: The Health Consequences of Detention for Asylum Seekers," Physicians for Human Rights and The Bellevue/NYU Program for Survivors of Torture, June 2003, at 56, available at http://physiciansforhumanrights.org/library/documents/reports/report-perstoprison-2003.pdf; "Mental health implications of detaining asylum seekers: systematic review," The British Journal of Psychiatry, 2009, Katy Robjant, Rita Hassan and Cornelius Katona, 194: 306–312, (Finding high levels of mental health problems among detained asylum seekers and refugees and a suggested independent adverse effect of detention on mental health).

16 For more information, see Appendix A, *OIG Audit Request Mental Health, June 18, 2009*, available at http://www.aclu.org/images/asset_upload_file666_41134.pdf.

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guidance on how to handle unrepresented immigrants with mental disabilities. This has led to inconsistent decisions, protracted litigation, and prolonged detention. Unrepresented and mentally incompetent immigrants can languish in detention for many months while their cases are on hold because immigration judges may not accept admissions of removability from mentally incompetent individuals who proceed without representation. For these reasons, the ACLU recommends both appointing counsel and guardians *ad litem* for mentally incompetent individuals, as well as rewriting regulations providing for the protection of for immigration detainees with mental disabilities.[17]

In addition to their mistreatment and neglect during confinement, mentally ill immigration detainees also face the risk of illegal deportation. Due to their reduced capacity, U.S. citizens with mental disabilities have been illegally detained and even deported. In at least one case, a mentally disabled U.S. citizen was illegally deported to Mexico. Pedro Guzman, a U.S. citizen born in California, who is cognitively impaired and was living with his mother prior to being deported, ended up dumped in Mexico – a country where he had never lived – forced to eat out of trash cans and bathe in rivers. His mother, also a U.S. citizen, took leave from her Jack in the Box job to travel to Mexico in search of her son. She combed the jails and morgues of northern Mexico in search of her son. After he was located and allowed to reenter the U.S., Mr. Guzman was so traumatized that he could not speak for some time. To vindicate Mr. Guzman's rights and to prevent future DHS errors and abuses, the ACLU and the law firm of Morrison & Foerster filed a damages lawsuit against ICE and Los Angeles County in 2007.[18]

VI. The Results of Supermax Confinement and Mentally Ill Prisoners: Lessons to Be Learned from Mississippi's Far-Reaching Reforms

State prisons all over the country are facing crisis levels of mentally ill inmates. Large populations of mentally ill inmates, along with fiscal challenges and inadequate community resources, have created population management difficulties for prisons. More and more, Departments of Correction are turning to administration segregation as the solution. In supermaximum security ("supermax") prisons, inmates are typically confined to their cells alone or with a cellmate nearly 24 hours a day.

Long-term administrative segregation tends to exacerbate psychiatric dysfunction and misconduct. Research has shown that a very high percentage of prisoners suffering from SMI are consigned to long-term administrative segregation – where extreme isolation and idleness makes their psychiatric conditions and prognoses worse.

In Mississippi, beginning in 2002, prisoners' rights advocates brought litigation aimed at improving the plight of prisoners in the state's supermax, Unit 32 at Mississippi State Penitentiary ("Parchman"). The 1,000 men housed in Unit 32 were all permanently locked down in administrative segregation, in horrific conditions. Psychosis was rampant among the population, and use of force to control the unit was routine.

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17 See Appendix B, *Letter to Attorney General Holder July 24, 2009*, for more information, available at http://www.aclu.org/images/asset_upload_file893_41135.pdf.

18 Esquivel, Paloma. "Suit Filed Over Disabled U.S. Citizen's Deportation Ordeal." Los Angles Times. February 28, 2008.

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In contrast to some states where litigation over such conditions has led to endless court battles and little change, in Mississippi the adversarial relationship shifted after a few years of intensive litigation to a mostly collaborative and extremely productive relationship, ushering in far-reaching reforms in classification and mental health programming. These changes have resulted in significant, documented decreases in rates of violence, disciplinary infractions and use of force.

Mississippi's experience contradicts some widespread assumptions about administrative segregation. The popularity of the supermax unit is premised on the assumption that violence and misconduct in the prisons cannot be controlled without keeping a growing number of very dangerous prisoners in long-term administrative segregation. According to this assumption, releasing the majority of these prisoners from administrative segregation to general population would result in increased rates of violence, serious disciplinary incidents, and use of force. In Mississippi, however, these rates declined dramatically following the transfer of a majority of prisoners out of administrative segregation at Unit 32.

In 2002 the ACLU National Prison Project, the Mississippi ACLU and the law firm of Holland & Knight filed suit on behalf of the Death Row prisoners. In 2003 the U.S. District Court for the Northern District of Mississippi, the Hon. Jerry Davis, entered an injunction granting the relief plaintiffs had requested.[19] The U.S. Court of Appeals for the Fifth Circuit largely upheld the injunction.[20]

In 2005 the prisoners filed a new lawsuit to extend the remedies ordered in the Death Row case to all of Unit 32.[21] The new case also challenged the classification system, which permanently consigned the thousand-man population in Unit 32 to administrative segregation. A negotiated consent decree in Presley v. Epps incorporated all of the relief upheld by the Fifth Circuit in the Death Row case, excluded prisoners suffering from SMI from administrative segregation, and provided that prisoners could earn their way out of administrative segregation through good behavior.

To implement the consent decree, Plaintiffs retained a classification expert, Dr. James Austin, to carry out an objective analysis of the Unit 32 population. His analysis showed that 80 percent of the 1,000 men did not belong in administrative segregation and should be transferred to general population. In 2006 the parties met and agreed to collaborate to reform the classification system within a 12-month period. MDOC Commissioner Christopher Epps promptly established a Classification Task Force that included Dr. Austin and key DOC officials.

Addressing the mental health issues was essential to fully addressing the classification issues. Prisoners with untreated mental illness became more disturbed in administrative segregation; their illness led them to misbehave; security staff sprayed them with chemicals, and their mental health deteriorated further. This cycle put severe pressure on everyone who lived or worked in Unit 32.

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19 *Russell v. Johnson*, 2003 WL 22208029 (5/21/03)
20 *Gates v. Cook*, 385 F.3d 503 (5th Cir. 2004)
21 *Presley v. Epps*, (N.D. Miss. Nov. 18, 2007) (No. 4:05 Civ. 148)

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In 2007 Judge Davis held an evidentiary hearing on the mental health issues. At the end of six hours of testimony the Judge called the lawyers into chambers and advised them in the most urgent terms to come up with a joint plan to remedy the situation. He said that he feared Unit 32 was a tinder box about to explode. Unfortunately a few weeks later Unit 32 did explode. Beginning at the end of May 2007 and continuing into August, there was an outburst of gang warfare in which many inmates were stabbed and some died. Even in the face of this deep crisis in security, Commissioner Epps made the remarkably bold decision to go forward with implementing the recommendations of the Classification Task Force. Deputy Commissioner Sparkman left his home in Jackson to live at Parchman for months, overseeing the release of several hundred carefully selected men into general population, walking among them, speaking and interacting with them, getting to know their histories, and showing his staff at the prison that these men were not so dangerous that they needed to be in administrative segregation.

These remarkable acts of courage worked. Within a very few months, a striking transformation of Unit 32 had taken place. Nearly 80 percent of the unit's population had been reclassified from administrative segregation to general population. Program and recreation areas were constructed, and prisoners were allowed for the first time to play basketball and recreate together. General population housing areas were created, and prisoners were allowed to spend several hours per day out of their cells. A classroom was constructed, and for the first time classes were offered. A dining hall was constructed, and prisoners were allowed to eat meals together. In November 2007 the parties entered into a far-reaching supplemental consent decree on classification, mental health and use of force (Presley v. Epps).

As required by the consent decree, mental health staff now works in close collaboration with custody staff to develop an intermediate level treatment program, or step-down unit, for prisoners with serious mental illness. Prisoners who require inpatient psychiatric services are transferred to an inpatient psychiatric unit at another facility. Prisoners who require an intermediate level of mental health treatment, equivalent to halfway house or day treatment in the community, are candidates for the step-down unit, which provides for many prisoners the portal for leaving administrative segregation.

A comprehensive mental health training curriculum was expressly designed for correctional officers. Any officer working on the Step-Down Unit must undergo training on mental health issues. Completion of the mental health training is considered an honor, and is celebrated in a ceremony where officer graduates are given a special uniform patch and awarded the title of Correctional Mental Health Manager.

Prisoners remain in the step-down unit an average of three to six months. They are considered ready for discharge from the program when their treatment plan has been accomplished and their condition has stabilized. After being discharged, a prisoner may be readmitted if he experiences another relapse. If he is discharged for lack of compliance or behavioral issues, he may be considered for readmission following intensive individual treatment with mental health staff.

After a large proportion of prisoners were transferred to general population within Unit 32, the number of incidents requiring use of force plummeted. Monthly statistics showed a drop of

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almost 70 percent in serious incidents, both prisoner-on-staff and prisoner-on-prisoner incidents. Prisoners with SMI had been heavily over-represented in the earlier serious disciplinary incidents, and participation in the step-down unit has helped to keep this group out of trouble.

The program has proven to be an effective point of entry into mental health treatment for previously non-compliant prisoners with SMI. Prisoners in the program report they expect to be treated with respect and not to be inappropriately punished or otherwise abused. Recently the Step-Down program successfully graduated most of the Security Threat Group ("STG") leadership who were participants. One former STG leader has been granted Open C custody (essentially general population privileges). Two other STG leaders graduated with honors.

As the classification system was revised to permit prisoners in administrative segregation to earn their way to general population, and as MDOC administration focused greater attention on the professionalism of custody staff, the prisoners felt that they were being treated more fairly and could hope to gain their freedom. This helped them control their tempers and their behavior. These changes, plus the reduction in crowding as the population of Unit 32 declined, all promoted a greater calm and sense of fairness within the facility. The overall result is far fewer prisoners in need of administrative segregation.

The fact that there was a sharp decrease in the number of disciplinary offenses accumulated by prisoners with SMI after they were transferred to the step-down unit strongly supports a conclusion that prisoners with SMI tend to suffer psychiatric deterioration and get into disciplinary trouble in supermax administrative segregation, and that they fare much better in treatment programs. The changed management of prisoners with serious mental illness has also played a part in reducing the number of serious incidents and use of force at Unit 32.

The developments described here also illustrate something about the effect of litigation on corrections. In Mississippi, the Department of Corrections eventually welcomed the changes urged by Plaintiffs in a series of class action lawsuits, and this cleared the way for the changes to be put into effect in an atmosphere of collaboration, including collaboration between custody and mental health staff. In this kind of process, it becomes possible to devise management and treatment strategies for prisoners who might otherwise be considered incorrigible.

In fact, the assumption that a large number of prisoners are beyond help and will never change their unacceptable behaviors, and the practice of locking them away in segregation and punishing them harshly, predictably leads to worse behavior problems. In contrast, when custody and mental health work together to devise creative approaches to the management and treatment of some of the most difficult cases, and give prisoners clear and incremental requirements to win greater freedom, the prisoners' behavior usually improves significantly. Of course, problems and tough issues remain, and monitoring continues, but the problems encountered are less serious, and a collaborative approach to their resolution is becoming the norm.[22]

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22 The history of these far-reaching reforms and of the changing dynamic between Mississippi Department of Corrections officials and the prisoners' litigation team is recounted in a journal article jointly authored by those officials and Plaintiffs' team: *"Beyond Supermax Administrative Segregation: Mississippi's Experience Rethinking Classification and Creating Alternative Mental Health Programs* (Criminal Justice and Behavior, August 2009) (see Appendix C, available at http://www.aclu.org/images/asset_upload_file359_41136.pdf). An account of the

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VII. Conclusion

While many prisons, jails, juvenile detention facilities persist in the deplorable practice of isolating, punishing, and neglecting to appropriately treat incarcerated and detained individuals with mental illness, the experience of Mississippi State Penitentiary (Parchman)'s Unit 32 indicates that there are significantly more effective and humane ways to handle the mentally ill population. The ACLU urges Congress to fund Parchman-like models on the federal level and to create incentives for states to adopt Parchman-like models.

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experience by Plaintiffs' counsel also appeared in the Fall 2008 issue of *Litigation*, the quarterly journal of the American Bar Association, *"Parchman Farm Blues: Pushing for Reforms at Mississippi State Penitentiary"* (Fall 2008) (see Appendix D, available at http://www.aclu.org/images/asset_upload_file829_41138.pdf).

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AMERICAN
PSYCHOLOGICAL
ASSOCIATION

Written Statement of

The American Psychological Association

Before the

U.S. Senate Committee on the Judiciary

Subcommittee on Human Rights and the Law

On

Human Rights at Home: Mental Illness in

U.S. Prisons and Jails

September 15, 2009

On behalf of the 150,000 members and affiliates of the American Psychological Association (APA), we thank you for holding this important hearing on the issues of mental health and prisons.

APA is the largest scientific and professional organization representing psychology in the United States and is the world's largest association of psychologists. Comprising researchers, educators, clinicians, consultants, and students, APA works to advance psychology as a science, a profession, and as a means of promoting health, education, and human welfare. Psychologists play a vital role in providing mental health and substance abuse screening, assessment, and treatment services to the juvenile and criminal justice populations, as well as in researching the many complex issues involved in the causes of violence and crime and how best to address related social and individual needs.

APA has a longstanding commitment to issues impacting criminal and juvenile justice. Some of the Association's many related statements and initiatives include: a resolution on the families of incarcerated offenders; resolutions supporting the ratification of the U.N. Convention on the Rights of the Child, which includes a mandate for participating nations to abolish the practice of sentencing individuals to life without parole for crimes committed before the age of 18; the submission of amicus curiae in the U.S. Supreme Court cases of Roper v. Simmons and Graham/Sullivan v. Florida, which address developmental science and juvenile sentencing practices; and a range of advocacy activities surrounding legislative and regulatory proposals in the area of juvenile justice.

Background Issues

Individuals in the criminal and juvenile justice systems experience diagnosable mental health and substance abuse needs at rates far greater than those seen in the general population. Sixty-six percent of males and 74 percent of females detained in the juvenile justice system meet the criteria for at least one mental or behavioral health diagnosis, and 46 percent of males and 57 percent of females detained in the juvenile justice system meet the criteria for two or more such diagnoses. Youth experiencing serious emotional disturbance make-up approximately 15-20 percent of the population in juvenile justice facilities, a rate up to 10 times higher than their representation in the community.

In addition, recent federal reports demonstrate that juvenile justice systems regularly act as providers of mental health services and weigh-stations where youth await treatment, functions not intended for juvenile justice. In 2003, the Government Accountability Office reported on the tragedy of parents being forced to relinquish legal and physical custody of their children to child welfare and juvenile justice agencies for the sole purpose of securing otherwise unavailable mental health services for their children. Data for 2001 from 19 States and 30 counties showed that nearly 9,000 children and adolescents were sent to the juvenile justice system for this reason.

Furthermore, in 2004, the U.S. House Committee on Government Reform revealed that young people are being held in secure detention facilities, some with no charges pending against them, while they await community mental health services. More than 15,000

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children and youth over a six-month period in 2003 were held in this manner, some of them as young as seven years old.

For justice-involved youth, a mental health or substance abuse need represents an additional vulnerability; the potential exists for those held in secure detention settings to experience abuse, trauma, and the worsening of existing mental health conditions. These issues reveal an urgent need for reform. Federal actions to address these problems, however, also need to occur within a broader context of juvenile justice reform that focuses on the unique characteristics and needs of juvenile delinquents, as compared to adult criminals.

In amicus curiae submitted in the 2003 U.S. Supreme Court case of *Roper v. Simmons* and the upcoming U.S. Supreme Court case of *Graham/Sullivan v. Florida*, APA made clear statements, based on the best developmental and neuroscientific evidence, about the appropriateness of the death penalty and life without parole sentences, respectively, for crimes committed by minors.

In these briefs, APA stated that three aspects of development illustrate critical differences between young people and adults and that these differences contribute to the increased level of risk-taking, including delinquency and criminal activity, in adolescence. Adolescents: show immaturity in their ability to make sound decisions; are more vulnerable than adults to outside influences, including peer pressure and their legal inability to move away from or alter their family, school, and neighborhood situations; and change in ways not seen in adults, when they commit crimes. With regard to adolescents' changeability, individuals in this period of development tend to engage in risky, antisocial, and criminal behavior as a corollary of the formation of identity, and most of this behavior subsides as adulthood emerges.

The structure of, and changes occurring within, the adolescent brain support the picture that emerges from the developmental literature of significant differences between adolescents and adults. Indeed, brain structures and connections associated with planning, decision-making, assessing risks, evaluating potential consequences, and emotional processing, continue to develop throughout adolescence and even into young adulthood.

In *Roper v. Simmons*, the majority opinion cited developmental and neuroscientific data, and the Court ruled the death penalty, when applied to crimes committed by individuals under the age of 18, unconstitutional on Eighth Amendment grounds.

What developmental psychology and neuroscience say about adolescence also carries serious implications for the way that society addresses the majority of juvenile delinquency, which rarely involves acts for which a death or life sentence would be considered a reasonable response. The science regarding adolescence urges the adoption of responses to juvenile crime that are: applied, to the maximum extent possible, within the community; developmentally appropriate, while still holding young offenders accountable for their actions; and aligned with what research shows to be effective.

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Unless a young person represents a risk to the safety of the community, it provides maximum benefits to the individual and to society to keep them out of secure facilities. Conditions within these settings pose health and safety hazards, and incarceration is expensive and increases the likelihood of recidivism and subsequent incarceration. Alternately, applying sanctions and providing rehabilitation in the community helps to realize healthy developmental outcomes, including the decrease in criminal behavior that corresponds with the emergence of adulthood.

Recommendations

Juvenile Justice and Delinquency Prevention Act (JJDPA) Reauthorization

With regard to mental health and substance abuse issues, this critical reauthorization must address two seemingly conflicting goals: helping to remove incentives to drive youth deeper into juvenile justice systems to access mental health and substance abuse care, while still fostering and ensuring an appropriate range of critical services. APA strongly urges the Committee to consider the following recommendations during the reauthorization of JJDPA:

- Direct States to end the practice of holding minors in secure facilities when they do not have any charges pending against them, as they await mental health services, and ensure appropriate supports for these efforts;
- Require that States plan for the development of strong cross-system collaborations, to allow for the diversion, as public safety considerations allow, of youth with mental health and substance abuse needs from juvenile justice to the care of other child-serving agencies;
- Require that States plan for appropriate, research-based treatment within secure detention and corrections facilities, for those youth with mental health and substance abuse needs who must be held in such facilities;
- Require that States plan for the use of evidence-based mental health and substance abuse screening, assessment, referral, and treatment services;
- Establish high-impact training and technical assistance at the Office of Juvenile Justice and Delinquency Prevention, aimed at helping State and local juvenile justice agencies navigate the complexities of providing evidence-based screening, assessment, referral, and treatment services;
- Start to establish the necessary safeguards to ensure that psychotropic medications given to justice-involved youth are provided only as part of a treatment plan, based on a mental health assessment performed by a qualified, licensed mental health professional;
- Establish new research efforts to investigate the use of mental health and substance abuse screening data to inform juvenile justice practice and change the culture of juvenile justice facilities; and
- Establish new research on the impact of a parent's incarceration on their children and family and the development of evidence-based practices to help mitigate the associated negative consequences of such situations.

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The reauthorization of the *Juvenile Justice and Delinquency Prevention Act* also must account for the developmental perspective and foster alternatives to incarceration and supports for individuals returning to the community from secure facilities. Such a perspective does not seek to excuse criminal behavior. However, it recognizes that supporting the healthy development of young people in the juvenile justice system greatly increases the chances that these individuals will find stable jobs, pay taxes, and contribute to the community in additional, meaningful ways. Recommendations in this area include:

- Strengthening the law's core requirements, which provide critical protections to children and youth and help to keep individuals out of secure facilities, in a manner that protects public safety;
- Supporting State and local efforts to provide community- and home-based alternatives to detention; and
- Ensuring that JJDPA funds support evidence-based programs and practices, whenever possible, and provide for strong evaluation of non-evidence based programs and practices.

Other key legislative priorities

- Enact H.R. 1064 and S. 435, the *Youth Prison Reduction through Opportunities, Mentoring, Intervention, Support, and Education (Youth PROMISE) Act*, which would provide important resources to communities with crime reduction needs, to address gaps in the availability of evidence-based and promising practices for youth at-risk for criminal and gang activity;
- Enact S. 714, the *National Criminal Commission Act of 2009*, which would establish a commission to study the entirety of the American criminal justice system and make recommendations for system-wide overhaul; and
- Re-introduce and enact the *Keeping Families Together Act*, which would expand systems of care to address the mental health needs of children and youth and reduce the unnecessary entry of young people into the juvenile justice system.

Conclusion

The American Psychological Association would like to thank you for the opportunity to share our perspective on the intersection of juvenile justice and mental health and substance abuse, adolescent development, and the need for changes to the federal investment in juvenile justice and delinquency prevention. Current challenges also provide opportunities to affect better outcomes for society and for justice-involved and at-risk youth. We appreciate the Committee's ongoing commitment and leadership to addressing vital juvenile and criminal justice issues and look forward to continuing to work with you on these critically important efforts.

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Statement of Amnesty International to the United States Senate Judiciary Committee, Subcommittee on Human Rights and the Law regarding the hearing entitled "Human Rights at Home: Mental Illness in U.S. Prisons and Jails"

Hearing Date: September 15, 2009
Statement Submitted: September 21, 2009

Amnesty International welcomes the hearing conducted by your Committee on mental illness in U.S. prisons and jails.

We are aware that there are many thousands of people with severe mental illness incarcerated in the USA and recognize the challenges this can present.[1] In meeting such challenges, the U.S. authorities have an obligation under international as well as U.S. standards to ensure that all those in custody are held in a safe, secure and humane environment and receive adequate treatment for any illness or disability.

While the issue before the committee is a broad one, Amnesty International has raised particular concern about the impact of long-term isolation in U.S. "super-maximum security" facilities on prisoners' mental and physical health.

Most recently, Amnesty International expressed concern about conditions prevailing in Tamms CMAX facility, in Illinois, in which scores of prisoners have been confined for ten or more years in enclosed cells, with little exercise or human contact and no work, religious or educational programs.[2] Prisoners at Tamms reportedly exercise alone for a maximum of 5-7 hours a week in a bare, high-walled, partially-covered yard with no view apart from a small section of sky. The cell doors are made of heavy gauge perforated steel and are difficult to see through, compounding the sense of isolation. The narrow, horizontal windows in each cell are positioned too high to see out of unless the prisoner stands on his bunk. Contact with the outside world is severely restricted, with

[1] According to a survey by the Bureau of Justice Statistics, at mid-year 2005 more than half of all prison and jail inmates had a mental health problem, including 705,600 inmates in State prisons, 78,800 in Federal prisons, and 479,900 in local jails; a significant proportion suffered from major depressive or psychotic symptoms (Bureau of Justice Statistics Special Report, Mental Health Problems of Prison and Jail Inmates, September 2006 http://www.ojp.usdoj.gov/bjs/pub/pdf/mhppji)

[2] http://www.amnesty.org/en/library/info/AMR51/042/2009/en
http://www.amnesty.org/en/library/info/AMR51/096/2009/en
http://www.amnesty.org/en/library/info/AMR51/097/2009/en

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prisoners denied phone calls to their families and allowed only non-contact visits conducted through a thick glass screen and an intercom system.

Amnesty International is concerned by reports that a significant number of prisoners housed at Tamms suffer from mental illness or psychological problems which are exacerbated by the harsh conditions of isolation. Prisoners have been described as engaging in disturbed behavior such as self-mutilation, smearing feces on cell surfaces, throwing bodily liquids or howling, yet few have been transferred to the prison's special treatment center. It is alleged that seriously mentally ill prisoners or those with histories of mental illness have been sent to Tamms, despite regulations which allow for the exclusion of such individuals from the facility.

There is evidence in the USA and elsewhere that prolonged isolation can cause serious psychological and physical harm, particularly if accompanied by other deprivations such as lack of external stimuli, confinement to an enclosed space and inadequate exercise. Such conditions can have a severe impact on individuals with no pre-existing health problems, and may cause particular harm and suffering in the case of those who are already mentally ill.[3]

The conditions described above are not limited to Tamms but apply in similar form in many other U.S. super-maximum security facilities. Amnesty International believes that such conditions, when imposed long-term and cumulatively, are incompatible with the USA's obligations to treat all prisoners humanely. Failure to treat prisoners who are mentally ill also contravenes international standards specifying that everyone has the right to the highest attainable standard of mental health.

The USA has ratified the International Covenant on Civil and Political Rights, Article 10 of which requires that "all persons deprived of their liberty shall be treated with humanity and respect for the inherent dignity of the human person". The Human Rights Committee (the treaty monitoring body) has further emphasized that the absolute prohibition of torture or cruel, inhuman or degrading treatment under international law "relates not only to acts that cause physical pain but also to acts that cause mental suffering" and has stated that prolonged solitary confinement may amount to torture or other ill-treatment.[4] Both the Human Rights Committee and the United Nations (UN) Committee against Torture

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3 Findings of studies have been described in a number of articles, including Stuart Grassian, "Psychological Effects of Solitary Confinement", American Journal of Psychiatry, 140:1450-1454, 1983; Terry A. Kupers, "The SHU Syndrome and Community Mental Health", Community Psychiatrist, summer 1998; Craig Haney, "Mental Health Issues in Long-Term Solitary" and "Supermax Confinement", Crime and Delinquency, vol. 49, No. 1 (January 2003) and in court rulings and testimony. A study by three independent psychiatrists on prisoners held in isolation units in the UK found inmates suffered from physical disorders resulting from their highly restricted surroundings which included impaired eyesight, weight loss, muscle wastage and memory loss and that some inmates had developed "mental illnesses which go beyond the ordinary and expected anticipatory anxiety". The study's findings are described in an Amnesty International Report, UK Special Security Units – Cruel, Inhuman and Degrading Treatment, 1997 (AI Index EUR 45/06/97).

4 Human Rights Committee General Comment 20: Article 7 (Prohibition of torture or cruel, inhuman or degrading treatment or punishment), adopted during the forty-fourth session (1992), paragraph 6.

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have criticized the excessively harsh conditions of isolation in some U.S. super-maximum security facilities.[5]

Several U.S. states now ban prisoners with mental illness from being placed in long-term isolation, in recognition of the particular harm that such conditions may cause to such individuals.[6] Amnesty International also is concerned that mentally ill inmates may not be able to meet the criteria for progressing out of isolation units and that their deteriorating health without treatment may consign them to such units indefinitely.

Amnesty International believes that such a ban should be extended nationwide and urges the Committee to include this in its recommendations.

Amnesty International also believes that housing prisoners in highly restrictive settings such as Tamms and other super-maximum security or segregation facilities should be appropriately regulated. Such measures should include fair and transparent procedures for transfers to and from such facilities, with due process hearings and effective oversight. There should be regular mental health reviews of all prisoners held in isolation and prisoners who are seriously mentally ill should be treated in appropriate mental health facilities, as provided under international standards.[7]

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5 http://www.unhchr.ch/tbs/doc.nsf/0/34d0a773a44de02bc125725a0034cbdf?Opendocument
http://www.unhchr.ch/tbs/doc.nsf/0/e2d4f5b2dccc0a4cc12571ee00290ce0/$FILE/G0643225.DOC

6 Restrictions on placement of mentally ill persons in U.S. supermax units have been as a result of lawsuits in which findings of studies on the impact of such confinement have been presented. States with bans on placement of mentally ill in long-term isolation include Wisconsin and Indiana.

7 The Standard Minimum Rules for the Treatment of Prisoners, adopted in 1955 by the United Nations (UN) Congress on the Prevention of Crime and the Treatment of Offenders, Rule 22 (1): medical services should be available in prisons and organized in close relationship to the general health administration of the community and should include psychiatric services for diagnosis and treatment of states of mental abnormality; Rule 82(1) Persons who are found to be insane shall not be detained in prisons and arrangements shall be made to transfer them to mental institutions; Rule 82 (2) Prisoners who suffer from other mental diseases or abnormalities shall be observed and treated in specialized institutions under medical management.

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Department of Justice

STATEMENT OF

SAMUEL BAGENSTOS
DEPUTY ASSISTANT ATTORNEY GENERAL
CIVIL RIGHTS DIVISION

BEFORE

SUBCOMMITTEE ON HUMAN RIGHTS AND THE LAW
COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE

AT A HEARING ENTITLED

"HUMAN RIGHTS AT HOME: MENTAL ILLNESS IN U.S. PRISONS AND JAILS"

PRESENTED

SEPTEMBER 15, 2009

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Hearing before
the Subcommittee on Human Rights and the Law
Committee on the Judiciary
United States Senate

Entitled
"Human Rights at Home: Mental Illness in U.S. Prisons and Jails"

September 15, 2009

Statement of
Samuel Bagenstos
Deputy Assistant Attorney General
Civil Rights Division

Chairman Durbin, Ranking Member Coburn, and Members of the Subcommittee, it is an honor to appear before you today to discuss the Civil Rights Division's enforcement of the Civil Rights of Institutionalized Persons Act (CRIPA) to protect the rights of incarcerated persons with mental illness.

Congress adopted the Civil Rights of Institutionalized Persons Act in 1980. The statute was a response to an unfortunately widespread record of state and local violations of the rights of incarcerated and institutionalized persons. The Senate Judiciary Committee report recommending passage of CRIPA pointed to a number of cases in which the Civil Rights Division of the Department of Justice had been forced to litigate to ensure that jails and prisons would accord the most basic of constitutional rights to inmates. *See* S. Rep. No. 96-416 (1979), as reprinted in 1980 U.S.C.C.A.N. 787.

CRIPA gives the Division authority to investigate and bring complaints against state and locally operated residential facilities, including jails and prisons, juvenile correctional facilities, nursing homes, mental health facilities and facilities for individuals with developmental disabilities. As especially relevant here, the statute authorizes us to seek judicial remedies for any pattern or practice of conduct that violates the constitutional rights of persons with mental illness who are incarcerated in prisons and jails. In order to carry out this authority, the Division's Special Litigation Section reviews individuals' complaints, conducts investigations, monitors and enforces court orders, litigates complex institutional reform cases, and writes amicus briefs on issues of national importance. The Section works closely with nationally recognized experts to evaluate institutional conditions by touring facilities, observing relevant practices and procedures, evaluating records, and interviewing residents, staff, and other individuals knowledgeable about the conditions at the institutions.

In the nearly three decades since the enactment of CRIPA, the Division has investigated more than 430 facilities across the country in an effort to protect the federal rights of the individuals in these institutions, and has been able to improve conditions for tens of thousands of individuals housed in state and local facilities. The Division currently has 24 ongoing CRIPA

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investigations involving jails and prisons, and is enforcing compliance with consent decrees and other agreements covering 21 correctional facilities nationwide.

Jail and prison inmates with mental illness retain a number of important constitutional rights under prevailing case law. Accused defendants who are held in jail prior to standing trial retain a Fourteenth Amendment right to be free from conditions that amount to punishment. See, *e.g.*, *Bell v. Wolfish*, 441 U.S. 520, 535 (1979). They also retain a Fourteenth Amendment right to be free from exposure to conditions or practices that are not reasonably related to the legitimate objectives of safety, order and security. See *id.* at 538-540. Convicted inmates retain the Eighth Amendment's right to be free from cruel and unusual punishment. The Supreme Court has consistently held that these constitutional guarantees impose an affirmative duty on jail and prison officials to provide humane conditions of confinement, including access to adequate medical and mental health care. See, *e.g.*, *Farmer v. Brennan*, 511 U.S. 825, 832-833 (1994). And they impose a duty to protect jail and prison inmates from self-inflicted injury where jail and prison officials know or have reason to know of potential suicide risks.

Inadequate mental health care in the nation's jails and prisons poses a critical problem for inmate safety, and can stand in the way of real rehabilitation for those incarcerated without access to treatment. In our CRIPA enforcement, we have uncovered systemic deficiencies in mental health care in jails and prisons across the Nation. We have aggressively pursued reforms to ensure that inmates are afforded their constitutional rights.

Deficiencies in Mental Health Care and Treatment

Where our investigations of jails and prisons reveal constitutional deficiencies, we commonly find that the deficiencies involve inadequate mental health care for inmates with mental illness. These deficiencies range from inadequate training for corrections staff to a lack of procedures to detect suicide risk. In some matters, our investigation, findings, and resolution have focused entirely on the inadequacy of mental health treatment.

We have discovered deficiencies in mental health treatment at every phase of incarceration, from initial intake and screening to services provided throughout an inmate's incarceration.

Suicide Prevention

Perhaps the most urgent issue jails and prisons encountered is the lack of adequate procedures for the detection of suicide risk, and the concomitant lack of measures for suicide prevention. Often, we find that jails and prisons process and house inmates without regard to suicidal history or mental health history. In one instance, we discovered that a jail had failed to take the proper precautions and observe an inmate with a known history of suicidal thoughts, despite a specific alert from his family. The inmate committed suicide within hours of his arrest.

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Other deficiencies have included the failure to remove features in cells that have proven conducive to suicide. These features include objects that protrude from cell walls or ceilings and are thus easy for inmates to hang themselves from.

Division investigators have also encountered situations where supervision of suicidal inmates was insufficient. In one facility, corrections officials discovered that an inmate who had attempted to commit suicide by cutting himself had kept 30 disposable razors in his cell. Yet four months later, another inmate was able to commit suicide by cutting himself with a razor. In other facilities, correctional officers lacked adequate safety equipment, such as cut-down tools, to quickly respond to suicide attempts.

Isolation, Restraint and Excessive Force

Our investigations frequently find that jail and prison staff use harmful methods of isolation, seclusion or restraint as a substitute for mental health treatment, often in response to behaviors that inmates cannot control.

In one facility we investigated, detainees were regularly placed on "suicide watch," which involved isolation for 23 hours a day, sometimes for days or weeks at a time. Detainees did not receive adequate assessment or treatment. They sometimes waited days for an initial evaluation. Several times, detainees placed in isolation injured themselves due to psychosis-related behavior. One inmate used a blanket as a buffer when slamming his body into the door of his cell. Staff responded by taking away the blanket.

We also find that inmates with mental illness are often vulnerable to attack by other inmates, yet jail and prison officials fail to provide adequate protection. In one jail, we found that inmates killed two fellow inmates who had mental illness. One victim had exhibited behavior symptomatic of early dementia, which made him the target of violent assaults. In the other incident, the assailant himself had mental illness, and had experienced psychiatric problems just days before the incident, but the jail failed to protect his fellow inmate.

Other deficiencies

Many of the deficiencies our investigations uncover stem from two basic problems: the failure to commit sufficient resources to provide adequate care; and the failure to provide adequate training to jail and prison staff.

One facility we investigated housed 217 detainees receiving psychotropic medications and 110 detainees in units reserved for inmates with the most serious mental illnesses. But the facility had only two part-time psychiatrists on staff, and it often resorted to lock-down because of staff shortages.

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In some instances, staff members who are not trained to deal with inmates with mental illness respond with excessive and inappropriate use of force. An investigation at one facility revealed that a group of corrections officers physically punished an inmate with mental illness who exposed himself to a female office. They took the inmate to a secluded room, handcuffed him, and beat him—causing severe head trauma.

Investigations frequently reveal that facilities lack a program for consistent evaluation of inmates to identify those who need mental health care, or that they consistently fail to provide adequate and timely treatment or therapy.

Remedies Sought

When our investigations of prisons and jails reveal constitutional violations in the treatment of inmates with mental illness, the Civil Rights Division works closely with expert consultants to devise specific measures to address the deficiencies. CRIPA requires that the Division notify the jurisdiction of its findings in a detailed findings letter at least 49 days before any lawsuit can be filed. Such findings must set forth for the jail or prison the conditions at the facility that violate constitutional rights, the supporting facts giving rise to the findings of constitutional violations, and the minimum remedial measures that will resolve the violations. The Attorney General must personally sign any CRIPA complaint, and he must certify that reasonable efforts at informal, voluntary correction of the constitutional violations have not succeeded.

The Special Litigation Section has been successful in resolving the vast majority of the violations we discover through voluntary agreements, without contested litigation. The types of reforms for mental health care deficiencies that we seek include:

- Policies and procedures regarding adequate suicide screening and detection, paying close attention to factors which may warrant close observation, such as suicidal thoughts, severity of criminal charges, and so forth;
- Appropriate housing in suicide resistant housing units;
- Adequate suicide prevention observation, including staggered rounds;
- Training for all correctional staff in detection of mental health needs and referral for treatment;
- Adequate staffing of mental health professionals including psychiatrists and psychologists;
- Policies and procedures to ensure adequate mental health treatment, including counseling and other treatment plans;
- Policies and procedures to ensure that isolation and restraints are not used as a substitute for appropriate mental health treatment;
- Policies and procedures to prohibit the use of chemical restraints for punitive measures or convenience of staff; and

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- Policies and procedures to ensure that inmates with mental illness are not victimized by other inmates and are not punished for behavior beyond their control.

For example working cooperatively with the State of Wisconsin, we entered into a memorandum of agreement in September 2008 with the state to address deficiencies with respect to inmates with mental illness in Taycheedah Correctional Institution, Wisconsin's only women's prison. The memorandum lays out the specific remedies that the state will take to ensure adequate mental health screening and treatment. The detailed action plan includes requiring at least eight hours of mental health training for new security officers hired, and three hours of continuing training each year. The agreement also required the facility to hire new psychiatric staff, to adopt adequate mental health screening procedures and to implement counseling and treatment programs for inmates with mental illness. Those programs include access to psychiatry appointments and group therapy as determined necessary.

The State of Wisconsin has been a cooperative partner with us in implementing our agreement concerning mental health treatment at Taycheedah, and that agreement has already led to tangible improvements. For example, in the year since we entered the agreement, there have been no suicides in the prison. That agreement, as with all of our agreements under CRIPA, is closely monitored to ensure compliance. Access to sufficient mental health care is a critical need in jails and prisons across the nation, and the Civil Rights Division is committed to ensuring inmates with mental illness receive adequate treatment, in safe conditions.

Thank you again for the opportunity to testify before you today.

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SENATE JUDICIARY COMMITTEE
SUBCOMMITTEE ON HUMAN RIGHTS AND THE LAW

Hearing:

"Human Rights at Home: Mental Illness in U.S. Prisons and Jails"

September 15, 2009
10:00 AM

Written Testimony of Richard Burr, Houston, Texas

Richard Burr's Testimony

Richard Burr is an attorney in private practice in Houston, Texas. Since 1979, he has devoted his practice to the defense of people facing capital charges in the state and federal courts. Since 1997, he has, as part of his practice, been a member of the Federal Death Penalty Resource Counsel project, through which experienced capital defense attorneys are funded (by contract with the Administrative Office of the United States Courts) to consult with defense counsel whose clients face federal capital charges.

In the course of his twelve years as a Federal Death Penalty Resource Counsel, Mr. Burr has communicated with a number of the men currently housed on federal death row (the Special Confinement Unit) at the Federal Correctional Complex at Terre Haute, Indiana. Mr. Burr and his Resource Counsel colleagues have learned of and caused to be investigated recurring problems suffered by the men on federal death row.

His testimony consists of a summary of his and colleagues' investigation into the lack of mental health care and services for the men confined on federal death row.

Mental Health Needs of the Men Confined in the Special Confinement Unit (SCU) (Death Row) at the Federal Correctional Complex Terre Haute (FCCTH)

Prisoners uniformly report that they lack meaningful access to even the most basic level of mental health care. Evaluations are cursory, programming is unavailable, and the Complex lacks an on-site psychiatrist. Treatment of mentally ill prisoners is minimal.

1. Lack of Meaningful Evaluation

A mental health care provider tours the unit periodically, accompanied by security staff. The provider stops at each cell and, through the cell door, asks the prisoner if he is doing okay. Quite literally, prisoners are asked if they are "alright" and the "clinical" encounter ends just seconds after it began. Frequently, these conversations occur within listening distance of security staff and other prisoners, making confidential communication impossible. Prisoners express serious concerns about whether these conversations could be used as evidence in their post-conviction proceedings and, understandably, are extremely hesitant to participate. Even if they chose to participate, the value of a "drive-by" mental health consult would be limited. Minute-long cell-front consultations do not satisfy the Bureau's legal duty to provide mental health care to prisoners. Further, the notes written by clinical staff are often boilerplate, even when the subject is a prisoner with serious, documented mental illness. In one instance, it appears that a prisoner's periodic mental health evaluation was based on observations made while the prisoner was having his teeth cleaned. Based on this observation, the Ph.D. psychologist concluded that the prisoner "does not appear to be a danger to self or others at this time."

2. Insufficient Staffing and Treatment

Prisoners who receive care beyond these cursory screenings are seen by a provider in Springfield, Missouri via a tele-psychiatry consult. It is my understanding that these consultations are solely for the purpose of prescribing psychotropic medications. Putting aside the question of whether a condemned prisoner's mental health needs can be adequately met by an unfamiliar provider located hundreds of miles away, the therapeutic value of these interactions is questionable. It appears that prisoners do not receive psychotherapy or counseling of any sort, and it is unclear whether prisoners receive the kind of medication monitoring that should accompany all courses of psychotropic medications. Further, prisoners report that there is no on-site psychiatrist at FCCTH, despite a population of approximately 3,500 prisoners. The Seventh Circuit has characterized the lack of an on-site psychiatrist as a "serious system deficiency" contributing to a finding of deliberate indifference to a serious medical need. *Wellman* v. *Faulkner,* 715 F.2d 269, 272-73 (7th Cir. 1983). Indeed, so little mental health care is provided that a systemic evaluation is difficult. The Bureau's own policy speaks of "an overall effective,

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integrated mental health program for the institution."[1] Nothing of the sort exists for prisoners confined in the SCU, many of whom require both acute and chronic psychiatric care.

3. Examples of lack of treatment

Prisoner A

Prisoner A suffers from severe, debilitating mental illness. Both his counsel and fellow prisoners paint a sad portrait of his symptoms. He rarely leaves his cell and, when he does, he frequently dresses in just his underwear. He showers only when forced to do so by staff. His cell is filthy; he urinates in the corners and ejaculates on the walls, often without regard to who may be watching. His pathology is evident to even the most casual observer; he screams at the television and will stare at a blank screen, listening to the static. He has attacked a microwave oven with a broom and complains of implanted devices controlling his thoughts and actions. In July 2006, for several days in a row, Prisoner A jettisoned urine and feces from his cell, believing that BOP had rendered his toilet inoperable. Recently, he flooded his cell for no apparent reason. But more shocking than his behavior is the Bureau's response. Counsel for Prisoner A informs me that, in her client's nearly nine years at USP-TH, he has received no meaningful mental health treatment.

Prisoner B

Equally disturbing as the BOP's failures to treat mental illness are the lengths to which the Bureau has gone to affirmatively prevent prisoners from receiving adequate mental health care. Multiple SCU prisoners report that BOP staff discontinued their psychotropic medications upon arrival at USP-TH. This is a dangerous practice. Prisoner B has a long history of symptoms of mental illness. In the past, a regimen of psychotropic medications helped Prisoner B keep his symptoms under control. However, it appears that BOP abruptly discontinued these medications after he arrived at USP-TH. On February 14, 2007, Prisoner B filed papers dropping his *habeas* proceedings and volunteering for execution. Among his reasons for doing so, Prisoner B cited BOP's denial of mental health treatment. Prisoner B' s volunteering for execution should have, at a minimum, alerted Bureau staff that he needed psychiatric assessment and treatment. Instead, the Bureau focused its resources on opposing a motion by his counsel seeking treatment for their client. Prisoner B withdrew his motion to be executed but the court denied the motion for psychiatric treatment, and he continues to suffer needlessly.

4. Increased Attention Is Needed to the Mental Health Needs of Condemned Prisoners

Special mental health issues confront every prisoner awaiting execution. These men are

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[1]Program Statement 5310.12 (Psychology Services Manual) § 3.2(A). It should be noted that this document is dated August 30, 1993 and references American Correctional Association Standards that have since been superseded.

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locked down in supermax-style cells for most of the day. Hundreds or thousands of miles separate them from their families and attorneys. Many may have organic brain disorders, histories of substance abuse and trauma, and suffer from serious (and often poorly treated) medical conditions. Some of these men arrived with diagnosed mental disorders and had their treatment plans abruptly interrupted and discontinued. Others may have developed disorders while incarcerated. And all must cope with the nagging, chronic stress of awaiting their trip to the death chamber.[2]

In 1972, the California Supreme Court noted that "Penologists and medical experts agree that the process of carrying out a verdict of death is often so degrading and brutalizing to the human spirit as to constitute psychological torture."[3] And psychologists have recognized that "the incidence of psychological symptoms and mental health problems among death row inmates calls for comprehensive mental health services. Effective treatment of psychological symptoms and disorders among death row inmates is not only humane, but likely to facilitate institutional management and reduce disciplinary misconduct."[4]

As the Bureau's Clinical Guideline points out, simple screening methods have a high sensitivity for detecting depressive disorders.[5] And there are myriad cost-effective treatment options available to clinicians for depression and other mental disorders suffered by SCU prisoners. There is no defensible reason why any prisoner in need of mental health care should go untreated, and yet the men on the SCU go untreated.

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[2]*See* American Bar Association, *ABA Guidelines for the Appointment and Performance of Defense Counsel in Death Penalty Cases* (rev. ed. 2003), 31 Hofstra L. Rev. 913,1082 (2003) ("Even if their executions have been safely stayed, however, the mental condition of many capital clients will deteriorate the longer they remain on death row. This may result in suicidal tendencies and/or impairments in realistic perception and rational decisionmaking."). *See also* Mark E. Olive & Russell Stetler, *Using the Supplementary Guidelines for the Mitigation Function of Defense Teams in Death Penalty Cases to Change the Picture in Post-Conviction*, 36 Hofstra L. Rev. 1067, 1086 (2008) ("conditions of confinement on death row often exacerbate preexisting disorders or give rise to new ones").

[3]*People v. Anderson*, 493 P.2d 880, 894 (Cal. 1972) *recognized as superseded by state constitutional amendment, People v. Hill*, 3 Cal.4th 959, 1017 (1992).

[4]Mark D. Cunningham & Mark P. Vigen, *Death Row Inmate Characteristics, Adjustment, & Confinement: A Critical Review of the Literature*, 20 Behav. Sci. & L. 191, 207 (2002).

[5]BOP Clinical Practice Guidelines: Management of Major Depressive Disorder (2001), at 9.

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Byrne/JAG Appropriations

JAG Formula Grant: This grant allows funds to be used "for state and local initiatives, technical assistance, training, personnel, equipment, supplies, contractual support, information systems for criminal justice, as well as research and evaluation activities that will improve or enhance law enforcement and corrections programs. **Specifically, one program purpose includes, "Byrne programs designed to provide additional public correctional resources and improve the corrections system, including treatment in prisons and jails, intensive supervision programs and long-range corrections and sentencing strategies."**

This program was intended to be broad so state and local governments had significant latitude when deciding what programs to fund.

Byrne Discretionary (Earmarks): The following are specific earmarks in the FY 2010 CJS Appropriations Report specifically directing funds to help mentally ill offenders:

- Cook County, Chicago, IL: Mental health services for female offenders - $300,000
- County of Peoria, Peoria, IL: To establish a mental health court - $500,000
- Iowa Dept. of Corrections: Transitional mental health reentry program to provide transitional services for mentally ill offenders - $250,000

The earmarks below are written broadly enough that the funds could also be used for mentally ill offenders:

- The Ridge House, Reno, NV: Prisoner re-entry program for substance abuse and prisoner reentry services - $200,000
- New Mexico Dept of Corrections: Prisoner re-entry program - $500,000
- Washington County Youth Service Bureau, VT: To fund a transitional living program for young male offenders - $200,000

Byrne Competitive Grants

These grants have 4 award categories. The first, Preventing Crime & Drug Abuse, includes "programs that help build partnerships among law enforcement and community-based organizations." This could easily include collaboration programs envisioned by the MIOTCRA grant program. The second category, Enhancing Local Law Enforcement, solicits "applications...to improve or enhance the administration and operations of the law enforcement function in local adult criminal justice systems." The fourth category is specifically on point, and is entitled, Enhancing Local Corrections & Offender Reentry. These grants are to "improve or enhance the administration and operations of the corrections function and offender reentry initiatives in local adult criminal justice systems. Applications are solicited **for programs that address the issue of justice system and mental health needs** through training and technical assistance, and programs that improve correctional system access to necessary criminal intelligence and support greater collaboration between law enforcement and correctional system personnel for purposes of reducing crime and managing offender populations."

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Given the broad nature of Byrne programs, although the final decision would be up to the DOJ's Office of Justice Programs for the JAG and Competitive grants, funding for various programs for mentally ill for pre and post-incarceration, as well as during incarceration, are allowed. Plus, the earmarks already direct funds toward these programs.

Thus, funding other than under MIOTCRA and the Second Chance Act is available for mentally ill offenders and duplicative in some situations. Under MIOTCRA, there is a specific grant for mental health courts; yet, Congress is already funding such programs via Byrne earmarks.

Appropriations for Byrne Formula, Byrne Discretionary, Byrne Competitive, LLEBG, and JAG, FY1999-FY2009
(Funding in millions of $)

FY	Byrne Formula	Byrne Discretionary	LLEBG	JAG	Byrne Competitive	Total
1999	$505.0	$47.0	$523.0	—	—	$1,075.0
2000	$500.0	$52.0	$523.0	—	—	$1,075.0
2001	$500.0	$69.1	$523.0	—	—	$1,092.1
2002	$500.0	$94.5	$400.0	—	—	$994.5
2003	$500.0	$150.9	$400.0	—	—	$1,050.9
2004	$500.0	$159.1	$225.0	—	—	$884.1
2005	—	$170.0	—	$634.0	—	$804.0
2006	—	$191.7	—	$416.5	—	$608.2
2007	—	$239.3[1]	—	$519.9	—	$759.2
2008	—	$187.5	—	$170.4	$16.0	$373.9
2009	—	$178.5	—	$546.0	$30.0	$754.5
Stimulus						$3,000.0

The House-passed FY 2010 appropriations include a total of $693 million, and the Senate CJS subcommittee included $728 million.

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CAMPAIGN FOR
YOUTH JUSTICE
BECAUSE THE CONSEQUENCES AREN'T MINOR

Testimony of Liz Ryan
President and CEO
Campaign for Youth Justice

Submitted to the U.S. Senate Judiciary Committee
Subcommittee on Human Rights and the Law
Hearing on "Human Rights at Home: Mental Illness in U.S. Prisons and Jails"

September 15, 2009

Thank you Chairman Durbin, Ranking Member Coburn, and other members of the subcommittee for holding this hearing on individuals with mental illness in prisons and jails here in the United States. I appreciate your attention to this matter and the opportunity to submit testimony on this issue, particularly as it relates to youth under the age of 18 who are held in adult prisons and jails.

My name is Liz Ryan and I am the President and CEO of the Campaign for Youth Justice, a national organization working to end the practice of prosecuting youth in adult court and to promote more effective approaches in the juvenile justice system as an alternative.

Researchers estimate approximately 200,000 youth have their cases processed in adult criminal court each year. As a result of increased prosecution of youth in adult criminal courts in the States, the number of youth in adult jails and prisons has increased so that, on any given day, an estimated nearly 10,000 youth under the age of 18 are incarcerated in adult facilities - 7,500 in adult jails and an additional 2,000 in adult prisons.

In my testimony today, I will address the conditions that youth face in adult jails and prisons and how these conditions affect youths' mental health, access to mental health services, and the

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unintended public safety consequences of prosecuting youth as adults. I will also discuss specific recommendations on how Congress can help keep youth prosecuted as adults safe.

Negative Effects of Placing Youth Under the Age of 18 in Adult Jails and Prisons

As various reports and research indicate, youth placed in adult jails face specific hardships that can either create or exacerbate mental health conditions, many of which are documented in a November 2007 by the Campaign entitled "Jailing Juveniles: The Dangers of Incarcerating Youth in Adult Jails in America." First, youth in adult jails and prisons are frequently the target of sexual violence and abuse. According to the U.S. Department of Justice's Bureau of Justice Statistics (BJS), 21% and 13% of all substantiated victims of inmate-on-inmate sexual violence in jails in 2005 and 2006 respectively, were youth under the age of 18. These numbers are surprisingly high given that only 1% of jail inmates are juveniles. The National Prison Rape Elimination Commission (NPREC) also recently found that "more than any other group of incarcerated persons, youth incarcerated with adults are probably at the highest risk for sexual abuse" and recommended that youth be housed separately from adults.

Second, youth in adult jails and prisons are frequently separated from adults for safety reasons. While separating children from adults in adult jails will reduce contact with adults that could result in physical or emotional harm to children, children are then often placed in isolation, which can also produce harmful consequences. Youth are frequently locked down 23 hours a day in small cells with no natural light. These conditions can cause anxiety, paranoia, and exacerbate existing mental disorders and put youth at risk of suicide. In fact, youth unfortunately have the highest suicide rates of all inmates in jails. Youth are 36 times more likely to commit suicide in an adult jail than in a juvenile detention facility, and 20 times more likely to commit suicide in an adult jail than youth in the general population. Attached to this testimony please find several newspaper

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articles detailing conditions for youth in and suicides by youth at several adult facilities over the past year.

Third, recent research has specifically documented the incidence of mental health issues for youth prosecuted in adult court and incarcerated in adult prisons. The study, published last month in *Psychiatric Services* and attached to this testimony, found that "juveniles in adult prison may manifest some of the most substantial mental health treatment needs among all juveniles involved in the justice system." The authors noted that, although it was unclear whether youth sent to adult prisons were exhibiting more severe symptoms of mental illness before their placement in adult prisons when compared to youth in juvenile facilities, youth placed in adult prisons were more likely to show symptoms of a psychiatric disorder than youth who were prosecuted in adult court, but received a lighter sentence. The report also noted a need for ensuring the availability of developmentally appropriate treatment for youth in adult corrections facilities. Finally, the report noted that little research has been done on the mental health needs of youth prosecuted in adult court.

Unintended Public Safety Consequences of Placing Youth in Adult Jails and Prisons

Unfortunately, the conditions that youth under the age of 18 face in adult jails and prisons not only cause incredible harm to these youth, but do not ultimately increase public safety. Various reports, including reports from the Office of Juvenile Justice and Delinquency Prevention (OJJDP) and the Centers for Disease Control and Prevention (CDC), led by a non-federal Task Force on Community Preventive Services, have shown that prosecuting youth in the adult criminal justice system significantly increases crime. The CDC report found that youth who have been previously tried as adults are, on average, 34% more likely to commit crimes than youth retained in the juvenile justice system. The report also found other violent outcomes associated with the transfer of youth to the adult system including an increase in pretrial violence; victimization of juveniles in adult

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facilities; and elevated suicide rates for juveniles incarcerated in adult facilities. After conducting this extensive review of published scientific evidence, the Task Force on Community Preventive Services recommended against "laws or policies facilitating the transfer of juveniles from the juvenile to the adult judicial system."

OJJDP also recently released a report on the effectiveness of trying youth as adults entitled "Juvenile Transfer Laws: An Effective Deterrent to Delinquency?." In its report, OJJDP found that transfer laws substantially increase recidivism, particularly for first time violent offenders. The report attributed these higher recidivism rates to a number of factors including the youth's stigmatization and negative labeling effects of being labeled as a convicted felon, a sense of resentment and injustice about being tried as an adult, a learning of criminal mores and behavior while incarcerated with adults, decreased access to rehabilitation and family support in the adult system, and decreased employment and community integration opportunities due to a felony conviction.

The OJJDP report also found that laws to make it easier to transfer youth to the adult criminal court system have little or no general deterrent effect, meaning they do not prevent youth from engaging in criminal behavior. Also, youth transferred to the adult system are more likely to be rearrested and to reoffend than youth who committed similar crimes, but were retained in the juvenile justice system. Due to these findings, OJJDP recommended changing laws to decrease the number of youth transferred to the adult criminal justice system, particularly for first-time, violent offenders.

In 2008, The Future of Children, a collaboration between The Woodrow Wilson School of Public and International Affairs at Princeton University and The Brookings Institution, released a policy brief entitled "Keeping Adolescents Out of Prison." This brief discussed the history and purpose of the juvenile justice system, which is to recognize the differences between youth and

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adults. These differences have been highlighted in recent years through research that has found major disparities between how youth and adults brains functions.

On the topic of trying youth as adults, the report stated that "at a minimum the practice of harsh sentences for adolescents does not work; it may even be counterproductive." Indeed the report recommends that "[a]bove all, youth should be kept out of the adult criminal system unless they have committed repeat violent offenses. This course of action is especially recommended because most youth who commit criminal offenses will abandon illegal behavior at roughly the same age as they exit adolescence."

Recommendations

As stated above, youth under the age of 18 who are placed in adult jails and prisons are particularly vulnerable to conditions and circumstances that may exacerbate existing mental health issues or even create mental health issues for some youth. For these reasons, we firmly believe that adult jails and prisons are simply not equipped to keep youth safe. Therefore, our overarching recommendation is to end the placement of youth under the age of 18 in adult jails and prisons. Placing youth in these facilities actually may create more harm - both in terms of long-term negative or deadly consequences for youth and decreased public safety. Due to these and other considerations, approximately 40 States follow best practice and allow youth who are *convicted* in adult court to serve their sentence in juvenile facilities rather than adult prison.

In the interim, the Campaign urges Congress to take the following steps to ensure the safety of youth who are currently in adult jails and prisons:

- Reauthorize the Juvenile Justice and Delinquency Prevention Act (JJDPA) to expand the jail removal and sight and sound protections to youth who are pre-trial in adult jails: The JJDPA - the main vehicle for juvenile justice reform at the federal level - is currently due for reauthorization. This September also marks the 35th anniversary of the JJDPA, which has

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provided meaningful protections for youth in the juvenile justice system. The JJDPA currently contains two provisions - the jail removal and sight and sound core requirements - that address youth in adult jails and prisons. The jail removal core protection protects youth who are under the jurisdiction of the juvenile justice system by prohibiting these youth from being held in adult jails and lock-ups except in very limited circumstances, such as while waiting for transport to appropriate juvenile facilities. In these limited circumstances where youth are placed in adult jails and lock-ups, the sight and sound core protection limits the contact these youth have with adult inmates.

While these core protections have worked to keep most children out of adult jails for 30 years, the JJDPA does not apply to youth under the jurisdiction of the adult criminal court. Therefore, we recommend that Congress amend the JJDPA to extend the jail removal and sight and sound protections of the Act to all youth, regardless of whether they are awaiting trial in juvenile or adult court. In the limited exceptions allowed under the JJDPA where youth can be held in adult facilities, they should have no sight or sound contact with adult inmates. We thank the Senate Judiciary Committee for including this expansion in S. 678, the Juvenile Justice and Delinquency Prevention Reauthorization Act of 2009, and we urge the Senate Judiciary Committee to pass S. 678 as quickly as possible.

- Oppose any legislation or amendment that increases the number of youth prosecuted in or transferred to the adult criminal justice system: Given the harmful effects of prosecuting youth in or transferring youth to the adult system, the Campaign urges Members of Congress to oppose any amendment or legislation that would allow more youth to be prosecuted in or transferred to State or federal adult courts.
- Ensure additional research is conducted on the issue of youth prosecuted as adults: While research has generally shown the effects of prosecuting youth in adult courts in terms of

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recidivism, many other issues facing this unique population of youth have little to no information. For example, in the *Psychiatric Services* report mentioned above, little information is known on the incidence of mental health issues facing youth prosecuted in the adult system, what - if any - treatment options are available to these youth, and whether placement in adult jails or prisons exacerbates or creates mental health issues for youth. Other potential areas of research for youth prosecuted in adult courts include the availability, quality, and utilization of age-appropriate services, such as educational, health and mental health, and substance abuse services, while a youth is placed in juvenile residential facilities or adult jails and prisons; the unique collateral consequences faced by youth who are prosecuted in adult courts, such as educational consequences; and the availability, quality, and utilization of discharge and re-entry planning.

- Enhance protections for youth who are currently placed in adult jails and prisons: Currently, the JJDPA does not address conditions of confinement for youth in juvenile facilities, let alone conditions for youth in adult jails and prisons. For the first time, S. 678 would add language to the JJDPA that would expressly allow JJDPA funds to be utilized to monitor and improve conditions of confinement in juvenile facilities. We appreciate the inclusion of this language and attention to this issue in S. 678 and hope that similar language could be included in later reauthorizations to include the monitoring and improvement of conditions for youth placed in adult jails and prisons.

Again, thank you for holding this hearing and we look forward to continuing to work with you to ensure that all youth are in the safest, most appropriate, and least harmful conditions while in the criminal justice system.

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Psychiatric Symptoms Among Juveniles Incarcerated in Adult Prison

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Objective: **Although studies reveal substantial mental health treatment needs among youths in the juvenile justice system, far less is known about young offenders transferred to adult criminal court. This statewide study examined the mental health needs of young offenders who committed serious crimes and were transferred to adult court and subsequently incarcerated in a prison for adults.** ***Methods:*** **Sixty-four boys aged 16 and 17 years who were incarcerated in the Texas adult correctional system completed the Massachusetts Youth Screening Instrument–Version 2 (MAYSI-2), a mental health screening measure widely used in the juvenile justice system. Scores from the youths in adult prison were compared with those of a matched sample of youths in juvenile correctional facilities, drawn from the MAYSI-2 normative data.** ***Results:*** **Youths in adult prison reported substantial symptoms of mental health problems. Most youths surveyed (51%) scored above the highest clinical cutoff (the "warning" range) on at least one MAYSI-2 subscale. For every clinical subscale except suicide ideation, the majority of youths (54% to 70%, depending on the subscale) scored above the "caution" range. Juveniles in adult prison reported higher rates of symptoms than did those in juvenile correctional facilities (effect sizes ranged from d=.18 to d=.65, depending on the subscale).** ***Conclusions:*** **Although the mental health needs of youths in the juvenile justice system are well documented, this study reveals that mental health treatment needs appear to be even more pronounced in the small subgroup of youths transferred to the adult criminal justice system and incarcerated in adult prison. (*Psychiatric Services* 60:1092–1097, 2009)**

Most youths in the juvenile justice system show symptoms of mental health problems. Over the past decade, studies using a structured diagnostic interview revealed that more than 60% of youths in juvenile detention met criteria for at least one psychiatric disorder (1) and that around 50% met criteria for at least two disorders (2). Recent research examining youths who had been incarcerated for nine months revealed even higher rates, with 88% of males and 92% of females meeting criteria for at least one disorder (3). Studies using the Massachusetts Youth Screening Instrument–Version 2 (MAYSI-2) (4)—a measure designed to identify self-reported symptoms of mental health problems, rather than formal diagnoses—also suggest that mental health problems are commonplace within the juvenile justice system. In a national sample of over 70,000 youths in the juvenile justice system (including youths in intake probation, detention, and correctional facilities), 72% of girls and 63% of boys scored above the clinical cutoff on at least one MAYSI-2 subscale (5).

As clinicians and policy makers have become more aware of mental health needs in the juvenile justice system, practice and policy have changed. For example, the federal government published guidance to help juvenile justice agencies screen for or assess mental health symptoms (6–8), and at least 42 states screen for mental health problems using the MAYSI-2 at some point of entry to the juvenile justice system (9).

Despite increased research and policy addressing mental health needs among youths in the juvenile justice system, there remains one important subgroup of young offenders about whom we know little. No published research has studied juveniles incarcerated in adult prisons to identify their mental health symptoms or gauge their treatment needs.

For decades, the law has allowed juvenile courts to select a few juveniles for waiver, where they face trial in adult criminal court and might be sentenced to adult prisons. In *Kent v. United States* (10), the Supreme Court

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suggested specific factors that courts should consider when selecting which youths warranted waiver to adult court (for example, the nature of alleged offenses, sophistication or maturity of the juvenile, and potential for rehabilitation). Nearly all states allow for this type of judicial waiver (11). However, after the increases in juvenile crime during the late 1980s and early 1990s, most states amended their criminal codes so that youths could more easily be tried in adult courts and sentenced to adult prisons (12). Now, many more youths are eligible for adult criminal sentences simply because of their age or the category of crime that they committed. Consequently, the number of juvenile inmates in adult prisons more than doubled between the mid-1980s and the mid-1990s (13).

Given policy changes that moved more juvenile offenders to adult courts, it seems important to ask whether youths incarcerated in adult prisons have mental health treatment needs similar to those of youths in the juvenile justice system (14). Unfortunately, we have few data to answer this question. The available data regarding mental health needs among juveniles in adult prisons involves isolated reports from advocacy groups. For example, reports suggest that juveniles in adult prisons are more likely to commit suicide than youths in the juvenile justice system (15) and that they are more vulnerable to rape and physical assaults than their adult counterparts (16). Although these observations have profound treatment and safety implications, a comprehensive plan for providing psychiatric treatment to juveniles in adult prisons will also require more specific data regarding the actual psychiatric symptoms that these juveniles report.

As a first step in identifying the treatment needs among juveniles in adult prisons, we administered the MAYSI-2 (4) to boys incarcerated in the adult correctional system in one state. We used the MAYSI-2 because it is the most widely used measure of mental health symptoms among delinquent youths. Thus the measure provides a common metric to compare our sample of juveniles in an adult prison to national samples of youths in the juvenile justice system. To facilitate this comparison, we present MAYSI-2 scores from our sample of boys incarcerated in the adult correctional system alongside scores from a subsample of boys in juvenile correctional facilities drawn from the national normative data for the MAYSI-2 (5) and matched for age range, race, and ethnicity. Although the MAYSI-2 norms also include youths from other points in the juvenile justice system (that is, probation and detention), we selected only sentenced, incarcerated youths to use as a comparison. We assumed that these incarcerated youth—likely convicted of more serious or persistent crime—would be the most similar to juveniles in adult prisons.

Methods

Participants

Participants were 64 boys aged 16 (N=9, 14%) or 17 (N=55, 86%) in a youthful offender program within a large adult prison. These boys were a subset of a larger study of 149 youthful offenders who had been convicted of crimes in Texas criminal courts and sentenced to adult prison in Texas when they were between the ages of 13 and 17. Because the primary study measure, the MAYSI-2, was not normed for individuals older than 17, we present data only for the participants under age 18, whose results we can compare to MAYSI-2 normative data. At the time of data collection, no inmate in our sample was younger than 16.

Regarding race and ethnicity, of the 64 boys, eight (13%) self-identified as white, 28 (44%) as African American, 20 (31%) as Hispanic, and one (2%) as "other" race. The remaining seven (11%) declined to report their ethnicity. Because the Texas Department of Criminal Justice maintains a Youthful Offender Program in which juveniles are offered classes and group treatment sessions separately from older offenders, all boys resided in the same correctional unit. Although a few girls have been sentenced to the adult correctional system in Texas, they reside in a separate unit for women and were not a part of this study.

The comparison sample was taken from the MAYSI-2 national normative data (4,5), an archival data set of over 70,000 cases obtained from juvenile justice programs in 19 states. In order to construct a reasonably matched comparison sample, we initially extracted the 9,244 cases of males aged 16 or 17 (mean±SD age, 16.90±.59 years) from juvenile, secure correctional facilities (that is, long-term facilities in which youths are incarcerated to serve their sentences; this sample did not include youths in detention facilities awaiting trial). The racial and ethnic breakdown of this initial comparison sample featured approximately equal proportions of white, African-American, and Hispanic youths. Therefore, we randomly extracted from the sample data for white and Hispanic youths until we achieved a sample that was more similar, in terms of racial and ethnic composition, to our sample of juveniles in adult prison. The final comparison group from the MAYSI-2 national normative data set included 6,071 males, of whom 702 (12%) were white, 2,827 (47%) were African American, 1,900 (31%) were Hispanic, and 642 (11%) were other or unknown race. These comparison data came from 31 secure correctional facilities in 12 states (including Texas).

Measures

The MAYSI-2 is the most widely used and best validated mental health screening measure for youths involved in the criminal justice system (17). Designed for youths aged 12–17, it can be administered by nonclinical criminal justice professionals (4). Youths who complete the brief screening measure mark "yes" or "no" to indicate whether they have experienced each of 52 items that reflect symptoms or behaviors related to mental health or substance abuse problems within the past few months. The MAYSI-2 was not designed to provide psychiatric diagnoses per se but to identify youths experiencing emotional distress or problematic behaviors that are of particular concern to criminal justice or correctional facilities (17). These areas of concern correspond to seven MAYSI-2 subscales: alcohol/drug use, angry-irritable, depressed-anxious, somatic com-

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Table 1

Mean scores on the subscales of the Massachusetts Youth Screening Instrument–Version 2 (MAYSI-2) for youths in adult prison and youths in juvenile correctional facilities[a]

Subscale	Adult prison (N=64)		Juvenile correctional facility (N=6,044)[b]		Effect size (Cohen's d)
	M	SD	M	SD	
Alcohol/drug use[c]	3.76	2.44	3.31	2.68	.18
Angry-irritable[d]	5.02	2.92	3.19	2.74	.65
Depressed-anxious[d]	3.15	2.14	2.29	2.16	.40
Somatic complaints[e]	2.62	1.94	2.08	1.79	.29
Suicide ideation[f]	1.25	1.63	.56	1.18	.48
Thought disturbance (for boys only)[f]	1.25	1.24	.79	1.12	.39

[a] Juveniles in adult prison were study participants. Juveniles in juvenile correctional facilities were a comparison group drawn from MAYSI-2 normative data. The comparison group was matched to the study group for age and racial-ethnic composition.

[b] Ns range from 6,010 to 6,044.

[c] Possible scores range from 0 to 8, with higher scores indicating a higher level of the reported symptom.

[d] Possible scores range from 0 to 9, with higher scores indicating a higher level of the reported symptom.

[e] Possible scores range from 0 to 6, with higher scores indicating a higher level of the reported symptom.

[f] Possible scores range from 0 to 5, with higher scores indicating a higher level of the reported symptom.

plaints, suicide ideation, thought disturbance (for boys only), and traumatic experiences.

High scores on the MAYSI-2 reflect either of two levels of clinical concern: "caution" or "warning." The caution cutoff scores were determined by comparing scores on the MAYSI-2 subscales to conceptually comparable scales on well-validated, clinical assessments of adolescent mental health symptoms (18). Thus youths scoring above the caution cutoff scores on the MAYSI-2 would likely score in the clinically significant range on the other well-validated scales of adolescent mental health symptoms. The warning cutoff scores were established by examining the original Massachusetts normed sample and identifying scores for the 10% of youths who scored highest on each subscale. Youths scoring in the warning range on a given subscale tend to be among the most distressed and have the most substantial treatment needs, with respect to the condition the subscale measures (4). The only subscale for which MAYSI-2 developers did not provide cutoff scores is the subscale measuring traumatic experiences.

Procedure

After the relevant institutional approvals, staff from the research department of the state correctional system administered the paper-and-pencil version of the MAYSI-2 to participants during the spring of 2006. Staff explained the purpose of the study to youths in general terms, describing it as a voluntary survey of youths' concerns, feelings, and experiences (youths received no compensation or incentive for participation). Staff obtained informed assent from youths (parental consent was not feasible), clarified the anonymous nature of the survey, and sealed survey materials in a manner to protect anonymity. Although 65 youths surveyed agreed to participate, one returned an incomplete protocol, which was not used in study analyses and gave us a sample of 64 participants.

Results

Table 1 presents mean scores on the MAYSI-2 subscales for the study participants and the comparison sample. As detailed in Table 1, youths in adult prison had higher mean scores—that is, greater distress or treatment needs—across every subscale on the MAYSI-2 than did the comparison group in juvenile correctional facilities. These differences in scores ranged from small to medium-large based on Cohen's d, a measure of effect size.

The most common way of examining MAYSI-2 results is to consider the proportion of youths scoring above the caution and warning thresholds (Table 2). Across every condition that the MAYSI-2 measures—except for alcohol and drug use—higher proportions of youths in adult prison scored in the caution and warning ranges, compared with the control group. For all conditions except suicide ideation, most participants in adult prison had subscale scores at least in the caution range, with a substantial minority (7% to 28%, depending on the subscale) also scoring in the warning range. In terms of suicide ideation, 32% reported sufficient symptoms to warrant clinical attention (caution range), and 20% warranted intense attention (warning range).

Finally, to explore comorbidity, we examined the number of subscales on which youths received elevated scores (Table 3). Most (51%) participants had scores in the warning range for at least one subscale (compared with 44% of youths from the comparison sample), and one-third scored in the warning range on two or more scales (compared with 19% of the comparison sample). Almost all (90%) participants had scores in the caution range for at least one subscale, and nearly three-fourths (73%) had scores in the caution range for more than one scale (compared with 77% and 55% of the comparative sample, respectively).

Discussion

This small study was the first to explore symptoms of mental health problems among juveniles incarcerated in adult prison. Because participants completed the MAYSI-2, the screening measure most commonly used in juvenile justice settings, we could compare participants' self-reported symptoms to those from a normative sample of youths in the juvenile justice system. We selected the subsample from the MAYSI-2 normative data that is probably most com-

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parable to our participants—that is, a sample of boys aged 16 or 17 in a juvenile correctional facility (rather than probation or detention) with a racial and ethnic composition similar to that of our sample. We emphasize that this comparison group is not a matched sample in the strictest sense because we could not match for criminal history or most recent offense. The comparison group is also not perfectly matched in that it included youths from 11 states in addition to Texas (although most of these states are similar in terms of their laws and procedures related to juvenile waiver). Nevertheless, a national comparison sample from juvenile correctional facilities helps to place in perspective the results from our participants in adult prison.

Overall, juveniles in adult prison demonstrated substantial distress or treatment needs. Most scored above the highest clinical cutoff (warning cutoff) score on at least one clinical subscale. For all clinical scales except suicide ideation, the majority of youths scored above the caution cutoff score. Results are consistent with a general pattern across MAYSI-2 research wherein youths in the "deep end" of the criminal justice system, for example, correctional settings, tend to have higher MAYSI-2 scores than youths in the "shallow end" of the system, such as probation contexts (4,19). Extending this trend, our small sample of juveniles in adult prison appear to have reported, on average, more substantial treatment needs than any other published sample of youths who have completed the MAYSI-2. Just as comorbidity appears to be the norm in juvenile justice samples (2), the majority of our sample warranted clinical attention in more than one clinical domain.

This study raises, but cannot answer, several important questions about mental health symptoms among juveniles in adult prison. Do these youths—compared with those who remained in the juvenile justice system—manifest more psychiatric symptoms before incarceration, raising the possibility that having a substantial number of symptoms contributed to substantial offending? Or did their symptoms increase over the

Table 2

Juveniles in adult prison and in juvenile correctional facilities scoring above the "caution" and "warning" cutoff scores on the subscales of the Massachusetts Youth Screening Instrument–Version 2 (MAYSI-2)[a]

	"Caution" cutoff				"Warning" cutoff			
	Adult prison (N=61)		Juvenile correctional facility (N=6,044)		Adult prison (N=61)		Juvenile correctional facility (N=6,044)	
Subscale	N	%	N	%	N	%	N	%
Alcohol/drug use	32	54	2,867	47	8	14	1,621	27
Angry-irritable	37	61**	1,935	32	16	26**	562	9
Depressed-anxious	35	57**	2,362	39	10	16	597	10
Somatic complaints	31	51	2,268	38	4	7	277	5
Suicide ideation	19	32**	879	14	12	20*	516	8
Thought disturbance	42	70**	2,713	45	17	28*	1,172	19

[a] Juveniles in adult prison were study participants (Ns range from 59 to 61 because of missing data). Juveniles in juvenile correctional facilities were a comparison group drawn from MAYSI-2 normative data (Ns range from 6,010 to 6,044 because of missing data). The comparison group was matched to the study group for age and racial-ethnic composition. Youths scoring above the caution cutoff scores on the MAYSI-2 reported a clinically significant degree of distress or symptoms. The warning cutoff scores were established by examining the original Massachusetts normative sample and identifying scores for the 10% of youths who had the highest scores on the subscales. Thus youths scoring in the warning range on a given subscale tended to be among the most distressed and to manifest the most substantial treatment needs.

*p<.05; difference between juveniles in adult prison and the comparison sample

**p<.001; difference between juveniles in adult prison and the comparison sample

Table 3

Number of subscales on which juveniles in adult prison and in juvenile correctional facilities scored above the "caution" and "warning" cutoff scores on the Massachusetts Youth Screening Instrument–Version 2 (MAYSI-2)[a]

	"Caution" cutoff				"Warning" cutoff			
	Adult prison (N=61)		Juvenile correctional facility (N=6,044)		Adult prison (N=61)		Juvenile correctional facility (N=6,044)	
Number of subscales	N	%	N	%	N	%	N	%
0	6	10	1,369	23**	30	49	3,411	56
1	10	16	1,330	22	12	20	1,503	25
2	9	14	1,017	17	8	13	585	10
3	5	8	837	14	5	9	311	5
4	11	18	680	11*	4	7	160	3
5	11	18	563	9**	2	3	71	1
6	9	15	269	4***	0	—	24	<1

[a] Juveniles in adult prison were study participants (N=61 because of missing data). Juveniles in juvenile correctional facilities were a comparison group drawn from MAYSI-2 normative data (Ns range from 6,010 to 6,044 because of missing data). The comparison group was matched to the study group for age and racial-ethnic composition. Youths scoring above the caution cutoff scores on the MAYSI-2 reported a clinically significant degree of distress or symptoms. The warning cutoff scores were established by examining the original Massachusetts normative sample and identifying scores for the 10% of youths who had the highest scores on the subscales. Thus youths scoring in the warning range on a given subscale tended to be among the most distressed and to manifest the most substantial treatment needs. Chi square tests were used to compare the proportion of juveniles in adult prison versus that of the comparison group meeting caution or warning cutoff scores.

*p<.05

**p<.01

***p<.001

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course of incarceration? In the comparison sample youths completed the MAYSI-2 at intake into the facility. In our sample youths were incarcerated in adult prison for an average of 14.60±10.61 months (range one to 43 months) before completing the MAYSI-2. Thus our study cannot determine whether our participants in adult prison had more severe symptoms before incarceration than their juvenile counterparts.

However, one recent study may shed some light on these questions (20). Data from the Northwestern Juvenile Project (1), which administered diagnostic interviews to youths in the Cook County Juvenile Temporary Detention Center between 1995 and 1998, allowed researchers to compare psychiatric diagnoses among youths tried in juvenile court and those transferred to adult court (where they were subsequently sentenced to adult prison or given a more lenient sentence). They found that overall, there were few substantial diagnostic differences between the youths processed through juvenile court versus those transferred to adult court; all had high rates of psychiatric illness. However, when researchers examined only youths transferred to adult court, they found that those sentenced to adult prison had significantly higher odds of manifesting a psychiatric disorder, compared with those who were transferred to adult court and subsequently received a lighter sentence. In other words, even though diagnostic interviews took place before any youth was transferred to adult prison, the prison-bound group demonstrated greater psychiatric illness at the time of evaluation (compared with youths who remained in the juvenile justice system and youths who were transferred to adult court but were not sentenced to adult prison). Thus both our study and the much larger Northwestern Juvenile Project suggest that the few youths whom the criminal justice system selects for incarceration in adult prison appear to be a group particularly in need of psychiatric treatment.

Of course, to better understand the nature and progression of mental health problems among juveniles in adult prison, longitudinal research is essential. Future studies should examine not only the longitudinal course of symptoms but also formal diagnoses, which cannot be measured with screening instruments such as the MAYSI-2.

This small study should be considered in light of several caveats. First, the sample included boys only. Research with young offenders has demonstrated that girls tend to manifest more psychiatric symptoms than boys (21,22). Thus we might expect different findings in the very small population of girls in adult prisons. Second, the above-mentioned timing of the MAYSI-2 administration (upon intake for youths in juvenile facilities but after months of incarceration for youths in adult prison) might also explain the slightly lower rates of substance abuse problems reported by our sample, because they probably did not have as recent access to drugs and alcohol as did the comparison group. Thus results may underestimate our sample's substance abuse before incarceration.

Finally, this sample of juveniles in adult prison in Texas may not be representative of all juveniles in adult prisons nationwide. Texas maintains a Youthful Offender Program to provide some specialized treatment services to juveniles in an adult prison. Conceivably, juveniles in other state prisons—who are less segregated from adults and more isolated from peers and from developmentally appropriate programming—might report greater distress or more psychiatric symptoms.

Conclusions

Despite the preliminary nature of this research, results carry important implications. First, these results bolster the growing national concern regarding mental health problems among youths in the juvenile justice system (23) and suggest that this concern should extend to juveniles who have been transferred to the adult criminal justice system and incarcerated in adult prisons. At the individual level, clinicians who assess and treat juveniles in the adult criminal justice system should recognize the likelihood of substantial psychiatric symptoms. At the level of policy and institutional practice, results suggest a need for developmentally appropriate treatments within adult correctional systems that are responsible for juvenile offenders. Case law (24) and professional organizations (25,26) offer some guidance regarding mental health treatment in corrections. But treating juveniles in adult prisons will require interventions based on the large body of research specific to juvenile offenders (27), which may differ substantially from interventions, even empirically supported interventions, that were designed for adult offenders.

Although juveniles in adult prisons make up only a small portion of prison inmates and a small portion of juvenile offenders, these juveniles pose unique challenges with respect to policy and treatment. Indeed, results from this study suggest that juveniles in adult prison may manifest some of the most substantial mental health treatment needs among all juveniles involved in the justice system.

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The authors report no competing interests.

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Newspaper Coverage: Youth in Adult Jails - Suicides and Conditions

Teen suicide at Pueblo County jail under investigation
Story By: Bea Karnes
Source: KOAA
Published Tue Jun 16, 2009, 11:33 AM MDT
Updated Tue Jun 16, 2009, 05:51 PM MDT

The Pueblo County Sherrif's Office says a 17-year old committed suicide at the county jail Monday night. Jail workers attempted life-saving efforts. The boy was transported to Parkview Hospital where he was pronounced dead.

The coroner has identified the juvenile as Robert Borrego, 17. According to a news release, Borrego was alone in a wing on the third floor of the jail. The sheriff's office says Borrego tied a bed sheet around his neck and hung himself from a toilet partition. The coroner says Borrego died from a lack of oxygen.

The 17-year old was being held at the county jail because he was being charged as an adult for second degree assault with a deadly weapon. Pueblo Police say in March Borrego allegedly stabbed someone who spit on him during an event at the state fairgrounds.

News First asked the Sheriff's Office is Borrego ever expressed thoughts of suicide. Undersheriff J.R. Hall wouldn't comment about that part of the case--citing the on-going investigation. "I will say that upon intake of any inmate that type of question is answered and asked by staff here, and if there was something like that he would have been treated for that at that time,"

A critical incident team has been activated to investigate the case further.

Deadly sentences for juveniles – *The Denver Post*
By Rep. Claire Levy
Posted: 08/30/2009 01:00:00 AM MDT

Two teenage boys have committed suicide in Colorado jails within the past 10 months.

Jimmy Stewart was 17 years old last November when he foolishly took his father's car and drove while he was intoxicated, killing another person. He was in a juvenile detention facility for three weeks before he was transferred to jail. He was remorseful. The detention center put him on suicide watch.

No one was watching him in the Denver County Jail. After several days in jail, he killed himself.

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Robert Borrego was also 17 when he was arrested on May 26 in Pueblo for assault and possession of an illegal weapon (a butterfly knife). According to news reports, Borrego got into a fight outside the state fairgrounds following a tough-man competition and stabbed another kid. He had been in isolation in the county jail when he killed himself on June 15.

Neither of these young men was in jail because they had been a behavior problem in detention. They weren't in jail to protect the public; juvenile detention facilities are locked and secure. They weren't in jail because of a considered decision that jail was where they belonged. No one had assessed their psychological condition, criminal history, risk of flight, seriousness of the offense, and other factors particular to them before putting them in jail.

They were in jail because they were being charged as adults.

Their deaths were senseless tragedies because the high risk of suicide by juveniles in jails is well known by experts on juvenile justice.

Juveniles who are charged as adults are transferred from a locked juvenile detention facility to the county jail. In the county jail, the kid is not allowed to see or hear the adult inmates. If there are no other juveniles in the jail, these restrictions mean they are in what amounts to solitary confinement. They aren't in school. They aren't in programs to address their mental health or behavior problems. In some jails, they can't get a hug, a hand squeeze or pat on the back from a visiting relative. They just sit.

Being held in isolation causes anxiety and paranoia and exacerbates existing mental disorders. These youth are 36 times more likely to commit suicide in an adult jail than in a juvenile detention facility.

Statewide, about 100 kids are confined in jail every year while awaiting trial. The average case takes about 180 days to be resolved. Although these kids have been charged with serious crimes, six months in jail awaiting trail could prove to be a death sentence.

The Centers for Disease Control has found that juveniles who are prosecuted and sentenced as adults are 34 percent more likely to be re-arrested than those who stay in the juvenile system. They become more violent and better criminals when they have been in the adult system. Many of them have been victims of abuse and neglect in their own homes. They are two to three times more likely than the general population to have a mental disorder. They lack the maturity and judgment to appreciate the seriousness of their acts, and have poor self-control.

Nationally, as many as half of the youth who are charged as adults and transferred to jails are either not convicted of anything or end up back in juvenile court. Twenty percent of them will have spent over six months in an adult jail without adequate education and other services. During this time, lasting damage is done.

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Here in Colorado, thanks to the newly passed House Bill 1321, some thought will now be given to whether a juvenile should be moved to jail when they get charged with an adult crime. The prosecutor will have to consult with the defense attorney and consider a host of factors in determining where to hold him until the case is resolved.

While HB 1321 may save some lives, we must also reconsider the current practice of charging juveniles as young as 14 with adult offenses. Research shows that with the exception of the most violent and hardened offenders, treating juvenile offenders like adult criminals is counter- productive. It simply pushes troubled youth farther down the path toward a lifetime of crime.

It is costly as well. Every dollar spent on evidence-based programs for juveniles can yield up to $13 in cost savings. When we prevent a child from engaging in repeat criminal offenses, we save the community as much as $3.4 million.

Colorado should join the growing list of states that are rethinking their approach to juvenile offenders. We cannot afford to give up on these kids.

State Rep. Claire Levy of Boulder represents House District 13.

Teen in jail hanged
02/23/2009
Newsday

A 17-year-old jailed on a criminal contempt charge was found hanging from a piece of sheet in his maximum security cell at Suffolk County jail, authorities said.

The teen's death is being considered a suicide, said Chief Michael Sharkey of the Suffolk County Sheriff's Department. A cause of death will be determined by the county medical examiner.

A correction officer found Jesse Haszinger, of Lindenhurst, hanging from the bars of his single-person cell at about 9 p.m. Saturday, Sharkey said.

Haszinger had been held since Jan. 15 in the Riverhead jail, Sharkey said, in an area for minors that houses inmates 18 years and younger.

He had been charged as an adult, Sharkey said.

A woman who answered the door at the Haszinger family's Lindenhurst home last night said the family did not wish to comment.

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Houston Press
May 26, 2009
For Their Own Good

Harris County juveniles certified as adults are jailed in isolation 23 hours a day — without being convicted of a crime.
By Chris Vogel
George awakes scared and confused. He's had the dream again, the one where he is living back at home, where he can wander into the kitchen at any hour to down a glass of milk or fix himself a bowl of his favorite cereal.

He'd had dreams like this before, and every time he wakes up, it takes him only an instant to realize the lie. All he needs to do is feel the jailhouse mattress underneath his body and open his eyes to see the light shining in the corner of his cell, the light that taunts him 24 hours a day and that he can never snuff out.

For the past six months, George has been living alone in a small cell on the second floor of the Harris County jail awaiting trial on charges of aggravated robbery with a deadly weapon. Prosecutors say he was one of a group of boys who robbed and assaulted a married couple at gunpoint.

George (not his real name) has been held in isolation 23 hours a day even though he has not been convicted of a crime.

He is 15 years old.

He desperately misses his mom.

In most cases, teens ages 14 to 16 would be held before trial in the county's juvenile facility, but George has been certified to stand trial as an adult, which means he is housed across the street at the "Big Jail."

Authorities say that to keep George and other juveniles like him safe from older, hardened criminals in the general population, George should spend his days in near solitary confinement.

But this decision to protect juveniles may actually make life much worse for them, critics say.

Liz Ryan, Director of Youth Justice, an advocacy group in Washington, D.C., says data shows that juveniles are 36 times more likely to commit suicide in an adult jail than a juvenile detention facility and 19 times more likely to kill themselves in isolation than in general population.

George is one of 83 teens certified as adults in Harris County in 2008. For the past 12 years, an average of 89 juveniles have been certified here every year, the majority

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charged with violent and heinous crimes with expensive bonds that their families cannot pay. They have not been convicted of anything, yet their treatment — the isolation — is akin to the severe, short-term punishment of adult prisoners who have already been condemned. And there they sit, for months, even years, before ever going to trial.

In some cases, there never is a trial.

Take Bobby, for instance, who would only be interviewed under the condition of anonymity. He was arrested when he was 16 and charged with aggravated robbery. He spent about five months in the juvenile detention center before being certified as an adult and moved to the county jail. After more than a year, the prosecutor dropped the case, and he was set free.

He describes his time in isolation as mental agony.

"It made me want to act crazy," he says, "but I knew I wasn't a crazy person. I know that in their eyes we're adults and criminals, but at the same time, we're very young and we haven't been convicted. We're just sitting there. You get crazy thoughts, like you want to hurt somebody or hurt yourself."

The pretrial confinement of these teens is not the only aspect of certification that's drawing fire. Critics also say the entire process is nothing more than a rubber stamp. And they object to the rules that say an appeal of the certification itself is only allowed after the criminal trial is over.

From 1999 through 2008, Harris County juvenile judges certified 745 youths. In that same time, they only denied 48 certifications, meaning they transferred more than 93 percent of the cases to adult court. In 2005 and 2004, judges did not deny a single one. According to the Austin-based advocacy group Texas Appleseed, Harris County certified more juveniles from 2006 to 2008 than the next five largest counties in Texas.

The treatment of these kids has slipped under the radar. Even the judges who certify them as adults and many county officials seem unaware that this legal determination sends the teens to isolation.

In Texas, any teen 14 or older charged with a violent felony or aggravated drug offense can be certified to stand trial as an adult. There is, however, nothing in the Texas Family Code requiring that a certified juvenile must be kept in the county jail while waiting to go to trial.

It's just something that's done in Harris County. It's convenient.

"It's an awful thing, solitary," once wrote Senator John McCain, who spent more than two years in isolation as a P.O.W. in Vietnam. "It crushes your spirit and weakens your resistance more effectively than any other form of mistreatment."

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Once a child is certified, says Ellen Marrus of the University of Houston Law Center, "we follow the adult court proceeding, which means being placed in juvenile detention is not an option. But there's nothing in the statutes that says we have to do that. The child could still remain in the juvenile facility where they could get the specialized treatment and education they need."

Beginning about four years ago, Harris County decided not only to keep all 14-to 16-year-old inmates in the same unit, apart from the adults, but also to segregate them from each other, to keep them from fighting by placing each one in his own cell 23 hours a day. They're allowed out for schooling, recreation, to see visitors and to go to court.

Marrus says many of the reasons why certified juveniles are held in the adult jail have to do with convenience. It makes it easier on the jail staff to take them to court hearings, and when the teen turns 17, he is moved into a unit with older inmates, "so it's easier for them to just keep the child there for the whole time," she says.

Susan Card, spokeswoman for the Harris County Sheriff's Office, which runs the jail, says simply that when a juvenile is certified, that legally makes him an adult, and therefore he is placed in the county jail.

It might make sense, then, that there would be laws or regulations protecting the kids. Not so, says Brandon Wood of the Texas Commission on Jail Standards. The agency's only recommendation is that jails with the ability to should separate the children from the adults.

Human Rights Watch has said that prolonged solitary confinement should be banned across the globe, calling it a "cruel and inhuman treatment."

Among psychologists, there are currently two basic schools of thought on the subject. The first, championed by Dr. Craig Haney of the University of California at Santa Cruz, is essentially that no one should ever be forced to suffer long-term isolation. Dr. Joel Dvoskin of the University of Arizona, who ran the forensic and correctional mental health system for the state of New York for ten years, advocates a more tempered notion. He believes that isolation doesn't necessarily cause mental illness, but it can. And in children, the effects are amplified.

"I'm kind of a hard-ass and believe that there are some people who deserve prison," he says, "but I think even the most even-handed people have said ... [isolation] is not socially normal in any sense of the word. We know that the prevalence of mental illness or emotional problems among juvenile offenders is very high, and it's certainly true that [isolation] can either cause or exacerbate mental illness in some people, so when you consider the risk factors, it's fair to say that it's at least as high and probably higher in minors."

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Certain considerations affect an inmate's ability to handle isolation, says Dvoskin, including whether the offender thinks he is being unfairly punished and whether he has any control over when he is released.

"If you are put in [isolation] simply because you are a minor," he says, "it's going to seem less fair and you're going to feel like you have no control because the only way to no longer be a minor is to kill yourself. You're stuck, and there's nothing you can do about it but wait for time to slowly creep by."

Sitting in the visitation area behind a thick pane of glass and wearing his county-issued orange shirt, pants and socks, George keeps his head down; he speaks softly and in short sentences.

"Doing the time is hard," says the scrawny teen, who could easily pass for 12. "I'm so scared and lonely. When I let myself think about it, I start to cry."

Police arrested George when he was 14. He turned 15 in jail.

When asked about his typical day, George says he tries not to think about suicide. Instead he spends hours watching the gnats buzz around his cell. He has a radio and a few books, but mostly George says he just sits on his bunk. Sometimes he'll move over to the metal chair — tucked underneath a metal desk, which is next to his toilet and sink — to write a letter to his mother. When she visits him, the glass partition prevents them from hugging or touching. For exercise, he paces or does sit-ups and push-ups. That tires him out and relaxes his muscles, allowing him to fall asleep. Some days, he says, it feels like the only reason to get up is to figure out a way to get back to sleep again.

Through a small window on his cell door, George can only see a wall. Below the window is a slot through which guards slide his meal tray three times a day. But George refuses to eat the "nastiness," choosing instead to live on a less than nutritious diet of prepackaged chips, candy and soda that he buys from the commissary using the money his mother deposits in his jail account.

When the food slot is open, George can hear the other kids in the unit, who like him have been certified as adults and are kept in segregation. He hears them scream and act out, beating on their doors, only to have the noise silenced when the guards reclaim the uneaten food and slam the slot shut.

George is allowed out of his cell once a day for an hour. He says he uses the time to shower, call home or socialize with fellow inmates in a common room. As required by law, he gets an education. George says he goes to class twice a week for an hour each time, though jail officials say kids his age go for five hours every Tuesday and Thursday. George says he does his homework in his cell, though he doesn't have much this week because he says all he did in class was watch the movie The Outsiders, starring Patrick Swayze and Rob Lowe. He longingly remembers the time he spent in the juvenile

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detention center before being transferred, where he went to school all day and was allowed out of his cell far more often.

Recreation time at the adult jail, says George, is a joke. Twice a week he gets an hour and a half to exercise and play, but it's always indoors. There are basketballs, but no hoop. Volleyballs, but no net. Not that it would matter. George says he's often kept in shackles, so all he and his fellow teens can do is shoot the shit. Then it's back into his cell.

Harris County is by no means alone when it comes to housing certified teens in isolation. Ryan says that 40 states permit or require that juveniles certified as adults be held before trial in an adult jail, and that on any given day 7,500 youths are incarcerated in adult jails across the country.

In one example, two youths placed in isolation tried to kill themselves seven years ago in the Los Angeles County jail. The incidents made headlines in the Los Angeles Times and public outcry began to grow. Finally, the L.A. County Sheriff decided to contract for beds in a nearby state juvenile facility. There, the youths receive all-day schooling five days a week, can socialize with each other and receive counseling.

"Solitary confinement is really damaging," says Sue Burrell, a lawyer with the Youth Law Center in San Francisco, an advocacy group involved in the L.A. County case, "but for young people it's much worse. As we all know, a child's brain is still developing, they are still developing emotionally and they have a much different perception of time. Five minutes can feel like five hours. So being forced to sit in a cell away from their family, their friends, with sensory deprivation, is incredibly damaging to their mental health. Our experience has been they either get really depressed or they get really angry. And sometimes they flip-flop between the two."

Bobby says that's exactly what happened to him.

"Being with people helps you keep your mind off a lot of different things," he says. "If you're just sitting there, you go crazy. And yes, you get out of your cell for 30 or 60 minutes a day, but when you do you'll probably do something you don't want to do. You want to cause a problem."

Today, says Burrell, the majority of certified youths held pretrial in California are kept in juvenile facilities.

Juvenile justice advocates in Texas are aware that certified youths are held pretrial in isolation inside county jails throughout the state, but so far have done little to try to stop it.

Will Harrell, Ombudsman for the Texas Youth Commission, says he is "deeply concerned" about the practice, but that he has no jurisdiction over the adult system, therefore his hands are tied. Isela Gutierrez of the Juvenile Justice Initiative in Austin says she doesn't have a good answer as to why this issue has slipped under the radar.

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"It's a good question," she says. "The kids being certified are primarily kids of color so I think that could be a reason why people are not paying attention. Maybe there's a willingness to accept that these are really hard-core criminals who are beyond rehabilitation. The truth is, juvenile justice was off everyone's radar for a really long time, but now more attention is being paid to what we're doing with our kids and we're asking, is it working?"

Christene Wood couldn't believe her own eyes. She'd been a civil lawyer for several years, but sitting there in Harris County juvenile judge Pat Shelton's courtroom during a certification hearing was like nothing she'd ever experienced.

"Shelton was surfing the Internet and never made eye contact with the boy," she says. "He covered his mouth and laughed during my closing argument. It was the most shocking and appalling proceeding I've ever seen as a lawyer in my career."

Wood was representing Christian — whose name has been changed because of his age and for fear of retribution by jail staff — the 16-year-old friend of Wood's daughter. He is currently awaiting trial in the Harris County jail, charged with murder. According to court records, eyewitnesses stated that Christian was being assaulted in a car during a marijuana buy when a gun went off, killing another boy. A third youth admitted to being the shooter and gunshot residue was found on his hands, but he later recanted. When police interviewed Christian, he admitted to the shooting, though his lawyers claim gunshot residue tests on him were negative and he was never Mirandized.

The factual allegations of the criminal case, however, are not the only elements a judge must consider when deciding whether to certify a juvenile and transfer him to adult court. The Texas Family Code requires that a judge must also weigh the sophistication and maturity of the child, the previous history of the child, the protection of the public and the likelihood of rehabilitation.

During Christian's hearing, the prosecutor called one witness: a detective who recounted the alleged facts unearthed during the investigation. The assistant district attorney never presented evidence relating to the other criteria, according to the transcript of the proceeding.

On the other hand, Christian's defense team did. Christian's juvenile probation officer testified that Christian had neither attendance nor behavioral issues at school, and juvenile corrections officer Ulysses Galloway told the court that Christian was "one of the best kids I have seen come through as far as his intelligence and obedience and the way he carries himself in the facility." When asked if he believed Christian would be amenable to treatment, Galloway said, "Yes, I would."

That sentiment was echoed by forensic psychologist Dr. Seth Silverman, whose report to the court stated that Christian might be harmed by being transferred to the adult jail due to the lack of rehabilitation there, and could benefit from a supportive juvenile setting.

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The prosecutor never presented evidence that treatment available in the juvenile system would be ineffective, according to court records.

In addition, it came out at the hearing that Christian had discovered only a year earlier that the reason his mother was serving time in prison was for suffocating Christian's baby sister and dumping her in a trash can when Christian was two years old.

Still, at the end of the hearing, Shelton certified Christian. The court order does not list any individualized reasons; it's simply a form order signed by the judge. Christian was then taken to the county jail and placed in segregation. It wasn't until months later that he was indicted.

Lawyers from the prestigious international law firm Jones Day, which has offices in Houston, are currently working on Christian's case pro bono. They have filed a petition for writ of mandamus seeking relief from the state's First Court of Appeals to essentially reverse the certification decision and have Christian placed in juvenile detention.

Jones Day attorney Jack Carnegie takes issue with several aspects of the certification process. For starters, he believes that judges should be forced to include individualized findings as to why juveniles are being certified, as opposed to simply signing a generic form.

"The form orders make the same findings in every case," he says, "and that results in these cases turning solely on the severity of the crime, and there's a real question about whether those other factors that the Legislature says the court is supposed to consider are being properly considered."

Or as Marrus of the University of Houston puts it, "What judges tend to do is rubber-stamp...rather than consider all of the information and the individualized nature of the child's case, which is what the juvenile court is supposed to do."

Carnegie and Marrus are not alone in their suspicions and concerns.

Criminal defense attorney Vivian King, who has represented a teen during a certification hearing, says she thinks the process is "a joke. The judges don't listen to the facts and they just certify the kids. There's no meaningful consideration of the evidence, the age; I didn't see any of that."

Dena Fisher was a juvenile probation officer for 15 years before becoming a prosecutor in the Harris County D.A.'s office. She says just thinking about the certification hearings makes her "squirm."

"I think that certification is a very big decision made with usually only one side of the story, the officer's testimony," she says. "And it's supposed to be based on the best interest of society and whether the kid can be rehabilitated. It is usually a very quick decision on a very important matter."

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This, however, is not the routine in every county, says Sean McAlister, a former Harris County juvenile prosecutor.

"In Fort Bend County," he says, "it's a much more formal and involved process. You see, Harris County has always sort of read between the lines...so they dismiss with a lot of the formalities. And even though technically that's okay, you have other counties like Fort Bend that actually go through the process of calling all their witnesses, almost like a trial."

Three judges currently preside over certification hearings in Harris County: Shelton, who has been on the bench since 1994; Judge John Phillips, who was elected in 2002; and Judge Michael Schneider, who started the job in 2006. Nearly every year, Shelton has certified the most juveniles, almost double Schneider's number. In 2007, Shelton approved 40 versus Schneider's 15. Phillips's numbers fall between the two.

Neither Shelton nor Phillips returned numerous requests to address the allegations. Schneider, however, responded.

"I can tell you that in my court," he says, "we follow the criteria in the Family Code in every single case. Not only do we look at the seriousness of the case, but also whether the juvenile system has something to offer as opposed to the adult system." As to why the percentage of certifications is so high, he says, "I don't know."

Schneider also says he had no idea that certified juveniles were kept in 23-hour isolation when they were transferred into the county jail.

"It's something I've never considered because it's never been presented into evidence," he says. "This is the first time I've heard of it."

In Texas, it is up to prosecutors to choose which youths they want certified and to request certification hearings.

"We try to send the worst of the worst over to adult court," says Juvenile Division Chief Bill Moore, "the people we really want to get out of society."

Moore says he believes his attorneys do try to address all the factors as required by law during a certification hearing and that it is not a rubber-stamp proceeding.

"I think they get a fair shake in court," says Moore. "The percentage [of certifications] does seem high, but if it's true, I guess it means we're doing a good job picking them."

The fact that the youths are held in isolation does not enter the minds of prosecutors when deciding whether to seek certification, says Moore.

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"Would I love it if the state and county had the money and resources to really take care of these kids and really try to get them so they can come back into society?" he says. "Heck yes. But we seek to certify the ones we get a sense from the juvenile probation people are beyond rehabilitation. Are we right all the time? Who knows, but as prosecutors we really have to be concerned with protecting people from these kids getting back out and committing another robbery or murder."

Using Christian's hearing as an example, Moore's rationale appears flawed. Christian's juvenile probation officer testified that Christian was in fact responsive to rehabilitation and Moore's language assumes that a child is guilty. By placing Christian and others in the jail and subsequently in isolation to await trial, argues John Vernon, an attorney with Appleseed, "the judge has essentially convicted and punished" them, "potentially causing irreparable harm."

Also at issue in Christian's court petition is the fact that after a child is certified, he cannot appeal the decision until the criminal trial is over. According to Carnegie, this means "you may have a child, who is wrongfully certified, end up in adult prison for a long time awaiting trial and they can't appeal the certification for months or even years."

Harris County attorneys responded, arguing simply that a right to appeal exists; the fact that it might take years is irrelevant.

When it comes to keeping teens locked up in isolation, jail administrators don't like it any better than the kids themselves.

"It's a Catch-22," says Liz Ryan of Youth Justice. "They don't want the kid in isolation and they don't want the kid in general population. They know it's not safe either way."

Dennis McKnight used to run the adult jail in Bexar County, where he felt forced to keep certified juveniles in their own cells alone 23 hours a day. Not that he really wanted to.

"If I had my absolute druthers," he says, "they'd be housed in a juvenile facility or a special facility just for them. It creates tremendous burdens on the local detention centers. Lots of kids have mental or emotional issues and it adds a layer of stuff we have to deal with that we're not set up to deal with."

He likens a county jail to a garbage Dumpster. Jail administrators don't get to pick and choose what gets tossed in, but they have to make room for whatever comes their way.

Harris County sheriff's spokesman Lieutenant John Legg says the jail does not make special accommodations for juveniles.

"They're treated like any other inmate," he says.

Except for one glaring difference: isolation.

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One reason for this, says Legg, "is for their own safety." He says several years ago, teens were allowed into common areas with each other during the day, but they would fight and steal each other's commissary items, so jail officials decided to keep them in their cells for a majority of the time. A choice, says Legg, "which has had the desired result."

While the violence may be down, isolation has not eliminated it, if you listen to the kids themselves. All of the juveniles that the Houston Press interviewed who are currently in the jail say they or their fellow teens sneak out of their cells from time to time by placing toilet paper in their cells' door locks, making it appear to the guards that the doors are shut, when in fact they are open. The kids say they do this to get out of their cells and fight each other.

This doesn't surprise McKnight. He acknowledges what psychologists say, which is that isolation can make young inmates feel the need to act out.

"They're already under a lot of stress because they are in jail charged with a pretty heavy offense," he says. "And then shoving them in isolation, that doesn't help any. That makes it much more stressful and increases your suicide and violence risk. They might just flare up at any moment because they're pent up with all that anxiety and something's gotta blow."

According to the sheriff's office, the teens are allowed out of their cells 20 hours a week, including recreation time and schooling. The kids themselves, however, told the Press that they receive somewhere between two and four hours a week of classes and that they don't always get a full three hours of recreation time.

Still, 20 hours a week outside of their cells means the teens spend nearly 90 percent of their time locked up alone.

Legg, though, doesn't quite see it that way.

"Out of a 24-hour day," he says, "I think it would be safe to take at least eight hours of that time out because they are sleeping. So they're not really locked down, so to speak, for 23 hours."

Sue Burrell says that line of thinking is "garbage. However you slice it, it means that kids are out of their room for [approximately] one hour a day...and they are defending that practice? Unbelievable."

To the adult jailors, though, it all comes down to a choice between the lesser of two evils: general population or segregation and isolation.

"They shouldn't be held in 23-hour lockdown," admits McKnight, "but unfortunately that's where we have to put them for their safety and for everyone else's safety. It's a trade-off that we are forced to make."

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Peering through the glass wall in the jail's visitation area, a 16-year-old we'll call Diego is excited to see a visitor. It means he gets to try to have a conversation, or at least some version of one.

"It's hard to talk with people," says Diego, who has been in the county jail for the past six months, charged with aggravated robbery. "There's nothing to relate to. I'm in here by myself 23 hours a day."

He is happy, though, because at least he gets out of his cell.

"It's always the best part of my day," he says.

Like George, Diego says time drones on, blending into one seamless, never ending day. He is bored constantly. So bored, he says, that some days he can't even concentrate to read. Occasionally, he catches himself talking to himself out loud. At times he's thought he was hallucinating. Like many other teens in segregation, he'll beat on his cell door and try to start a riot, "sometimes because we didn't get our full hour out of our cell and sometimes because there's nothing else to do."

He says he can't wait to turn 17 and get placed in with other inmates, or get convicted and go to prison, just so he can escape the isolation.

"The worst thing is the pain of being alone in my cell 23 hours a day," he says. "This is the worst place I have ever been."

If only, he muses, he could go back to the juvenile detention facility, where he was held before being certified as an adult.

"I'm too young to be in here," he says. "It would be much better to have school all day and some therapy."

As it is, he says, he receives no counseling at all.

It's no secret that the adult criminal justice system is not geared toward rehabilitation, and when it comes to teens, numerous studies prove the point. According to the Office of Juvenile Justice and Delinquency Prevention, part of the U.S. Department of Justice, "six large-scale studies" found higher recidivism rates among juveniles who had been transferred to the adult system, compared to those who remained in the juvenile system (see "For Their Own Good: A Chance at Rehabilitation").

A few state and federal lawmakers have taken notice and are attempting to change both the certification process and the way in which certified teens are held pretrial.

In Texas, Representative Sylvester Turner of Houston has introduced a bill that would require judges to specifically state the reasons for transferring a child to the adult court, ending the use of form orders.

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In Congress, Senator Patrick Leahy, Democrat of Vermont, has introduced a change to the Juvenile Justice and Delinquency Prevention Act. The amendment states that in order for counties to receive funding through the federal justice program, they must detain all children in juvenile facilities, even if they've been certified. If and only if a judge determines after a hearing and in writing that the child is a risk to public safety, can the juvenile be held in adult jail.

In juvenile detention, according to Kendall Mayfield of the Harris County Probation Department, children receive seven hours a day of schooling, contact visits with their parents, therapy, and they get to socialize more normally with their peers.

When asked about the possible solution of holding certified youths in the juvenile facility, Legg refused to discuss hypothetical situations because "as the sheriff has said in response to other similar types of questions, 'it really doesn't matter what I feel; it wouldn't change the reality of the situation right now.'"

Harvey Hetzel, head of the Harris County Juvenile Probation Department, however, says his facility has enough beds to house certified youths.

"I didn't realize they were being put in isolation," he says, "and I certainly don't think that's appropriate. We could better deal with them, but it's a different population than what we have, so we'd have to gear up for it."

It all boils down to where the county spends its money and political will.

When asked if he would support additional resources for Hetzel to house certified juveniles, County Judge Ed Emmett declined to comment. His spokesman, Joe Stinebaker, says Emmett did not know that certified juveniles were held pretrial in isolation most of the time and does not want to talk about a situation he knows little about.

Aside from a lack of awareness on the issue, says McKnight, "the average person wants the county to spend money on more officers, not more cells. They want the [inmate] in or under the jail, fed bread and water, and that's it."

Unfortunately, for many people, it's an all or nothing mentality when it comes to criminal justice.

"You're either in favor of locking up everybody and everything and are 'hard on crime,'" Dvoskin says, "or you're a yellow-bellied coward who wants to let these guys rape everybody's daughter. But nobody gets elected saying, 'Let's use some common sense.' This is a very complex issue. We have to ask ourselves, 'Do we want to give up on these kids?' And if so, how hard a decision should that be?"

In the meantime, kids such as George sit alone in their cells, waiting for their day in court, taking refuge the only place they can: in their dreams.

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JUSTICE CENTER
THE COUNCIL OF STATE GOVERNMENTS

Hearing before the
Senate Committee on the Judiciary
Subcommittee on Human Rights and the Law

on

"Human Rights at Home: Mental Illness in U.S. Prisons and Jails"

Tuesday, September 15, 2009
Dirksen Senate Office Building Room 226
10:00 a.m.

Testimony submitted by

Fred C. Osher, MD
Director of Health Systems and Services Policy,
Council of State Governments Justice Center

The Problem

I am dismayed to be "forced to authorize the confinement of persons with mental illness in the Williamsburg jail, against both my conscience and the law" because of lack of appropriate services. (Governor of Virginia, 1773)[1]

People with mental illnesses (most of whom have co-occurring substance use disorders) are overrepresented at every stage of the criminal justice system. Increasingly large numbers of these individuals come in contact with law enforcement agencies, courts, jails, community corrections, and prisons. Recently, researchers documented serious mental illnesses in 14.5 percent of male jail inmates and 31 percent of female jail inmates;[2] rates in excess of three to six times those found in the general population.[3] Generalized to the findings that more than 13 million jail admissions were reported in 2007, this implies that more than 2 million bookings of a person with a serious mental illness occurs annually.[4] The presence of so many people with mental illnesses in criminal justice settings represents an enormous challenge for federal and state corrections and behavioral health systems of care, our communities, families, and those with mental illnesses. It is also the case that the vast majority of people with mental illnesses will be returned to the community from jail or prison. However, with states facing the grim reality of enormous budget shortfalls, it is difficult to identify resources to fund effective transition strategies such as specialized community corrections supervision, effective mental

[1] Deutsch A. *Mental Illness in America: A History of Their Care and Treatment from Colonial Times* (New York: Columbia University Press, 1937).

[2] Steadman, H. J., F. C. Osher, P. C. Robbins, B. Case, and S. Samuels. "Prevalence of Serious Mental Illness among Jail Inmates." *Psychiatric Services* 6 (2009): 761–65.

[3] The estimate for the prevalence of serious mental illness in the general population is 5.4 percent (Kessler, R. C., C. B. Nelson, K. A. McKinagle, Edlund, R. G. Frank, and P. J. Leaf, The epidemiology of co-occurring addictive and mental disorders: Implications for prevention and service utilization. *American Journal of Orthopsychiatry* 66 (1996): 17–31.

[4] Sabol, W. J., and T. D. Minton. *Jail Inmates at Midyear 2007* (Washington: Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, 2008).

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health and co-occurring substance abuse treatments, supported employment, and supportive housing.

The majority of individuals with mental illnesses who wind up in jails have committed nonviolent misdemeanors, often as a result of their untreated mental illnesses and many with co-occurring substance use disorders. For these individuals, contact with the criminal justice system starts a cycle of arrest, incarceration, release, and re-arrest that poses nearly insurmountable challenges to recovering from their mental illnesses. With more serious charges, or failure to comply with conditions of probation and parole, prisons become the institutional home for these individuals. There is no doubt that many individuals who have mental illnesses commit crimes for which they should be incarcerated. As one component in efforts to improve public safety, individuals with mental illnesses who commit violent crimes must be held responsible for their actions. However, most correctional officials agree with community-based treatment providers that jail and prison environments are not the best treatment setting for the vast majority of individuals with mental illnesses—in fact, this environment can exacerbate mental illnesses in a manner that poses risks to the individuals, the general corrections population, and supervising staff.

Prisons were never intended to serve as mental health facilities, and all too often prisoners receive little or inadequate care, despite the best efforts of corrections administrators. The Eighth Amendment provides prisoners a right to humane conditions of confinement, and corrections administrators and their staffs work hard to achieve these conditions despite ballooning prison populations and shrinking operations dollars. Unfortunately, for too many incarcerated individuals with mental illnesses, many do not have access to the level of care that

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they require. Prisons are overcrowded and over-stimulating environments where violence is commonplace and prisoners with mental illnesses are disproportionately victims of this violence. Prisoners with mental illnesses generally have more trouble adhering to rules, resulting in punishment for misconduct, long disciplinary histories, and little accumulation of "good time." Dorothea Dix crusaded for humane responses to the needs of inmates with mental illnesses in the mid-1800s and her work was translated into state systems that traded punishment for care. We have come full circle and find ourselves asking the same questions that she posed 150 years ago: Why are we incarcerating people with mental illnesses, in environments that can be toxic, when we know recovery is possible if they are afforded adequate care? "This national disgrace, kept hidden for too long, represents one area in civil rights where we have actually lost ground."[5]

These conditions exist despite the fact that spending on corrections has risen faster than spending on nearly every other state budget item, and now tops $45 billion a year.[6] Although the amount of dollars has skyrocketed, the majority of resources have been devoted to capital construction to accommodate prison population booms, whereas treatment and programming budgets can't keep pace with growing demands. The result is understaffing, limited programming, insufficient facilities, and inadequate care. There is unanimity from administrators, staff, those incarcerated, and their families, that a safer and more rehabilitative environment is needed.

[5] Report of the National Leadership Forum on Behavioral Health/Criminal Justice Services, *Fixing an American Tragedy: Addressing the Needs of Justice-Involved People with Mental Illnesses and Co-occurring Disorders*. 2009, in press.

[6] National Association of State Budget Officers. *State Expenditures Report 2006* (Washington: National Association of State Budget Officers, 2007).

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Although the available treatments and conditions that people with mental illnesses in prison experience far too often demand remedy, I've chosen to focus the remainder of my comments on strategies to keep people with mental illnesses who don't need to be in jails and prisons out, and assist those who are reentering society from jail and prison from coming back.

Heterogeneity of the population

In discussing incarcerated individuals with mental illnesses, it is important to keep in mind the heterogeneity of this group. They differ in terms of the seriousness of their mental illnesses, charge levels, criminogenic risks, and access to community supports. Unfortunately, the criminal justice system rarely does an adequate job of screening, assessing, and individualizing responses to those identified as having a mental illness. Lumping prisoners with mental illnesses into a single class does not allow for prioritization of scarce resources to those most in need. The need for valid and reliable screening and assessment processes has never been greater.

Why are there so many people with mental illnesses in jail and prison?

To develop appropriate responses to with mental illnesses in jail and prison, it is important to understand the reasons why they wind up in jail and prison. There are a number of common explanations:

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- First, people with mental illnesses may be more visible to law enforcement because of behaviors stemming from lack of treatment (e.g., public disturbance or other "nuisance" offenses).

- Second, people with mental illnesses are at increased risk of developing substance use disorders over the course of their lifetimes, and arrests for drug offenses have skyrocketed since 1980. Research has found that nearly three-quarters of men and women with mental illnesses in jails also have a co-occurring substance use disorder.[7]

- Third, incarcerated persons with mental illnesses are much more likely to have been homeless at the time of their arrest than those without mental illnesses.[8] Being homeless makes a person very visible in our communities and their panhandling or public intoxication are frequent causes of calls to law enforcement. In addition, not having a stable place to live severely complicates the reentry of a person with mental illness after release from prison.

- Fourth, limited access to over-burdened community-based treatment may make individuals with untreated symptoms more likely to be arrested, increase delays in release from jail and prison, and may limit individuals' ability to successfully reintegrate into their communities. As such, cuts in mental health services have

[7] Abram, K. M., and L. A. Teplin, "Co-occurring Disorders among Mentally Ill Jail Detainees: Implications for Public Policy." *American Psychologist* 46 (1991): 1036-45.

[8] Ditton, P. M. *Mental Health and Treatment of Inmates and Probationers* (Washington: US Bureau of Justice Statistics, 1999).

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an impact on the prevalence of mental illnesses in jails and prisons insofar as they make it more difficult for treatment providers to dedicate resources, time, and treatment slots to this population.

- Fifth, the conditions in many jails and prisons can have a harmful effect on the mental health of all prisoners. Overcrowded, high-intensity interactions with regular threats to personal safety, and limited access to treatment can make the prison experience a prolonged traumatic event. Privacy is non-existent. The noise levels within jail and prison settings throughout the day and night are excessive and there is absolutely nothing the prisoner or inmate can do about it. And yes, this is incarceration after all, but the deleterious effects of these circumstances on a person with serious mental illnesses are predictable – ranging from despair or psychotic symptoms to violent acting-out. These reactions are exacerbated by the use of special housing units that isolate individuals acting out as a result of their mental illness from contact with others and psychiatric services.

- Sixth, once in jail and prison, people with mental illnesses tend to stay longer, and are less likely to be placed on probation or parole, than others charged with similar offenses. Parole board members may lack confidence in community resources for individuals with mental illnesses, have misconceptions about mental illnesses, or fear negative public reactions. As a result, people with mental illnesses more often serve the maximum sentence allowed by law.[9]

[9] Council of State Governments Justice Center, Criminal Justice/Mental Health Consensus Project Report, 2002.

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- And finally, once released, without adequate treatment, supports, and supervision, prisoners with mental illnesses are more likely to recidivate. In a study that examined data on people released to parole in California during 2004 (more than 100,000 people), researched found that people on parole with mental illnesses were more likely to return to prison for a parole violation within one year (33 percent), compared to people without mental illnesses (20 percent).[10]

Recommendations

To address the large numbers of people with serious mental illnesses in jails and prisons, and their heterogeneity, will require multiple approaches. Some central features of this response should include the following:

- Improve the process of identifying prisoners with mental health needs.
    - Ensure jail and prison screening, assessment, and follow-up facilitates individuals' safe and effective placement and programming while in custody and during the transition back to the community—recognizing that individuals with mental illnesses who pose limited public safety risk, many of whom are pre-trial detainees, are sensitive to stress and trauma that can result in the worsening of

[10] Louden, Dickenger, and Skeem. Parolees with Mental Disorder; Toward Evidence-based Practice. in press.

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their condition. The use of validated screening instruments and assessment processes at every criminal justice site is of paramount importance.

- Increase appropriations for the Mentally Ill Offender Treatment and Crime Reduction Act.
    - Research shows that community-based treatment works for the vast majority of people with serious mental illnesses, and the overwhelming majority of people with serious mental illnesses have no contact with the criminal justice system. For those who are involved with the criminal justice system, specialized responses have been shown to increase access to treatments and services and some interventions show promise in reducing recidivism. Communities have established such promising practices as police-based interventions that divert people with mental illnesses into treatment in lieu of arrest when appropriate, problem-solving court-based models (such as mental health courts) that mandate treatment in return for charge-reduction or dismissal, enhanced transition planning from jail and prison to the community, and specialized probation and parole supervision models that aim to reduce recidivism rates for this population post-adjudication.
    - These activities are supported by the Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA). MIOTCRA was signed into law in 2004 and authorized a $50 million grant program to be administered by the U.S. Department of Justice (DOJ). This law created the Justice and Mental Health Collaboration Program (JMHCP) to help states and counties design and implement collaborative efforts between criminal justice and mental health

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systems. The grants available through the MIOTCRA are in high demand. In the first three years of the program only about 11 percent of grant applications were funded. In 2008, Congress reauthorized the MIOTCRA program for an additional five years. Communities around the country are applying MIOTCRA grant dollars to implement evidence-based interventions such as specialized police-based responses; mental health courts; jail interventions that provide continuity of care; training for community correction officers to break the cycle of re-incarceration; and the provision of specialized reentry services and supports.

- Improve access to income supports and entitlements to individuals with mental illnesses upon release from prison.
    - Getting immediate access to income supports and entitlements on release from a corrections facility can be a significant event associated with reduced recidivism. These benefits allow individuals to receive critical treatment and medications. States such as Oklahoma have developed innovative partnerships between the departments of corrections, human services, and the state social security administration to ensure access to benefits on release. Evaluating and expanding these initiatives can make a critical difference.
- Address the tremendous cost of incarceration by the reinvestment of resources into community-based services that can reduce recidivism.
    - With state prison populations projected to continue increasing over the next decade, state policymakers are finding themselves at a crossroads: they must find

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new dollars to build and operate additional corrections facilities or identify strategies to manage the growth of the prison population. In response, policymakers in various states have been planning, designing, and applying a justice reinvestment strategy to increase public safety and save millions of dollars that would have otherwise been spent to build new prisons. Because of the overrepresentation of mental illnesses within corrections settings, some of this investment should fund effective community-based mental health services.

- Fund comprehensive reentry services through the Second Chance Act.
    - The Second Chance Act (P.L. 110-199) was signed into law on April 9, 2008. The Second Chance Act is an investment in programs proven to reduce recidivism and the financial burden of corrections on state and local governments, while increasing public safety. The bill authorizes $165 million in grants to state and local government agencies and community organizations to provide employment and housing assistance, substance abuse treatment, family programming, mentoring, victim support and other services that help people returning from prison and jail avoid criminal activity and succeed in their communities. Mental health services are a critical component of the Second Chance Act and these services are needed to help reduce the revolving doors of jail and prison that are too often experienced by people with mental illnesses.

Thank you for the opportunity to address the critical issue of persons with mental illnesses in our jails and prisons. Acting now can both alleviate systemic problems that are choking correctional

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facilities and enable justice-involved individuals with mental illnesses to achieve their full potential.

About the Justice Center

The Council of State Governments Justice Center is a national nonprofit organization that serves policymakers at the local, state, and federal levels from all branches of government. The Justice Center provides practical, nonpartisan advice and consensus-driven strategies—informed by available evidence—to increase public safety and strengthen communities. The Center's work focuses on areas in which the criminal justice system intersects with other disciplines, which requires that we bring together broad coalitions of disparate groups to develop cross-systems solutions.

CSG's Justice Center is a strong proponent of coordinated and integrated mental health/substance abuse services that can reduce contacts with the criminal justice system. The Center released the *Consensus Project Report* in 2002, which was written by staff under the guidance of more than 100 national experts from law enforcement, courts, corrections, community supervision, mental health, addictions, and victims' agencies. The Consensus Project helps policymakers and practitioners improve the response to people with mental illnesses who come into contact with the criminal justice system—many of whom have co-occurring substance use problems and cycle through both the justice system and emergency services.

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Statement of Senator Tom Coburn, M.D.

"Human Rights at Home: Mental Illness in U.S. Prisons and Jails"
Subcommittee on Human Rights and the Law
United States Senate Committee on the Judiciary
September 15, 2009

Thank you, Chairman Durbin, for allowing me the opportunity to make an opening statement this morning. As some of you may know, the Judiciary Committee re-established the Subcommittee on Human Rights and the Law this summer, and I am pleased to be working with Senator Durbin and his staff once again on these very important issues.

In the past, while this Subcommittee has examined extremely important topics within the field of human rights, its focus has been mostly on events occurring outside of the United States. Today, we turn inward to an issue specifically affecting our own country in many different ways. As a physician, I am acutely aware of the plight of our mentally ill citizens. Historically, this country maintained the traditional model of *institutional* mental health systems. Over the course of the last 50-60 years, however, that model has changed to more *community-based* treatment, largely due to positive developments in mental health care, such as effective medications and improved rehabilitation methods. However, many individuals who could benefit from such treatment are often unable to access the mental health system, and many end up in contact with our criminal justice system instead.

As a result, I recognize that both our federal and state criminal justice systems must accommodate mentally ill offenders, and that such a task is difficult and costly. States, in particular, face quite a challenge, as they incarcerate the vast majority of mentally ill offenders—1.4 million in 2007, as compared to 199,600 in the federal system. While states have an awesome responsibility on this issue, they also have a great opportunity to lead by way of experience and example. They can and have done so by developing and funding their own innovative ideas to enhance programs for and treatment of mentally ill inmates. I commend those states for their commitment to treating these offenders.

Among the states, however, there is diversity among the types of inmates that are incarcerated. States like Illinois and New York, which have significant urban areas, likely incarcerate a much different population than Oklahoma. Moreover, inmates housed in the federal system also likely exhibit different characteristics than state inmates. As a result, there is no one type of programming

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or amount of funding that will fit the needs of all prison systems and inmates. My hope is that today's hearing will facilitate an exchange of ideas about what works and what doesn't, so that prison systems across the country can benefit from our discussion.

I thank the Chairman for holding this hearing, and I look forward to hearing from each of our witnesses, as each brings a different perspective to this issue. There is a need for improvement in the treatment of mentally ill offenders in both the federal and state criminal justice systems, and I look forward to hearing your innovative ideas on how to accomplish this task.

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Statement of

The Honorable Richard J. Durbin

United States Senator
Illinois
September 15, 2009

Opening Statement of Senator Dick Durbin
Chairman, Subcommittee on Human Rights and the Law
Hearing on "Human Rights at Home:
Mental Illness in U.S. Prisons and Jails"
September 15, 2009

This hearing of the Human Rights and the Law Subcommittee will come to order. The subject of today's hearing is "Human Rights at Home: Mental Illness in U.S. Prisons and Jails."

At the outset, I want to thank Judiciary Committee Chairman Patrick Leahy for reestablishing this Subcommittee. This is yet another measure of Senator Leahy's longstanding commitment to human rights. I also want to thank Senator Jeff Sessions, the Committee's Ranking Member, for his support for this Subcommittee.

Finally, I want to express my appreciation to Senator Tom Coburn for again serving as the Ranking Member of this Subcommittee. Senator Coburn and I have had a very cooperative and productive relationship, which I look forward to continuing.

In the 110th Congress, the Human Rights and the Law Subcommittee focused and reflected on issues like genocide in Darfur, internet censorship in China, and rape as a weapon of war in the Democratic Republic of Congo. But we must also reflect on ourselves.

Today in the United States, more than 2.3 million people are imprisoned. This is – by far – the most prisoners of any country in the world and – by far – the highest per capita rate of prisoners in the world. African Americans are incarcerated at nearly six times the rate of whites. And many of these prisoners are nonviolent drug offenders and individuals with serious and persistent mental illness.

Senator Webb has introduced legislation that would create a commission to examine our criminal justice system and make recommendations for reform. This comprehensive review is much-needed and long overdue. But there are critical reforms needed now and we should not wait to address them.

Earlier this year, Senator Graham and I held a hearing on the sentencing disparity between crack

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and powder cocaine, which leads to excessive prison sentences for many non-violent drug offenders. We are working with Senator Coburn, Chairman Leahy, Ranking Member Sessions and other colleagues on the Judiciary Committee on legislation to address this problem.

Today, we are going to address another aspect of our criminal justice system that raises important human rights issues: the treatment of mental illness in U.S. prisons and jails.

The late Paul Simon, my friend and mentor, first brought this issue to my attention many years ago and the problem has only grown worse since then.

In a 2006 study, the Bureau of Justice Statistics found that more than half of all prison and jail inmates, including 45 percent of federal prisoners, 56 percent of state prisoners, and 64 percent of local jail inmates suffer from a mental health problem.

In fact, the three largest mental health facilities in the United States are Los Angeles County Jail, Rikers Island Jail, and Cook County Jail.

Women and children are especially vulnerable. BJS found that 61 percent of females in federal prisons have mental health problems, compared to 44 percent of males.

According to a recent survey, nearly two thirds of boys and three quarters of girls detained in juvenile facilities in Cook County, Illinois, have at least one mental illness. Juvenile offenders with serious mental illnesses are more likely to be abused by other juvenile offenders and to have their incarceration extended because of conduct related to their mental illnesses.

By allowing our prisons and jails to become our nation's primary provider of mental health services, we have taken a step backward in the effort to protect the human rights of people with mental illness. Two hundred years ago, people with mental illness were incarcerated in jails and prisons. By the beginning of the twentieth century, we transitioned to a system of state mental hospitals. Growing public revulsion about conditions in mental hospitals led to the deinstitutionalization movement in the second half of the twentieth century. Community mental health services were supposed to replace state mental hospitals, but sufficient services have never been available. It is stunning to read that eight years ago the GAO found that 9000 children were surrendered to juvenile justice systems so that they could receive mental health services.

As a result of all this, many people with mental illness cycle in and out of correctional institutions, presenting a danger to themselves, correctional officers, and the public. We have returned to the loathsome, indefensible practice of incarcerating the mentally ill.

While in prison, many mentally ill prisoners have limited or no access to mental health services and their conditions frequently deteriorate. They often have difficulty complying with prison rules and, as a result, are disproportionately represented in solitary confinement, which exacerbates mental illness.

I am deeply troubled by reports about conditions for persons with mental illness at Tamms Correctional Center, a super-maximum security facility in my home state of Illinois. Governor

Quinn recently ordered a review of Tamms and I look forward to discussing this issue with one of our witnesses, Michael Randle, who heads the Illinois Department of Corrections.

And I want to salute Gary Marx of the Chicago Tribune and especially George Pawlaczyk and Beth Hundsdorfer of the Belleville News-Democrat for their provocative and thorough articles on the Tamms Correctional Center.

I also look forward to hearing from our witnesses about best practices for dealing with people with mental illness in the criminal justice system, including mental health courts to divert appropriate individuals into mental health treatment and a continuum of care for incarcerated individuals from entry screening to discharge planning.

The United States was founded on the principle that all people are created equal and endowed with certain inalienable rights. This was, and still is, the promise of America. For generations, this singular idea has inspired freedom fighters, toppled ruthless dictators, and given hope to the disempowered and disenfranchised around the world. We must keep faith with our founders by working to keep America's promise at home and abroad.

That is true even for, in fact especially for, the least among us – whether it is a crack addict serving a mandatory minimum sentence or a person with mental illness who cycles endlessly through shelters, hospitals, jails, and prisons. This is the right thing to do, but it also is the smart thing to do because it will keep police and corrections officers and the public safer and dramatically reduce costs for incarceration at a time of fiscal crisis for many states.

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Mental Health Problems of Prison and Jail Inmates

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At midyear 2005 more than half of all prison and jail inmates had a mental health problem, including 705,600 inmates in State prisons, 78,800 in Federal prisons, and 479,900 in local jails. These estimates represented 56% of State prisoners, 45% of Federal prisoners, and 64% of jail inmates. The findings in this report were based on data from personal interviews with State and Federal prisoners in 2004 and local jail inmates in 2002.

Mental health problems were defined by two measures: a recent history or symptoms of a mental health problem. They must have occurred in the 12 months prior to the interview. A recent history of mental health problems included a clinical diagnosis or treatment by a mental health professional. Symptoms of a mental disorder were based on criteria specified in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV).

	Percent of inmates in —		
Mental health problem	State prison	Federal prison	Local jail
Any mental problem	56%	45%	64%
Recent history	24	14	21
Symptoms	49	40	60

More than two-fifths of State prisoners (43%) and more than half of jail inmates (54%) reported symptoms that met the criteria for mania. About 23% of State prisoners and 30% of jail inmates reported symptoms of major depression. An estimated 15% of State prisoners and 24% of jail inmates reported symptoms that met the criteria for a psychotic disorder.

Highlights

High prevalence of mental health problems among prison and jail inmates

	Percent of inmates in —			
	State prison		Local jail	
Selected characteristics	With mental problem	Without	With mental problem	Without
Criminal record				
Current or past violent offense	61%	56%	44%	36%
3 or more prior incarcerations	25	19	26	20
Substance dependence or abuse	74%	56%	76%	53%
Drug use in month before arrest	63%	49%	62%	42%
Family background				
Homelessness in year before arrest	13%	6%	17%	9%
Past physical or sexual abuse	27	10	24	8
Parents abused alcohol or drugs	39	25	37	19
Charged with violating facility rules*	58%	43%	19%	9%
Physical or verbal assault	24	14	8	2
Injured in a fight since admission	20%	10%	9%	3%

*Includes items not shown.

- Nearly a quarter of both State prisoners and jail inmates who had a mental health problem, compared to a fifth of those without, had served 3 or more prior incarcerations.
- Female inmates had higher rates of mental health problems than male inmates (State prisons: 73% of females and 55% of males; local jails: 75% of females and 63% of males).
- About 74% of State prisoners and 76% of local jail inmates who had a mental health problem met criteria for substance dependence or abuse.
- Nearly 63% of State prisoners who had a mental health problem had used drugs in the month before their arrest, compared to 49% of those without a mental health problem.
- State prisoners who had a mental health problem were twice as likely as those without to have been homeless in the year before their arrest (13% compared to 6%).
- Jail inmates who had a mental health problem (24%) were three times as likely as jail inmates without (8%) to report being physically or sexually abused in the past.
- Over 1 in 3 State prisoners and 1 in 6 jail inmates who had a mental health problem had received treatment since admission.
- State prisoners who had a mental health problem were twice as likely as State prisoners without to have been injured in a fight since admission (20% compared to 10%).

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A quarter of State prisoners had a history of mental health problems

Among all inmates, State prisoners were most likely to report a recent history of a mental health problem (table 1). About 24% of State prisoners had a recent history of a mental health problem, followed by 21% of jail inmates, and 14% of Federal prisoners.

A recent history of mental health problems was measured by several questions in the BJS' inmate surveys. Offenders were asked about whether in the past 12 months they had been told by a mental health professional that they had a mental disorder or because of a mental health problem had stayed overnight in a hospital, used prescribed medication, or received professional mental health therapy. These items were classified as indicating a recent history of a mental health problem.

State prisoners (18%), Federal prisoners (10%), and jail inmates (14%) most commonly reported that they had used prescribed medication for a mental problem in the year before arrest or since admission. They were least likely to report an overnight stay in a hospital for a mental health problem. Approximately, 5% of inmates in State prisons, 2% in Federal prisons, and 5% in local jails reported an overnight stay in a hospital for a mental health problem.

Prevalence of symptoms of mental disorders among prison and jail inmates

The Survey of Inmates in State and Federal Correctional Facilities, 2004, and the Survey of Inmates in Local Jails, 2002, included a modified structured clinical interview for the DSM-IV. The surveys collected information on experiences of inmates in the past 12 months that would indicate symptoms of major depression, mania, or psychotic disorders. The surveys did not assess the severity or duration of the symptoms, and no exclusions were made for symptoms due to medical illness, bereavement, or substance use. Inmates in mental hospitals or otherwise physically or mentally unable to complete the surveys were excluded from the sample.

Estimates of DSM-IV symptoms of mental disorder provide a baseline indication of mental health problems among inmates rather than a clinical diagnosis of mental illness. Major depression or mania symptoms covered a range of feelings and behaviors, such as persistent sadness, loss of interest in activities, insomnia or hypersomnia, psychomotor agitation, and persistent anger or irritability.

Insomnia or hypersomnia and persistent anger were the most frequently reported major depression or mania episodes with nearly half of jail inmates (49%) reporting these symptoms. Attempted suicide was the least reported symptom by State prisoners (13%), Federal prisoners (6%) and local jail inmates (13%).

A psychotic disorder was indicated by any signs of delusions or hallucinations during the 12-month period. Delusions were characterized by the offenders' belief that other people were controlling their brain or thoughts, could read their mind, or were spying on them. Hallucinations included reports of seeing things others said they did not see or hearing voices others did not hear. Approximately, 24% of jail inmates, 15% of State prisoners, and 10% of Federal prisoners reported at least one symptom of psychotic disorder (table 1).

Symptoms in past 12 months or since admission	Percent of inmates in — State prison	Federal prison	Local jail
Major depressive or mania symptoms			
Persistent sad, numb or empty mood	32.9%	23.7%	39.6%
Loss of interest or pleasure in activities	35.4	30.8	36.4
Increased or decreased appetite	32.4	25.1	42.8
Insomnia or hypersomnia	39.8	32.8	49.2
Psychomotor agitation or retardation	39.6	31.4	46.2
Feelings of worthlessness or excessive guilt	35.0	25.3	43.0
Diminished ability to concentrate or think	28.4	21.3	34.1
Ever attempted suicide	13.0	6.0	12.9
Persistent anger or irritability	37.8	30.5	49.4
Increased/decreased interest in sexual activities	34.4	29.0	29.5
Psychotic disorder symptoms			
Delusions	11.8%	7.8%	17.5%
Hallucinations	7.9	4.8	13.7

Note: Data are based on inmate self-report in the Survey of Inmates in State and Federal Correctional Facilities, 2004, and the Survey of Inmates in Local Jails, 2002. See *References* for sources on measuring symptoms of mental disorders based on a modified Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV).

Number of positive responses	Percent of inmates in — State prison	Federal prison	Local jail
Major depressive disorder symptoms			
0	29.5%	38.8%	22.8%
1-2	26.1	27.9	23.8
3-4	20.5	17.1	23.0
5 or more	23.9	16.2	30.4
Mania disorder symptoms			
0	27.3%	35.6%	22.5%
1	21.5	23.3	17.0
2	20.5	17.7	20.1
3	17.7	14.0	22.0
4	13.1	9.4	18.4
Psychotic disorder symptoms			
0	84.6%	89.8%	76.0%
1	11.1	7.8	16.8
2	4.2	2.4	7.2

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Symptoms of mental disorder highest among jail inmates

Jail inmates had the highest rate of symptoms of a mental health disorder (60%), followed by State (49%), and Federal prisoners (40%). Symptoms of a mental health disorder were measured by a series of questions adopted from a structured clinical interview for diagnosing mental disorders based on the DSM-IV (see box on page 2 and *References* for sources on DSM-IV measures). The questions addressed behaviors or symptoms related to major depression, mania, or psychotic disorders that occurred in the 12 months before the interview.

To meet the criteria for major depression, inmates had to report a depressed mood or decreased interest or pleasure in activities, along with 4 additional symptoms of depression. In order to meet the criteria for mania, during the 12-month period inmates had to report 3 symptoms or a persistent angry mood. For a psychotic disorder, 1 symptom of delusions or hallucinations met the criteria.

The high rate of symptoms of mental health disorder among jail inmates may reflect the role of local jails in the criminal justice system. Jails are locally operated correctional facilities that receive offenders after an arrest and hold them for a short period of time, pending arraignment, trial, conviction, or sentencing. Among other functions, local jails hold mentally ill persons pending their movement to appropriate mental health facilities.

While jails hold inmates sentenced to short terms (usually less than 1 year), State and Federal prisons hold offenders who typically are convicted and sentenced to serve more than 1 year. In general, because of the longer period of incarceration, prisons provide a greater opportunity for inmates to receive a clinical mental health assessment, diagnosis, and treatment by a mental health professional.[1]

[1]Persons who have been judged by a court to be *mentally incompetent to stand trial* or *not guilty by reason of insanity* are not held in these correctional facilities and are not covered by this report.

Table 1. Recent history and symptoms of mental health problems among prison and jail inmates

Mental health problem	Percent of inmates in — State prison	Federal prison	Local jail
Any mental health problem	56.2%	44.8%	64.2%
Recent history of mental health problem[a]	24.3%	13.8%	20.6%
Told had disorder by mental health professional	9.4	5.4	10.9
Had overnight hospital stay	5.4	2.1	4.9
Used prescribed medications	18.0	10.3	14.4
Had professional mental health therapy	15.1	8.3	10.3
Symptoms of mental health disorders[b]	49.2%	39.8%	60.5%
Major depressive disorder	23.5	16.0	29.7
Mania disorder	43.2	35.1	54.5
Psychotic disorder	15.4	10.2	23.9

Note: Includes inmates who reported an impairment due to a mental problem. Data are based on the Survey of Inmates in State and Federal Correctional Facilities, 2004, and the Survey of Inmates in Local Jails, 2002. See *Methodology* for details on survey sample. See *References* for sources on measuring symptoms of mental disorder based on a Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV).

[a]In year before arrest or since admission.

[b]In the 12 months prior to the interview.

Table 2. Prevalence of mental health problems among prison and jail inmates

Mental health problem	State prison inmates Number	Percent	Federal prison inmates Number	Percent	Local jail inmates Number	Percent
Any mental health problem*	705,600	56.2%	70,200	44.8%	479,900	64.2%
History and symptoms	219,700	17.5	13,900	8.9	127,800	17.1
History only	85,400	6.8	7,500	4.8	26,200	3.5
Symptoms only	396,700	31.6	48,100	30.7	322,900	43.2
No mental health problem	549,900	43.8%	86,500	55.2%	267,600	35.8%

Note: Number of inmates was estimated based on the June 30, 2005 custody population in State prisons (1,255,514), Federal prisons (156,643, excluding 19,311 inmates held in private facilities), and local jails (747,529).

*Details do not add to totals due to rounding. Includes State prisoners, Federal prisoners, and local jail inmates who reported an impairment due to a mental problem.

High proportion of inmates had symptoms of a mental health disorder without a history

Around 4 in 10 local jail inmates and 3 in 10 State and Federal prisoners were found to have symptoms of a mental disorder without a recent history (table 2). A smaller proportion of inmates had both a recent history and symptoms of mental disorder: 17% in State prisons, 9% in Federal prisons, and 17% in local jails.

An estimated 7% of State prisoners, 5% of Federal prisoners, and 3% of local jail inmates were found to have a recent history of a mental health problem and no symptoms.

About 1 in 10 persons age 18 or older in the U.S. general population met DSM-IV criteria for symptoms of a mental health disorder

• An estimated 11% of the U.S. population age 18 or older met criteria for mental health disorders, based on data in the National Epidemiologic Survey on Alcohol and Related Conditions, 2001-2002 (NESARC).

• Similar to the prison and jail inmate populations, females in the general population had higher rates of mental disorders than males (12% compared to 9%).

	Percent of U.S. population age 18 or older with symptoms of a mental disorder Total	Male	Female
Any symptom	10.6%	8.7%	12.4%
Major depression[a]	7.9	5.5	10.1
Mania disorder[a]	1.8	1.6	2.0
Psychotic disorder[b]	3.1	3.2	3.1

Note: See *Methodology* for sources on mental health disorders in the general population.

[a]In the last 12 months, not excluding symptoms due to bereavement, substance use, or a medical condition.

[b]Based on life-time occurrence.

Source: National Institute on Alcohol Abuse and Alcoholism, NESARC, 2001-2002.

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Table 3. Prison and jail inmates who had a mental health problem, by selected characteristics

Characteristic	Percent of inmates in — State prison	Federal prison	Local jail
All inmates	56.2%	44.8%	64.2%
Gender			
Male	55.0%	43.6%	62.8%
Female	73.1	61.2	75.4
Race			
White[a]	62.2%	49.6%	71.2%
Black[a]	54.7	45.9	63.4
Hispanic	46.3	36.8	50.7
Other[a,b]	61.9	50.3	69.5
Age			
24 or younger	62.6%	57.8%	70.3%
25-34	57.9	48.2	64.8
35-44	55.9	40.1	62.0
45-54	51.3	41.6	52.5
55 or older	39.6	36.1	52.4

[a]Excludes persons of Hispanic origin.
[b]Includes American Indians, Alaska Natives, Asians, Native Hawaiians, other Pacific Islanders, and inmates who specified more than one race.

Mental health problems more common among female, white, and young inmates

Female inmates had much higher rates of mental health problems than male inmates. An estimated 73% of females in State prisons, compared to 55% of male inmates, had a mental health problem (table 3). In Federal prisons, the rate was 61% of females compared to 44% of males; and in local jails, 75% of females compared to 63% of male inmates.

The same percentage of females in State prisons or local jails (23%) said that in the past 12 months they had been diagnosed with a mental disorder by a mental health professional. This was almost three times the rate of male inmates (around 8%) who had been told they had a mental health problem.

Mental problem*	Percent of inmates in — State prison Male	State prison Female	Local jail Male	Local jail Female
Recent history	22%	48%	18%	40%
Diagnosed	8	23	9	23
Overnight stay	5	9	4	9
Medication	16	39	12	30
Therapy	14	32	9	23
Symptoms	48%	62%	59%	70%

*See table 1 for detailed description of categories.

Table 4. Homelessness, employment before arrest, and family background of prison and jail inmates, by mental health status

Characteristic	Percent of inmates in — State prison With mental problem	State prison Without	Federal prison With mental problem	Federal prison Without	Local jail With mental problem	Local jail Without
Homelessness in past year	13.2%	6.3%	6.6%	2.6%	17.2%	8.8%
Employed in month before arrest[a]	70.1%	75.6%	67.7%	76.2%	68.7%	75.9%
Ever physically or sexually abused before admission	27.0%	10.5%	17.0%	6.4%	24.2%	7.6%
Physically abused	22.4	8.3	13.7	5.4	20.4	5.7
Sexually abused	12.5	3.8	7.3	1.7	10.2	3.2
While growing up —						
Ever received public assistance[b]	42.5%	30.6%	33.3%	24.9%	42.6%	30.3%
Ever lived in foster home, agency or institution	18.5	9.5	9.8	6.3	14.5	6.0
Lived most of the time with —						
Both parents	41.9%	47.7%	45.4%	50.5%	40.5%	49.1%
One parent	43.8	40.8	39.8	38.8	45.4	40.4
Someone else	11.6	10.2	13.5	10.3	12.0	9.4
Parents or guardians ever abused —	39.3	25.1	33.3	20.0	37.3	18.7
Alcohol	23.6	16.9	21.7	15.4	23.2	14.1
Drugs	3.1	1.9	2.2	1.4	2.7	1.1
Both alcohol and drugs	12.7	6.2	9.4	3.2	11.5	3.4
Neither	60.7	74.9	66.7	80.0	62.7	81.3
Family member ever incarcerated —	51.7%	41.3%	44.6%	38.9%	52.1%	36.2%
Mother	7.2	4.0	5.0	3.2	9.4	3.4
Father	20.1	13.4	15.3	9.9	22.1	12.6
Brother	35.5	29.4	29.4	27.0	34.8	25.8
Sister	7.0	5.1	5.5	4.2	11.3	5.1
Child	2.7	2.3	3.4	2.8	4.0	2.6
Spouse	1.7	0.9	2.6	1.8	2.4	0.9

[a]The reference period for jail inmates was in the month before admission.
[b]Public assistance includes public housing, AFDC, food stamps, Medicaid, WIC, and other welfare programs.

The prevalence of mental health problems varied by racial or ethnic group. Among State prisoners, 62% of white inmates, compared to 55% of blacks and 46% of Hispanics, were found to have a mental health problem. Among jail inmates, whites (71%) were also more likely than blacks (63%) or Hispanics (51%) to have a mental health problem.

The rate of mental health problems also varied by the age of inmates. Inmates age 24 or younger had the highest rate of mental health problems and those age 55 or older had the lowest rate. Among State prisoners, an estimated 63% of those age 24 or younger had a mental health problem, compared to 40% of those age 55 or older. An estimated 70% of local jail inmates age 24 or younger had a mental health problem, compared to 52% of those age 55 or older.

Homelessness, foster care more common among inmates who had mental health problems

State prisoners (13%) and local jail inmates (17%) who had a mental health problem were twice as likely as inmates without a mental health problem (6% in State prisons; 9% in local jails) to have been homeless in the year before their incarceration (table 4).

About 18% of State prisoners who had a mental health problem, compared to 9% of State prisoners who did not have a mental problem, said that they had lived in a foster home, agency, or institution while growing up.

Among jail inmates, about 14% of those who had a mental health problem had lived in a foster home, agency, or institution while growing up, compared to 6% of jail inmates who did not have a mental health problem.

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Low rates of employment, high rates of illegal income among inmates who had mental problems

An estimated 70% of State prisoners who had a mental health problem, compared to 76% of those without, said they were employed in the month before their arrest. Among Federal prisoners, 68% of those who had a mental health problem were employed, compared to 76% of those who did not have a mental problem.

Among jail inmates, 69% of those who had a mental health problem reported that they were employed, while 76% of those without were employed in the month before their arrest.

Of State prisoners who had a mental health problem, 65% had received income from wages or salary in the month before their arrest. This percentage was larger for inmates without a mental health problem (71%). Over a quarter (28%) of State prisoners who had a mental health problem reported income from illegal sources, compared to around a fifth (21%) of State prisoners without a mental problem.

Sources of income[a]	Percent of State prison inmates	
	With mental problem	Without
Wages, salary	65%	71%
Welfare	6	4
Assistance from family or friends	14	8
Illegal income	28	21
Compensation payments[b]	9	6

[a]Includes personal income in month before arrest, except for compensation which was in the month before admission.
[b]Includes Supplemental Security Income (SSI) payments and pension.

Table 5. Substance dependence or abuse among prison and jail inmates, by mental health status

Substance dependence or abuse	Percent of inmates in — State prison		Federal prison		Local jail	
	With mental problem	Without	With mental problem	Without	With mental problem	Without
Any alcohol or drugs	74.1%	55.6%	63.6%	49.5%	76.4%	53.2%
Dependence	53.9	34.5	45.1	27.3	56.3	25.4
Abuse only	20.2	21.1	18.5	22.2	20.1	27.8
Alcohol	50.8%	36.0%	43.7%	30.3%	53.4%	34.6%
Dependence	30.4	17.9	25.1	12.7	29.0	11.8
Abuse only	20.4	18.0	18.6	17.7	24.4	22.8
Drugs	61.9%	42.6%	53.2%	39.2%	63.3%	36.0%
Dependence	43.8	26.1	37.1	22.0	46.0	17.6
Abuse only	18.0	16.5	16.1	17.2	17.3	18.4
No dependence or abuse	25.9%	44.4%	36.4%	50.5%	23.6%	46.8%

Note: Substance dependence or abuse was based on criteria specified in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV). For details, see *Substance Dependence, Abuse and Treatment of Jail Inmates, 2002*, <http://www.ojp.usdoj.gov/bjs/abstract/sdatji02.htm>.

Past physical or sexual abuse more prevalent among inmates who had mental health problems

State prisoners who had a mental health problem (27%) were over two times more likely than those without (10%) to report being physically or sexually abused in the past.

Jail inmates who had a mental health problem were three times more likely than jail inmates without to have been physically or sexually abused in the past (24% compared to 8%).

Family members of inmates with mental problems had high rates of substance use and incarceration

Inmates who had a mental health problem were more likely than inmates without to have family members who abused drugs or alcohol or both. Among State prisoners, 39% of those who had a mental health problem reported that a parent or guardian had abused alcohol, drugs, or both while they were growing up. In comparison, 25% of State prisoners without a mental problem reported parental abuse of alcohol, drugs, or both.

A third (33%) of Federal prisoners who had a mental health problem, compared to a fifth (20%) of those without, reported that a parent or guardian had abused alcohol, drugs, or both while they were growing up.

An estimated 37% of jail inmates who had a mental health problem said a parent had abused alcohol, drugs, or both while they were growing up. This was almost twice the rate for jail inmates without a mental health problem (19%).

The majority of prison and jail inmates who had a mental health problem (52%) reported that they had a family member who had been incarcerated in the past. Among those without a mental health problem, about 41% of State inmates and 36% of jails inmates reported that a family member had served time.

Over a third of both State prisoners and local jail inmates who had a mental health problem (35%) had a brother who had served time in prison or jail. The rate for inmates without a mental health problem was 29% in State prisons and 26% in local jails.

High rates of both mental health problems and substance dependence or abuse among State prison and local jail inmates

- An estimated 42% of inmates in State prisons and 49% in local jails were found to have both a mental health problem and substance dependence or abuse.
- Slightly less than a quarter (24%) of State prisoners and a fifth (19%) of local jail inmates met the criteria for substance dependence or abuse only.

Mental health problems and substance dependence or abuse	Percent of inmates in — State prison	Federal prison	Local jail
Both	41.7%	28.5%	48.7%
Dependence or abuse only	24.4	27.3	18.9
Mental problems only	14.5	16.3	15.0
None	19.5	27.8	17.3

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Inmates who had mental health problems had high rates of substance dependence or abuse

Among inmates who had a mental health problem, local jail inmates had the highest rate of dependence or abuse of alcohol or drugs (76%), followed by State prisoners (74%), and Federal prisoners (64%) (table 5). Substance dependence or abuse was measured as defined in the DSM-IV.[2]

Among inmates without a mental health problem, 56% in State prisons, 49% in Federal prisons, and 53% in local jails were dependent on or abused alcohol or drugs.

[2]For a detailed description of the DSM-IV measures, see *Substance Dependence, Abuse and Treatment of Jail inmates, 2002*, <http://www.ojp.usdoj.gov/bjs/abstract/sdatji02.htm.>

By specific type of substance, inmates who had a mental health problem had higher rates of dependence or abuse of drugs than alcohol. Among State prisoners who had a mental problem, 62% were dependent on or abused drugs and 51% alcohol. An estimated 63% of local jail inmates who had a mental problem were dependent on or abused drugs, while about 53% were dependent on or abused alcohol.

When dependence was estimated separately from abuse only, local jail inmates who had a mental health problem had the highest rate of drug dependence (46%). They were two and a half times more likely to be dependent on drugs than jail inmates without a mental problem (18%).

Table 6. Substance use among prison inmates and convicted jail inmates, by mental health status

	Percent of inmates in —					
	State prison		Federal prison		Local jail	
Type of substance	With mental problem	Without	With mental problem	Without	With mental problem	Without
Alcohol or drugs						
Regular use[a]	87.1%	77.2%	82.3%	75.4%	89.9%	78.7%
In month before offense	80.3	70.4	75.8	68.1	81.6	69.6
At time of offense	53.2	42.5	41.1	30.6	53.8	42.8
Drugs						
Regular use[a]	75.5%	61.2%	71.0%	59.2%	78.1%	57.5%
In month before offense	62.8	49.1	57.1	45.2	62.1	41.7
At time of offense	37.5	25.8	31.1	23.0	34.0	19.8
Alcohol						
Regular use[a]	67.9%	58.3%	66.0%	58.2%	72.6%	61.8%
In month before offense	61.7	52.5	59.5	53.6	80.7	74.1
At time of offense	34.0	27.5	21.7	15.1	35.0	30.4
Binge drinking[b]	43.5	29.5	37.8	25.7	48.2	29.9

[a]Regular alcohol use is defined as daily or almost daily or more than once a week for more than a month. Regular drug use is defined as once a week or more for at least one month.
[b]Binge drinking is defined as having consumed a fifth of liquor in a single day, or the equivalent of 20 drinks, 3 bottles of wine, or 3 six-packs of beer.

Table 7. Drug use in the month before the offense among convicted prison and jail inmates, by mental health status

	Percent of inmates in —					
	State prison		Federal prison		Local jail	
Types of drug used in month before offense	With mental problem	Without	With mental problem	Without	With mental problem	Without
Any drug	62.8%	49.1%	57.1%	45.2%	62.1%	41.7%
Marijuana or hashish	45.7%	33.3%	41.2%	32.0%	43.4%	27.1%
Cocaine or crack	24.4	17.9	21.1	15.5	24.2	14.7
Heroin/opiates	8.9	7.2	7.2	4.7	9.6	4.6
Depressants[a]	7.3	3.0	6.7	2.7	8.5	2.0
Methamphetamines	12.6	8.8	10.9	9.6	11.7	6.2
Other stimulants[b]	5.8	2.8	4.5	2.5	5.2	2.4
Hallucinogens[c]	8.0	3.4	9.3	3.0	7.5	2.9

[a]Include barbiturates, tranquilizers, and quaaludes.
[b]Include amphetamines.
[c]Include LSD, PCP, and ecstasy.

A larger percentage of State prisoners who had a mental health problem than those without were found to be dependent on drugs (44% compared to 26%). Among Federal prisoners, 37% who had a mental health problem were found to be dependent on drugs, compared to 22% of those without.

State prisoners (30%) and local jail inmates (29%) who had a mental health problem had about the same rate of alcohol dependence. A quarter of Federal prisoners (25%) who had a mental problem were dependent on alcohol.

Over a third of inmates who had mental health problems had used drugs at the time of the offense

Over a third (37%) of State prisoners who had a mental health problem said they had used drugs at the time of the offense, compared to over a quarter (26%) of State prisoners without a mental problem (table 6). Also, over a third (34%) of local jail inmates who had a mental health problem said they had used drugs at the time of the offense, compared to a fifth (20%) of jail inmates who did not have a mental problem.

Marijuana or hashish was the most common drug inmates said they had used in the month before the offense (table 7). Among inmates who had a mental health problem, more than two-fifths of those in State prisons (46%), Federal prisons (41%), or local jails (43%) reported they had used marijuana or hashish in the month before the offense.

Almost a quarter of inmates in State prisons or local jails who had a mental health problem (24%) reported they had used cocaine or crack in the month before the offense. A smaller percentage of inmates who had a mental health problem had used methamphetamines in the month before the offense — 13% of State prisoners, 11% of Federal prisoners, and 12% of jail inmates.

Binge drinking prevalent among inmates who had mental problems

Inmates who had a mental health problem were more likely than inmates without a mental problem to report a

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binge drinking experience. Among State prisoners who had a mental health problem, 43% said they had participated in binge drinking in the past, compared to 29% of State prisoners without mental problems.

Similarly, jail inmates who had mental problems (48%) had a much higher rate of binge drinking than jail inmates without mental problems (30%).

Inmates who had a mental problem were more likely than inmates without to have been using alcohol at the time of the offense (State prisoners, 34% compared to 27%; Federal prisoners, 22% compared to 15%; and jail inmates, 35% compared to 30%.)

Violent offenses common among State prisoners who had a mental health problem

Among State prisoners who had a mental health problem, nearly half (49%) had a violent offense as their most serious offense, followed by property (20%) and drug offenses (19%) (table 8). Among all types of offenses, robbery was the most common offense (14%), followed by drug trafficking (13%) and homicide (12%).

An estimated 46% of State prisoners without a mental health problem were held for a violent offense, including 13% for homicide and 11% for robbery.

About 24% of State prisoners without a mental problem were held for drug offenses, particularly drug trafficking (17%).

Almost an equal percentage of jail inmates who had a mental health problem were held for violent (26%) and property (27%) offenses. About 12% were held for aggravated assault. Jail inmates who had a mental health problem were two times more likely than jail inmates without a mental problem to be held for burglary (8% compared to 4%).

Use of a weapon did not vary by mental health status

Convicted violent offenders who had a mental health problem were as likely as those without to have used a weapon during the offense (table 9). An estimated 37% of both State prisoners who had a mental problem and those without said they had used a weapon during the offense.

By specific type of weapon, among convicted violent offenders in State prisons who had a mental health problem, slightly less than a quarter (24%) had used a firearm, while a tenth (10%) had used a knife or sharp object.

Violent criminal record more prevalent among inmates who had a mental health problem

State prisoners who had a mental health problem (61%) were more likely than State prisoners without (56%) to have a current or past violent offense.

Violent criminal record	Percent of State prison inmates with violent criminal record: With mental problem	Without
Any violent offense	61%	56%
Current violent offense, no prior	13	17
Violent recidivist	47	39

Note: Details may not add to total due to rounding.

Among repeat offenders, an estimated 47% of State prisoners who had a mental health problem were violent recidivists, compared to 39% of State prisoners without a mental problem (table 10).

Table 8. Most serious offense among prison and jail inmates, by mental health status

Most serious offense	State prison: With mental problem	State prison: Without	Federal prison: With mental problem	Federal prison: Without	Local jail: With mental problem	Local jail: Without
	Percent of inmates in —					
Total	100%	100%	100%	100%	100%	100%
Violent offenses	49.0%	46.5%	16.0%	13.2%	26.5%	23.7%
Homicide	11.6	12.9	2.5	2.3	2.6	2.5
Sexual assault*	11.0	10.4	1.1	0.7	3.4	3.6
Robbery	13.6	11.3	9.6	7.6	5.7	5.1
Assault	10.5	9.7	2.0	1.9	12.5	10.5
Property offenses	19.6%	17.7%	7.2%	6.1%	26.9%	19.7%
Burglary	8.6	7.7	0.7	0.3	7.9	4.2
Larceny/theft	4.2	3.5	0.5	0.4	7.7	5.6
Fraud	3.0	2.7	4.9	4.5	5.3	4.2
Drug offenses	19.3%	23.8%	51.3%	58.3%	23.4%	27.0%
Possession	5.7	6.3	2.0	3.8	10.1	12.3
Trafficking	12.9	17.0	47.7	52.6	11.6	12.9
Public-order offenses	11.9%	11.9%	22.3%	19.0%	22.6%	29.3%
Weapons	2.6	2.4	14.0	8.5	2.3	1.4
DWI/DUI	2.2	3.2	0.2	0.2	5.5	8.1

Note: Summary categories include offenses not shown.
*Includes rape and other sexual assault.

Table 9. Use of weapon, by mental health status of convicted violent State prison and local jail inmates

Use of weapons	State prison: With mental problem	State prison: Without	Local jail: With mental problem	Local jail: Without
	Percent of inmates in —			
Any weapon	37.2%	36.9%	20.6%	21.2%
Firearm	24.4	27.5	12.3	13.1
Knife or sharp object	10.2	7.4	6.1	5.1
Other weapons*	3.7	2.7	2.8	4.0
No weapon	62.8%	63.1%	79.4%	78.8%
Number of violent inmates	328,670	242,524	60,787	34,305

Note: Details do not add to total because inmates may have used more than one weapon.
*Other weapons include blunt objects, stun guns, toy guns, or other specified weapons.

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Nearly a third (32%) of local jail inmates who had a mental health problem were repeat violent offenders, while about a quarter (22%) of jail inmates without a mental problem were violent recidivists.

A larger proportion of inmates who had a mental health problem had served more prior sentences than inmates without a mental problem (table 11). An estimated 47% of State prisoners who had a mental health problem, compared to 39% of those without, had served 3 or more prior sentences to probation or incarceration. Among jail inmates, 42% of those with a mental health problem had served served 3 or more prior sentences to probation or incarceration, compared to 33% of jail inmates without a mental problem.

State prisoners who had mental health problems had longer sentences than prisoners without

Overall, State prisoners who had a mental health problem reported a mean maximum sentence that was 5 months longer than State prisoners without a mental problem (146 months compared to 141 months) (table 12). Among jail inmates, the mean sentence for those who had a mental problem was 5 months shorter than that for jail inmates without a mental problem (40 months compared to 45 months).

By most serious offense, excluding offenders sentenced to life or death, both violent State prisoners who had a mental health problem and those without had about the same mean sentence length. Violent State prisoners who had a mental health problem were sentenced to serve a mean maximum sentence length of 212 months and those without, 211 months.

Among prisoners sentenced to life or death, there was little variation in sentence length by mental health status (not shown in table). About 8% of State prisoners who had a mental health problem and 9% of those without were sentenced to life or death. Among Federal prisoners, 3% of both those who had a mental health problem and those without were sentenced to life or death.

Table 10. Criminal record of prison and jail inmates, by mental health status

	Percent of inmates in —					
	State prison		Federal prison		Local jail	
Criminal record	With mental problem	Without	With mental problem	Without	With mental problem	Without
No prior sentence	20.5%	27.0%	32.2%	36.9%	34.9%	43.3%
Current violent offense	13.4	16.9	5.1	4.9	12.1	13.8
Current drug offense	3.1	5.1	15.2	21.6	8.8	12.6
Current other offense	4.1	5.0	11.9	10.4	14.0	16.8
Violent recidivist	47.4%	39.2%	27.5%	23.8%	31.9%	22.4%
Current and prior violent	17.2	13.4	7.4	4.4	9.9	6.8
Current violent only	17.7	15.3	4.9	4.4	11.4	6.9
Prior violent only	12.5	10.4	15.3	15.0	10.5	8.7
Nonviolent recidivist	32.0%	33.8%	40.3%	39.2%	33.2%	34.3%
Prior drugs only	3.0	4.0	7.1	9.5	3.0	3.4
Other prior offenses	29.0	29.8	33.2	29.8	30.2	30.9

Note: Excludes inmates for whom offense and prior probation or incarceration sentences were unknown.

Table 11. Number of prior probation or incarceration sentences among prison and jail inmates, by mental health status

	Percent of inmates in —					
	State prison		Federal prison		Local jail	
Number of prior sentences	With mental problem	Without	With mental problem	Without	With mental problem	Without
0	22.1%	28.5%	34.1%	38.3%	24.5%	30.6%
1	15.3	16.1	14.9	16.5	16.8	18.9
2	15.5	16.8	15.6	14.9	16.7	17.2
3-5	26.3	24.0	21.3	20.1	22.8	20.3
6-10	13.9	10.6	10.0	7.1	12.4	8.6
11 or more	6.9	4.0	4.0	3.1	6.7	4.4

Note: Excludes inmates for whom prior probation or incarceration sentences were unknown.

Table 12. Mean maximum sentence length and mean total time expected to serve, by mental health status and offense

	Mean maximum sentence length[a]		Mean total time expected to serve until release[b]	
Most serious offense	With mental problem	Without	With mental problem	Without
State prison inmates				
All offenses[c]	146 mos	141 mos	93 mos	89 mos
Violent	212	211	139	138
Property	103	96	60	58
Drug	84	94	48	50
Public-order	81	66	51	40
Federal prison inmates				
All offenses[c]	128 mos	135 mos	99 mos	106 mos
Violent	174	202	119	131
Property	70	53	63	58
Drug	131	139	103	112
Public-order	102	100	87	83
Local jail inmates				
All offenses[c]	40 mos	45 mos	14 mos	18 mos
Violent	67	73	18	31
Property	41	36	16	14
Drug	40	59	18	25
Public-order	16	16	7	8

[a]Based on the total maximum sentence for all consecutive sentences. Excludes inmates for whom offense was unknown.
[b]Based on time served when interviewed and time to be served until the expected date of release. Excludes inmates for whom admission date or expected release date were unknown.
[c]Includes other offenses not shown.

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State prisoners who had a mental health problem expected to serve 4 months longer than those without

Overall, the mean time State prisoners who had a mental health problem expected to serve was 4 months longer than State prisoners without a mental problem (93 months compared to 89 months). Among convicted jail inmates who expected to serve their time in a local jail, there was little variation by mental health status in the amount of time expected to be served. About 55% of those who had a mental problem, and 54% of those without, expected to serve 6 months or less (table 13).

Table 13. Mean time expected to be served by convicted local jail inmates sentenced to jail

	Percent of convicted local jail inmates	
Mean time expected to be served	With mental problem	Without
Less than 3 months	27.4%	26.8%
3 to 6 months	27.9	27.3
7 to 12 months	24.0	22.4
13 to 24 months	9.7	8.7
25 to 36 months	3.7	3.4
37 to 60 months	3.2	5.0
More than 5 years	4.0	6.4
Number of inmates	115,290	72,356

Note: Excludes inmates for whom admission date or expected release date were unknown.

A third of State prisoners who had mental health problems had received treatment since admission

State prisoners who had a mental health problem (34%) had the highest rate of mental health treatment since admission, followed by Federal prisoners (24%) and local jail inmates (17%) (table 14).

All Federal prisons and most State prisons and jail jurisdictions, as a matter of policy, provide mental health services to inmates, including screening inmates at intake for mental health problems, providing therapy or counseling by trained mental health professionals, and distributing psychotropic medication.[3]

[3]See *Mental Health Treatment in State Prisons, 2000*, <http://www.ojp.usdoj.gov/bjs/abstract/mhtsp00.htm> and *Census of Jails, 1999*, <http://www.ojp.usdoj.gov/bjs/abstract/cj99.htm>.

Table 14. Mental health treatment received by inmates who had a mental health problem

	Percent of inmates who had a mental problem in —		
Type of mental health treatment	State prison	Federal prison	Local jails
Ever received mental health treatment	49.3%	35.3%	42.7%
Had overnight hospital stay	20.0	9.5	18.0
Used prescribed medications	39.5	28.0	32.7
Had professional mental health therapy	35.4	25.6	31.1
Received treatment during year before arrest	22.3%	14.9%	22.6%
Had overnight hospital stay	5.8	3.2	6.6
Used prescribed medications	15.8	10.1	16.9
On prescribed medication at time of arrest	11.3	7.3	12.3
Had professional mental health therapy	11.5	8.0	12.3
Received treatment after admission	33.8%	24.0%	17.5%
Had overnight hospital stay	5.4	2.7	2.2
Used prescribed medications	26.8	19.5	14.8
Had professional mental health therapy	22.6	15.1	7.3

Note: Excludes other mental health treatment.

Table 15. Mental health treatment received by all State prison inmates, 2004 and 1997

	Percent of State prison inmates	
Type of mental health treatment	2004	1997
Ever any mental health treatment	31.2%	28.3%
Had overnight hospital stay	12.2	10.7
Used prescribed medications	23.9	18.9
Had professional mental health therapy	21.6	21.8
Had other mental health treatment	3.6	3.3
Received treatment after admission	19.3%	17.4%
Had overnight hospital stay	3.1	3.8
Used prescribed medications	15.1	12.3
Had professional mental health therapy	12.7	12.3
Had other mental health treatment	1.9	1.9
Number of inmates	1,226,171	1,059,607

More than a fifth of inmates (22%) in State prison who had a mental health problem had received mental health treatment during the year before their arrest, including 16% who had used prescribed medications, 11% who had professional therapy, and 6% who had stayed overnight in a hospital because of a mental or emotional problem.

Among jail inmates who had a mental health problem, an estimated 23% had received treatment during the year before their arrest: 17% had used medication, 12% had received professional therapy, and 7% had stayed overnight in a hospital because of a mental or emotional problem.

Taking a prescribed medication for a mental health problem was the most common type of treatment inmates who had a mental health problem had received since admission to prison or jail. About 27% of State prisoners, 19% of Federal prisoners, and 15% of jail inmates who had a mental problem had used prescribed medication for a mental problem since admission.

An overnight stay in a hospital was the least likely method of treatment inmates had received since admission. Among inmates who had a mental problem, about 5% of those in State prisons, 3% in Federal prisons, and 2% in local jails had stayed overnight in a hospital for a mental problem.

Use of medication for a mental health problem by State prisoners rose between 1997 and 2004

The proportion of State prisoners who had used prescribed medication for a mental health problem since admission to prison rose to 15% in 2004, up from 12% in 1997 (table 15). There was little change in the percentage of inmates who reported an overnight stay in a hospital since admission (around 3%), or in the percentage who had received professional mental health therapy (around 12%).

State prisoners who said they had ever used prescribed medication for a mental or emotional problem in the past rose to 24% in 2004, up from 19% in 1997. Overall, 31% of State prisoners said they had ever received mental health treatment in the past, up from 28% in 1997.

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Among jail inmates, in 2002 around 30% said they had received treatment for a mental health problem in the past, up from 25% in 1996. The proportion who had received treatment since admission (11%) was unchanged.

Mental health treatment	Percent of jail inmates 2002	1996
Ever any treatment	30%	25%
Overnight stay	12	10
Medication	22	17
Therapy	22	18
Other treatment	3	3
Since admission	11%	11%
Overnight stay	1	1
Medication	9	9
Therapy	5	4
Other treatment	1	--

--Less than 0.5%.

Rule violations and injuries from a fight more common among inmates who had a mental health problem

Prison or jail inmates who had a mental health problem were more likely than those without to have been charged with breaking facility rules since admission (table 16). Among State prisoners, 58% of those who had a mental health problem, compared to 43% of those without, had been charged with rule violations.

An estimated 24% of State prisoners who had a mental health problem, compared to 14% of those without, had been charged with a physical or verbal assault on correctional staff or another inmate. Among Federal prisoners who had a mental health problem, 15% had been charged with a physical or verbal assault on correctional staff or another inmate compared to 7% of those without a mental problem.

Jail inmates who had a mental health problem were twice as likely as those without to have been charged with facility rule violations (19% compared to 9%).

Inmates in local jails who had a mental health problem were also four times as likely as those without to have been charged with a physical or verbal assault on correctional staff or another inmate (8% compared to 2%).

A larger percentage of inmates who had a mental health problem had been injured in a fight since admission than those without a mental problem (State prisoners, 20% compared to 10%; Federal prisoners, 11% compared to 6%; jail inmates, 9% compared to 3%).

Three-quarters of female inmates in State prisons who had a mental health problem met criteria for substance dependence or abuse

Female State prisoners who had a mental health problem were more likely than those without to —

- meet criteria for substance dependence or abuse (74% compared to 54%),
- have a current or past violent offense (40% compared to 32%),
- have used cocaine or crack in the month before arrest (34% compared to 24%),
- have been homeless in the year before arrest (17% compared to 9%).

They were also more likely to report —

- 3 or more prior sentences to probation or incarceration (36% compared to 29%),
- past physical or sexual abuse (68% compared to 44%),
- parental abuse of alcohol or drugs (47% compared to 29%),
- a physical or verbal assault charge since admission (17% compared to 6%).

Characteristics of females in State prison, by mental health status

Selected characteristics	Percent of female inmates With mental problem	Without
Criminal record		
Current or past violent offense	40.4%	32.2%
3 or more prior probations or incarcerations	35.9	28.7
Substance dependence or abuse	74.5%	53.6%
Alcohol	41.7	25.8
Drugs	65.5	45.6
Drug use in month before arrest*	63.7%	49.5%
Cocaine or crack	33.9	24.2
Methamphetamines	17.1	16.3
Family background		
Homeless in year before arrest	16.6%	9.5%
Past physical or sexual abuse	68.4	44.0
Parent abused alcohol or drugs	46.9	29.1
Charged with violating facility rules*	50.4%	30.6%
Physical or verbal assault	16.9	5.7
Injured in a fight since admission	10.3%	3.8%

*Includes items not shown.

Table 16. Disciplinary problems among prison and jail inmates since admission, by mental health status

Type of disciplinary problem since admission	Percent of inmates in — State prison With mental problem	State prison Without	Federal prison With mental problem	Federal prison Without	Local jail With mental problem	Local jail Without
Charged with rule violations*	57.7%	43.2%	40.0%	27.7%	19.0%	9.1%
Assault	24.1	13.8	15.4	6.9	8.2	2.4
Physical assault	17.6	10.4	11.0	5.4	4.7	1.6
Verbal assault	15.2	6.7	7.9	2.4	5.2	0.9
Injured in a fight	20.4%	10.1%	11.4%	5.8%	9.3%	2.9%

*Includes violations not shown (for example: possession of a weapon, stolen property or contraband, drug law violations, work slowdowns, food strikes, setting fires or rioting, being out of place, disobeying orders, abusive language, horseplay, or failing to follow sanitary regulations).

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Methodology

The findings in this report are based on data in the Survey of Inmates in State and Federal Correctional Facilities, 2004, and the Survey of Inmates in Local Jails, 2002. Conducted every 5 to 6 years since 1972, the BJS' inmate surveys are the only national source of detailed information on criminal offenders, particularly special populations such as drug and alcohol users and offenders who have mental health problems.

The survey design included a stratified two-stage sample where facilities were selected in the first stage and inmates to be interviewed in the second stage. In the second sampling stage, interviewers from the Census Bureau visited each selected facility and systematically selected a sample of inmates. Computer-assisted personal interviewing (CAPI) was used to conduct the interviews.

Survey of Inmates in State and Federal Correctional Facilities, 2004

The State prison sample was selected from a universe of 1,585 facilities. A total of 287 State prisons participated in the survey; 2 refused, 11 were closed or had no inmates to survey, and 1 was erroneously included in the universe. A total of 14,499 inmates in the State facilities were interviewed; 1,653 inmates refused to participate, resulting in a second-stage nonresponse rate of 10.2%.

The Federal prison sample was selected from 148 Federal prisons and satellite facilities. Thirty-nine of the 40 prisons selected participated in the survey. After the initial sample of inmates was drawn, a secondary sample of 1 in 3 drug offenders was selected. A total of 3,686 inmates in Federal facilities were interviewed and 567 refused to participate, resulting in a second-stage nonresponse rate of 13.3%.

Survey of Inmates in Local Jails, 2002

The local jail sample was selected from a universe of 3,365. Overall, 465 jails were selected, and interviews were held in 417 jails; 39 jails refused or were excluded for administrative reasons; and 9 were closed or had no inmates. A total of 6,982 inmates were interviewed; 768 inmates refused to participate, resulting in a second-stage nonresponse rate of 9.9%.

Accuracy of survey estimates

The accuracy of the survey estimates depends on sampling and measurement errors. Sampling errors occur by chance because a sample of inmates rather than all inmates were interviewed. Measurement error can be attributed to many sources, such as nonresponse, recall difficulties, differences in the interpretation of questions among inmates, and processing errors.

The sampling error, as measured by an estimated standard error, varies by the size of the estimate and the size of the base population. These standard errors may be used to construct confidence intervals around percentages. For example, the 95% confidence interval around the percentage of jail inmates in 2002 who had a mental health problem is approximately 64.2% plus or minus 1.96 times .83% (or 62.6% to 65.8%). Standard error tables for data in this report are provided in the Appendix which is available in the electronic version of the report at <http://www.ojp.usdoj.gov/bjs/abstract/mhppji.htm>.

A detailed description of the methodology for the State and Federal Prison survey, including standard error tables and links to other reports or findings will be available at <http://www.icpsr.umich.edu> in Winter 2007. A detailed description of the methodology for the Survey of Inmates in Local Jails is available at <http://webapp.icpsr.umich.edu/cocoon/NACJD-STUDY/04359.xml>.

Measures of mental health problems in the general population

Caution should be used when making comparisons between prison and jail inmates and the general population based on the a 12-month DSM-IV structured interview. There are significant variations in the questionnaire design and data analysis. For example, questions on the severity or duration of symptoms and questions about whether symptoms are due to breavement, substance use, or a medical condition may vary from survey to survey.

For details on the methodology used in the National Epidemiologic Survey on Alcohol and Related Conditions, sponsored by the National Institute on Alcohol Abuse and Alcoholism, see the Data Reference Manual, <http://niaaa.census.gov/>. For additional information on the prevalence of mental disorders in the general population, see the National Survey on Drug Use and Health, sponsored by the Substance Abuse and Mental Health Services Administration, <http://www.oas.samhsa.gov/nsduh.htm>. Also, see the National Comorbidity Survey Replication Study, sponsored primarily by the National Institute of Mental Health, <http://www.nimh.nih.gov/healthinformation/ncs-r.cfm>.

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Doris J. James and Lauren E. Glaze wrote this report, under the supervision of Allen J. Beck. Laura M. Maruschak, Todd D. Minton, and Tracy L. Snell verified the report. Rebecca L. Medway provided programming assistance. Tina Dorsey edited the report and Jayne Robinson prepared it for final printing, under the supervision of Marianne Zawitz.

Tracy L. Snell, under the supervision of Allen J. Beck, was project manager for the Survey of Inmates in State and Federal Correctional Facilities.

For the State and Federal prisoners survey, at the U.S. Census Bureau Steven M. Bittner, Colette Heiston, and Kenneth Mayo carried out questionnaire design, data collection and processing, under the supervision of Marilyn M. Monahan, Demographic Surveys Division. Renee Arion programmed the questionnaire and Dave Keating programmed the listing instrument, under the supervision of Rob Wallace, Technologies Management Office. Programming assistance in the Demographic Surveys Division was provided by Chris Alaura, Mildred Ballenger, Bach-Loan Nguyen, and Scott Raudabaugh, under the supervision of David Watt.

Dave Hornick and Danielle N. Castelo, Demographic Surveys Methods Division, under the supervision of Thomas F. Moore, designed the sample and weighting specifications. Sydnee Chattin-Reynolds and Luis Padilla, Field Division, under the supervision of Richard Ning, coordinated the field operations. The affiliations for the Census Bureau date to the time of the survey.

Contributors to the Survey of Inmates in Local Jails are listed in *Profile of Jail Inmates, 2002*, at <http://www.ojp.usdoj.gov/bjs/abstract/pji02.htm>.

September 2006, NCJ 213600

This report in portable document format and in ASCII and its related statistical data and tables— including appendix tables— are available at the BJS World Wide Web Internet site: <http://www.ojp.usdoj.gov/bjs/mhppji.htm>

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December 2008, NCJ 224280

Prisoners in 2007

By Heather C. West
and William J. Sabol, Ph.D.
BJS Statisticians

This report presents data from the National Prisoner Statistics program. It describes the change in the prison population during 2007 and the characteristics of the 1,598,316 prisoners under state or federal jurisdiction on December 31, 2007. Additionally, it provides the imprisonment rates and age, race, gender distributions for the 1,532,817 prisoners sentenced to more than one year. It quantifies changes in prison admissions and releases, inmates held in custody, prison capacity, and components of the total incarcerated population.

Growth in the prison population slowed during 2007

At yearend 2007, federal and state correctional authorities had jurisdiction over 1,598,316 prisoners (1,483,896 males; 114,420 females) (table 1). *Jurisdiction* refers to the legal authority over a prisoner, regardless of where the prisoner is held. After increasing 2.8% during 2006, the growth of the prison population slowed to 1.8% during 2007. The 1.8% increase was slower than the average annual growth witnessed from 2000 to 2006 (2.0%).

During 2007, the prison population increased more rapidly than the U.S. resident population. The imprisonment rate—the number of sentenced prisoners per 100,000 residents—increased from 501 prisoners per 100,000 U.S. residents in 2006 to 506 prisoners per 100,000 U.S. residents in 2007. From 2000 through 2007, the imprisonment rate increased from 475 per 100,000 U.S. residents to 506 per 100,000 U.S. residents. During these seven years, the number of sentenced prisoners increased by 15% while the general population increased by 6.4%.

As in previous years (with the exception of 2002) the majority of the 2007 growth in the prison population occurred during the first 6 months of the year (figure 1). From December 31, 2006 to June 30, 2007, the prison population increased by 1.5%, whereas from June 30, 2007 to December 31, 2007, the prison population increased 0.2%.

Detailed information is available in appendix tables in the online version of this report on the BJS website at <http://www.ojp.usdoj.gov/bjs/pub/pdf/p07.pdf>.

Table 1. Prisoners under state or federal jurisdiction, December 31, 2000, 2006, and 2007

	Number of prisoners			Average annual change	Percent change
	2000	2006	2007	2000-06	2006-07
Total[a]	1,391,261	1,570,691	1,598,316	2.0%	1.8%
Federal	145,416	193,046	199,618	4.8	3.4
State	1,245,845	1,377,645	1,398,698	1.7	1.5
Gender					
Male	1,298,027	1,457,486	1,483,896	1.9%	1.8%
Female	93,234	112,459	114,420	3.2	1.7
Sentenced to more than 1 year[a]	1,331,278	1,504,660	1,532,817	2.1%	1.9%
Imprisonment rate[b]	478	501	506	0.7%	1.0%

[a]Includes prisoners under the legal authority of state or federal correctional officials.

[b]Imprisonment rates are based on U.S. Census Bureau population estimates per 100,000 U.S. residents. Resident population estimates are as of January 1 in each year following the reference year.

Annual and 6-month changes in the number of prisoners under state and federal jurisdiction

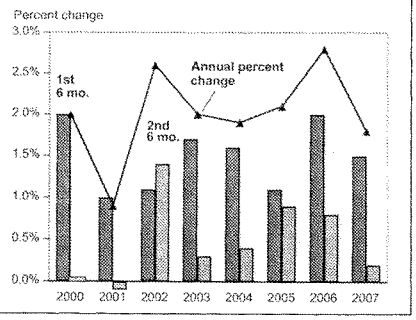

Figure 1

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During 2007, the prison population increased by 27,625 prisoners. The state prison population increased by 21,053—reaching 1,398,698 prisoners. The federal prison population increased by 6,572—reaching 199,618 prisoners.

The prison populations in 37 jurisdictions increased during 2007. The federal prison population experienced the largest absolute increase of 6,572 prisoners, followed by Florida (up 5,250 prisoners), Kentucky (up 2,457 prisoners) and Arizona (up 1,945 prisoners), resulting in 58.7% of the change in the overall prison population (table 2). Kentucky (12.3%), Mississippi (6.5%), Florida (5.6%), West Virginia (5.6%), and Arizona (5.4%) reported the largest percentage increases in their prison populations.

In the 12 months ending December 31, 2007, the prison populations in the remaining 14 states decreased. Michigan's (1,344) and California's (1,230) prison populations experienced the greatest absolute decrease. Vermont (down 3.2%), Montana (down 2.8%), Michigan (down 2.6%), and New Mexico (down 2.6%) prison populations had the largest percent decreases.

Table 2. Prisoners under state or federal jurisdiction by region and jurisdiction, December 31, 2007, and averages of the preceding 6 years

Region and jurisdiction	Number of prisoners 2000	2006	2007	Average annual change 2000-2006	Percent change 2006-2007
U.S. Total	1,391,261	1,570,691	1,598,316	2.0%	1.8%
Federal	145,416	193,046	199,618	4.8	3.4
State	1,245,845	1,377,645	1,398,698	1.7	1.5
Northeast	174,826	177,817	179,107	0.3%	0.7%
Connecticut[a]	18,355	20,566	20,924	1.9	1.7
Maine[b]	1,679	2,120	2,222	4.0	:
Massachusetts	10,722	11,032	11,436	0.5	3.7
New Hampshire	2,257	2,805	2,943	3.7	4.9
New Jersey	29,784	27,371	26,827	-1.4	-2.0
New York	70,199	63,315	62,623	-1.7	-1.1
Pennsylvania	36,847	44,397	45,969	3.2	3.5
Rhode Island[a]	3,286	3,996	4,018	3.3	0.6
Vermont[a]	1,697	2,215	2,145	4.5	-3.2
Midwest	237,378	261,413	263,039	1.6%	0.6%
Illinois[b]	45,281	45,106	45,215	-0.1	:
Indiana	20,125	26,091	27,132	4.4	4.0
Iowa[c]	7,955	8,838	8,732	1.8	-1.2
Kansas	8,344	8,816	8,696	0.9	-1.4
Michigan	47,718	51,577	50,233	1.3	-2.6
Minnesota	6,238	9,108	9,468	6.5	4.0
Missouri	27,543	30,167	29,857	1.5	-1.0
Nebraska	3,895	4,407	4,505	2.1	2.2
North Dakota	1,076	1,363	1,416	4.0	3.9
Ohio	45,833	49,166	50,731	1.2	3.2
South Dakota	2,616	3,359	3,311	4.3	-1.4
Wisconsin	20,754	23,415	23,743	2.0	1.4
South	561,214	623,543	639,578	1.8%	2.6%
Alabama	26,332	28,241	29,412	1.2	4.1
Arkansas	11,915	13,729	14,314	2.4	4.3
Delaware[a]	6,921	7,186	7,276	0.6	1.3
District of Columbia	7,456	~	~	:	:
Florida	71,319	92,969	98,219	4.5	5.6
Georgia[c]	44,232	52,792	54,256	3.0	2.8
Kentucky	14,919	20,000	22,457	5.0	12.3
Louisiana	35,207	37,012	37,540	0.8	1.4
Maryland	23,538	22,945	23,433	-0.4	2.1
Mississippi	20,241	21,068	22,431	0.7	6.5
North Carolina	31,266	37,460	37,970	3.1	1.4
Oklahoma	23,181	26,243	25,849	2.1	-1.5
South Carolina	21,778	23,616	24,239	1.4	2.6
Tennessee	22,166	25,745	26,267	2.5	2.0
Texas	166,719	172,116	171,790	0.5	-0.2
Virginia	30,168	36,688	38,069	3.3	3.8
West Virginia	3,856	5,733	6,056	6.8	5.6
West	272,427	314,872	316,974	2.4%	0.7%
Alaska[a]	4,173	5,069	5,167	3.3	1.9
Arizona[c]	26,510	35,801	37,746	5.1	5.4
California	163,001	175,512	174,282	1.2	-0.7
Colorado	16,833	22,481	22,841	4.9	1.6
Hawaii[a]	5,053	5,967	5,978	2.8	0.2
Idaho	5,535	7,124	7,319	4.3	2.7
Montana	3,105	3,563	3,462	2.3	-2.8
Nevada[b]	10,063	12,901	13,400	4.2	:
New Mexico	5,342	6,639	6,466	3.7	-2.6
Oregon	10,580	13,707	13,948	4.4	1.8
Utah	5,637	6,433	6,509	2.2	1.2
Washington	14,915	17,561	17,772	2.8	1.2
Wyoming	1,680	2,114	2,084	3.9	-1.4

:Not calculated.

~Not applicable. As of December 31, 2001, sentenced felons from the District of Columbia were the responsibility of the Federal Bureau of Prisons.

[a]Prisons and jails form one integrated system. Data include total jail and prison populations.

[b]Estimates only. Data for 2007 were not available at time of publication.

[c]Population based on custody counts.

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Rate of growth in admissions and releases slowed during 2007

During 2007, the number of sentenced prisoners (751,593) admitted to either state or federal prison was greater than the number who were released (725,402), a difference of 26,191 sentenced prisoners (table 3). The 0.2% increase in admissions during 2007 was the slowest growth since yearend 2000. This growth was also slower than the average annual increase of 2.7% witnessed from 2000 through 2007. In addition, the 1.7% increase in releases during 2007 was the lowest increase since yearend 2002 (0.2%) and was lower than the average annual increase of 2.6% from 2000 through 2007.

In 2007, federal admissions totaled 53,618 prisoners and state admissions totaled 697,975 prisoners (table 4). New court commitments accounted for 64.5% of all admissions, 62.4% of state admissions, and 90.8% of federal admissions (appendix table 5). Parole violators accounted for 33.8% of all admissions, 35.7% of state admissions, and 9.2% of federal admissions.

1 in every 198 U.S. residents was serving a sentence in state or federal prison in 2007

Males accounted for most (93.1%) of the 1.5 million sentenced prisoners under jurisdiction. Black males made up the largest percentage of the overall sentenced population (36.3%) and the sentenced male population (39.0%) (table 5). An estimated 471,400 white males made up 30.8% of the overall sentenced population and 33.0% of the sentenced male population. Hispanic males made up about a fifth of both populations. The largest absolute number and percentage of sentenced females were white (50,500 prisoners or 47.9%), followed by black females (29,300 prisoners or 27.8%) and Hispanic females (17,600 prisoners or 16.7%).

Table 3. Number of sentenced prisoners admitted and released from state and federal jurisdiction, 2000-2007

	Admissions			Releases		
Year	Total	Federal	State	Total	Federal	State
2000	625,219	43,732	581,487	604,858	35,259	569,599
2001	638,978	45,140	593,838	628,626	38,370	590,256
2002	661,082	48,144	612,938	630,176	42,339	587,837
2003	686,437	52,288	634,149	656,384	44,199	612,185
2004	699,812	52,982	646,830	672,202	46,624	625,578
2005	733,009	56,057	676,952	698,459	47,981	650,478
2006	749,798	57,495	692,303	713,473	47,920	665,553
2007	751,593	53,618	697,975	725,402	48,411	676,991
Average annual change, 2000-2006	3.1%	4.7%	2.9%	2.8%	5.2%	2.6%
Percent change, 2006-2007	0.2	-6.7	0.8	1.7	1.0	1.7

Note: Totals exclude transfers, escapes, and AWOLs.

Table 4. Number of sentenced admissions into state prisons, by type of admission, 2000-2007

	Admissions		
Year	Total[a]	New court commitments	Parole violators[b]
2000	581,487	350,431	203,569
2001	593,838	365,714	215,450
2002	612,938	392,661	207,961
2003	634,149	399,843	209,753
2004	646,830	411,300	219,033
2005	676,952	421,426	232,229
2006	692,303	441,606	239,495
2007	697,975	435,733	248,923

[a]Totals based on inmates with a sentence of more than a year. Totals exclude transfers, escapes, and AWOLs.

[b]Parole violators include prisoners with revoked parole, other conditional release violators, and intermediate sanctions imposed upon parolees in lieu of revoking parole.

Table 5. Sentenced prisoners under state or federal jurisdiction, December 31, 2000, 2006, and 2007

	Number of prisoners			Average annual change, 2000-2006	Percent change, 2006-2007
	2000	2006	2007		
Total[a]	1,331,300	1,504,700	1,532,800	2.1%	1.9%
Male[a]	1,247,000	1,401,400	1,427,300	2.0%	1.8%
White[b]	401,900	478,800	471,400	3.0	-1.5
Black[b]	532,400	535,100	556,900	0.1	4.1
Hispanic or Latino	242,600	291,000	301,200	3.1	3.5
Female[a]	84,300	103,300	105,500	3.4%	2.1%
White[b]	33,600	49,200	50,500	6.6	2.6
Black[b]	32,200	28,600	29,300	-2.0	2.4
Hispanic or Latino	13,100	17,500	17,600	4.9	0.6

Note: Includes prisoners serving a sentence of a year or more under state or federal jurisdiction. Estimates updated and may differ from previously published estimates.

[a]Includes American Indians, Alaska Natives, Asians, Native Hawaiians, other Pacific Islanders, and persons identifying two or more races.

[b]Excludes persons of Hispanic or Latino origin.

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Increases in the sentenced population resulted in higher imprisonment rates (the number of state or federal sentenced prisoners under state or federal jurisdiction per 100,000 U.S. residents). As of December 31, 2007, there were 506 sentenced prisoners per 100,000 U.S. residents (1 in every 198 U.S. residents) up from 501 per 100,000 at yearend 2006 (table 6). At yearend 2007, the federal imprisonment rate reached 59 prisoners per 100,000 U.S. residents. The state imprisonment rate reached 447 prisoners per 100,000 U.S. residents.

The 2007 sentenced male imprisonment rate (955 prisoners per 100,000 U.S. residents) was almost 14 times that of the female imprisonment rate (69 per 100,000). Black male offenders had the highest imprisonment rate (3,138 prisoners per 100,000 U.S. residents) of all racial groups, male or female. This was 6.5 times the imprisonment rate of white males and 2.5 times that of Hispanic males. Similarly, the black female imprisonment rate (150 prisoners per 100,000 U.S. residents) was almost double the imprisonment rates for Hispanic (79 prisoners per 100,000) and 3 times the rate for white females (50 per 100,000).

Table 6. Imprisonment rates for sentenced prisoners, December 31, 2000, 2006, and 2007

	Imprisonment rate per 100,000 U.S. residents			Change
	2000	2006	2007	2000-2007
Total[a]	478	501	506	28
Male[a]	915	943	955	40
White[b]	410	487	481	71
Black[b]	3,188	3,042	3,138	-50
Hispanic or Latino	1,419	1,261	1,259	-160
Female[a]	59	68	69	10
White[b]	33	48	50	17
Black[b]	175	148	150	-25
Hispanic or Latino	78	81	79	1

Note: Imprisonment rates are based on U.S. Census Bureau population estimates per 100,000 U.S. residents. Resident population estimates are as of January 1 in each year following the reference year.

[a]Includes American Indians, Alaska Natives, Asians, Native Hawaiians, other Pacific Islanders, and persons identifying two or more races.

[b]Excludes persons of Hispanic or Latino origin.

Table 7. Total change in number of sentenced prisoners, December 31, 2000 to 2007

	Total	Percent of total increase
Total[a]	201,500	100.0%
Male[a]	180,300	89.5
White[b]	69,500	34.5
Black[b]	24,500	12.2
Hispanic or Latino	58,600	29.1
Female[a]	21,200	10.5
White[b]	16,900	8.4
Black[b]	-2,900	-1.4
Hispanic or Latino	4,500	2.2

Note: Numbers are estimated and rounded to the nearest 100. Estimates updated and may differ from previously published estimates.

[a]Includes American Indians, Alaska Natives, Asians, Native Hawaiians, and other Pacific Islanders, and persons identifying two or more races.

[b]Excludes persons of Hispanic or Latino origin.

Black imprisonment rates have decreased since 2000

Between 2000 and 2007, the number of sentenced prisoners under state or federal jurisdiction increased by an estimated 201,500 prisoners (table 7). The increase of about 69,500 white males resulted in 34.5% of the overall change. Almost a third of the growth (29.1%) resulted from the increase of about 58,600 Hispanic males, followed by an estimated increase of 24,500 sentenced black males (12.2% of the overall increase). White women accounted for 8.4% of the overall change, and Hispanic females for about 2.2%. The number of imprisoned black females declined by approximately 2,900 during this period.

In 2000, Hispanic males comprised 18.2% of the sentenced male population. At yearend 2007, this percentage had increased to 19.7%. The percentage of white males also increased slightly from 30.2% to 30.8% while the percentage of black males decreased from 40.0% to 36.3%.

White females made up 2.5% of the total prison population in 2000 and 3.3% in 2007. During the same periods, the percentage of the prison population made up of black females decreased from 2.4% to 1.9%. The Hispanic female prison population was fairly stable, comprising 1.0% of all sentenced prisoners in 2000 and 1.1% in 2007.

While the imprisonment rates for most groups increased during the past 7 years, the imprisonment rates for black males and black females decreased. At yearend 2000, the black male imprisonment rate was 3,188 prisoners per 100,000 U.S. residents. White men were imprisoned at a rate of 410 prisoners per 100,000 U.S. residents. By yearend 2007, the black male imprisonment rate had decreased to 3,138 prisoners per 100,000 U.S. residents, while the white male imprisonment rate increased to 481 prisoners per 100,000 U.S. residents. These changes resulted in a decrease in the ratio of imprisoned black men to imprisoned white men. In 2000 the ratio was 8 to 1 and in 2007 the ratio was 7 to 1.

The ratio of the black female imprisonment rate to white female imprisonment rate also decreased. The imprisonment rate for black females dropped from 175 prisoners per 100,000 U.S. residents at yearend 2000 to 150 prisoners per 100,000 at yearend 2007. The white female imprisonment rate increased from 33 prisoners per 100,000 U.S. residents to 50 prisoners per 100,000. These changes resulted in a decreased in the ratio of imprisoned black females to imprisoned white females. The ratio at yearend 2007 was 3 to 1. In 2000 the ratio was 5 to 1.

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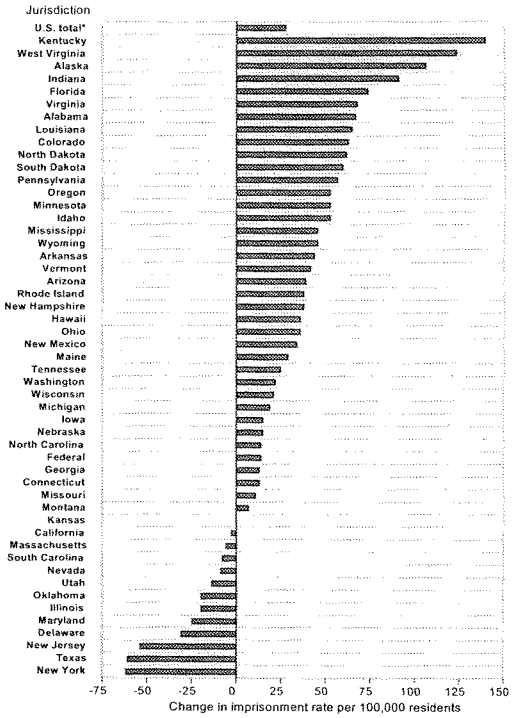
Trends in imprisonment rates, 2000-2007

From 2000 to 2007, the imprisonment rate increased from 478 prisoners per 100,000 U.S. residents to 506 residents per 100,000. *Imprisonment rate* refers to the number of prisoners sentenced to more than one year, under state or federal jurisdiction, per 100,000 U.S. residents. State (37 states) and federal imprisonment rates increased between yearend 2000 and yearend 2007. States with the largest increases during these years were Kentucky (up by 139 prisoners per 100,000 residents), West Virginia (up by 123 prisoners per 100,000), Alaska (up by 106 prisoners per 100,000), and Indiana (up by 91 prisoners per 100,000) (figure 2). The sentenced jurisdiction populations of these four states also increased during these years. With the exception of Alaska, the general populations of these states increased only slightly.

During the same time period, the imprisonment rates in 12 states decreased. New York experienced the largest decrease of 62 prisoners per 100,000 residents, followed by Texas, down 61 prisoners per 100,000 residents, and New Jersey, down 54 prisoners per 100,000 residents. The sentenced prison populations in New York and New Jersey declined during this period. In Texas the prison population increased from 2000 to 2007, while the state resident population increased at a faster rate, leading to the decline in the imprisonment rate. Kansas was the only state in which there was no change in the imprisonment rate.

Change in imprisonment rates, 2000-2007



*Illinois, Nevada, and Maine did not provide data for 2007. The U.S., Illinois, Nevada, and Maine imprisonment rates are estimated. See *Methodology*.

Figure 2

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Number of inmates in custody reached nearly 2.3 million

As of December 31, 2007, there were 2,293,157 inmates held in custody in state and federal prisons and in local jails. *Custody* comprises all inmates held in state or federal public prisons or local jails, regardless of sentence length or the state having jurisdiction.[1] This 1.5% increase during 2007 was slightly smaller than the rate of growth in the jurisdiction and sentenced populations (table 8). Two-thirds of inmates in custody (1,512,576 inmates) were held in state or federal prisons. The remaining third (780,581 inmates) were being held in local jails.

During 2007, the incarceration rate rose to 756 inmates per 100,000 U.S. residents—up from 751 per 100,000 in 2006.[2] At yearend 2007, 1 in every 132 persons in the United States was held in custody.

[1]The total custody count does not include inmates held in U.S. territories, military facilities, U.S. Immigration and Customs Enforcement facilities, jails in Indian country, and juvenile facilities.

[2]Incarceration rate refers to the number of inmates held in the custody of state or federal prisons or in local jails per 100,000 U.S. residents.

States increased prison capacity during 2007

State and federal correctional authorities provide three measures of their facilities' capacity:

Rated capacity is the number of beds or inmates assigned by a rating official to institutions within the jurisdiction.

Operational capacity is the number of inmates that can be accommodated based on a facility's staff, existing programs, and services.

Design capacity is the number of inmates that planners or architects intended for the facility.

Highest capacity is the sum of the maximum number of beds and inmates reported by the states or federal system across the three capacity measures, and the lowest capacity is the minimum of these three measures. Estimates of prison populations as a percentage of capacity are based on the custody population. In general, a state's capacity and custody counts exclude inmates held in private facilities. Some states include prisoners held in private facilities as part of the capacity of their prison systems. In these states, prison population as a percent of capacity includes private prisoners.

Table 8. Inmates in custody in state or federal prisons or in local jails, December 31, 2000, 2006, and 2007

	Number of inmates			Average annual change, 2000-2006	Percent change, 2006-2007
	2000	2006	2007		
Total inmates in custody[a]	1,937,482	2,258,983	2,293,157	2.6%	1.5%
Federal prisoners[b]					
Total	140,064	190,844	197,285	5.3	3.4
Prisons	133,921	183,381	189,154	5.4	3.1
Federal facilities	124,540	163,118	165,975	4.6	1.8
Privately-operated facilities	9,381	20,263	23,179	13.7	14.4
Community Corrections Centers[c]	6,143	7,463	8,131	3.3	9.0
State prisoners	1,176,269	1,302,129	1,315,291	1.7%	1.0%
Inmates held in local jails[d]	621,149	766,010	780,581	3.6%	1.9%
Incarceration rate[e]	684	751	756		

Note: Counts include all inmates held in public and private adult correctional facilities and in local jails.

[a]Total includes all inmates held in state or federal public prison facilities or in local jails. It does not include inmates held in U.S. territories, military facilities, U.S. Immigration and Customs Enforcement facilities, jails in Indian Country, and juvenile facilities.

[b]After 2001, responsibility for sentenced felons from the District of Columbia was transferred to the Federal Bureau of Prisons.

[c]Non-secure, privately-operated community corrections centers.

[d]Counts for inmates held in local jails are for the last working day of June in each year. Counts were estimated from the Annual Survey of Jails in every year except 2005 when a Census of Jail Inmates was conducted. See *Methodology.*

[e]The total number of inmates in custody per 100,000 U.S. residents. Resident population estimates were as of January 1 of the following year for December 31 estimates.

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At yearend 2007, the federal system reported a capacity of 122,461 beds. The highest capacity reported by states was 1,280,037 and the lowest capacity was 1,091,934 (table 9).[3] States operated at 96% of their highest capacity and 113% of their lowest reported capacity. Since yearend 2006, highest capacity has increased by 2.1% and lowest capacity by 1.6%.

During 2007, 19 states and the federal system were operating at more than 100% of highest capacity. An equal number of states (19) operated in a range between 90% and 99% of capacity. The federal system was operating 36% above capacity.

The total incarcerated population reached 2.4 million

At yearend 2007, the total incarcerated population reached 2,413,112 inmates (table 10). The total incarcerated population comprises all inmates held in custody in state or federal public prisons, local jails, U.S. territories, military facilities, U.S. Immigration and Customs Enforcement (ICE) facilities, jails in Indian country, and juvenile facilities. The majority (62.7%) of these inmates were held in state or federal correctional facilities. Another 32.3% of these inmates were held in local jails. A very small percentage (5.0%) were divided among territorial, U.S. Immigration and Customs Enforcement, military and juvenile facilities, and jails in Indian country.

During 2007, the incarcerated populations decreased in military facilities (7.7%), and territorial prisons (3.5%). The largest absolute decrease occurred in territorial prisons (527 inmates), followed by the decrease in military facilities (150).

[3]Capacity numbers for Illinois, Maine, and Nevada are based on capacity reported at yearend 2006.

Table 9. State prison population as a percent of capacity, 1995, and 2000-2007

Year	Highest capacity	Lowest capacity
1995	114%	125%
2000	100	115
2001	101	116
2002	101	117
2003	100	116
2004	99	115
2005	99	114
2006	98	114
2007	96	113
State capacity, 2007	1,280,037	1,091,934

Note: Capacity excludes prisoners held in local jails and in privately-operated facilities.

Table 10. Total incarcerated population, December 31, 2000, 2006 and 2007

	Number of inmates		Percent change,
	2006	2007	2006-2007
Total[a]	2,380,465	2,413,112	1.4%
Federal and state prisons	1,492,973	1,512,576	1.3
Territorial prisons	15,205	14,678	-3.5%
Local jails[b]	766,010	780,581	1.9
ICE facilities	9,615	9,720	1.1
Military facilities	1,944	1,794	-7.7
Jails in Indian country[c]	--	2,163	:
Juvenile facilities[d]	92,845	--	:

--Not available.
:Not calculated.

[a]Total includes all inmates held in state or federal public prison facilities, local jails, U.S. territories, military facilities, U.S. Immigration and Customs Enforcement facilities, jails in Indian country, and juvenile facilities.

[b]Counts for inmates held in local jails are for the last working day of June in each year. Counts were estimated from the Annual Survey of Jails in every year except 2005 when a Census of Jail Inmates was conducted. See *Methodology.*

[c]The Survey of Jails in Indian Country was not conducted in 2006. The 2006 inmate population was estimated.

[d]Counts are from the Census of Juveniles in Residential Placement (CJRP), conducted by the Office of Juvenile Justice Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice. Data for 2007 are BJS estimates. See *Methodology.*

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Other available information

The following topics are detailed in appendix tables 1-19, following *Methodology*:

- Appendix table 1. Male prisoners under jurisdiction of state or federal correctional authorities
- Appendix table 2. Female prisoners under jurisdiction of state or federal correctional authorities
- Appendix table 3. Number of sentenced prisoners under the jurisdiction of state or federal correctional authorities
- Appendix table 4. Number of sentenced prisoners admitted and released from state or federal jurisdiction, by region and jurisdiction
- Appendix table 5. Number of sentenced prisoners admitted and released from state or federal jurisdiction, by type
- Appendix table 6. Imprisonment rates of sentenced prisoners under the jurisdiction of state or federal correctional authorities, by region, and jurisdiction
- Appendix table 7. Estimated number of persons under state or federal jurisdiction, by gender, race, Hispanic origin, and age
- Appendix table 8. Estimated number of persons held in state or federal jurisdiction per 100,000 U.S. residents, by gender, race, Hispanic origin, and age
- Appendix table 9. Imprisonment rates of sentenced male and female prisoners under the jurisdiction of state or federal correctional authorities, by gender
- Appendix table 10. Estimated number of sentenced prisoners under state jurisdiction, by offense, gender, race, and Hispanic origin
- Appendix table 11. Estimated percent of sentenced prisoners under state jurisdiction, by offense, gender, race, and Hispanic origin
- Appendix table 12. Number of sentenced prisoners in federal prisons by most serious offense
- Appendix table 13. Number of state and federal prisoners under jurisdiction housed in private facilities
- Appendix table 14. Number of state and federal prisoners under jurisdiction housed in local jails
- Appendix table 15. Reported state and federal prison capacities
- Appendix table 16. Prisoners in custody of correctional authorities in the U.S. territories and commonwealths
- Appendix table 17. Prisoners under military jurisdiction, by branch of service
- Appendix table 18. Number of detainees held by U.S. Immigration and Customs Enforcement (ICE), by facility type
- Appendix table 19. Number of detainees held in custody by U.S. Immigration and Customs Enforcement authorities, by offense type

Detailed information is available in appendix tables in the online version of this report on the BJS website at <http://www.ojp.usdoj.gov/BJS/pub/pdf/p07.pdf>.

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Methodology

National Prisoner Statistics

Begun in 1926 under a mandate from Congress, the National Prisoner Statistics (NPS) program collects statistics on prisoners at midyear and yearend. The Census Bureau serves as the data collection agent for Bureau of Justice Statistics (BJS). BJS depends entirely on the voluntary participation by states' departments of corrections and the Federal Bureau of Prisons for NPS data.

The NPS distinguishes between prisoners in custody and prisoners under jurisdiction. To have custody of a prisoner, a state or federal prison must hold that prisoner in one of its facilities. To have jurisdiction over a prisoner, a state or federal prison must have legal authority over the prisoner. Some states are unable to provide counts that distinguish between custody and jurisdiction.

The NPS jurisdiction counts include prisoners serving a sentence within a jurisdiction's facilities, including prisons, penitentiaries, correctional facilities, halfway houses, boot camps, farms, training/treatment centers, and hospitals. They include prisoners who are:

• temporarily absent (less than 30 days), out to court, or on work release

• housed in privately-operated facilities, local jails, or other state or federal facilities

• serving concurrent sentences for more than one correctional authority.

The NPS custody counts include all inmates held within a respondent's facilities, including inmates housed for other correctional authorities. The custody counts exclude inmates held in local jails and in other facilities. With a few exceptions for several respondents, the NPS custody counts exclude inmates held in privately-operated facilities.

Additionally NPS data include counts of inmates in combined jail-prison systems in Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont. NPS prisoner counts have excluded prisoners held by the District of Columbia. Since yearend 2001 the District of Columbia has operated only a jail system. Prisoners sentenced under the District of Columbia criminal code are housed in federal facilities.

Ratio estimates were used to generate the jurisdiction counts for gender and sentenced individuals in Illinois during 2007 using data provided in 2006. Yearend 2007 data were not received from Illinois Department of Corrections.

Maine and Nevada were not able to provide data for December 31, 2007. Estimates were calculated using ratio estimates. All numbers were reviewed and approved by individuals at the respective departments of corrections.

For more information about the NPS data collection instruments, see: <http://www.ojp.usdoj.gov/bjs/correct.htm#nps>.

Military Corrections Statistics

BJS obtains yearend counts of prisoners in the custody of U.S. military authorities from the Department of Defense Corrections Council. In 1994, the council, composed of representatives from each branch of military service, adopted a standardized report (DD Form 2720) with a common set of items and definitions. This report obtains data on persons held in U.S. military confinement facilities inside and outside of the continental United States, by branch of service, gender, race, Hispanic origin, conviction status, sentence length, and offense. It also provides data on the number of facilities and their design and rated capacities.

Other inmate counts

In 1995, BJS began collecting yearend counts of inmates from the departments of corrections in the U.S. Territories (American Samoa, Guam, and the U.S. Virgin Islands) and U.S. Commonwealths (Northern Mariana Islands and Puerto Rico). These counts include all inmates for whom the territory or commonwealth had legal authority (jurisdiction) and all inmates in physical custody (held in prison or local jail facilities). The counts are collected by gender, race, Hispanic origin, and sentence length. In addition, BJS obtains reports on the design, rated, and operational capacities of these correctional facilities.

BJS obtains yearend counts of persons detained by U.S. Immigration and Customs Enforcement (ICE), formerly the U.S. Immigration and Naturalization Service, an agency within the Department of Homeland Security. ICE holds persons for immigration violations in federal, state, and locally operated prisons and jails, as well as in privately-operated facilities under exclusive contract and ICE-operated facilities.

Data on the number of inmates held in the custody of local jails are from the BJS Annual Survey of Jails (ASJ). The ASJ provides data on inmates in custody at midyear. For more information about the ASJ, see *Methodology* in *Jail Inmates at Midyear 2007*. See <http://www.ojp.usdoj.gov/bjs/abstract/jim07.htm>.

Data on federal prisoners are obtained from BJS' Federal Justice Statistics Program (FJSP). The FJSP obtains data from the Federal Bureau of Prisons. These data include individual-level records of prisoners in federal facilities as of September 30. Specifically the FJSP provides counts of sentenced federal inmates by gender, race, Hispanic origin, and offense.

Estimates of juvenile inmates for 2007 are based on average annual change from 2003 to 2006 as reported by the Office of Juvenile Justice and Delinquency Prevention (OJJDP), Office of Justice Programs, U.S. Department of Justice.

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Estimating age-specific imprisonment rates

Estimates are provided for the number of sentenced prisoners under state or federal jurisdiction by gender. Further, within genders, prisoners are characterized by age group, race (non-Hispanic white and non-Hispanic black), and Hispanic origin. The detailed race and Hispanic origin categories exclude estimates of persons identifying two or more races.

For 2000 and 2007, estimates were produced separately for prisoners under state and federal jurisdiction, and then combined to obtain a total estimated population. State estimates were prepared by combining information about the gender of prisoners from the NPS with information on self-reported race and Hispanic origin from the 2005 Survey of Inmates of State Correctional Facilities.

For the estimates of federal prisoners, the distributions of FJSP counts of sentenced federal prisoners by gender, age, race, and Hispanic origin on September 30, 2007, were applied to the NPS counts of sentenced federal prisoners by gender at yearend 2007.

Estimates of the U.S. resident population for January 1, 2008, by age, gender, race, and Hispanic origin, were generated by applying the December 31, 2007 age distributions within gender, race, and Hispanic origin groups to the January 1, 2008 population estimates by gender. The population estimates were provided by the U.S. Census Bureau.

Age-specific rates of imprisonment for each demographic group were calculated by dividing the estimated number of sentenced prisoners within each age group by the estimated number of U.S. residents in each age group. That number was multiplied by 100,000, and then rounded to the nearest whole number. Gender totals include all prisoners and U.S. residents regardless of racial or Hispanic origin. Imprisonment rates for detailed race and Hispanic origin groups exclude persons identifying two or more races.

NPS jurisdiction notes

Alaska—Prisons and jails form one integrated system. All NPS data include jail and prison populations housed in-state and out of state. Jurisdictional counts exclude inmates held in local jails that are operated by communities.

Arizona—Population counts are based on custody data and inmates in contracted beds.

California—Jurisdiction counts include felons and unsentenced inmates who are temporarily absent, i.e., housed in local jails, hospitals, etc.

Colorado—Counts include 211 inmates in the Youthful Offender System, which was established primarily for violent juvenile offenders.

Capacity figures exclude seven privately run facilities under contract with the Department of Corrections.

Delaware—Prisons and jails form one integrated system. All NPS data include jail and prison populations.

Federal—Custody counts include inmates housed in secure facilities where the BOP contracted directly with a private operator or subcontracted with a private provider at a local government facility. Custody includes inmates held in non-secure privately-operated community corrections centers, e.g., halfway houses, and on home confinement.

Florida—Counts are not comparable to last year due to new methods of data collection by Florida correctional officials.

Georgia—Counts are based on custody data.

Hawaii—Prisons and jails form one integrated system. All NPS data include jail and prison populations.

Illinois—Data for 2007 were not received. All data for December 31, 2007 are based on ratio estimates using NPS 1b data from 2005. Population counts are based on jurisdiction data. Counts of inmates with a sentence of more than a year include an undetermined number of inmates with a sentence of less than a year. These estimates will be updated upon receipt of data.

Iowa—Population counts are based on custody data. Population counts for inmates with a sentence of more than a year include an undetermined number of inmates with a sentence of less than a year and unsentenced inmates. Iowa does not differentiate between these groups in its data system. Due to a change in reporting in 2006, out of state inmates have been included in jurisdiction counts.

Kansas—Admission and release data are based on the custody population. Due to a new, electronic reporting system, 2007 admission and release data are not comparable to previous years' counts.

Louisiana—Counts are as of December 27, 2007. Counts include 15,789 mates and 1,289 females housed in local jails as a result of a partnership with the Louisiana Sheriffs' Association and local authorities. Custody and jurisdiction counts include evacuees from Hurricane Katrina and other pre-trial offenders from Orleans and Jefferson parish jails. Due to the effects of Hurricane Katrina, Orleans and Jefferson parish prison capacities are down. Therefore, local jail population is down from the 2004 counts.

Maine—Data for 2007 were not available at the time of publication. Estimates based on 2006 numbers were used for all tables. These estimates will be updated upon receipt of data.

Maryland—The number of prisoners listed with their race as "unknown" has increased due to changes in the information system.

Massachusetts—By law, offenders may be sentenced to terms of up to 2 years and 6 months in locally-operated jails and correctional institutions. Such populations are included in counts and rates for local jails and correctional institutions. About 6,200 inmates with sentences of more than one year were held in local jails. Jurisdiction and custody counts include an undetermined number of inmates who were remanded to court, transferred to the custody of another state, federal, or locally-operated system, and subsequently released.

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NPS jurisdiction notes (continued)

Minnesota—Counts include inmates temporarily housed in local jails or private contract facilities, or on work release and community work crew programs.

Mississippi—Operational and design capacities include private prison capacities.

Missouri—Design capacities are not available for older prisons. Operational capacity is defined as the number of available beds including those temporarily offline. Missouri Department of Corrections does not have updated design capacity for prison extensions or improvements.

Montana—Population counts include a small number of inmates with unknown sentence lengths.

Capacity figures include two county operated regional prisons (an estimated 300 beds), one private prison (500 beds), and a state operated boot camp (60 beds).

In 2006, the Department of Corrections changed the method of accounting for community corrections offenders placed in residential treatment programs. To track growth patterns, a new standard process was applied to historic populations which resulted in some changes to previous years' counts.

Nevada—Due to a system conversion, data for 2007 were calculated with ratio estimates, and are based on 2006 numbers. All estimates were reviewed by individuals at the Nevada Department of Corrections.

New Jersey—Counts of inmates with a sentence of more than a year include an undetermined number of inmates with sentences of just a year. The Department of Corrections has no jurisdiction over inmates with sentences of less than a year or over unsentenced inmates.

Rated capacity figures are not maintained.

North Carolina—Capacity figures refer to standard operating capacity, based on single occupancy per cell and 50 square feet per inmate in multiple occupancy units.

Ohio—Counts of inmates with a sentence of more than a year include an undetermined number of inmates with sentences of a year or less.

Oklahoma—Population counts for inmates with sentences of less than a year consist mainly of offenders ordered by the court to the Delayed Sentencing Program for Young Adults pursuant to 22 O.S. 996 through 996.3.

As of November 4, 1998, Oklahoma has one type of capacity, which includes state prisons, private prisons, and contract jails.

Oregon—Counts include an undetermined number of inmates with sentences of a year or less. County authorities retain jurisdiction over the majority of these types of inmates.

Pennsylvania—As of May 31, 2004, the Department of Corrections began using a new capacity reporting system based on design as well as other crucial factors such as facility infrastructure, support services, and programming.

Rhode Island—Prisons and jails form one integrated system. All NPS data include jail and prison populations.

South Carolina—Population counts include 36 inmates who were unsentenced, under safekeeping, or ICC status. As of July 1, 2003, South Carolina Department of Corrections (SCDC) began releasing inmates due for release and housed in SCDC institutions on the 1st day of each month. Because January 1, 2008 was a holiday, inmates eligible for release on January 1 were released on December 31, 2007. Therefore, the inmate count was at its lowest point for the month on December 31, 2007.

Texas—Jurisdiction counts include inmates serving time in a pre-parole transfer (PPT) or intermediary sanctions facility (ISF), substance abuse felony punishment facility (SAFPF), private facilities, halfway houses, temporary releases to counties, and paper-ready inmates in local jails.

Vermont—Prisons and jails form one integrated system. All NPS data include jail and prison populations. Improved methods were used to measure admissions and releases. Admission and release data for 2006 and 2007 are not comparable.

Virginia—Jurisdiction counts are as of December 28, 2007. Rated capacity is the Department of Corrections' count of beds, which takes into account the number of inmates that can be accommodated based on staff, programs, services and design.

Washington—A recently revised law allows increasing numbers of certain inmates with sentences of less than a year to be housed in prison.

Wisconsin—Operational capacity excludes contracted local jails, federal and other state and private facilities.

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This report in portable document format (includes 19 appendix tables) and in ASCII and its related statistical data are available at the BJS World Wide Web Internet site: <http://www.ojp.usdoj.gov/bjs/abstract/p07.htm>.

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The Bureau of Justice Statistics is the statistical agency of the U.S. Department of Justice. Michael D. Sinclair is the acting director.

BJS Bulletins present the first release of findings from permanent data collection programs.

The Bulletin was written by Heather C. West and William J. Sabol, Ph.D. Todd Minton verified the report and provided statistical support.

Steve Simoncini carried out the data collection and processing under the supervision of Charlene M. Sebold, Governments Division, Census Bureau, U.S. Department of Commerce. Duane H. Cavanaugh provided technical assistance.

Catherine Bird edited the report. Tina Dorsey and Georgette Walsh produced the report. Jayne E. Robinson prepared the report for final printing under the supervision of Doris J. James.

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Appendix table 1. Male prisoners under jurisdiction of state or federal correctional authorities, December 31, 2000, 2006, and 2007

Region and jurisdiction	Number of male prisoners			Average annual change	Percent change
	2000	2006	2007	2000-2006	2006-2007
U.S. Total[a]	1,298,027	1,457,486	1,483,896	1.9%	1.8%
Federal	135,171	180,071	186,280	4.9	3.4
State[a]	1,162,856	1,277,415	1,297,616	1.6	1.6
Northeast	165,744	168,087	169,400	0.2%	0.8%
Connecticut[b]	16,949	18,972	19,428	1.9	2.4
Maine	1,613	1,975	2,070	3.4	4.8
Massachusetts	10,059	10,186	10,646	0.2	4.5
New Hampshire	2,137	2,633	2,741	3.5	4.1
New Jersey	28,134	25,943	25,417	-1.3	-2.0
New York	66,919	60,456	59,869	-1.7	-1.0
Pennsylvania	35,268	42,148	43,506	3.0	3.2
Rhode Island[b]	3,048	3,716	3,736	3.4	0.5
Vermont[b]	1,617	2,058	1,987	4.1	-3.4
Midwest	222,780	243,743	245,207	1.5%	0.6%
Illinois	42,432	/	/	:	:
Indiana	18,673	23,924	24,837	4.2	3.8
Iowa[c]	7,363	8,049	8,015	1.5	-0.4
Kansas	7,840	8,178	8,071	0.7	-1.3
Michigan	45,587	49,407	48,153	1.4	-2.5
Minnesota	5,870	8,546	8,866	6.5	3.7
Missouri	25,550	27,588	27,335	1.3	-0.9
Nebraska	3,629	3,994	4,106	1.6	2.8
North Dakota	1,008	1,206	1,269	3.0	5.2
Ohio	43,025	45,465	46,909	0.9	3.2
South Dakota	2,416	3,009	2,942	3.7	-2.2
Wisconsin	19,387	21,991	22,216	2.1	1.0
South	521,562	575,711	591,075	1.7%	2.7%
Alabama	24,506	26,191	27,254	1.1	4.1
Arkansas	11,143	12,687	13,248	2.2	4.4
Delaware[b]	6,324	6,615	6,699	0.8	1.3
District of Columbia	7,100	~	~	:	:
Florida	67,214	86,480	91,365	4.3	5.6
Georgia[c]	41,474	49,235	50,711	2.9	3.0
Kentucky	13,858	17,942	20,016	4.4	11.6
Louisiana	32,988	34,623	35,082	0.8	1.3
Maryland	22,319	21,864	22,249	-0.3	1.8
Mississippi	18,572	19,279	20,469	0.6	6.2
North Carolina	29,363	34,774	35,344	2.9	1.6
Oklahoma	20,787	22,950	23,242	1.7	1.3
South Carolina	20,358	22,013	22,635	1.3	2.8
Tennessee	20,797	23,787	24,344	2.3	2.3
Texas	153,097	158,317	157,859	0.6	-0.3
Virginia	28,109	33,795	35,136	3.1	4.0
West Virginia	3,553	5,159	5,422	6.4	5.1
West	252,770	289,874	291,934	2.3%	0.7%
Alaska[b]	3,889	4,551	4,603	2.7	1.1
Arizona[c]	24,546	32,650	34,286	4.9	5.0
California	151,840	163,535	162,654	1.2	-0.5
Colorado	15,500	20,179	20,506	4.5	1.6
Hawaii[b]	4,492	5,233	5,232	2.6	0.0
Idaho	5,042	6,347	6,519	3.9	2.7
Montana	2,799	3,209	3,161	2.3	-1.5
Nevada	9,217	11,765	12,221	4.2	3.9
New Mexico	4,831	5,972	5,890	3.6	-1.4
Oregon	9,984	12,687	12,888	4.1	1.6
Utah	5,256	5,810	5,878	1.7	1.2
Washington	13,850	16,065	16,258	2.5	1.2
Wyoming	1,524	1,871	1,838	3.5	-1.8

/Not reported.
:Not calculated.
~Not applicable. As of December 31, 2001, sentenced felons from the District of Columbia were the responsibility of the Federal Bureau of Prisons.
[a]Totals estimated. Illinois did not provide data in 2006 and 2007. Maine and Nevada did not provide data in 2007.
[b]Prisons and jails form one integrated system. Data include total jail and prison populations.
[c]Population based on custody counts.

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Appendix table 2. Female prisoners under jurisdiction of state or federal correctional authorities, December 31, 2000, 2006, and 2007

Region and jurisdiction	Number of female prisoners			Average annual change	Percent change
	2000	2006	2007	2000-2006	2006-2007
U.S. Total[a]	93,234	112,459	114,420	3.2%	1.7%
Federal	10,245	12,975	13,338	4.0	2.8
State[a]	82,989	99,484	101,082	3.1	1.6
Northeast	9,082	9,730	9,707	1.2%	-0.2%
Connecticut[b]	1,406	1,594	1,496	2.1	-6.1
Maine	66	145	152	14.0	4.8
Massachusetts	663	846	790	4.1	-6.6
New Hampshire	120	172	202	6.2	17.4
New Jersey	1,650	1,428	1,410	-2.4	-1.3
New York	3,280	2,859	2,754	-2.3	-3.7
Pennsylvania	1,579	2,249	2,463	6.1	9.5
Rhode Island[b]	238	280	282	2.7	0.7
Vermont[b]	80	157	158	11.9	0.6
Midwest	14,598	17,670	17,832	3.2%	0.9%
Illinois	2,849	/	/	:	:
Indiana	1,452	2,167	2,295	6.9	5.9
Iowa[c]	592	789	717	4.9	-9.1
Kansas	504	638	625	4.0	-2.0
Michigan	2,131	2,170	2,080	0.3	-4.1
Minnesota	368	562	602	7.3	7.1
Missouri	1,993	2,579	2,522	4.4	-2.2
Nebraska	266	413	399	7.6	-3.4
North Dakota	68	157	147	15.0	-6.4
Ohio	2,808	3,701	3,822	4.7	3.3
South Dakota	200	350	369	9.8	5.4
Wisconsin	1,367	1,424	1,527	0.7	7.2
South	39,652	47,086	48,503	2.9%	3.0%
Alabama	1,826	2,050	2,158	1.9	5.3
Arkansas	772	1,042	1,066	5.1	2.3
Delaware[b]	597	571	577	-0.7	1.1
District of Columbia	356	~	~	:	:
Florida	4,105	6,489	6,854	7.9	5.6
Georgia[c]	2,758	3,557	3,545	4.3	-0.3
Kentucky	1,061	2,058	2,441	11.7	18.6
Louisiana	2,219	2,389	2,458	1.2	2.9
Maryland	1,219	1,081	1,184	-2.0	9.5
Mississippi	1,669	1,789	1,962	1.2	9.7
North Carolina	1,903	2,686	2,626	5.9	-2.2
Oklahoma	2,394	2,547	2,607	1.0	2.4
South Carolina	1,420	1,603	1,604	2.0	0.1
Tennessee	1,369	1,958	1,923	6.1	-1.8
Texas	13,622	13,799	13,931	0.2	1.0
Virginia	2,059	2,893	2,933	5.8	1.4
West Virginia	303	574	634	11.2	10.5
West	19,657	24,998	25,040	4.1%	0.2%
Alaska[b]	284	518	564	10.5	8.9
Arizona[c]	1,964	3,151	3,460	8.2	9.8
California	11,161	11,977	11,628	1.2	-2.9
Colorado	1,333	2,302	2,335	9.5	1.4
Hawaii[b]	561	734	746	4.6	1.6
Idaho	493	777	800	7.9	3.0
Montana	306	354	301	2.5	-15.0
Nevada	846	1,136	1,179	5.0	3.8
New Mexico	511	667	576	4.5	-13.6
Oregon	596	1,020	1,060	9.4	3.9
Utah	381	623	631	8.5	1.3
Washington	1,065	1,496	1,514	5.8	1.2
Wyoming	156	243	246	7.7	1.2

/Not reported.
:Not calculated.
~Not applicable. As of December 31, 2001, sentenced felons from the District of Columbia were the responsibility of the Federal Bureau of Prisons.
[a]Totals estimated. Illinois did not provide data in 2006 and 2007. Maine and Nevada did not provide data in 2007.
[b]Prisons and jails form one integrated system. Data include total jail and prison populations.
[c]Population based on custody counts.

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Appendix table 3. Number of sentenced prisoners under jurisdiction of state or federal correctional authorities, December 31, 2000, 2006, and 2007

Region and jurisdiction	Number of prisoners			Average annual change	Percent change
	2000	2006	2007	2000-2006	2006-2007
U.S. Total[a]	1,331,278	1,504,660	1,532,817	2.1%	1.9%
Federal	125,044	173,533	179,204	5.6	3.3
State[a]	1,206,234	1,331,127	1,353,613	1.7	1.7
Northeast	166,632	166,078	167,667	-0.1%	1.0%
Connecticut[b]	13,155	13,746	14,397	0.7	4.7
Maine	1,635	1,997	2,093	3.4	4.8
Massachusetts	9,479	9,472	9,699	0.0	2.4
New Hampshire	2,257	2,737	2,930	3.3	7.1
New Jersey[c]	29,784	27,371	26,827	-1.4	-2.0
New York	70,199	62,974	62,177	-1.8	-1.3
Pennsylvania	36,844	43,998	45,446	3.0	3.3
Rhode Island[b]	1,966	2,149	2,481	1.5	15.4
Vermont[b]	1,313	1,634	1,617	3.7	-1.0
Midwest	236,458	260,347	261,391	1.6%	0.4%
Illinois	45,281	45,106	45,215	-0.1	0.2
Indiana	19,811	26,055	27,114	4.7	4.1
Iowa[c,d]	7,955	8,838	8,732	1.8	-1.2
Kansas[c]	8,344	8,816	8,696	0.9	-1.4
Michigan	47,718	51,577	50,233	1.3	-2.6
Minnesota	6,238	9,108	9,468	6.5	4.0
Missouri	27,519	30,146	29,844	1.5	-1.0
Nebraska	3,816	4,204	4,329	1.6	3.0
North Dakota	994	1,363	1,416	5.4	3.9
Ohio[c]	45,833	49,166	50,731	1.2	3.2
South Dakota	2,613	3,350	3,306	4.2	-1.3
Wisconsin	20,336	22,618	22,307	1.8	-1.4
South	538,997	597,828	615,535	1.7%	3.0%
Alabama	26,034	27,526	28,605	0.9	3.9
Arkansas	11,851	13,713	14,310	2.5	4.4
Delaware[b]	3,937	4,195	4,201	1.1	0.1
District of Columbia	5,008	~	~	:	:
Florida	71,318	92,874	98,219	4.5	5.8
Georgia[d]	44,141	52,781	54,232	3.0	2.7
Kentucky	14,919	19,514	21,823	4.6	11.8
Louisiana	35,207	36,376	37,341	0.5	2.7
Maryland	22,490	22,316	22,780	-0.1	2.1
Mississippi	19,239	19,219	21,502	0.0	11.9
North Carolina	27,043	32,219	33,016	3.0	2.5
Oklahoma	23,181	23,889	24,197	0.5	1.3
South Carolina	21,017	22,861	23,314	1.4	2.0
Tennessee	22,166	25,745	26,267	2.5	2.0
Texas	158,008	162,193	161,695	0.4	-0.3
Virginia	29,643	36,688	37,984	3.6	3.5
West Virginia	3,795	5,719	6,049	7.1	5.8
West	264,147	306,874	309,020	2.5%	0.7%
Alaska[b]	2,128	3,116	3,072	6.6	-1.4
Arizona[d]	25,412	33,557	35,490	4.7	5.8
California	160,412	173,942	172,856	1.4	-0.6
Colorado[c]	16,833	22,481	22,841	4.9	1.6
Hawaii[b]	3,553	4,373	4,367	3.5	-0.1
Idaho	5,535	7,124	7,319	4.3	2.7
Montana	3,105	3,563	3,431	2.3	-3.7
Nevada	10,063	12,753	13,245	4.0	3.9
New Mexico	4,666	6,361	6,225	5.3	-2.1
Oregon[c]	10,553	13,667	13,918	4.4	1.8
Utah	5,541	6,340	6,415	2.3	1.2
Washington	14,666	17,483	17,757	3.0	1.6
Wyoming	1,680	2,114	2,084	3.9	-1.4

Note: Sentenced prisoner is defined as a prisoner sentenced to more than 1 year.
/Not reported.
:Not calculated.
~Not applicable. As of December 31,2001, sentenced felons from the District of Columbia were the responsibility of the Federal Bureau of Prisons.

[a]Totals estimated. Illinois did not provide data in 2006 and 2007. Maine and Nevada did not provide data in 2007.

[b]Prisons and jails form one integrated system. Data include total jail and prison populations.

[c]Includes some inmates sentenced to 1 year or less.

[d]Population based on custody counts.

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Appendix table 4. Number of sentenced prisoners admitted and released from state or federal jurisdiction, by region and jurisdiction, 2000, 2006, 2007

Region and jurisdiction	Admissions					Releases				
	2000	2006	2007	Average annual change, 2000-2006	Percent change, 2006-2007	2000	2006	2007	Average annual change, 2000-2006	Percent change, 2006-2007
U.S. Total	625,219	749,798	751,593	3.1%	0.2%	604,858	713,473	725,402	2.8%	1.7%
Federal	43,732	57,495	53,618	4.7	-6.7	35,259	47,920	48,411	5.2	1.0
State	581,487	692,303	697,975	2.9	0.8	569,599	665,553	676,991	2.6	1.7
Northeast	67,765	71,523	73,795	0.9%	3.2%	70,646	67,970	71,968	-0.6%	5.9%
Connecticut	6,185	6,904	6,982	1.8	1.1	5,918	6,019	6,056	0.3	0.6
Maine[a]	751	609	640	-3.4	5.1	677	501	524	-4.9	4.6
Massachusetts	2,062	2,686	3,653	4.5	36.0	2,889	2,254	3,273	-4.1	45.2
New Hampshire	1,051	1,312	1,290	3.8	-1.7	1,044	1,187	1,179	2.2	-0.7
New Jersey	13,653	13,980	13,791	0.4	-1.4	15,362	13,986	14,358	-1.6	2.7
New York	27,601	25,710	26,291	-1.2	2.3	28,828	25,079	27,009	-2.3	7.7
Pennsylvania	11,777	17,106	17,666	6.4	3.3	11,759	15,648	16,340	4.9	4.4
Rhode Island	3,701	876	1,120	:	:	3,223	967	884	:	:
Vermont	984	2,340	2,362	:	:	946	2,329	2,345	:	:
Midwest	117,776	155,549	153,906	4.7%	-1.1%	114,382	150,438	153,616	4.7%	2.1%
Illinois	29,344	/	/	:	:	28,876	/	/	:	:
Indiana	11,876	17,671	17,653	6.8	-0.1	11,053	16,410	17,099	6.8	4.2
Iowa	4,656	6,565	5,706	5.9	-13.1	4,379	5,834	5,718	4.9	-2.0
Kansas	5,002	5,063	4,849	0.2	-4.2	5,231	5,318	4,966	0.3	-6.6
Michigan	12,169	14,643	13,330	3.1	-9.0	10,874	12,641	14,685	2.5	16.2
Minnesota	4,406	7,253	7,856	8.7	8.3	4,244	7,591	7,971	10.2	5.0
Missouri	14,454	18,429	18,300	4.1	-0.7	13,346	20,092	19,323	7.1	-3.8
Nebraska	1,688	1,939	2,076	2.3	7.1	1,503	2,041	1,952	5.2	-4.4
North Dakota	605	1,101	1,028	10.5	-6.6	598	1,039	977	9.6	-6.0
Ohio	23,780	31,866	30,808	5.0	-3.3	24,793	28,552	29,236	2.4	2.4
South Dakota	1,400	2,429	3,227	9.6	32.9	1,327	3,137	3,259	15.4	3.9
Wisconsin	8,396	8,703	8,592	0.6	-1.3	8,158	8,749	8,903	1.2	1.8
South	217,950	255,495	258,223	2.7%	1.1%	210,777	247,588	246,343	2.7%	-0.5%
Alabama	6,296	10,039	10,708	8.1	6.7	7,136	11,283	11,079	7.9	-1.8
Arkansas	6,941	5,992	6,651	-2.4	11.0	6,308	5,668	6,045	-1.8	6.7
Delaware	2,709	1,546	1,899	-8.9	22.8	2,260	1,470	1,905	-6.9	29.6
Florida[b]	35,683	36,295	33,552	0.3	-7.6	33,994	35,454	28,705	0.7	-19.0
Georgia	17,373	22,347	21,134	4.3	-5.4	14,797	17,468	19,119	2.8	9.5
Kentucky[a]	8,116	14,051	15,359	9.6	9.3	7,733	13,381	13,819	9.6	3.3
Louisiana	15,735	15,067	14,548	-0.7	-3.4	14,536	14,618	14,984	0.1	2.5
Maryland	10,327	10,295	10,716	-0.1	4.1	10,004	10,176	10,123	0.3	-0.5
Mississippi	5,796	9,918	9,749	9.4	-1.7	4,940	10,123	8,455	12.7	-16.5
North Carolina	9,848	10,594	10,834	1.2	2.3	9,687	9,976	10,074	0.5	1.0
Oklahoma	7,426	8,508	8,795	2.3	3.4	6,628	7,867	8,486	2.9	7.9
South Carolina	8,460	9,597	9,912	2.1	3.3	8,676	9,208	9,461	1.0	2.7
Tennessee	13,675	13,655	14,535	0.0	6.4	13,893	15,298	15,537	1.6	1.6
Texas	58,197	71,927	72,525	3.6	0.8	59,776	70,413	73,023	2.8	3.7
Virginia	9,791	12,834	13,973	4.6	8.9	9,148	12,794	12,559	5.7	-1.8
West Virginia	1,577	2,830	3,333	10.2	17.8	1,261	2,391	2,969	11.3	24.2
West	177,996	209,736	212,051	2.8%	1.1%	173,794	199,557	205,064	2.3%	2.8%
Alaska	2,427	3,065	3,272	4.0	6.8	2,599	2,719	3,286	0.8	20.9
Arizona	9,560	13,954	14,046	6.5	0.7	9,100	12,209	12,560	5.0	2.9
California	129,640	138,523	139,608	1.1	0.8	129,621	133,905	135,920	0.5	1.5
Colorado	7,036	10,468	10,959	6.8	4.7	5,881	9,441	10,604	8.2	12.3
Hawaii	1,594	1,455	1,514	-1.5	4.1	1,379	1,500	1,518	1.4	1.2
Idaho	3,386	4,129	4,055	3.4	-1.8	2,697	3,808	3,850	5.9	1.1
Montana	1,202	2,304	2,055	11.5	-10.8	1,031	2,262	2,176	14.0	-3.8
Nevada[a]	4,929	6,108	6,375	3.6	4.4	4,374	4,700	4,904	1.2	4.3
New Mexico	3,161	4,337	4,146	5.4	-4.4	3,383	4,274	4,507	4.0	5.5
Oregon	4,059	5,484	5,331	5.1	-2.8	3,371	5,138	5,080	7.3	-1.1
Utah	3,270	3,532	3,466	1.3	-1.9	2,897	3,469	3,393	3.0	-2.2
Washington	7,094	15,540	16,478	14.0	6.0	6,764	15,363	16,488	14.7	7.3
Wyoming	638	837	746	4.6	-10.9	697	769	778	1.7	1.2

Note: Totals exclude transfers, escapees, and AWOLs.
:Not calculated.
/Not reported.
[a]2007 counts were estimated. See *Methodology*.
[b]A change in the reporting in 2004 excluded unsentenced prisoners and those sentenced to less than 1 year.

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Appendix table 5. Number of sentenced prisoners admitted and released from state or federal jurisdiction, by type, December 31, 2007

Region and jurisdiction	Admissions			Releases		
	Total	New court commitments	Parole violators	Total	Conditional releases	Unconditional releases
U.S. Total	751,593	484,424	253,847	725,402	508,927	200,875
Federal	53,618	48,691	4,924	48,411	1,545	46,804
State	697,975	435,733	248,923	676,991	507,382	154,071
Northeast	73,795	48,340	23,508	71,968	51,983	17,034
Connecticut	6,982	5,516	1,409	6,056	3,048	2,621
Maine[a]	640	412	228	524	318	198
Massachusetts	3,653	3,344	309	3,273	996	2,243
New Hampshire	1,290	615	653	1,179	960	211
New Jersey	13,791	9,969	3,751	14,358	9,269	4,840
New York	26,291	16,461	9,724	27,009	23,732	3,006
Pennsylvania	17,666	10,222	5,753	16,340	11,195	3,161
Rhode Island	1,120	993	127	884	401	474
Vermont	2,362	808	1,554	2,345	2,064	280
Midwest	153,906	107,249	43,048	153,616	121,632	30,167
Illinois	/	/	/	/	/	/
Indiana	17,653	14,919	2,734	17,099	15,778	1,264
Iowa	5,706	3,297	839	5,718	3,608	1,290
Kansas	4,849	3,335	1,485	4,966	3,453	1,479
Michigan	13,330	8,714	4,091	14,685	12,429	1,721
Minnesota	7,856	5,067	2,781	7,971	6,632	1,326
Missouri	18,300	9,735	8,541	19,323	17,159	2,077
Nebraska	2,076	1,798	278	1,952	993	947
North Dakota	1,028	762	266	977	745	232
Ohio	30,808	26,778	3,829	29,236	15,272	13,812
South Dakota	3,227	1,229	870	3,259	2,873	371
Wisconsin	8,592	5,085	3,502	8,903	8,357	506
South	258,223	187,233	67,176	246,343	145,534	92,508
Alabama	10,708	9,247	1,436	11,079	6,920	4,000
Arkansas	6,651	4,771	1,821	6,045	5,707	286
Delaware	1,899	1,386	467	1,905	1,595	216
Florida[b]	33,552	32,253	246	28,705	7,870	19,424
Georgia	21,134	12,156	8,896	19,119	3,451	15,542
Kentucky[a]	15,359	10,969	4,390	13,819	8,928	4,769
Louisiana	14,548	9,360	4,952	14,984	13,788	1,053
Maryland	10,716	6,846	3,866	10,123	9,308	741
Mississippi	9,749	8,523	1,198	8,455	5,105	1,930
North Carolina	10,834	10,492	337	10,074	2,968	6,972
Oklahoma	8,795	6,398	2,397	8,486	5,684	2,703
South Carolina	9,912	6,596	3,161	9,461	5,044	4,195
Tennessee	14,535	8,623	5,912	15,537	10,466	5,016
Texas	72,525	44,641	26,199	73,023	55,557	13,809
Virginia	13,973	13,214	759	12,559	1,552	10,920
West Virginia	3,333	1,758	1,139	2,969	1,591	932
West	212,051	92,911	115,191	205,064	188,233	14,362
Alaska[c]	3,272	/	/	3,286	1,768	1,348
Arizona	14,046	11,912	2,134	12,560	9,637	2,270
California	139,608	46,980	92,628	135,920	133,776	1,925
Colorado	10,959	6,470	4,486	10,604	9,070	1,347
Hawaii	1,514	743	771	1,518	699	298
Idaho	4,055	3,815	240	3,850	3,309	522
Montana	2,055	678	1,374	2,176	1,945	215
Nevada[a]	6,375	5,642	733	4,904	3,170	1,734
New Mexico	4,146	2,404	1,329	4,507	2,791	1,323
Oregon	5,331	3,615	1,466	5,080	4,835	12
Utah	3,466	1,822	1,644	3,393	2,525	861
Washington	16,478	8,172	8,298	16,488	14,272	2,174
Wyoming	746	658	88	778	436	333

Note: Totals exclude transfers, escapes, and AWOLs. Total admissions include new court commitments, returned parole violators, returns from appeals and other admissions. Total releases include conditional releases, unconditional releases, individuals out on appeal or bond, deaths, and other unspecified releases.

/Not reported.

[a]2007 numbers are estimated. See *Methodology*.

[b]A change in reporting in 2004 excluded unsentenced prisoners and those sentenced to less than 1 year.

[c]New reporting systems prevent the disaggregation of admission type.

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Appendix table 6. Imprisonment rates of sentenced prisoners, yearend 2000-2007

Region and jurisdiction	Imprisonment rate, December 31[a]			Change, 2000-2007
	2000	2006	2007	Number
U.S. Total[b]	478	501	506	28
Federal	45	58	59	14
State[b]	432	445	447	15
Northeast	320	303	306	-13
Connecticut[c]	398	392	410	13
Maine	129	151	159	29
Massachusetts[d]	252	243	246	-6
New Hampshire	185	207	222	38
New Jersey	362	313	308	-54
New York	383	326	322	-62
Pennsylvania	307	353	365	57
Rhode Island[c]	197	202	235	38
Vermont[c]	218	262	260	42
Midwest	371	391	393	22
Illinois	371	:	:	:
Indiana	335	411	426	91
Iowa[e]	276	296	291	15
Kansas	312	318	312	0
Michigan	480	511	499	19
Minnesota	128	176	181	53
Missouri	494	514	506	11
Nebraska	228	237	243	15
North Dakota	158	214	221	62
Ohio	406	428	442	36
South Dakota	353	426	413	60
Wisconsin	376	393	397	21
South	539	547	556	17
Alabama	549	595	615	67
Arkansas	458	485	502	44
Delaware[c]	513	488	482	-31
District of Columbia	971	~	~	:
Florida	462	509	535	74
Georgia[e]	550	558	563	13
Kentucky	373	462	512	139
Louisiana	801	846	865	65
Maryland	429	396	404	-25
Mississippi	688	658	734	46
North Carolina	347	360	361	14
Oklahoma	685	664	665	-20
South Carolina	532	525	524	-8
Tennessee	399	423	424	25
Texas	730	683	669	-61
Virginia	422	477	490	68
West Virginia	211	314	333	123
West	423	437	438	15
Alaska[c]	341	462	447	106
Arizona[e]	515	509	554	39
California	474	475	471	-3
Colorado	403	469	465	63
Hawaii[c]	302	338	338	36
Idaho	430	480	483	53
Montana	348	374	356	7
Nevada	518	503	509	-9
New Mexico	279	323	313	34
Oregon	316	367	369	53
Utah	254	246	239	-14
Washington	251	271	273	22
Wyoming	349	408	394	46

: Not calculated. Data not provided for 2007. Estimates used to get the U.S. imprisonment rate. See *Methodology.*

~Not applicable. As of December 31, 2001, sentenced felons from D.C. were the responsibility of the Federal Bureau of Prisons.

[a]The number of prisoners sentenced to more than 1 year per 100,000 U.S. residents. Based on Census estimates for January 1, 2008.

[b]Totals estimated. See *Methodology.*

[c]Prisons and jails form one integrated system. Data include total jail and prison populations.

[d]The imprisonment rate includes an estimated 6,200 inmates sentenced to more than a year, but held in local jails or houses of corrections.

[e]Population based on custody counts.

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Appendix table 7. Estimated number of sentenced prisoners under state or federal jurisdiction, by gender, race, Hispanic origin, and age, December 31, 2007

	Male[a]				Female[a]			
Age	Total[b]	White[c]	Black[c]	Hispanic	Total[b]	White[c]	Black[c]	Hispanic
Total	1,427,300	471,400	556,900	301,200	105,500	50,500	29,300	17,600
18-19	23,700	6,400	10,200	5,000	1,000	400	300	200
20-24	207,900	58,800	84,200	49,600	11,600	5,400	3,000	2,300
25-29	246,000	65,300	102,100	61,500	16,000	7,300	4,400	3,200
30-34	237,200	69,800	96,200	55,300	18,400	8,900	5,000	3,200
35-39	225,000	74,200	89,200	46,600	20,900	9,900	6,000	3,300
40-44	201,700	74,800	76,700	36,100	18,100	8,700	5,200	2,700
45-49	135,200	52,400	50,500	22,800	10,700	5,200	3,100	1,500
50-54	75,000	31,000	26,600	12,500	5,000	2,400	1,400	700
55-59	38,600	18,600	11,700	6,200	2,100	1,200	500	300
60-64	18,900	10,500	4,600	2,900	900	600	200	100
65 and older	15,500	9,000	3,600	2,200	600	400	100	100

Note: State sentenced prisoner counts are based on estimates by gender, race, Hispanic origin, and age from the 2005 Survey of Inmates in State Correctional Facilities and updated form jurisdiction counts by gender at yearend 2007. Federal sentenced prisoner counts are based on data from the BJS Federal Justice Statistics Program from September 30, 2007 and updated from jurisdiction counts at yearend 2007.

[a]Sentenced prisoners are limited to those sentenced to more than 1 year.

[b]Total includes American Indians, Alaska Natives, Asians, Native Hawaiians, other Pacific Islanders, and persons identifying two or more races.

[c]Excludes Hispanics and persons identifying two or more races.

Appendix table 8. Estimated number of sentenced prisoners under state or federal jurisdiction per 100,000 U.S. residents, by gender, race, Hispanic origin, and age, December 31, 2007

	Male[a]				Female[a]			
Age	Total[b]	White[c]	Black	Hispanic	Total[b]	White[c]	Black	Hispanic
Total	955	481	3,138	1,259	69	50	150	79
18-19	539	238	1,561	656	24	16	47	28
20-24	1,915	887	5,580	2,507	114	86	203	134
25-29	2,256	1,025	7,256	2,624	154	117	303	172
30-34	2,385	1,214	8,166	2,500	191	157	386	175
35-39	2,113	1,124	7,215	2,344	199	151	434	191
40-44	1,859	1,044	6,106	2,111	166	121	364	176
45-49	1,196	658	4,013	1,619	93	65	214	113
50-54	719	404	2,422	1,164	46	31	108	66
55-59	432	274	1,337	787	22	17	47	36
60-64	266	188	771	526	12	10	26	16
65 and older	95	68	294	200	3	2	5	7

Note: Based on estimates of the U.S. resident population on January 1, 2008, by gender, race, Hispanic origin, and age. Detailed categories exclude persons identifying two or more races.

[a]Sentenced prisoners are limited to those serving sentences of more than 1 year.

[b]Includes American Indians, Alaska Natives, Asians, Native Hawaiians, other Pacific Islanders, and persons identifying two or more races.

[c]Excludes Hispanics and persons identifying two or more races.

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Appendix table 9. Imprisonment rates of sentenced prisoners under jurisdiction of state or federal correctional authorities, by gender, December 31, 2007

Region and jurisdiction	Imprisonment rate, December 31, 2007[a]		
	Total	Male	Female
U.S. Total[b]	506	955	69
Federal	59	112	8
State[b]	447	844	61
Northeast	306	599	29
Connecticut[c]	410	794	45
Maine	159	303	21
Massachusetts[d]	246	301	8
New Hampshire	222	420	29
New Jersey	308	597	32
New York	322	635	27
Pennsylvania	365	710	38
Rhode Island[c]	235	463	21
Vermont[c]	260	495	32
Midwest	393	743	52
Illinois	:	:	:
Indiana	426	791	71
Iowa[e]	291	542	47
Kansas	312	584	44
Michigan	499	971	41
Minnesota	181	341	23
Missouri	506	948	83
Nebraska	243	449	41
North Dakota	221	394	46
Ohio	442	838	65
South Dakota	413	736	92
Wisconsin	397	748	50
South	556	1,050	79
Alabama	615	1,180	85
Arkansas	502	949	73
Delaware[c]	482	945	47
Florida	535	1,013	73
Georgia[e]	563	1,069	72
Kentucky	512	934	107
Louisiana	865	1,664	111
Maryland	404	793	39
Mississippi	734	1,385	121
North Carolina	361	696	41
Oklahoma	665	1,211	131
South Carolina	524	1,009	64
Tennessee	424	804	61
Texas	669	1,244	97
Virginia	490	921	74
West Virginia	333	610	68
West	438	807	67
Alaska[c]	447	785	82
Arizona[e]	554	1,009	97
California	471	880	62
Colorado	465	829	96
Hawaii[c]	338	594	79
Idaho	483	854	106
Montana	356	649	62
Nevada	509	911	92
New Mexico	313	580	54
Oregon	369	686	56
Utah	239	428	46
Washington	273	500	46
Wyoming	394	686	95

: Not calculated.

[a]The number of prisoners sentenced to more than 1 year per 100,000 U.S. residents. Based on Census estimates for January 1, 2008.

[b]Totals estimated. Illinois did not provide data.

[c]Prisons and jails form one integrated system. Data include total jail and prison populations.

[d]The imprisonment rate includes an estimated 6,200 inmates sentenced to more than 1 year, but held in local jails or houses of corrections.

[e]Population based on custody counts.

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Appendix table 10. Estimated number of sentenced prisoners under state jurisdiction, by offense, gender, race, and Hispanic origin, yearend 2005

	All inmates	Male	Female	White[a]	Black[a]	Hispanic
Total	1,296,700	1,208,500	88,200	470,700	504,700	240,100
Violent offenses	687,700	656,400	31,200	235,800	275,700	131,500
Murder[b]	166,700	156,800	9,800	49,300	72,100	32,200
Manslaughter	16,700	15,100	1,700	6,900	6,500	2,300
Rape	60,800	60,300	500	30,000	20,900	6,800
Other sexual assault	103,800	102,300	1,500	58,000	21,200	21,500
Robbery	177,900	170,300	7,600	38,700	95,200	30,700
Assault	129,200	121,400	7,700	40,500	48,100	32,000
Other violent	32,500	30,200	2,400	12,400	11,700	6,000
Property offenses	248,900	223,700	25,200	114,700	81,300	38,800
Burglary	124,400	118,800	5,600	54,500	42,900	20,500
Larceny	45,200	38,200	7,100	20,500	16,200	5,700
Motor vehicle theft	22,400	21,100	1,300	9,100	5,500	6,700
Fraud	32,100	22,800	9,200	17,900	9,600	2,400
Other property	24,800	22,800	2,100	12,800	7,200	3,500
Drug offenses	253,300	228,000	25,300	72,300	113,500	51,100
Public-order offenses[c]	98,700	93,400	5,300	44,200	31,600	17,500
Other/unspecified[d]	8,100	7,100	1,100	3,700	2,600	1,300

Note: Data are for inmates sentenced to more than 1 year under the jurisdiction of state correctional authorities. The estimates for gender were based on jurisdiction counts at yearend (NPS 1B). The estimates by race and Hispanic origin were based on data from 2005 Survey of Inmates in State Correctional Facilities and updated by yearend jurisdiction counts; estimates within offense categories were based on offense distributions from the National Corrections Reporting Program, 2005, updated by yearend jurisdiction counts. All estimates were rounded to the nearest 100. Detail may not add to total due to rounding.

[a]Excludes Hispanics and persons identifying two or more races.

[b]Includes negligent manslaughter.

[c]Includes weapons, drunk driving, court offenses, commercialized vice, morals and decency offenses, liquor law violations, and other public-order offenses.

[d]Includes juvenile offenses and other unspecified offense categories.

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Appendix table 11. Estimated percent of sentenced prisoners under state jurisdiction, by offense, gender, race, and Hispanic origin, yearend 2005

	All inmates	Male	Female	White[a]	Black[a]	Hispanic
Total	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %
Violent offenses	53.0 %	54.3 %	35.4 %	50.1 %	54.6 %	54.7 %
Murder[b]	12.9	13.0	11.2	10.5	14.3	13.4
Manslaughter	1.3	1.2	1.9	1.5	1.3	1.0
Rape	4.7	5.0	0.6	6.4	4.1	2.8
Other sexual assault	8.0	8.5	1.7	12.3	4.2	9.0
Robbery	13.7	14.1	8.6	8.2	18.9	12.8
Assault	10.0	10.0	8.8	8.6	9.5	13.3
Other violent	2.5	2.5	2.7	2.6	2.3	2.5
Property offenses	19.2 %	18.5 %	28.6 %	24.4 %	16.1 %	16.2 %
Burglary	9.6	9.8	6.3	11.6	8.5	8.6
Larceny	3.5	3.2	8.0	4.3	3.2	2.4
Motor vehicle theft	1.7	1.7	1.5	1.9	1.1	2.8
Fraud	2.5	1.9	10.4	3.8	1.9	1.0
Other property	1.9	1.9	2.3	2.7	1.4	1.5
Drug offenses	19.5 %	18.9 %	28.7 %	15.4 %	22.5 %	21.3 %
Public-order offenses[c]	7.6 %	7.7 %	6.1 %	9.4 %	6.3 %	7.3 %
Other/unspecified[d]	0.6 %	0.6 %	1.2 %	0.8 %	0.5 %	0.5 %

Note: Data are for inmates with a sentence of more than 1 year under the jurisdiction of state correctional authorities. Detail may not add to total due to rounding.

[a]Excludes Hispanics and persons identifying two or more races.

[b]Includes negligent manslaughter.

[c]Includes weapons, drunk driving, court offenses, commercialized vice, morals and decency offenses, liquor law violations, and other public-order offenses.

[d]Includes juvenile offenses and other unspecified offense categories.

Appendix table 12. Number of sentenced prisoners in federal prison, by most serious offense, 2000, 2006, and 2007

Offense	2000	2006	2007	Average annual change, 2000-2006	Percent change, 2006-2007
Total	131,739	176,268	179,204	5.0%	1.7%
Violent offenses	13,740	16,507	15,647	3.1%	-5.2%
Homicide[a]	1,363	2,923	2,915	13.6	-0.3
Robbery	9,712	9,645	8,966	-0.1	-7.0
Other violent	2,665	3,939	3,767	6.7	-4.4
Property offenses	10,135	10,015	10,345	-0.2%	3.3%
Burglary	462	519	504	2.0	-2.9
Fraud	7,506	6,437	7,834	-2.5	21.7
Other property	2,167	3,059	2,006	5.9	-34.4
Drug offenses	74,276	93,751	95,446	4.0%	1.8%
Public-order offenses	32,325	54,336	56,273	9.0%	3.6%
Immigration	13,676	19,496	19,528	6.1	0.2
Weapons	10,822	24,298	25,435	14.4	4.7
Other	7,827	10,542	11,311	5.1	7.3
Other/unspecified[b]	1,263	1,659	1,492	4.7%	-10.0%

Note: All data are from the BJS Federal Justice Statistics Program. Data are for September 30 and based on all sentenced inmates, regardless of sentence length.

[a]Includes murder and negligent and nonnegligent manslaughter.

[b]Includes offenses not classified.

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Appendix table 13. Number of state and federal prisoners under jurisdiction housed in private facilities, December 31, 2000, 2006, and 2007

Region and jurisdiction	Number of prisoners			Percent of prisoners
	2000	2006	2007	2007
U.S. Total	87,369	113,697	125,975	7.9%
Federal[a]	15,524	27,726	31,310	15.7
State	71,845	85,971	94,665	6.8
Northeast	2,509	4,107	4,246	2.4%
Connecticut	0	0	0	0.0
Maine	11	19	20	0.9
Massachusetts	0	0	0	0.0
New Hampshire	0	0	0	0.0
New Jersey[b]	2,498	2,602	2,686	10.0
New York	0	0	0	0.0
Pennsylvania	0	962	1,022	2.2
Rhode Island	0	0	0	0.0
Vermont[b]	0	524	518	24.1
Midwest	7,836	4,364	5,048	1.9%
Illinois	0	/	/	:
Indiana	991	1,290	1,683	6.2
Iowa	0	0	0	0.0
Kansas	0	0	0	0.0
Michigan	449	0	0	0.0
Minnesota	0	979	1,183	12.5
Missouri	0	0	0	0.0
Nebraska	0	0	0	0.0
North Dakota	96	0	0	0.0
Ohio	1,918	2,080	2,138	4.2
South Dakota	45	12	21	0.6
Wisconsin	4,337	3	23	0.1
South	45,560	53,205	56,117	8.8%
Alabama[c]	0	9	355	1.2
Arkansas	1,540	0	0	0.0
Delaware	0	0	0	0.0
District of Columbia	2,342	~	~	:
Florida	3,912	6,350	8,769	8.9
Georgia	3,746	5,075	4,974	9.2
Kentucky	1,268	2,507	2,404	10.7
Louisiana	3,068	3,066	3,004	8.0
Maryland	127	121	151	0.6
Mississippi	3,230	4,860	4,794	21.4
North Carolina	330	194	213	0.6
Oklahoma	6,931	5,708	5,917	22.9
South Carolina	0	13	9	0.0
Tennessee	3,510	5,126	5,121	19.5
Texas	13,985	18,627	18,871	11.0
Virginia	1,571	1,549	1,535	4.0
West Virginia	0	0	0	0.0
West	15,940	24,295	29,254	9.2%
Alaska	1,383	1,681	1,524	29.5
Arizona	1,430	5,213	7,790	20.6
California	4,547	2,844	5,087	2.9
Colorado	...	4,855	4,878	21.4
Hawaii	1,187	1,915	2,129	35.6
Idaho	1,162	1,925	1,969	26.9
Montana	986	1,195	1,324	38.2
Nevada	508	0	0	0.0
New Mexico	2,155	2,930	2,720	42.1
Oregon	0	0	0	0.0
Utah	208	0	0	0.0
Washington[b]	0	954	1,203	6.8
Wyoming	275	783	630	30.2

/Not reported.
:Not calculated.
~Not applicable. As of December 31, 2001, sentenced felons from the District of Columbia were the responsibility of the Federal Bureau of Prisons.

[a]Includes federal inmates held in non-secure, privately-operated facilities (6,143 in 2000, 7,463 in 2006, and 8,131 in 2007).

[b]Includes inmates held in out-of-state private facilities.

[c]Increase in number is a result of the transfer of prisoners in the state system.

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Appendix table 14. Number of state and federal prisoners under jurisdiction housed in local jails, December 31, 2000, 2006, and 2007

Region and jurisdiction	Number of prisoners			Percent of prisoners
	2000	2006	2007	2007
U.S. Total	62,884	77,912	80,371	5.0%
Federal	2,438	2,010	2,144	1.1
State	60,446	75,902	78,227	5.6
Northeast	3,823	2,022	1,677	0.9
Connecticut[a]	~	~	~	~
Maine	24	0	0	0.0
Massachusetts	457	177	136	1.2
New Hampshire	14	13	52	1.8
New Jersey	3,225	1,821	1,468	5.5
New York	45	11	21	0.0
Pennsylvania	58	~	~	~
Rhode Island[a]	~	~	~	~
Vermont[a]	~	~	~	~
Midwest	2,103	2,536	3,381	1.3%
Illinois	0	/	/	:
Indiana	1,187	1,180	2,002	7.4
Iowa	0	0	0	0.0
Kansas	0	0	0	0.0
Michigan	286	62	43	0.1
Minnesota	149	508	518	5.5
Missouri	0	0	0	0.0
Nebraska	0	0	0	0.0
North Dakota	38	48	48	3.4
Ohio	0	0	0	0.0
South Dakota	16	61	55	1.7
Wisconsin	427	677	715	3.0
South	47,128	65,212	67,071	10.5%
Alabama	1,074	1,160	1,596	5.4
Arkansas	728	842	1,007	7.0
Delaware[a]	~	~	~	~
District of Columbia[b]	1,329	~	~	~
Florida[c]	0	34	1,147	1.2
Georgia	3,888	4,970	4,919	9.1
Kentucky	3,850	5,921	7,912	35.2
Louisiana	15,599	16,230	17,079	45.5
Maryland	118	162	151	0.6
Mississippi	3,700	4,684	4,952	22.1
North Carolina	0	0	0	0.0
Oklahoma	970	1,955	1,892	7.3
South Carolina	433	381	377	1.6
Tennessee	5,204	6,451	7,019	26.7
Texas	6,477	15,091	12,774	7.4
Virginia	2,962	5,965	5,097	13.4
West Virginia	796	1,366	1,149	19.0
West	7,392	6,132	6,098	1.9%
Alaska[a]	~	~	~	~
Arizona	237	43	46	0.1
California	2,758	2,468	2,782	1.6
Colorado	2,178	430	175	0.8
Hawaii[a]	~	~	~	~
Idaho	450	459	575	7.9
Montana	548	615	522	15.1
Nevada	147	148	155	1.2
New Mexico	0	140	116	1.8
Oregon	7	55	23	0.2
Utah	1,050	1,328	1,286	19.8
Washington	0	424	362	2.0
Wyoming	17	22	56	2.7

~ Not applicable.
/Not reported.
:Not calculated.

[a]Prisons and jails form one integrated system.

[b]As of December 31, 2001, sentenced felons from the District of Columbia were the responsibility of the Federal Bureau of Prisons.

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Appendix table 15. Reported state and federal prison capacities, December 31, 2007

Region and jurisdiction	Type of capacity measure			Custody population as a percent of—	
	Rated	Operational[1]	Design	Highest capacity[a]	Lowest capacity[a]
Federal	122,461	...	...	136%	136%
Northeast					
Connecticut[b]	...	...	...	...%	...%
Maine[c]	1,885	1,885	1,885	:	:
Massachusetts	...	...	7,875	141	141
New Hampshire	2,524	3,000	2,270	92	122
New Jersey	...	23,300	16,876	97	134
New York	60,242	61,390	57,768	102	109
Pennsylvania	41,692	41,692	41,692	107	107
Rhode Island	4,004	4,004	4,265	88	94
Vermont	1,732	1,732	1,371	94	119
Midwest					
Illinois[c]	33,971	33,971	59,959	:%	:%
Indiana	...	24,989	...	94	94
Iowa	...	...	7,413	117	117
Kansas	9,317	...	...	94	94
Michigan	...	51,343	...	98	98
Minnesota	...	7,807	...	103	103
Missouri	...	30,788	...	97	97
Nebraska	...	3,969	3,175	111	139
North Dakota	1,044	991	1,044	133	140
Ohio	38,320	...	...	125	125
South Dakota	...	3,487	...	93	93
Wisconsin[d]	...	17,383	...	131	131
South					
Alabama[e]	...	25,686	13,728	97%	181%
Arkansas	12,961	13,610	12,863	98	103
Delaware	7,103	6,757	5,319	100	134
Florida[e]	...	95,241	72,556	91	119
Georgia[f]	...	58,231	...	102	102
Kentucky	...	13,682	14,017	92	95
Louisiana[f]	20,461	20,641	...	114	115
Maryland	...	23,155	...	99	99
Mississippi[f]	...	22,725	22,725	77	77
North Carolina[e]	33,359	38,512	...	99	115
Oklahoma[f]	24,845	24,845	24,845	96	96
South Carolina	...	23,918	...	99	99
Tennessee	20,258	19,804	...	70	71
Texas[d]	162,560	158,578	162,560	86	88
Virginia	32,765	...	...	96	96
West Virginia	4,135	5,015	4,135	98	119
West					
Alaska	3,058	3,206	...	113%	119%
Arizona	29,119	39,690	34,474	75	103
California	...	165,409	82,936	101	201
Colorado	...	14,937	13,027	119	137
Hawaii	...	3,487	2,451	95	136
Idaho[f]	6,348	6,031	6,348	111	117
Montana[d]	...	2,441	...	119	119
Nevada[c]	11,061	10,811	8,326	:	:
New Mexico[f]	...	7,131	6,653	52	56
Oregon	...	13,188	13,188	101	101
Utah	...	6,650	6,886	75	78
Washington	13,777	15,502	15,502	109	123
Wyoming	1,511	1,436	1,428	86	91

...Data not available.
/Not reported.
:Not calculated.

[a]Population counts are based on the number of inmates held in facilities operated by the jurisdiction. Excludes inmates held in local jails, in other states, or in private facilities.

[b]Connecticut no longer reports capacity because of a law passed in 1995.

[c]Capacity based on numbers reported in 2006.

[d]Excludes capacity of county facilities and inmates housed in them.

[e]Capacity definition differs from BJS definition, see Jurisdiction Notes.

[f]Includes capacity of private and contract facilities and inmates housed in them.

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Appendix table 16. Prisoners in custody of correctional authorities in the U.S. Territories and Commonwealths, December 31, 2006 and 2007

Jurisdiction	Total 2006	Total 2007	Total Percent change, 2006-2007	Sentenced to more than 1 year 2006	Sentenced to more than 1 year 2007	Sentenced to more than 1 year Percent change, 2006-2007	Sentenced to more than 1 year Incarceration rate, 2007*
Total	15,205	14,678	-3.5%	11,743	11,465	-2.4%	261
American Samoa	210	236	12.4	113	122	8.0	188
Guam	495	535	8.1	337	320	-5.0	182
Commonwealth of the Northern Mariana Islands	126	137	8.7	76	78	2.6	90
Commonwealth of Puerto Rico	13,788	13,215	-4.2	10,789	10,553	-2.2	267
U.S. Virgin Islands	586	555	-5.3	428	392	-8.4	357

*The number of prisoners with a sentence of more than 1 year per 100,000 persons in the resident population. July 1, 2007 population estimates were provided by the U.S. Census Bureau, International Data Base.

Appendix table 17. Prisoners under military jurisdiction, by branch of service, yearend 2006 and 2007

Branch of service	Total 2006	Total 2007	Total Percent change, 2006-2007	Sentenced to more than 1 year 2006	Sentenced to more than 1 year 2007	Sentenced to more than 1 year Percent change, 2006-2007
Total	1,944	1,794	-7.7%	1,135	1,089	-4.1%
To which prisoners belong						
Air Force	328	280	-14.6	215	185	-14.0
Army	880	829	-5.8	542	555	2.4
Marine Corps	407	396	-2.7	167	164	-1.8
Navy	315	268	-14.9	201	173	-13.9
Coast Guard	14	21	50.0	10	12	20.0
Holding prisoners						
Air Force	92	61	-33.7	20	9	-55.0
Army	996	912	-8.4	711	721	1.4
Marine Corps	329	338	2.7	98	97	-1.0
Navy	527	483	-8.3	306	262	-14.4

Appendix table 18. Number of detainees held by U.S. Immigration and Customs Enforcement (ICE), by facility type, December 31, 2006 and 2007

Facility type	2006	2007	Percent change, 2006-2007
Total	27,368	30,431	11.2%
Intergovernmental Service Agreement and Bureau of Prisons	17,753	20,711	16.7
ICE owned and contract	9,615	9,720	1.1

Note: Not comparable with numbers reported prior to 2006. The classification of categories have changed.

Appendix table 19. Number of detainees in custody by U.S. Immigration and Customs Enforcement authorities, by offense type, December 31, 2007

Reason held	2006	2007	Change, 2006-2007 Number of detainees	Change, 2006-2007 Percent change
Total	27,368	30,431	3,063	11.2%
Immigration law violation	13,427	13,580	153	1.1
Criminal offense	11,687	12,889	1,202	10.3
Pending charge/disposition	2,254	3,962	1,708	75.8

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Federal Grant Programs Available for Treatment of Mentally Ill Offenders

- **Mentally Ill Offender Treatment & Crime Reduction Act (MIOTCRA)**
  - Mental Health Courts Grant: FY 2009- $10 million; FY 2010- **Senate**: $10 million; **House**: $12 million

- **Second Chance Act**
  - ***Adult and Juvenile Offender State and Local Re-entry Demonstration Grant*** Provides grants to States and local governments that may be used to promote the safe and successful reintegration into the community of individuals who have been incarcerated.
  - ***Mentoring Grants***: Non-profit groups receiving funds may use the money for transitional services for inmates to reintegrate into society.
  - FY 2010 - **Senate**: $50 million. Of the $50 million, $25 million is for offender re-entry demonstration programs and $15 million is for offender re-entry mentoring programs.
    - **House**: $100 million. Of the $100 million, $37 million is for offender re-entry demonstration programs and $15 million is for offender re-entry mentoring programs. Included under COPS.
  - FY 2009 - $25 million. Of the $25 million, $15 million was for offender re-entry demonstration programs and $10 million was for offender re-entry mentoring programs. Included under COPS.

- **Byrne Justice Assistance Grants (JAG) (formula)**
- **Byrne Discretionary Grants (Earmarks)**
- **Byrne Competitive Grants**

Appropriations for Byrne Formula, Byrne Discretionary, Byrne Competitive, LLEBG, and JAG
(Funding in millions of $)

FY	Byrne Formula	Byrne Discretionary	LLEBG	JAG	Byrne Competitive	Total
1999	$505.0	$47.0	$523.0	—	—	$1,075.0
2000	$500.0	$52.0	$523.0	—	—	$1,075.0
2001	$500.0	$69.1	$523.0	—	—	$1,092.1
2002	$500.0	$94.5	$400.0	—	—	$994.5
2003	$500.0	$150.9	$400.0	—	—	$1,050.9
2004	$500.0	$159.1	$225.0	—	—	$884.1
2005	—	$170.0	—	$634.0	—	$804.0
2006	—	$191.7	—	$416.5	—	$608.2
2007	—	$239.3[1]	—	$519.9	—	$759.2
2008	—	$187.5	—	$170.4	$16.0	$373.9
2009	—	$178.5	—	$546.0	$30.0	$754.5
Stimulus						$3,000.0

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*FY 2010: **House**: $693 million; **Senate CJS subcommittee:** $728 million.

- **Serious & Violent Offender Reentry Initiative (SVORI)**
  - This program focuses on funding to develop reentry strategies focusing on the safety of the community and the reduction of serious, violent crime.
  - The program started in 2003, and is sponsored by the Departments of Justice, Labor, Education, HUD and HHS. All grantees must establish and support a partnership between institutional and community agencies.
  - Since its inception, a total of $110 million has been distributed to 69 grantees to develop or expand existing programs offering integrated supervision and reentry services to adults and juveniles. Individually, grantees received between $500,000 and $2 million in single, 3-year awards.
  - Prisoner Reentry Initiative: Replaced SVORI in 2006, and provides funding for reentry grant programs during 3 phases of offender reentry: detention facilities, prior to and after the offender's release and during an ex-offender's long-term transition to the community. Appropriations in 2006 were $8 million; 2007, $7.8 million; and in 2008, $11.7 million.

- **Jail Diversion Targeted Capacity Expansion (TCE) Program**
  - This program is managed by SAMHSA at HHS in coordination with the DOJ's Mental Health Court grant program.
  - This grant is for programs that divert offenders with mental illness from the criminal justice system to mental health treatment and appropriate support services.
  - From 2002-2006, 33 grants were awarded for a total of $10.87 million.
  - From 2002-2004, awards of no more than $300,000 in total costs (direct and indirect) were awarded per grant. Each grantee was eligible to receive funding for up to 3 years. In addition, grantees provided matching of 25 percent (includes cash or in-kind fairly evaluated).
  - For 2009, appropriations were $6.68 million, and the maximum per grant award was $400,000. It appears that no matching was required in 2009.
  - For 2010, the Senate CJS Subcommittee approved the Administration's request of $6.684 million.

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Statement of

The Honorable Russ Feingold

United States Senator
Wisconsin
September 15, 2009

Senate Judiciary Committee
Hearing on "Human Rights at Home: Mental Illness in U.S. Prisons and Jails"
Tuesday, September 15, 2009

Statement of U.S. Senator Russell D. Feingold

Mr. Chairman, thank you for holding this important hearing.

Mental illness is, unfortunately, a problem that is often ignored or unaddressed by the criminal justice system in this country. A report by the Justice Center of the Council of State Governments underscores the seriousness of this problem. Nearly 15% of men and 31% of women inmates have a serious mental illness, i.e. either bipolar disorder, schizophrenia, or major depression. According to the National Alliance of Mental Illness, about 40% of adults with a serious mental illness will come into contact with the criminal justice system some time during their lives.

It is undisputed that if these mentally ill people had received adequate treatment in the first place, the vast majority would not have become involved in the criminal justice system. And once incarcerated, mentally ill inmates often have no access at all to treatment. Without the ability to receive adequate mental health care, these inmates can become very dangerous for both guards and other inmates.

Mentally ill inmates also cost significantly more to incarcerate than regular inmates, and they tend to serve longer sentences for identical crimes. One study of the Miami-Dade County jail found that the cost to incarcerate a mentally ill inmate is seven times higher and the sentence is likely to be eight times longer than for a person without mental illness who is arrested for the exact same offense.

Of course, law enforcement and correctional facilities are not necessarily entirely to blame for the problems arising out of this unique inmate population. Experts agree that prisons are ill-equipped to meet the needs of those with serious mental illnesses. I applaud the ongoing efforts throughout our country, even with very limited manpower and financial resources, to reform our justice system for mentally ill prisoners. However, the justice system needs Congress's leadership on this issue. More federal funding is needed to help address this problem in state and federal prisons and jails.

In 1963, President Kennedy signed a $3 billion authorization that would have created a national network of community mental health facilities for the whole country. Unfortunately, none of that funding was appropriated, and today we allocate scant resources to support persons with mental illnesses. Training for judges, correctional, law enforcement, and emergency response personnel is essential to ensuring adequate diagnosis and treatment of the mentally ill.

I am pleased that Chairman Durbin has organized this hearing and is calling attention to this important issue. I look forward to hearing from today's witnesses about how we can better address mental illness in U.S. prisons and jails.

Thank you.

STATEMENT OF SENATOR AL FRANKEN ON

"HUMAN RIGHTS AT HOME: MENTAL ILLNESS IN US PRISONS AND JAILS"

U.S. SENATE JUDICIARY COMMITTEE

September 15, 2009

Thank you, Mr. Chairman and Ranking Member Coburn. I truly appreciate the opportunity to participate in this hearing, which touches on two issues that are of utmost important to me: caring for those with mental illness and working to reform our country's deeply flawed prison system.

The sheer volume of people that we imprison in this country is a crime. As of 2008, more than 2.3 million people were being held in prisons and local jails. Since 1980, the rate of incarceration in this country has increased more than 350 percent. These statistics are unacceptable to me. They show that too often we're using our prison system as a dumping ground for members of our society who are not necessarily criminals. In fact, thousands of people who are

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being held in our criminal justice system get in trouble with the law because they are not receiving the services they need in our communities--such as treatment for the mentally ill and meaningful educational opportunities for disadvantaged youth.

As a society, we are guilty of failing the thousands of young people who, instead of receiving education and support, are growing into adulthood behind bars, a fate which virtually dooms these children from ever becoming productive citizens. As a country, we are also guilty of failing those who are most vulnerable among us--people with severe and persistent mental illness. With ongoing stigma and shrinking access to community-based resources, there is no doubt that people with mental illness are often living in the shadows of our country. Thus, I am deeply grateful to have the opportunity to shed light on this issue as we hear today's experts and work together to find a workable solution to this dire situation.

I believe our efforts to address mental health in the criminal justice system must involve a three-pronged approach, all of which require our urgent attention. First, we must prevent Americans

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with mental illness from becoming unnecessarily involved in the criminal justice system. This requires consistent investment in community mental health services and supportive housing which enable people with mentally illness to be productive and healthy members of our communities.

Right now, community-based programs such as those funded through the Mentally Ill Offender Treatment and Crime Reduction Act are sorely underfunded. We must fund these programs fully and build on the models that we know are working, such as mental health courts. Without these community-based services and innovative diversion programs, mentally ill citizens end up in the criminal justice system unnecessarily—costing taxpayers far more money than it takes to support them in a community environment.

The second key element to address mental illness in the prison system is to ensure that there are effective treatment and resources available for those individuals who are already within our prisons and jails. According to mental health screening data in Minnesota from 2005, about 70 percent of juveniles in the justice system

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demonstrated a need for mental health services. Given these statistics, I am deeply concerned by reports of juvenile offenders who are being held without access to mental health services. Perhaps even more disturbing is the prevalence of youth being kept in solitary confinement, which has been shown to exacerbate symptoms of mental illness in many cases. These youth deserve the right to mental health care and to humane prison practices. We should look to successful models such as the Crisis Intervention Teams which have improved police response to mental health crises. Perhaps this model can be adapted to train prison and jail staff to learn how to more appropriately handle youth and adult prisoners with mental illness.

As Mr. Fuller's testimony illustrates, we must also address the needs of offenders who have dual diagnoses of mental illness and substance abuse. In Minnesota, drug and felony DWI offenses account for more than 50 percent of the prison population growth. This means that over half of the new prisoners in my state likely have a substance abuse problem. The research shows that if we

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don't address the co-occurrence of these issues, these prisoners will end up as chronic offenders and costing tax payers more than if we provided prisoners with effective treatment while they're incarcerated.

Thirdly, we must provide resources to ensure a smooth transition for those who are mentally ill and are returning to our communities from prisons and jails. Discharge planning is crucial for all prisoners to reduce recidivism and support a positive transition back into society.

Because of the additional challenges to health care and housing that people with mental illness often face, there is a real urgency to provide discharge services for prisoners with mental illness. For example, in Minnesota, 25 percent of prison inmates take medication for mental illness. It is crucial that these prisoners are linked to medical services to ensure that they have access to medications after they're released. Unfortunately, right now, most prisons and jails don't have funding or incentives to provide these services.

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In closing, I want to reiterate that we simply have too many people in prison in this country. And too many of these people are there for the wrong reasons. One of the most important ways to address this problem is to end the criminalization of mental illness. We must ensure that taxpayer dollars are used effectively by using prisons for those offenders who truly need to be kept from the rest of society, and by helping those with treatable mental illness to remain as contributing members of our communities.

Mr. Chairman, thank you again for holding this hearing and I look forward to hearing from today's witnesses.

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United States Senate Committee on the Judiciary

Subcommittee on Human Rights and the Law

Hearing on Human Rights at Home: Mental Illness in US Prisons and Jails

Tuesday, September 15, 2009 10:00 AM

Dirksen Senate Office Building

Washington, DC

Room 226

The Testimony of Mr. David L. Fuller, Certified Psychiatric Rehabilitation Practioner and Forensic Peer Specialist; a Person with History of Incarceration and Psychiatric Disability

Mr. Chairman, Ranking Member Coburn, and distinguished members of this Subcommittee, it is an honor to provide testimony before this body. My purpose in testifying is to bring to light some of the experiences people with mental illness encounter when they enter the criminal justice system and to expose the inhumane treatment they receive. I have also included information on how this travesty in human rights can start to be corrected.

With the ability of hindsight, I can say I started to experience depression at an early age. The first twinge of it was in elementary school at the time of Martin Luther King, Jr.'s assassination. I can remember thinking, "The people in this country will never change. If they could kill a man as good as him what chance do I have?" These thoughts were in the context of experiencing racism through my entire life, from times visiting family in the rural south as a young child to going to a majority white school in my native New York from elementary through high school. I think now, and feel seven years old is too young to feel hopelessness, especially in a country that has as much as this country.

When I was seventeen I experienced my first arrest. New York City's Rikers Island at that time was called the "gladiator school" by local youth. I was arrested for illegal gambling because I had betted a few dollars on some numbers and was caught near the "number spot." Honestly, I used to bet to get a thrill because even at that age, it was hard for me to feel joy or happiness like other young men, so I used to fill that void with

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thrill seeking and other non goal-producing behaviors like drugs and alcohol use. This charge was considered a misdemeanor in New York City State.

In the few days it took for me to post bail I experienced suicidal thoughts and was actually stabbed by another inmate for the jacket I was wearing. I was afraid to go to the clinic because I knew they would put me in isolation on suicide watch and I felt punished enough.

When I became eighteen years old, things were not getting better for me. I was abusing drugs like heroin and crack cocaine. My family did not know what to do. I was trying to outrun someone I could never outrun, myself. By the time I was twenty-one years old, I had been arrested several times for drug possession/sale and gambling. I was using a large amount of drugs and got caught in a drug den during a police raid. I was facing a lot of time and was scared to death. My family found me a good attorney who eventually got the charges dismissed and suggested that I seek drug treatment. I went to a long-term drug treatment facility in New York State. I did not like being there, but I thought maybe I could get help with the problems I had been experiencing. I told my counselor I thought I had more than just a drug problem—that I felt sad and lonely pretty much all the time no matter what I did. I also told him I thought about ending my life quite a bit. When he heard this, he warned me that if I mentioned that again I would be discharged from the program and sent to a mental hospital. I never mentioned it again. I graduated from the program after a year, went back home, picked up drugs again in less than two weeks, and was back in the street like nothing ever changed.

Through the next twenty years, I went back and forth to jail. My ability to function was slowly, but steadily, declining. I was arrested at least twenty or thirty times in that time period. I served sentences from ten days to one year. The first six to ten times I would ask my lawyer or the staff in the jail for help with the issues I had, I got the same answer every time—that is, if they bothered to answer—; that either I went to drug treatment or the mental hospital. I knew one or the other by itself would not work, so I gave up asking for help from the system.

Towards the last few years of my suffering, I experienced my first hospitalization for psychiatric reasons; it was after my first suicide attempt. I was there for a couple of months. I went to therapy, and I was put on medication. It helped; I became stable and was discharged from the hospital. I did not have stable housing when I was discharged. I was referred to a "¾ house" to live and it was worse than living on the streets, so that is what I did. I ended up not taking my medication, not participating in therapy, and quickly re-offended.

When I went to jail the next time I didn't stand up for the count. I was written up and put into punitive segregation ("the box"). In segregation, I was put in a cold, dark, barren

cell—no TV, no books— where the environment exaggerated my symptoms and I even experienced some new ones like audio hallucinations. The officers were verbally and physically abusive. There was no point in making an official complaint because the officers would just abuse you more and nothing would ever be done about it.

This cycle would repeat itself many more times: get out, no place to live, stop taking my medication, use drugs, become suicidal, then go back to jail. I remember I "caught a ticket" in jail one time and before they could send me to the box I tried to hang myself in my cell, my cellmate found me before the officers did and untied the sheet. He did not tell the officers because he knew what would happen. I wept in my cell the rest of the night; I was discharged after two days.

There were fights with other inmates almost every time I went to jail. Because of my depression, I would appear to be an easy victim and some of the other inmates would try to steal my food. Most of the time I would win the fight, but lose the battle for my self-esteem and self-respect—fighting for food like a common animal.

"There is no HIPAA in jail" because there is really no privacy in regards to your psychiatric care. Either you are on the "Mental Observation Unit" with all the stigma and dangers that implies, or you are living in general population where every time you go for medication or need to see the doctor it is announced through the cell block. When you are getting your medication you are on a line with a hundred other inmates and inmates going back and forth on the other side of the hall. People are buying and selling medication and other illicit drugs. Everybody pretty much knows what the other person is getting. When you go to the "clinic" to see the doctor you have to wait for hours on end and once again, everybody knows what you are there for. You can hear staff talking about other patients when you are meeting someone about yourself, so you think about whether they talk about you when you leave, so you do not share much and do not get the help you need.

For 28 years of my life, I struggled with depression and then later PTSD. I used hard drugs most of this period and it seemed like I was always going in and out of jail. Violence was always around me. Through my periods in jail and being homeless I have been stabbed and shot. I was abused by the very people and system that were supposed to be helping me, and keeping me safe. I did not have access to the services I needed; I was alienated from friends and family. I felt isolated and alone. I dwelled in hopelessness, shame, guilt, and fear of the future. I believed God had abandoned me and things would never change.

I turned down treatment a few times in the past when I was in jail before because I was never offered a place I could address my psychiatric disability and my drug addiction at

the same time, in the same place. I had been through treatment many times for one or the other at different times and it seemed to never work for me.

I am happy to say things did change. The last time I was incarcerated I was offered an opportunity to participate in a Mentally Ill/Chemically Addicted (M.I.C.A) — residential treatment rather than stay in jail. It turned my life around. I was able to be around people who had similar experiences and I did not feel so alone. I talked to people like me who had recovered and on their way to happy, productive lives. For the first time in a long time, I had real hope for the future.

I learned I had to be honest, open-minded, and willing to do the footwork in order to recover. I had to take responsibility for my life. I gained a relationship with a higher power that I choose to call God. I confronted my fears and insecurities and made friends with other people, some like me and some that did not have the same experiences as me. I did not use my past as an excuse to fail; I used it as a source of strength and truth to move me forward. I learned to love again; first myself and then others. I learned to forgive. It set me free.

I went back to work with the help of my peers at the Howie T. Harp Advocacy Center, a supportive employment/training center for people with histories similar to my own, got a place to live, and found someone special to share my life with. I learned to be a father, a husband, a citizen—a man!

Eight years ago I never thought I would be able to say this, but I am happy, joyous, and free. Today, all things are possible!

Through my years of suffering, the government has probably spent about one million dollars (not including court and law enforcement costs) on incarceration and treatments that just made my life worse and were ineffective in diminishing or eliminating the problem. All my drug use was a desperate attempt to medicate symptoms that I did not understand and that society had made me ashamed and fearful to get help for. All of my arrests were due to my drug use. Why did I have to be punished so severely, for so long, for being sick?

Psychiatric disability and substance abuse are chronic illnesses similar to hypertension or diabetes. The last time I checked, people with those illnesses were not being put in jail and shunned by society. People can live with all of these disorders with proper treatment and support.

In closing, I encourage everyone to read *Ending an American Tragedy: Addressing the Needs of Justice-Involved People with Mental Illnesses and Co-Occurring Disorders,* which I have attached.

I believe this document can point this committee in the right direction in changing the way services are given; in a cost-effective and humane way that benefits the community as a whole.

Sincerely,

Mr. David L. Fuller

A CALL TO ACTION

Ending an American Tragedy: Addressing the Needs of Justice-Involved People with Mental Illnesses and Co-Occurring Disorders

National Leadership Forum on
Behavioral Health/Criminal Justice Services

September, 2009

National Leadership Forum
for Behavioral Health/Criminal Justice Services

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In 1841, Dorothea Dix was appalled by the conditions she observed in Massachusetts jails and crusaded for more humane responses to the needs of those inmates with mental illnesses. Within a decade her work was translated into therapeutic state run institutions that traded punishment for care. Over the next century, without sustained commitment to Dix's vision for recovery, these facilities fell into disrepair to the point that today, hundreds of thousands of people with mental illnesses crowd our county jails and state prisons.

In 1946, Life Magazine published an exposé detailing cruel and inhumane conditions in State psychiatric hospitals across the United States.[1] The article described widespread abuse of patients resulting, in part, from *"public neglect and legislative penny pinching;"* and was punctuated by a series of haunting photographs depicting desolate and shameful conditions under which people with mental illnesses were being confined, often for years or even decades on end. The author referenced grand jury reports as well as State and Federal investigations documenting widespread abuses and hazardous living conditions in State institutions. Citing severely inadequate staffing, substandard treatment, inappropriate use of restraints, and provision of little more than custodial care, the institutions were described as, *"...costly monuments to the States' betrayal of the duty they have assumed to their most helpless wards"*

Although the population of State psychiatric hospitals continued to grow over the next decade, the publication of this article, along with similar accounts from other media sources, began to expose a crisis that had existed largely hidden from public view for far too long. As more light was shed on the horrific treatment people received in State psychiatric hospitals, along with the hope offered by the availability of new medications, a flurry of federal lawsuits resulted in court decisions leading to substantial reductions in the numbers of people housed in State psychiatric hospitals.

Unfortunately, while State hospital beds were shut down by the thousands, the types of comprehensive community-based services and supports promised as a condition of their closing were never developed. Combined with changes in sentencing practices,

1 (1946). Bedlam 1946: Most U.S. mental hospitals are a shame and a disgrace.



Courtesy State Archives of Florida

1940s State hospital

evolution of quality of life ordinances, and restricted definitions of eligibility for public sector behavioral health services, this has resulted in many individuals with mental illnesses and co-occurring substance use disorders repeatedly coming into contact with the criminal justice system. Our Nation is once again in the midst of another shameful and costly mental health crisis that has been allowed to fester and grow, largely out of public sight. It is a secret of stunning proportions; in numbers and in harm.

Everyday, in every community in the United States, our law enforcement officers, courts, and correctional institutions are witness to a parade of misery brought on by an inadequately funded, antiquated, and fragmented community mental health system that is unable to respond to the needs of people with serious mental illnesses. Each year, more than 1.1 million people diagnosed with mental illnesses are arrested and booked into jails in the United States. Roughly three-quarters of these individuals also experience co-occurring substance use disorders, which increase their likelihood of becoming involved in the justice system. On any given day, between 300,000 and 400,000 people with mental illnesses are incarcerated in jails and prisons across the United States, and more than 500,000 people with mental illnesses are under correctional control in the community.

Over the past 50 years we have gone from institutionalizing people with mental illnesses, often in subhuman conditions, to incarcerating them at unprecedented and appalling rates—putting recovery out of reach for millions of Americans.

These people are not all the same. They are a heterogeneous group.

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- A small subgroup does resemble the State hospital patients of yesteryear, and their presence in our jails/prisons is one of the most egregious and disturbing images related to our failed systems of care. The availability of intensive care models, including hospital care for some, is critical.

- Many other citizens with mental illnesses in our jails have less disabling conditions and with access to appropriate community treatment and support, will do quite well.

- A third subgroup includes people with mental illnesses who have traits that are associated with high arrest and recidivism rates. These individuals would be best served with good treatment and supports, which include interventions targeted to their dynamic risk factors for arrest.

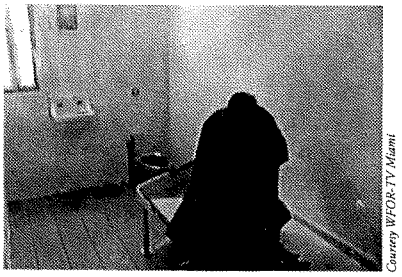
As we attempt to respond to the needs of these people and respect the legitimate public safety concerns of all community members, conditions in these correctional settings, which are designed for detention and not therapeutic purposes, are often far worse than conditions described in the State hospitals of the 1940s. Moreover, when justice-involved persons with co-occurring disorders leave correctional institutions, they repeatedly are left adrift only to recycle through the criminal justice system. Furthermore, individuals who become involved in the justice system often must contend with the additional stigma of criminal records, which make access to basic needs in the community, such as housing, education, and employment, even more difficult to obtain.

This national disgrace, kept hidden for too long, represents one area in civil rights where we have actually lost ground. This failed policy has resulted in a terrible misuse of law enforcement, court, and jail resources, reduced public safety, and compromised public health.

These conditions have recently resulted in investigations into the treatment of people with mental illnesses in institutional settings, only this time the institutions are correctional facilities that were never intended to serve as de facto psychiatric hospitals. Over the past decade alone, the U.S. Department of Justice has issued findings from investigations of mental health conditions in more than 20 jail and prison systems across the United States, with additional investigations currently ongoing. Equally reminiscent of the past, among the more pervasive findings from these investigations are severely inadequate staffing, substandard treatment, inappropriate use of restraints, and provision of little more than custodial care.

The following excerpts are taken from recent grand jury and Department of Justice reports:

- "During our tour, we observed inmate JM hitting her head on the window of her cell and talking with slurred speech. She was housed in a hospital cell under suicide watch. She spoke of seeing angels and said that she was afraid of her cellmate (who was in the advanced stages of pregnancy) was trying to harm her. She had been at [the jail] for approximately one month prior to our visit. JM stated on her intake



Courtesy WFOR-TV Miami

2009 county jail psychiatric unit

form that she had previously been treated at a mental hospital in Little Rock and that she had been seen at a local hospital in January 2005 for seeing 'spiritual things.' Shortly after her admission to [the jail], she was placed on suicide watch for making statements about going to sleep and not getting up and 'not caring if she was alive or not.' Her medical record notes numerous instances of 'talking wildly' and 'talking to herself.' She told us that she had a history of hypothyroidism and told us the names of various psychiatric medications that she had been taking before being admitted to [the jail]. Throughout our tour, we could hear JM moaning and crying and at times

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screaming. In spite of all this, this inmate was never evaluated by a mental health care provider. We were told that she was not started on any psychiatric medications or sent to the local hospital because she did not have the ability to pay."

- "Inmate M.K. hung herself on January 5, 2003 after having been admitted on December 4, 2002. Her record contained the following inmate request form dated two days before her death on January 3, 2003. The note indicated the following:

  'I need to see the doctor to get my medicine straightened out. I am not getting my meds that my doctor faxed prior orders for me, and I brought in the medication myself and paid for it. I cannot afford to be treated this way! Please help me! I need my medicine.'

  There is no indication that M.K. received her medication before her death."

There are no comparable Department of Justice investigations into a lack of community services, because there is no constitutional right to community-based services as there is for persons who are incarcerated. However, by contrast, there are success stories in the community. A recent report by the Health Foundation of Greater Cincinnati offers a number of compelling personal stories from four Forensic Assertive Community Treatment (FACT) Teams they fund.



Courtesy State Archives of Florida

1940s State hospital

- "My housing is a lot better. My Social Security just got approved today, so I start receiving that again. They cut it off while I was in prison. I did 18 months in prison. I got [Social Security] back with the help of [the FACT team]. And they've been helping me with my housing. And that's a lot better 'cause now I can get adjusted to a certain environment. And I don't have to worry about where I'm going to live, one week to the next for whatever reason."

- "Well, I was really in bad shape. I didn't know how to go about getting help. The only thing that I really knew that I had to do was try to care for myself and my habit. And that's what leads to criminal behavior, which limited me on jobs. I felt like I couldn't work because of my record. So, I had to keep being a criminal to support myself and my habit. I didn't know where to go for help. I didn't know who to talk to. I was suicidal all the time. And I really hated myself for all the feelings and things that I was doing. I had an apartment but I was evicted because I couldn't pay the rent. And then, I was just, like, going from place to place and sometimes in homeless shelters and sometimes with friends or just wherever. I was in jail all the time. I just spent two years in the penitentiary. I've been in the penitentiary 3 times and I've been in jail probably 30 to 40 times." The same consumer, when asked about life after receiving FACT services, reported: "Yeah, I haven't had any problems. I work at McDonalds full-time."

Clearly, jails and prisons were never intended as a community's primary setting to provide acute care services to individuals experiencing serious mental illnesses. In most cases they are ill equipped to do so.

When we look at community-based services, we find current policies governing the funding and organization of community mental health care have resulted in people with more intensive and chronic treatment needs being underserved or unserved in typical community-based settings. This is due in large part to rules and regulations that limit flexibility in designing service and reimbursement strategies targeting the specific needs of people with serious mental illnesses. For example, the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Medicare and

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Medicaid Services (CMS) are two agencies housed within the U.S. Department of Health and Human Services (DHHS). SAMHSA has identified intensive case management, psychosocial rehabilitation, supported employment, and supported housing as evidence-based interventions, consistently yielding positive outcomes for persons with serious mental illnesses.

However there are several obstacles to using Medicaid to pay for these effective services. These include categorical restrictions on eligibility, which exclude many people with serious mental illnesses and co-occurring substance use disorders who have been involved in the criminal justice system, as well as fragmentation in coverage for treatment of medical, mental health, and substance abuse problems. Narrow criteria for "medical necessity" and definitions of covered services that are often not aligned with what we know about evidence-based practices create barriers to more effective service delivery and recovery outcomes. As a result, there is an increased demand for services provided in hospitals, emergency settings, and the justice system, contributing to extraordinarily high costs for local communities, states, and the Federal government.

Furthermore, new practices have been slow to be made available to justice-involved persons with co-occurring disorders. For example, it has now become widely accepted that all services for people with serious mental illnesses, particularly those with criminal justice involvement, be trauma-informed. Among both women and men with criminal justice involvement, histories of trauma are nearly universal. Ninety-three percent of 2,000 women and men in federally funded jail diversion programs between 2002 and 2008 reported at least one incident of physical or sexual abuse in their lifetime. Sixty-one percent reported physical or sexual abuse in the last 12 months. Yet few programs, institutional or community-based, offer environments that are trauma informed or trauma specific.

Moreover, a recent study found 31 percent of women being booked into local jails with current symptoms of serious mental illness.[2] This compares with 14 percent of men. These rates exacerbate the issues of providing



Courtesy WFOR-TV Miami

2009 county jail psychiatric unit

adequate services for women in predominantly male facilities whose physical plants and staffing are geared to men. Gender-specific services that reflect a trauma-informed culture must be developed in all institutional and community settings to respond to the frighteningly high rates of mental illness among women in contact with the criminal justice system.

In addition, we know that individuals using mental health services—often referred to as "consumers"—have a significant impact on creating recovery-oriented mental health and substance abuse services. For people involved in the criminal justice system, forensic peer specialists—those with histories of mental illness and criminal justice system involvement—can help pave the way for a successful return to the community.

The ability to effectively design, implement, and reimburse treatment providers for delivering high quality services targeting specialized treatment needs is critical to establishing an effective community-based system of care for people who experience serious mental illnesses. In the absence of what are now seen as essential services for people with mental illnesses living in the community, people will continue to be forced into more costly, deep-end services in hospitals, crisis centers, emergency rooms, and the justice system.

The result is a recycling of individuals between jails, prisons, shelters, short-term hospitalizations, and homelessness—with public health, public safety, and public administration implications that are staggering. Now more than ever, as we strive to provide health care to our most vulnerable citizens, *we must address this serious public health and public safety crisis. It is*

2 Steadman HJ, Osher F, Clark Robbins P, Case, BA, & Samuels S. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric Services*, 60: 761-765.

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high time to be open and honest about the deplorable conditions that exist and take steps to address them. We offer four recommendations for immediate action.

Recommendations for Immediate Action

✓ **The President should appoint a Special Advisor for Mental Health/Criminal Justice Collaboration.**

Currently, there is no fixed responsibility within the Federal government to promote effective mental health/criminal justice activities and ensure accountability for the use of public dollars. The Special Advisor will serve as an advocate and ombudsman across the wide array of Federal agencies that serve the multiple needs of justice-involved people with mental and substance use disorders. One of his or her tasks will be to implement an immediate review of all CMS and SAMHSA regulations to identify conflicts and inconsistencies for people with mental illnesses and co-occurring substance use disorders—particularly those involved in the justice system.

✓ **Federal Medicaid policies that limit or discourage access to more effective and cost-efficient health care services for individuals with serious mental illnesses and co-occurring substance use disorders should be reviewed and action taken to create more efficient programs.**

Congress is encouraged to review Medicaid policies and take action that will enable states to create more effective and appropriate programs targeting eligible beneficiaries most likely to experience avoidable admissions to acute care settings. Such programs should allow states flexibility in designing and implementing targeted outreach and engagement services, coordinated care management, and community support services that are likely to reduce expenditures on deep-end services, and engage people in prevention, early intervention, and wellness care in the community. Services provided should reflect evidence-based and promising practices and should be designed around principles of recovery, person-centered planning, and consumer choice. Because of the high rates of co-morbid health care needs among people with serious mental illnesses and co-occurring substance use disorders, programs should seek to establish more effective integration of primary and behavioral health care service delivery system as well.

✓ **All States should create cross-system agencies, commissions, or positions charged with removing barriers and creating incentives for cross-agency activity at the State and local level.**

No one system can solve this problem alone. These cross-system groups or individuals will play a key role in spanning the different administrative structures, funding mechanisms, and treatment philosophies of the mental health, substance abuse, and criminal justice systems. States must make clear that collaboration is not only possible but expected. In Montana, for example, the State Department of Corrections and Department of Public Health and Human Services jointly fund a boundary spanner position that facilitates shared planning, communication, resources, and treatment methods between the mental health and criminal justice systems.

✓ **Localities must develop and implement core services that comprise an Essential System of Care:**

Recognizing the limited resources often available and the complexities of the cross-system collaborations required, the eight components of an Essential System of Care are best approached in two phases. Phase 1 includes less expensive, easier to mount services. Phase 2 includes essential evidence-based practices that are more expensive and more challenging to implement, but are critical to actually increasing positive public safety and public health outcomes.

Phase 1

- **Forensic Intensive Case Management**
- **Supportive Housing**
- **Peer Support,** and
- **Accessible and Appropriate Medication**

These four services are the ones we believe are minimally necessary to break the cycle of illness, arrest and incarceration, and recidivism. We believe these services—described in brief below—can be

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implemented quickly, cost-effectively, and with positive results. However, these services can only be effective if the programs that provide them are structured and staffed by people who understand and are prepared to address trauma as a risk factor for both mental health problems and criminal justice involvement. A trauma-informed system that features trauma-specific interventions can help ensure public health and public safety and transform individuals' lives.

Forensic Intensive Case Management (FICM) is designed for justice-involved people with multiple and complex needs and features services provided when and where they are needed. FICM focuses on brokering rather than providing services directly, making it less expensive than ACT. For a brokered service model to be effective, communities must have adequate and accessible services to which individuals can be linked. What makes these services "forensic" is "criminal justice savvy,"[3] that is, providers understand the criminal justice system and the predicaments of their clients involvement in it.

Supportive Housing is permanent, affordable housing linked to a broad range of supportive services, including treatment for mental and substance use disorders. Supportive housing can significantly decrease the chance of recidivism to jails and prisons and is less costly on a daily basis than jail or prison. Unfortunately, affordable housing is in short supply in many communities, and ex-offenders with drug-related offenses often have trouble securing public housing assistance. Housing for ex-offenders must balance the needs for supervision and the provision of social services.

Peer Support services can expand the continuum of services available to people with mental and substance use disorders and may help them engage in treatment. Forensic peer specialists bring real-world experience with multiple service systems and an ability to relate one-on-one to people struggling to reclaim their lives. The practice of consumer-driven care—as exemplified by the involvement of mental health consumers in service design, delivery, and evaluation—is at the heart of a transformed mental health system.

3 Morrissey J, Meyer P, & Cuddeback G. (2007). Extending Assertive Community Treatment to criminal justice settings: Origins, current evidence, and future directions. *Community Mental Health Journal*, 43(5).



Courtesy Sharon Wise

Youth support family members with mental health and substance abuse issues, 2008

Accessible and Appropriate Medication supports continuity of care for individuals with mental illnesses whose treatment often is disrupted when they become involved in the criminal justice system. They may not receive appropriate medication in jail or prison or adequate follow-up when they return to the community. It is imperative that people with mental illnesses and co-occurring substance use disorders have access to the right medication at the right dosage for their condition, as determined by the individual together with his or her clinician.

Phase 2

Clearly, the Phase 1 services are necessary, but not sufficient. Services that support the Essential System of Care include several evidence-based practices for people with serious mental illnesses. These services may be more expensive or difficult to implement than the four listed above, but we encourage States and communities to move toward development of these services by codifying them in policy, supporting them in practice, and rewarding their implementation. Phase 2 services include:

- **Integrated Dual Diagnosis Treatment**, which provides treatment for mental and substance use disorders simultaneously and in the same setting
- **Supported Employment**, which is an evidence-based practice that helps individuals with mental illnesses find, get, and keep competitive work
- **Assertive Community Treatment (ACT)/ Forensic Assertive Community Treatment**

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(**FACT**), which is a service delivery model in which treatment is provided by a team of professionals, with services determined by an individual's needs for as long as required, and

- **Cognitive Behavioral Interventions Targeted to Risk Factors** specific to offending, are a set of interventions, well researched within both institutional settings and community settings, that have a utility when extended to community treatment programs.

This list of evidence-based and promising practices is illustrative but not exhaustive. Clearly, however, there is much that can be done to help people with mental and substance use disorders avoid arrest and incarceration and return successfully to their communities after jail or prison. We acknowledge that in difficult financial times, new dollars may not be available. However, though new money is not always required for systems change, new ways of thinking are.

To meet the public health and public safety needs of our communities demands a fully collaborative campaign involving both the behavioral health and criminal justice systems. Neither system can continue business as usual. The criminal justice system needs to do an adequate job of screening, assessing, and individualizing responses to detainees and inmates identified with mental illness. The behavioral health system needs to refine and deliver evidence-based practices with an awareness of its responsibility to not only improve the quality of life of its clients, but to address interventions to factors associated with criminal recidivism in these clients and to more directly involve clients as partners in a recovery process that recognizes the community's public safety concerns.

Prime examples of this Essential System of Care have been developed within the CMHS TCE Jail Diversion program since 2002. San Antonio, TX, has become a national model with a highly integrated system of care that reflects strong behavioral health and criminal justice partnerships that have resulted in a centralized police drop-off that directly links persons to case management, medications, housing, and peer support. A medium-size city that has built a comprehensive, integrated system around an existing community mental health center is Lincoln, NB. These are but two examples of successfully moving entire communities forward via a jail diversion program to achieve Phase 1 services and move towards Phase 2 implementation. These goals are achievable even in today's economic tough times.

We must move toward a day when people with mental and substance use disorders receive the effective community-based interventions they need and deserve, and jails and prisons no longer are forced to serve as primary, de facto treatment facilities. We know what works to address successfully the needs of people with mental and substance use disorders who come in contact with the criminal justice system; now we have to *DO* what works. *The time for action is now!*

National Leadership Forum Members

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Ohio Department of Mental Health
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David Fuller
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NORTHWESTERN
UNIVERSITY

October 1, 2009

Richard J. Durbin
Chairman
Subcommittee on Human Rights and the Law
United States Senate Committee on the Judiciary
224 Dirksen Senate Office Building
Washington, DC 20510

Tom Coburn
Ranking Member
Subcommittee on Human Rights and the Law
United States Senate Committee on the Judiciary
224 Dirksen Senate Office Building
Washington, DC 20510

Dear Senator Durbin, Senator Coburn and Committee Members:

I am submitting this written testimony to coincide with the Senate Committee on the Judiciary, Subcommittee on Human Rights and the Law's hearing on September 15, 2009, entitled "Human Rights at Home: Mental Illness in U.S. Prisons and Jails." In particular, I am focusing on the issue of mental illness in the juvenile justice system. My comments are based on my experience as an assistant public defender in juvenile court, as a clinical psychologist who has treated mentally ill juvenile justice youth and as a researcher who has studied the effectiveness of community-based service programs for this population.

Federally funded research has consistently found a high prevalence of mental illness among youth in the juvenile justice system. Approximately two thirds of the youth carry some psychiatric diagnosis, with a higher rate for females. Over half of those diagnosed have a co-occurring substance abuse disorder. Several excellent screening and assessment tools are available for use with this population.

Research has also clearly established the effectiveness of community-based interventions for mentally ill youth in the juvenile justice system. Various interventions have been designed for different stages of the juvenile justice process such as when a youth is arrested by the police, when the state's attorney files a case in juvenile court, when a judge orders a youth held in detention and when a youth who has been found delinquent is sentenced by the court. Corresponding programs can include diverting a youth to a Community Assessment Center, assigning a case to a Mental Health Court, conducting mental health assessments with community linkage for youth in detention (such as Illinois' Mental Health Juvenile Justice Initiative), or sentencing a youth to community based mental health care (including multiple options, such as Multi Systemic Therapy, Wraparound Milwaukee or Redeploy Illinois). No jurisdiction employs all these options and choosing among these programs requires weighing a number of factors, including the number of youth to be targeted and which resources will be made available. All of these programs have proven effective at improving the clinical condition of the youth that are treated as well as lowering recidivism rates, while costing less than longer term institutional care. They also demonstrate the vital importance of including the family in the treatment process in order to sustain the gains made.

In my work with youth in juvenile justice, mental health, public education and child welfare, I have found that each system is struggling to serve the same youth. In my opinion, when a child acts up, the system to which he or she is referred is based as much on social policy decisions and the interpretations made by adults as it is on the actual needs of the child. 'Build it and they will come' might apply equally to community mental health centers and juvenile detention centers. Assume for the moment that a youth is impulsive, does not listen and gets in fights. Is this a youth who is a delinquent and should be punished; a youth with an attention problem that should be assessed for medication; or a youth who has been mistreated and traumatized? Any of those interpretations might explain the negative behavior. It is the adults who make the interpretation and their decisions will drive the youth into very different programs.

The latest research on adolescent brain development, the impact of early adverse childhood experiences and the growing field of child trauma calls for a more integrated approach to dealing with children. Positive changes can be made to assist mentally ill youth within the juvenile justice system but even greater gains can be had by coordinating the approach of the multiple public sector systems. In Illinois, for example, both the Illinois Child Mental Health Partnership and the Illinois Childhood Trauma Coalition have members from public and private sector agencies that share information and resources. A common understanding of child development, early intervention and promoting resilience can significantly improve the life of all youth in our systems.

Thank you for considering my testimony. I am also including references to three articles I have co-authored that address different aspects of this testimony. Please let me know if I can provider further information.

Sincerely,

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Griffin, G., Martinovich, Z., Gawron, T., & Lyons, J. Strengths Moderate the Impact of Trauma on Risk Behaviors in Child Welfare. Residential Treatment for Children and Youth 26:1–14 (2009)

Lyons, J.S., Griffin, G., Quintenz, S., Jenuwine, M., & Shasha, M. Clinical and Forensic Outcomes from the Illinois Mental Health Juvenile Justice Initiative. 54 Psychiatric Services, 54:1629-1634 (2003).

Griffin, G. & Jenuwine, M.J. Using Therapeutic Jurisprudence to Bridge the Juvenile Justice and Mental Health Systems. University of Cincinnati Law Review 71:65-93 (2002).



National Immigrant Justice Center

Statement of
Heartland Alliance's National Immigrant Justice Center
Senate Judiciary Committee
Subcommittee on Human Rights and the Law
Hearing on Human Rights at Home: Mental Illness in U.S. Prisons and Jails
September 15, 2009

Heartland Alliance's National Immigrant Justice Center (NIJC) is a non-governmental organization based in Chicago dedicated to safeguarding the rights of noncitizens, in particular those held in immigration detention. NIJC advocates for immigrants, refugees, and asylum seekers through direct legal representation, policy reform, impact litigation, and public education. NIJC and its *pro bono* partners provide legal representation to approximately 8,000 individuals annually, including low-income immigrants, refugees, victims of human trafficking, unaccompanied minors, and asylum seekers. During the past 25 years, NIJC has developed the largest network of *pro bono* attorneys in the United States, totaling more than 1,000 attorneys from leading law firms.

NIJC is grateful for the opportunity to submit this statement for the hearing record. Our years of experience serving the detained immigrant population prompt us to make the following points and recommendations for reform.

Background

U.S. Immigration and Customs Enforcement (ICE) arrests and detains more than 400,000 immigrant men, women, and children each year. On any given day, more than 32,000 immigrants are held in ICE custody at more than 350 detention centers and county jails across the country. Most of these individuals have no criminal history. Despite their status as civil detainees, they are held in federal detention centers and county jails, sometimes for months or years at a time. Immigrant detainees have the worst of both worlds – they are treated like criminal detainees but they are denied the due process protections of the criminal justice system. Many of these facilities are located in remote rural areas, far from immigration lawyers and social service providers who might otherwise be able to assist immigrant detainees who have no guarantee of representation.

NIJC staff regularly visit ICE-contracted county jails in Illinois, Wisconsin, and Kentucky to offer legal rights orientations, conduct individual legal consultations, and accept cases for representation. Because individuals in immigration proceedings do not have a right to court-appointed legal counsel, these presentations are often the only opportunity for detained immigrants and asylum seekers to gain an understanding of their legal rights and the available avenues for complaint and redress. During jail visits, we often meet with detained individuals with mental disabilities who are not receiving the

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treatment that they need. Isolated from family and legal counsel, these individuals are particularly incapable of navigating the complex immigration system without assistance.

ICE detention facilities are governed by the ICE Performance-Based National Detention Standards, which ICE created with input from the American Bar Association and non-governmental organizations, to apply to facilities that hold non-citizens in ICE custody for 72 hours or more. The detention standards were created to ensure that detainees' most basic due process and human rights, including adequate medical and mental health care, are respected. ICE has steadfastly refused to codify the standards in statute or regulation, leaving them legally unenforceable. Therefore, immigrant detainees and their advocates have little recourse when the government refuses to enforce its own rules.

In order to illustrate the consequences of ICE's failure to address the mental health needs of individuals in its custody, we would like to share the stories of two women who were detained in the Chicago area.

Deadly Neglect: Hassiba Belbachir's Story

Hassiba Belbachir, an Algerian asylum seeker, was detained at the McHenry County Jail in Woodstock, Illinois, in 2005.[1] According to the complaint filed in a civil rights and wrongful death suit brought by her estate, on March 13, 2005, Ms. Belbachir, who suffered from severe depression and panic attacks, told a nurse of her desire to take her own life. The next day, she saw a social worker and again expressed her suicidal feelings. The social worker recommended she see a psychiatrist. Rather than scheduling an emergency appointment, the nurse placed her on a list to see the psychiatrist at his routine weekly jail visit a full four days later. Ms. Belbachir committed suicide before she had an opportunity to see the psychiatrist. In further demonstration of the gross negligence of care, on the day of Ms. Belbachir's death, jail staff saw her motionless body on the floor of her cell in the medical pod, but did not intervene for 40 minutes, when they finally called for emergency service. By the time jail staff entered her cell, it was far too late.

Significantly, ICE authorities knew from annual inspections before Ms. Belbachir's death that McHenry County Jail had a history of violating ICE detention standards that require facilities to provide adequate mental health and suicide screenings to ICE detainees, maintain a written suicide prevention policy, and train staff to prevent suicides. Even so, according to the Belbachir complaint, ICE authorities did not enforce the detention standards until after Ms. Belbachir's death. Furthermore, no one charged with overseeing her custody and care was disciplined in any matter related to this gross failure of medical and mental health care and supervision.

[1] The case of Hassiba Belbachir is discussed publicly because it is the subject of federal litigation.

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Systemic Failures: Maleah's Story

Maleah,[2] a 50-year-old native of the Philippines, has lived in the United States as a lawful permanent resident since 1990 and is the mother of three children (two who are U.S. citizens and one lawful permanent resident). She suffers from depression, and had been in the care of a doctor who helped regulate her medication for four years before she was detained by ICE in October 2008 following two minor theft convictions. Despite her eligibility for immigration relief, ICE detained Maleah for more than nine months. Suffering from major depression exacerbated by her detention and unable to understand the full nature of the proceedings against her, Maleah appeared for a hearing in front of an immigration judge without a lawyer. Her mental illness rendered her unable to advocate effectively on her own behalf, and she was unaware of what evidence should be presented to the immigration judge in defense to her removal. Even though she had indicated in her petition that she sometimes heard voices, the immigration judge failed to acknowledge that Maleah may not have been competent to represent herself in a removal proceeding. Maleah was ordered removed.

During Maleah's time in immigration detention, ICE failed to provide her with proper mental health care and medication to treat her depression, and her health deteriorated significantly. ICE transferred her between detention facilities in Illinois, Kentucky, and Texas nine times; in several instances her medical records did not transfer with her and she was denied medication for days after arriving at a new detention facility. At the Illinois county jail where Maleah was detained for the majority of her time in ICE custody, staff distributed medications at irregular intervals. If Maleah was not present at the door of her pod when staff arrived to administer medications, usually because she was in the shower or in her cell on lock-down, jail staff reported that she had "refused medication" and failed to make any effort to make up her missed doses. Staff even used reports that Maleah had "refused medication" as reasoning to deny her medical requests. When ICE did provide medication for Maleah, they often gave her a different medication from what she had taken before she was detained – a dangerous course of action for those with mental illness. As a result of this inconsistent treatment, Maleah suffered side effects including severe headaches. After one lapse in medication, Maleah said she heard voices and felt like there was "a shadow on her." When she submitted a request to see a psychiatrist, her medication was resumed but she did not see a doctor until much later. Maleah saw a psychiatrist only once during her nine months of detention. For most of her time in custody, Maleah was effectively left to self-diagnose the side effects of new medications and inconsistent medical treatment. For example, Maleah passed out once after being administered a particularly strong medication. She chose to discontinue the medication because she did not think she was receiving enough food to offset its strength and feared further side effects.

The tragic and preventable death of Hassiba Belbachir illustrates the inhumane treatment faced by immigrants with mental illness in the U.S. detention system. Maleah's story outlines the failure of our immigration system to address immigrants' mental health needs, in the courtrooms as well as the detention centers. Due to a dearth of legal

[2] A pseudonym.

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counsel, most detained immigrants never know that they have a right to health care when they are detained by ICE and put in removal proceedings. Immigrants who do request treatment or complain about a lack of adequate care face insurmountable procedural obstacles and an accountability vacuum.

Recommendations:

The National Immigrant Justice Center advocates for key components of meaningful, humane reform of the U.S. immigration enforcement and detention system which include:

1. Congress should enact legislation designed to protect the rights and ensure the health and safety of immigrants in detention. The following bills are pending in the House of Representatives and the Senate. The National Immigrant Justice Center urges members of the Subcommittee to co-sponsor the legislation pending in the Senate:

   - *The Strong Safe Treatment, Avoiding Needless Deaths, and Abuse Reduction in the Detention System (Strong STANDARDS) Act (S. 1550)*, sponsored by Senators Menendez (D-NJ) and Gillibrand (D-NY), would create enforceable regulations governing critical basic standards of treatment for detainees. The required, basic standards would include adequate medical and mental health care, access to legal information and counsel, access to family and religious visitors, and a limitation on the use of solitary confinement and strip searches.

   - *The Secure and Safe Detention and Asylum Act (S. 1594)*, sponsored by Senators Lieberman (ID-CT) and Akaka (D-HI), would require improved detention conditions, including special standards for families and for victims of persecution and torture. This bill would also establish quality assurance measures to ensure that asylum seekers with a credible fear of persecution are not returned to their countries without a review of their cases.

   - *The Protect Citizens from Unlawful Detention Act (S. 1549)*, sponsored by Senators Menendez and Gillibrand, includes provisions to ensure that detainees understand their legal rights, allows for judicial review of the detention of U.S. citizens and vulnerable individuals during immigration enforcement actions, and requires reporting and oversight of enforcement practices as a check to their harmful impact on U.S. citizens.

   - *The Immigration Oversight and Fairness Act (H.R. 1215)*, sponsored by Representative Roybal-Allard (D-CA) and 31 co-sponsors would, among other provisions, require the Department of Homeland Security to use secure alternatives to detention for those immigrants who pose no threat to our communities and are not flight risks. The bill would increase protections for unaccompanied immigrant children who are in the custody of the federal government.

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2. ICE should exercise discretion with respect to whom it arrests and detains. Individuals who are not threats to our community and are not flight risks should not be detained, particularly if they members of a vulnerable population, such as individuals with mental or medical illnesses.

3. ICE should adopt an environment appropriate for civil detention, favoring non-restrictive settings as much as possible. There are alternatives to detention, such as supervised release programs, that have proven to be more humane, effective, and less expensive than punitive facilities that are ill-equipped to address the needs of individuals with mental illness.

4. ICE should develop enforceable standards that are specific, detailed and tailored to individuals with mental illness, in consultation with mental health experts, to develop a best practice model that is appropriate for civil detainees.

5. ICE should be required to certify that sub-contracted health care organizations are in full compliance with all relevant accreditation standards, including standards related to continuity of care, emergency response, and transfer of medical records.

6. ICE should consult with medical experts, including mental health experts, to develop and implement trainings on medical issues facing immigrants held in ICE custody for all corrections officers who are responsible for the health and safety of detained immigrants held in civil custody. In particular, ICE should require training on suicide prevention, safety assessment, and crisis management for both healthcare providers and corrections officers in contracted facilities.

7. ICE should allow independent observers, including non-governmental organizations, to visit and tour all facilities holding ICE detainees, meet privately with detainees, and take other reasonable steps to monitor compliance with ICE detention standards and international human rights standards. These organizations should be allowed to issue public reports on the findings gathered during their visits.

8. EOIR should have the authority to appoint counsel to indigent people in immigration court when fundamental fairness requires it, in particular for individuals with mental disabilities and unaccompanied immigrant children.

9. EOIR should appoint *guardians ad litem* to people in immigration court who are found mentally incompetent.

10. EOIR should enact regulations that standardize procedures for adjudicating competency in immigration court and that give immigration judges the authority to provide reasonable accommodations to protect the rights of people with mental

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disabilities, including the power to administratively close cases or terminate proceedings where appropriate.

11. EOIR should require trainings for immigration judges to recognize mental disabilities and make reasonable accommodations to ensure a fundamentally fair hearing.

Conclusion

The United States is a nation that values liberty and respects human rights and the rule of law. These values do not support the deprivation of health care to those in need and who, because they are incarcerated, have no opportunity to obtain treatment on their own. NIJC welcomes the Subcommittee's inquiry into the treatment of mental illness in U.S. prisons and jails. Unfortunately, immigrants in detention facilities are not even provided with the same access to medical care and procedural protections as individuals held in the criminal justice system. In addition to examining the treatment of individuals with mental illness in prisons, we encourage the Subcommittee to also address the needs of immigrant detainees with mental illness held in administrative custody.

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Mental Illness, Human Rights, and US Prisons

Human Rights Watch Statement for the Record
Senate Judiciary Committee
Subcommittee on Human Rights and the Law

Human Rights Watch appreciates the opportunity to present this statement on mental illness in US prisons to the Senate Judiciary Committee Subcommittee on Human Rights and the Law. We commend the Subcommittee for recognizing the importance of securing respect for human rights here in the United States as well as overseas. The specific focus on the rights of persons who have a mental illness and who are incarcerated in the United States is particularly welcome.

Human Rights Watch has worked for many years to improve protection for the rights of US prisoners, including those with mental illnesses, and we stand ready to assist the Subcommittee with its efforts in any way we can. In this statement we will present a brief overview of the problems faced by mentally ill persons who are incarcerated and the human rights that are implicated.[1] We will also offer several recommendations for Congressional action that we hope the Subcommittee will consider.

Prisons and Prisoners with Mental Illness: Overview

Prisons were never designed as facilities for the mentally ill, yet that is one of their primary roles today. Many of the men and women who cannot get mental health treatment in the community are swept into the criminal justice system after they commit a crime. According to the Bureau of Justice Statistics, 56 percent of state prisoners and 45 percent of federal prisoners have symptoms or a recent history of mental health problems.[2] Prisoners have rates of mental illness—including such serious disorders as schizophrenia, bipolar disorder, and major depression—that are two to four times higher than members of the general public. Studies and clinical experience consistently indicate that 8 to 19 percent of prisoners have psychiatric disorders that result in significant

[1] Our research, findings, and recommendations on this issue are fully developed in our report, Human Rights Watch, *Ill-Equipped: US Prisons and Offenders with Mental Illness*, October 2003, http://www.hrw.org/en/reports/2003/10/21/ill-equipped-0.

[2] Doris J. James and Lauren E. Glaze, "Mental Health Problems of Prison and Jail Inmates," Bureau of Justice Statistics, September 2006, http://www.ojp.usdoj.gov/bjs/abstract/mhppji.htm (accessed September 21, 2009).

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functional disabilities, and another 15 to 20 percent will require some form of psychiatric intervention during their incarceration.

Mental health treatment can help some prisoners recover from their illness and for many others it can alleviate its painful symptoms, prevent deterioration, and protect them from suicide. It can enhance independent functioning and encourage the development of more effective internal controls. By helping individual prisoners regain health and improve coping skills, mental health treatment promotes safety and order within the prison environment and enhances community safety when prisoners are ultimately released.

Unfortunately, prisons are ill-equipped to respond appropriately to the needs of prisoners with mental illness. Prison mental health services are all too frequently woefully deficient, crippled by understaffing, insufficient facilities, and limited programs. Many seriously ill prisoners receive little or no meaningful treatment.

Although there are many conscientious and committed mental health professionals working in corrections, they face daunting if not insurmountable challenges to meeting the needs of their patients: impossibly large caseloads, physically unpleasant facilities, and institutional cultures that are unsympathetic to the importance of mental health services. Gains in mental health staffing, programs, and physical resources that were made in recent years have all too frequently since been swamped by the tsunami of prisoners with serious mental health needs. Overburdened staff are hard pressed to respond even to psychiatric emergencies, much less to promote recovery from serious illness and the enhancement of coping skills. Mindful of budget constraints and scant public support for investments in the treatment (as opposed to punishment) of prisoners, elected officials have been reluctant to provide the funds and leadership needed to ensure prisons have sufficient mental health resources. Twenty-two out of forty state correctional systems reported in a recent survey that they did not have an adequate number of mental health staff.[3]

Without the necessary care, mentally ill prisoners suffer painful symptoms and their conditions can deteriorate. They are afflicted with delusions and hallucinations, debilitating fears, or extreme mood swings. They huddle silently in their cells, mumble incoherently, or yell incessantly. They refuse to obey orders or lash out without apparent provocation. They beat their heads against cell walls, smear themselves with feces, self-mutilate, and commit suicide.

Doing time in prison is hard for everyone. Prisoners struggle to maintain their self-respect and emotional equilibrium in facilities that are typically tense, overcrowded, fraught with the potential

[3] Cece Hill, "Inmate mental health care," *Corrections Compendium*, vol. 29, no. 5, 2004, pp.15-31.

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for violence, cut off from families and communities, and devoid of opportunities for meaningful education, work, or other productive activities. But life in prison is particularly difficult for prisoners with mental illnesses that impair their thinking, emotional responses, and ability to cope. They are more likely to be exploited and victimized by other prisoners. They are less likely to be able to adhere to the countless formal and informal rules of a strictly regimented life and often have higher rates of rule-breaking than other prisoners.

Supermaximum Security Prisons and Isolation

When mentally ill prisoners break the rules, officials punish them as they would any other prisoner, even when their conduct reflects the impact of mental illness.[4] If lesser sanctions do not curb the behavior, officials "segregate" the prisoners from the general prison population, placing them in supermaximum security ("supermax") prisons or in segregation units within regular prisons. Once isolated, continued misconduct—often connected to mental illness—can keep them there indefinitely. A disproportionate number of the prisoners in segregation are mentally ill.[5]

Prison officials across the country have increasingly embraced long-term segregation to manage and/or to discipline prisoners who are perceived to be dangerous, but also those who are seen as difficult or disturbing. Supermax prisons such as Tamms Correctional Center in Illinois or segregation units in other prisons constitute the modern day variant of solitary confinement. Prisoners are confined 23 to 24 hours a day in small cells that frequently have solid steel doors. They live with extensive surveillance and security controls, the absence of ordinary social interaction, abnormal environmental stimulus, a few hours a week of "recreation" alone in caged enclosures, and little, if any, educational, vocational, or other purposeful activities. They are handcuffed and frequently shackled every time they leave their cells.

Prolonged confinement under such conditions can be psychologically harmful to any prisoner, with the nature and severity of the impact depending on the individual, the duration, and the specific conditions (for example, access to natural light, radio, or books). It can provoke anxiety, depression, anger, cognitive disturbances, perceptual distortions, obsessive thoughts, paranoia, and psychosis.[6] But the risk of harm is particularly grave for prisoners who already have serious mental illnesses. The stress, lack of meaningful social contact, and unstructured days can exacerbate

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[4] Jamie Fellner, "A Corrections Quandary," *Harvard Civil Rights-Civil Liberties Law Review*, vol. 41, 2006, pp. 391-412.

[5] David Lovell, "Patterns of disturbed behavior in a supermax prison," *Criminal Justice and Behavior*, vol. 35, no. 8, 2008, pp.985-1004; Maureen L. O'Keefe and Marissa J. Schnell, "Offenders with mental illness in the correctional system," *Journal of Offender Rehabilitation*, vol. 45, no. 1, 2007, pp. 81-104.

[6] Jeffrey Metzner and Joel Dvoskin, "An overview of correctional psychiatry," *Psychiatric Clinics of North America*, vol. 29, no. 3, September 2006, pp. 761-772.

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symptoms of illness or provoke a reoccurrence. Suicides occur proportionately more often in segregation units than elsewhere in prison. All too frequently, mentally ill prisoners decompensate in isolation, requiring crisis care or psychiatric hospitalization. Many simply will not get better as long as they are isolated. According to one federal judge, putting mentally ill prisoners in isolated confinement "is the mental equivalent of putting an asthmatic in a place with little air...."[7] A recent story in the *Belleville News- Democrat* about Tamms profiled one prisoner with a well-documented history of paranoid schizophrenia who was held in solitary for nearly six years, mutilating himself and smearing feces.[8] Other Tamms prisoners reportedly cut themselves, eat their own flesh, attempt suicide, and engage in other behaviors consistent with suffering from serious and untreated or poorly treated mental illness.

The psychological harm of supermaximum security confinement is exacerbated because mental health professionals are not permitted to provide a full range of mental health treatment services to the prisoners. Mental health services are typically limited to psychotropic medication, a health care clinician stopping at the cell front to ask how the prisoner is doing (that is, "mental health rounds"), and occasional meetings in private with a clinician.[9] Individual therapy, group therapy, structured educational, recreational, or life-skill enhancing activities, and other therapeutic interventions are usually not available because of insufficient resources and clashes with prison rules—for example, insufficient numbers of custodial staff to take prisoners to and from their cells to private meetings with clinicians, and rules requiring prisoners to remain in their cells and prohibiting contact with other prisoners.[10]

In every class action challenging the placement of mentally ill prisoners in supermax confinement, plaintiffs have either won a court order or obtained a settlement prohibiting or greatly limiting such confinement.[11] As a result, in prisons covered by the litigation, mentally ill prisoners are given more time out of their cells and greater access to mental health professionals and programs. Improved clinical responses of prisoners with mental illness in these prisons have been achieved without compromising safety or security. Unfortunately, except in the small number of prisons covered by this litigation, mentally ill prisoners continue to be sent to segregation; indeed, they are often disproportionately represented in segregation units.

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[7] *Madrid v. Gomez*, 889 F. Supp. 1146, 1265 (N.D. Cal. 1995).

[8] Beth Hundsdorfer and George Pawlaczyk, "Trapped in Tamms: Inmates in Illinois' Only Supermax Prison Face Battle Proving Mistreatment," *Belleville News-Democrat*, August 4, 2009, http://www.bnd.com/600/story/865378.html (accessed September 16, 2009).

[9] See, for example, *Madrid v. Gomez*.

[10] Jeffrey Metzner and Joel Dvoskin, "An overview of correctional psychiatry," *Psychiatric Clinics of North America*.

[11] See David C. Fathi, "The Common Law of Supermax Litigation," *Pace Law Review*, vol. 24, 2004, 681-682.

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Re-entry

There is increasing awareness among public officials of the importance of providing re-entry services to prisoners leaving prison as an effective means of increasing the likelihood they will successfully make the transition back to the community. Men and women with mental illness have unique needs for discharge planning and re-entry services. In addition to support for housing, employment, and income, they also need links to appropriate mental health treatment and access to public assistance. According to the Council of State Governments:

> individuals with mental illnesses leaving prison without sufficient supplies of medication, connections to mental health and other support services, and housing are almost certain to decompensate, which in turn will likely result in behavior that constitutes a technical violation of release conditions or a new crime.[12]

Unfortunately, the need for re-entry services far exceeds the supply. All too many mentally ill prisoners leave prison without arrangements to ensure they will continue to receive an appropriate level of mental health treatment, without ready access to public assistance, and without assistance to navigate the difficult waters of life after prison, in which the stigma of being a felon now accompanies all the problems that existed before incarceration.

Mental Health and American Prisons: A Human Rights Framework

Human rights standards acknowledge the unique vulnerability of prisoners to abuse and afford special protections to them. The UN Human Rights Committee has affirmed the "positive obligation" of states to protect the rights of those whose vulnerability arises from their status as persons deprived of their liberty.[13]

Several discrete but inter-related human rights concepts are particularly relevant to the treatment of prisoners with mental illness: human dignity, the right to rehabilitation, the right to the highest attainable standard of health, and the right to freedom from torture or cruel, inhuman or degrading treatment or punishment. A prison operated within a human rights framework would provide a full range of mental health services with the staffing, resources, and facilities needed to serve the prison's population. Custodial policies and practices would be adjusted to ensure security and

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[12] Council of State Governments, "Criminal Justice/Mental Health Consensus Project Report, Chapter IV: Incarceration and Reentry, Policy Statement 21: Development of Transition Plan," June 2002, http://consensusproject.org/the_report/ch-IV/ps21-transition-plan (accessed September 21, 2009).

[13] Human Rights Committee, General Comment 21, article 10 (Forty-fourth session, 1992), replaces general comment 9 concerning humane treatment of persons deprived of liberty, U.N. Doc. HRI/GEN/1/Rev.1 at 33 (1994), http://www.unhchr.ch/tbs/doc.nsf/0/3327552b9511fb98c12563ed004cbe59?Opendocument (accessed September 21, 2009).

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safety needs do not compromise mental health treatment. Staff would no longer constantly find themselves forced to choose between what they know they "should" be doing in terms of standards of care and sound principles of treatment, and what is feasible in the circumstances.

Respect for human rights of prisoners not only underpins and protects the fundamental values agreed on by the international community, it promotes safe and effective prison management. Unfortunately, human rights standards are all too often honored in the breach in US prisons. They are little known and almost never directly applied.

Right to Humane Treatment and Rehabilitation

All human rights are grounded in the inherent dignity of all persons, as affirmed in 1948 by the Universal Declaration of Human Rights. Recognizing the temptation to ignore the human dignity of persons who are confined in prisons, article 10(1) of the International Covenant on Civil and Political Rights (ICCPR), to which the United States is a party, expressly requires all prisoners to be treated, by all officials and anyone else, "with humanity and with respect for the inherent dignity of the human person." Compliance with article 10 requires prison management to ensure mental health treatment for prisoners with mental disabilities as well as humane conditions of confinement. The failure to provide adequate mental health services in prison cannot be excused by the cost of ensuring adequate numbers of qualified staff or sufficient facilities for responding to mental health needs. The Human Rights Committee has affirmed that the application of article 10, promoting the right to humane treatment, "cannot be dependent on the material resources available."[14]

Respect for the human dignity of prisoners also requires operating prisons in ways that will enhance the likelihood of their successful re-entry into the community upon release. Article 10 of the ICCPR requires the "essential aim" of imprisonment to be "reformation and social rehabilitation." It thus mandates a positive goal for corrections, something beyond mere punishment through deprivation of liberty. As stated in the UN-approved Standard Minimum Rules for the Treatment of Prisoners ("SMR"), imprisonment should be "used to ensure, so far as possible, that upon his return to society the offender is not only willing but able to lead a law-abiding and self-supporting life...."[15] Mental health treatment obviously has an important role in rehabilitation for prisoners who have or are at risk of developing mental disorders. As the SMR states:

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[14] Ibid.

[15] Standard Minimum Rules for the Treatment of Prisoners (SMR), adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held at Geneva in 1955, and approved by the Economic and Social Council by its resolutions 663 C (XXIV) of 31 July 1957 and 2076 (LXII) of May 13, 1977, http://www2.ohchr.org/english/law/treatmentprisoners.htm (accessed September 21, 2009), art. 58.

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> The medical services of the institution shall seek to detect and shall treat any physical or mental illnesses or defects which may hamper a prisoner's rehabilitation. All necessary medical, surgical and psychiatric services shall be provided to that end.[16]

The SMR also sets forth different regimes that are appropriate depending on the severity of the mental illness. According to the SMR, persons found to be "insane" should not be kept in prisons but should instead be transferred to appropriate medical institutions; prisoners who are "mentally abnormal" should be "observed and treated in specialized institutions under medical management."[17] For prisoners with mental disabilities who remain in their care, all prisons should provide health services that are "organized in close relationship to the general health administration of the community or nation" and which include "a psychiatric service for the diagnosis and, in proper cases, the treatment of states of mental abnormality."[18]

A human rights approach to mental health treatment for prisoners further recognizes the importance of continuity of care to ensure that individuals have access to treatment once released. The SMR notes that correctional facilities should work with the appropriate agencies to determine what after-care services are necessary and can be arranged so that individuals will have necessary treatment, care, and support when they return to the community.[19]

Right to be Free from Abuse

Article 7 of the ICCPR states that no one "shall be subjected to torture or to other cruel, inhuman or degrading treatment or punishment,"[20] a prohibition that is further developed by the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) , to which the United States is also a party.[21] The Human Rights Committee has confirmed that "[n]o justification or extenuating circumstances may be invoked to excuse a violation of Article 7 for any reason."[22] Under

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[16] SMR, art. 62.

[17] SMR, art. 82.

[18] SMR, art. 22.1.

[19] SMR, art. 81.

[20] International Covenant on Civil and Political Rights (ICCPR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, entered into force March 23, 1976, ratified by the United States on June 8, 1992, http://www.hrweb.org/legal/cpr.html (accessed September 21, 2009).

[21] Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Convention against Torture), adopted December 10, 1984, G.A. res. 39/46, annex, 39 U.N. GAOR Supp. (No. 51) at 197, U.N. Doc. A/39/51 (1984), entered into force June 26, 1987, ratified by the Unites States on October 21, 1994, http://www.hrweb.org/legal/cat.html (accessed September 21, 2009).

[22] Human Rights Committee, General Comment 20, article 7 (Forty-fourth session, 1992), replaces general comment 7 concerning prohibition of torture, or other cruel, inhuman or degrading treatment or punishment, U.N. Doc. HRI/GEN/1/Rev.1 at 30 (1994), http://www.unhchr.ch/tbs/doc.nsf/0/6924291970754969c12563ed004c8ae5?Opendocument (accessed September 21, 2009).

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CAT, torture is defined as an act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for a specific purpose (for example, to obtain a confession or as punishment) and with the involvement of a public official.[23] The infliction, or in many cases, the toleration of suffering that does not constitute torture—for example, because it is less severe or because it is not intentionally inflicted—constitutes cruel, inhuman, or degrading treatment. Neglecting to provide needed treatment to alleviate mental suffering may violate article 7 as may deliberately withholding such treatment. The prohibition should be interpreted to extend the widest possible protection against abuses, whether physical or mental.

The UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment points out that persons with disabilities "are often segregated from society in institutions, including prisons ... [in which they] are frequently subjected to unspeakable indignities, neglect, severe forms of restraint and seclusion, as well as physical, mental and sexual violence."[24] In determining whether a person with disabilities has been subjected to torture or other prohibited cruel treatment, the Special Rapporteur notes that "assessing the level of suffering or pain, relative in its nature, requires considering the circumstances of the case, including the existence of a disability, as well as looking at the acquisition or deterioration of impairment as a result of the treatment or conditions of detention in the victim."[25]

If prisoners' mental health deteriorates and they endure serious psychological suffering because they have not been provided the mental health treatment that is needed, their right to be free of cruel or inhuman treatment may have been violated. Article 7 may also be violated if prisoners are confined under conditions that put them at high risk of psychological harm, such as solitary confinement.

Right to Health

The Universal Declaration of Human Rights (UDHR) affirms a person's right to health, irrespective of legal status.[26] Under the International Covenant on Economic, Social and Cultural Rights (ICESCR), to which the United States is a signatory, states must ensure "the right of everyone to the enjoyment of

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[23] "The prohibition in article 7 [of the ICCPR] relates not only to acts that cause physical pain but also to acts that cause mental suffering to the victim." Human Rights Committee, General Comment 20. For a recent discussion of psychological torture, see Hernan Reyes, "The worst scars are in the mind: psychological torture," *The International Review of the Red Cross*, vol. 89, no. 867, September 2007.

[24] UN General Assembly, Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak, A/63/175, July 28, 2008, http://daccessdds.un.org/doc/UNDOC/GEN/N08/440/75/PDF/N0844075.pdf?OpenElement (accessed September 21, 2009), pp. 10-11.

[25] Ibid.

[26] Article 25.1 of the Universal Declaration of Human Rights (UDHR) states, "Everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including food, clothing, housing and medical care..." UDHR, adopted December 10, 1948, G.A. Res. 217A(III), U.N. Doc. A/810 at 71 (1948), art. 25.1, http://www.udhr.org/UDHR/default.htm (accessed September 17, 2009).

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the highest attainable standard of physical and mental health" and, in furtherance of this goal, must create "conditions which would assure to all medical service and medical attention in the event of sickness."[27] The Committee on Economic, Social and Cultural Rights interprets the right to health under article 12 of the ICESCR to place states "under the obligation to *respect* the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services."[28] Although the United States has yet to ratify the Covenant, it is bound to honor its responsibilities as a signatory.

Principle 9 of the UN Basic Principles for the Treatment of Prisoners states, "Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation."[29] Similarly, principle 20 of the UN Principles for the Protection of Persons with Mental Illnesses and the Improvement of Mental Health Care states that all persons serving sentences "should receive the best available mental health care" with treatment and care consistent with that outlined for individuals who are not incarcerated.[30]

Convention on the Rights of Persons with Disabilities

On July 24, 2009, President Obama announced that the United States would sign the Convention on the Rights of Persons with Disabilities, which was then signed on July 30. Introducing this decision, President Obama stated, "Disability rights aren't just civil rights to be enforced here at home; they're universal rights to be recognized and promoted around the world."[31] The Convention makes clear that attention to disability—including mental disability—is not only an issue of treatment and welfare but is essential to the proper administration of justice.[32] As a signatory to the Convention,

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[27] International Covenant on Economic, Social and Cultural Rights (ICESCR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, entered into force January 3, 1976, http://www.un-documents.net/icescr.htm (accessed September 17, 2009), art. 12.

[28] CESCR, General Comment No. 14, The right to the highest attainable standard of health, E/C.12/2000/4 (2000), http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/40d009901358b0e2c1256915005090be?Opendocument (accessed September 17, 2009).

[29] UN Basic Principles for the Treatment of Prisoners, G.A. res. 45/111, annex, 45 U.N. GAOR Supp. (No. 49A) at 200, U.N. Doc. A/45/49 (1990), http://www.un.org/documents/ga/res/45/a45r111.htm (accessed September 17, 2009).

[30] UN General Assembly, UN Principles for the Protection of Persons with Mental Illnesses and the Improvement of Mental Health Care, Principle 20, GA Resolution 46/119 (1991), principles 4.2, 4.3, 13.1(d), available at http://www.un.org/documents/ga/res/46/a46r119.htm (accessed September 17, 2009).

[31] "Remarks by the President on the Signing of the Convention on the Rights of Persons with Disabilities Proclamation," The White House Press Release, July 24, 2009, http://www.whitehouse.gov/the_press_office/Remarks-by-the-President-on-Rights-of-Persons-with-Disabilities-Proclamation-Signing/ (accessed September 17, 2009).

[32] Article 13 of the Convention emphasizes that prison staff need training "to ensure effective access to justice for persons with disabilities." UN General Assembly, Convention on the Rights of Persons with Disabilities, adopted January 24, 2007, A/RES/61/106, entered into force May 3, 2008, signed by the United States on July 30, 2009, http://www.unhcr.org/refworld/docid/45f973632.html (accessed September 17, 2009).

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the United States has an opportunity and an obligation to expand its protection of people with disabilities, including those with mental disabilities who are incarcerated.

Many of the provisions of the Convention have unique relevance for prisoners with mental disabilities. The Convention in article 5, for example, prohibits discrimination on the basis of disability, and requires states to provide "reasonable accommodation" to persons with disabilities. The Special Rapporteur on Torture has pointed out that the lack of reasonable accommodation in detention facilities may increase the risk of exposure to neglect, violence, abuse, torture, and ill-treatment.[33] In addition, article 15 of the Convention affirms the right to be free of torture or cruel, inhuman or degrading treatment or punishment, article 16 prohibits violence, abuse, and exploitation of persons with disabilities, and article 17 recognizes the right of every person with disabilities to respect for his or her physical and mental integrity. In addition to violating other rights, placing prisoners with mental disabilities in solitary confinement may constitute a violation of the Convention on the Rights of Persons with Disabilities.

Human Rights and Supermax Prisons

Human rights experts have long criticized prolonged solitary confinement, understood as physical isolation in a cell for 22 to 24 hours a day, such as exists in US supermax prisons. In 2008, the Special Rapporteur on Torture concluded that "the prolonged isolation of detainees may amount to cruel, inhuman or degrading treatment or punishment, and, in certain instances, may amount to torture."[34] Based on his research, he found that "the key adverse factor of solitary confinement is that socially and psychologically meaningful contact is reduced to the absolute minimum, to a point that is insufficient for most detainees to remain mentally well functioning."[35] He stated that solitary confinement should only be used "in very exceptional cases" and "only as a last resort";[36] the Special Rapporteur further noted that holding persons with mental illness in solitary confinement "cannot be justified for therapeutic reasons, or as a form of punishment."[37] In 2007, the Special Rapporteur participated in the Fifth International Psychological Trauma Symposium held in Istanbul, Turkey, and with other prominent international experts produced a document titled the Istanbul Statement on the Use and Effects of Solitary Confinement. Noting that solitary confinement "harms prisoners who were not previously mentally ill and tends to worsen the mental health of those who are," the Istanbul Statement concludes that "solitary confinement should only be used in very

[33] UN General Assembly, Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak, July 28, 2008, pp. 10-11.

[34] Ibid., p. 18.

[35] Ibid., p. 21.

[36] Ibid.

[37] Ibid., p. 13.

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exceptional cases, for as short a time as possible and only as a last resort."[38] It should be "absolutely prohibited ... for mentally ill prisoners."[39]

In 2006, the Human Rights Committee, reviewing US compliance with the ICCPR, stated that it:

> reiterates its concern that conditions in some maximum security prisons are incompatible with the obligation contained in article 10 (1) of the Covenant to treat detainees with humanity and respect for the inherent dignity of the human person. It is particularly concerned by the practice in some such institutions to hold detainees in prolonged cellular confinement, and to allow them out-of-cell recreation for only five hours per week, in general conditions of strict regimentation in a depersonalized environment. It is also concerned that such treatment cannot be reconciled with the requirement in article 10 (3) that the penitentiary system shall comprise treatment the essential aim of which shall be the reformation and social rehabilitation of prisoners. It also expresses concern about the reported high numbers of severely mentally ill persons in these prisons, as well as in regular in U.S. jails.[40]

Similarly, the Committee against Torture on reviewing US compliance with CAT also expressed concern "about the extremely harsh regime imposed on detainees in 'supermaximum prisons'. The Committee is concerned about the prolonged isolation periods detainees are subjected to, the effect such treatment has on their mental health, and that its purpose may be retribution, in which case it would constitute cruel, inhuman or degrading treatment or punishment."[41]

Recommendations

Prescriptions for mental health care in prisons are plentiful. They are found in the standards and guidelines of the American Correctional Association and the National Commission on Correctional Health Care, in court rulings, expert reports, and in a voluminous professional literature. What is lacking in prison mental health services is not knowledge about what to do, but the resources and commitment to do it. We hope the work of the Subcommittee will help marshal those resources and that commitment. Compassion, common sense, fiscal prudence, and respect for human rights

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[38] Istanbul Statement on the Use and Effects of Solitary Confinement, adopted on December 9, 2007 at the International Psychological Trauma Symposium, Istanbul, available at: http://solitaryconfinement.org/uploads/Istanbul_expert_statement_on_sc.pdf (accessed September 21, 2009), pp. 80-81.

[39] Ibid.

[40] United Nations Human Rights Committee, "Consideration of reports submitted by States parties under Article 40 of the Covenant, Concluding Observations of the Human Rights Committee, United States of America," U.N. Doc. CCPR/C/USA/CO/3 (2006), http://www.unhchr.ch/tbs/doc.nsf/%28Symbol%29/CCPR.C.USA.CO.3.En?Opendocument (accessed September 21, 2009).

[41] United Nations Committee Against Torture, "Consideration of reports submitted by States parties under Article 19 of the Convention, Conclusions and Recommendations of the Committee against Torture, United States of America," U.N. Doc. CAT/C/USA/CO/2 (2006), http://www1.umn.edu/humanrts/cat/observations/usa2006.html (accessed September 21, 2009), art. 36.

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dictate a better approach to the treatment of persons with mental illness in US prisons than is evident today.

The recommendations that follow focus on several key steps we believe Congress should take.

1. Amend the Prison Litigation Reform Act (PLRA)

The Prison Litigation Reform Act of 1996 has placed serious obstacles in the path of prisoners seeking to protect their rights while incarcerated, including their rights to mental health treatment and services.[42] One PLRA provision requires federal courts to dismiss prisoner lawsuits if prisoners have not exhausted the prison or jail grievance system. Prisoners with mental illness can find it impossible to comply with all the deadlines and technical rules in a grievance system, and may then find themselves forever barred from vindicating their rights in court. On the other hand, correctional agencies legitimately want a reasonable opportunity to respond to prisoners' complaints before having to defend themselves in court. Congress should amend the PLRA to remove the current exhaustion requirement and substitute a provision allowing courts to stay lawsuits temporarily to allow prisoners to take their complaints through the grievance system. Congress should also repeal the PLRA provision that denies compensation for "mental or emotional injury" absent a prior showing of physical injury. Although isolated confinement and deficient mental health care can cause serious suffering and catastrophic injury to a prisoner's psychiatric condition, the PLRA's "physical injury" requirement bars a remedy for such injuries if the prisoner has not been physically injured as well. The Committee Against Torture called for repeal of the "physical injury" requirement when it last reviewed US compliance with the Convention Against Torture in 2006.[43]

2. Reduce High Incarceration Rates

The United States has the highest rate of incarceration in the world because it puts so many people behind bars for low-level, nonviolent offenses and for lengthy periods of time. Prison should be reserved for dangerous or violent prisoners who must be securely confined; alternative sanctions should be used for low-level, nonviolent offenders. If prison populations were reduced there would be fewer persons with mental illness behind bars and more resources available for those who must be incarcerated. Congress should enact incentives to encourage states to reduce their prison populations and it should review federal laws to ensure federal prisons are not needlessly incarcerating low-level prisoners, including low-level drug offenders.

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[42] See Human Rights Watch, *No Equal Justice: The Prison Litigation Reform Act in the United States*, June 2009, http://www.hrw.org/en/reports/2009/06/16/no-equal-justice-0.

[43] United Nations Committee Against Torture, "Consideration of reports submitted by States parties under Article 19 of the Convention, Conclusions and Recommendations of the Committee against Torture, United States of America," U.N. Doc. CAT/C/USA/CO/2 (2006), http://www1.umn.edu/humanrts/cat/observations/usa2006.html (accessed September 21, 2009), art. 29.

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3. Increase Funding for Mental Health Treatment in Prison

Through the Mentally Ill Offender Treatment and Crime Reduction Act of 2004, which was reauthorized and extended for an additional five years in 2008, Congress has provided resources to state and local governments to design and implement collaborative initiatives between criminal justice and mental health systems that will improve access to effective treatment for people with mental illnesses involved with the justice system. To date, however, most of the funding awarded by the Bureau of Justice Assistance under the Act has gone to either pre-trial or post-release initiatives. Congress should ensure that federal funds are also used to improve the provision of mental health services to persons with mental disorders while they are incarcerated.

4. Eliminate Prolonged Isolation of Mentally Ill Prisoners

Congress should use its powers to protect prisoners with mental illness from being confined in the harsh isolation conditions typical of supermax prisons and other segregation or isolation units. It should directly instruct the Bureau of Prisons (BoP) to end this harmful practice. It should also pass legislation precluding the awarding of federal funds for the construction or operation of any state prison or local jail if the jurisdiction has not instituted policies and practices to ensure mentally ill prisoners are not placed or kept in supermax prisons or other segregation units. Prisoners with mental illness who require extreme security precautions should be confined in specialized units that ensure human interaction and purposeful activities in addition to a full panoply of mental health services.

5. Improve Correctional Mental Health Services

In addition to increasing the flow of federal funds to support correctional mental health services provided by state and local jurisdictions, there are a number of other steps Congress could take to improve the treatment and conditions of confinement of prisoners with mental illness. We suggest only a few here.

a) With regard to the BoP, it should ensure periodic performance reviews of its mental health services by independent and qualified experts. The results of those evaluations should be public (with the names of prisoners kept confidential).

b) It should provide funds to states and localities to evaluate their mental health services and to develop corrective action plans.

c) It should ensure that the Special Litigation Section of the Civil Rights Division of the Department of Justice has sufficient staff and resources to investigate and where

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necessary litigate violations of the Eighth Amendment that result from deficient mental health treatment of prisoners and from their placement in supermax prisons or segregation units.

6. Improve Ex-prisoner Access to Public Benefits Covering Mental Health Services

Congress should secure changes to current law and regulations in federal programs that fund mental health services that lead to delays in the restoration of eligibility for benefits for prisoners released from prison. Enabling ex-prisoners to receive Medicaid, Supplemental Security Income, and Social Security Disability Insurance immediately upon leaving prison would enable them to pay for needed medication and mental health services in the community and to ensure continuity of care. Rapid restoration of benefits to released prisoners helps them manage their illness and reduces their risk of re-involvement with the criminal justice system.

September 22, 2009

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Department of Justice

STATEMENT OF

HARLEY G. LAPPIN
DIRECTOR
FEDERAL BUREAU OF PRISONS

BEFORE

SUBCOMMITTEE ON HUMAN RIGHTS AND THE LAW
COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE

AT A HEARING ENTITLED

"HUMAN RIGHTS AT HOME: MENTAL ILLNESS IN U.S. PRISONS AND JAILS"

PRESENTED

SEPTEMBER 15, 2009

Hearing before
the Subcommittee on Human Rights and the Law
Committee on the Judiciary
United States Senate

Entitled
"Human Rights at Home: Mental Illness in U.S. Prisons and Jails"

September 15, 2009

Statement of
Harley G. Lappin
Director
Federal Bureau of Prisons

Good morning Chairman Durbin, Ranking Member Coburn, and Members of the Subcommittee. I am pleased to testify on the very important topic of mental health care and mental health treatment in the Federal Bureau of Prisons (BOP). Inmates with mental health problems present a host of challenges and often need staff-intensive services. Over the past several years these challenges have become particularly difficult – the number of inmates with mental illness continues to increase and our agency operates within constrained budgets. Based on our work with the Association of State Corrections Administrators, the American Corrections Association and others, we are well aware that the challenges we face are not unique to the federal prison system.

As the inmate population has grown in recent years, so also has the number of mentally ill inmates in BOP custody. While the BOP's psychiatric referral centers are often used to handle the most severe of these cases, the vast majority of mentally ill inmates are maintained in non-medical institutions. Although the number of mentally ill inmates in any one institution is usually small, the high visibility of this special population, their potential for being disruptive, and their concentration in higher security institutions dictates they be closely monitored.

Traditionally, psychology services departments in non-medical institutions have provided services to these inmates, emphasizing institutional management and treatment options rather than referral for hospitalization. Successful long-term management of these cases requires a comprehensive program of institution-based care that includes accurate and early identification

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procedures, effective treatment programs, and in cases of acute psychological disturbance, timely referral to a specialty institution.

The BOP utilizes a wide variety of medical and mental health care professionals to fulfill the mission to provide appropriate care for inmates with mental illness. It is an ongoing challenge to recruit and retain these professionals in rural or high cost of living areas, where many of our institutions are located.

A study of BOP admissions cohorts from 2002 and 2003 revealed that 19 percent of the incoming offenders suffered from mental illness.

As in the community, the vast majority of mental health care in the BOP is provided on an outpatient basis at the institution by Psychology Services staff, working in collaboration with other staff including therapists, counselors and social workers, and either a full-time or consultant psychiatrist, as appropriate. We also conduct an array of forensic evaluations for the courts.

Individual and group counseling is available in all BOP institutions. Due to staffing shortages at many locations, we prioritize individual counseling based on the severity of the inmate's problem. BOP psychologists conducted 37,263 individual counseling sessions in fiscal year 2008.

Group counseling is a very effective method for the delivery of mental health services to inmates in the BOP. The number and frequency of groups vary by institution, depending on the needs of the inmate population. Group counseling is also part of the BOP's residential drug abuse treatment program, as well as a number of intensive mental health treatment programs described in the next section. Separate from the group counseling that occurs in these intensive and residential programs, general group counseling is very common practice. In August 2009, 7,943 inmates were actively participating in general group counseling across the BOP. In addition, the BOP has developed a number of intensive treatment programs to address the needs of mentally ill inmates.

Inpatient psychiatric services are provided to inmates as needed. Inpatient psychiatric beds and psychiatric services are located in the BOP's medical referral centers. These inpatient placements are reserved for acutely mentally ill individuals, and most of the mental health treatment for these inmates is provided in an outpatient setting. Some offenders are required to

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be housed in these facilities based on court orders regarding the need for hospitalization (See 18 U.S.C. §§ 4242 and 4245). The relevant statutes provide a variety of due process mechanisms to ensure inmate rights are protected.

Other provisions also exist for maintaining individuals in custody even after expiration of the sentence if the court determines their release would pose a danger as a result of mental illness or defect (See 18 U.S.C. § 4246). In 2006, Congress added another basis for maintaining individuals in custody beyond expiration of their sentence – the Adam Walsh Child Protection and Safety Act allows for civil commitment of those who are found to be sexually dangerous (See 18 U.S.C. § 4248). But note that the Fourth Circuit Court of Appeals struck down this provision in Unites States v. Comstock, 551 F.3d 274 (4th Cir 2009). The Supreme Court has granted the government's petition for certiorari on the question whether Congress has the constitutional authority to enact this provision, 129 S. Ct. 2828. While Federal law authorizes the transfer of inmates who are mentally ill to a State or local jurisdiction that has appropriate facilities and also authorizes the application for civil commitment under state law for certain individuals, such transfers are difficult to accomplish due to the unwillingness of States and others to assume responsibility for the costly care and treatment of these individuals.

Screening and Assessment

The BOP identifies inmates who are suffering from mental illness through screenings and assessments which are done at initial intake, during reviews of inmates in special housing units, and as part of ongoing evaluations of mentally ill inmates. BOP psychologists conducted 443,124 routine screenings and assessments in fiscal year 2008. Inmates found to be in need of treatment are referred for treatment evaluation and development of a treatment plan including further transfer to a different facility if necessary.

Intensive Treatment Programs

The BOP has developed a number of intensive treatment programs to address the needs of mentally ill inmates. These programs include:

- The Challenge Program: The Challenge Program is a residential treatment program for high-security inmates with a history of substance abuse and/or mental illness. Inmates may participate in the program at any point during their incarceration. The duration of the program varies based on inmate need, with a minimum duration of 9 months. Inmates may volunteer or be designated to the program. The Challenge Program is now available in all United States penitentiaries.

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- The Resolve Program: The Resolve Program is a nonresidential treatment program for female inmates with trauma-related mental illnesses. Inmates may participate in this voluntary program at any point during their incarceration. The duration of the program varies, based on the needs of the inmate. The program consists of a series of educational and cognitive-behavioral interventions addressing a range of trauma treatment needs. This program is available in 10 BOP facilities that confine female inmates.

- The Step-Down Program: The BOP has created special Mental Health Treatment Units (also known as Step-Down Programs) to provide intermediate care to chronically mentally ill inmates who do not require inpatient treatment, but lack the skills to function appropriately in a general prison population. Inmates of all security levels are eligible to participate in this program. The program is available at the Federal Correctional Center in Butner, North Carolina (for male inmates) and at the Federal Correctional Institution in Danbury, Connecticut (for female inmates).

- The Skills Program: The Skills Program is a residential treatment program for medium-security inmates who have cognitive and/or social deficits associated with mental illness or brain injury. Inmates with these deficits often have difficulty adjusting to incarceration, particularly with adhering to rules and interacting appropriately with staff and other inmates. This program provides a supportive environment for the inmate's development of essential life skills and coping skills. This program is available at the Federal Correctional Complex in Coleman, Florida.

- The Habilitation Program: The Habilitation Program is a residential and transitional treatment program for high- security inmates who cannot successfully adapt to a penitentiary environment, due to their mental health issues. The program allows these inmates to receive treatment in a medium-security setting and to transfer to another medium-security institution upon successful completion of the program. The Habilitation Program is located at the Federal Correctional Complex in Butner, North Carolina.

- The Dual Diagnosis Residential Drug Abuse Treatment Program: This special Residential Drug Abuse Treatment Program is available for inmates suffering from both a substance use disorder and a serious mental illness. This integrated treatment program is available at the Federal Medical Center in Lexington, Kentucky (for male inmates) and at the Federal Medical Center in Carswell, Texas (for female inmates).

Psychiatry Services

The BOP currently has 30 full-time psychiatrists within the system, located primarily at the agency's medical referral centers. Other facilities without a psychiatrist receive psychiatry services via tele-psychiatry or through a contractual psychiatrist. At present, 12 BOP psychiatrists provide tele-psychiatry services. All BOP institutions have the capability to use

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tele-psychiatry services and institution psychologists work closely with tele-psychiatrists to ensure inmates receive appropriate treatment services.

Forensic Evaluations

The BOP has 36 psychologists who provide court-ordered assessment services, in addition to their responsibilities in providing mental health screening and treatment services. In 2008, forensic evaluators completed 1,627 court-ordered forensic evaluations include those to determine competency to stand trial (see 18 U.S.C. § 4241), insanity at the time of offense (see 18 U.S.C. § 4242), dangerousness associated with mental illness (see 18 U.S.C. § 4246), the need for hospitalization due to mental illness (see 18 U.S.C. §§ 4244 and 4245), and sexual dangerousness (see 18 U.S.C. § 4248).

Suicide Prevention

For many individuals who suffer from mental illness, suicide is a real risk. All BOP staff is trained to recognize signs indicative of a potential suicide, to prevent suicides, and to understand and make appropriate use of the referral process. The BOP uses well-trained staff, skilled clinicians, frequent referrals, prevention techniques, and extended follow-up services to manage the suicide risk presented by Federal inmates.

While any suicide is tragic, over the past 10 years, the BOP's suicide rate has averaged 8.9 per 100,000 inmates. This rate is less than the rate for the general population (11 per 100,000) and approximately one-half the rate for males in the general population (17 per 100,000). The BOP will continue to look for ways to improve on our prevention strategies.

Transitional Services

The transition of mentally ill inmates from prison to the community poses a variety of challenges that must be addressed in order to reduce the likelihood of the offender returning to prison. The BOP works hard to ensure good communication with the supervising authorities – U.S. Probation and Court Services of Offender Supervision Agency for DC offenders as well as treatment providers in the community, through our network of residential reentry centers.

We use residential reentry centers – also known as community corrections centers or halfway houses – to place inmates in the community prior to their release from custody in order to help them adjust to life in the community, find post-release employment, and in many cases

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find suitable housing. These centers provide a structured, supervised environment and support in job placement, counseling, and other reentry services.

Prior to the release of a mentally ill inmate the treating psychologist prepares a treatment summary, that includes the inmate's current mental health status, treatment received within the BOP, and future mental health treatment needs. The summary is provided to the BOP's Transitional Services staff, who oversees treatment services for inmates housed in residential reentry centers. Transitional Services staff contract with community treatment providers to obtain appropriate mental health services for inmates in these prerelease settings, consistent with the requirements of the Second Chance Act. (*See footnote 1 below.*)

The Second Chance Act also requires the BOP to assess inmates' skills, develop reentry plans, determine program assignments, and provide incentives for participation in skills development programs, and that priority be given to the re-entry needs of high-risk populations, such as sex offenders and inmates with mental health problems.

The BOP is meeting this requirement through our implementation of the Inmate Skills Development initiative. The initiative includes an assessment of an inmate's strengths and skill deficits upon admission, the development of an individualized plan to address skill deficits, and the monitoring of skill enhancements throughout incarceration. The three principles of the Inmate Skills Development strategy are: (1) inmate participation in programs must be linked to the development of relevant inmate reentry skills; (2) inmates should acquire or improve a skill identified through the comprehensive assessment, rather than simply completing a program; and (3) resources are allocated to target inmates with a high risk for reentry failure.

The Inmate Skills Development Assessment Form includes a section on mental illness to help us identify these high-risk offenders. Staff will use the information from the assessment to enhance our current efforts in mental health care by targeting and prioritizing the placement of mentally ill inmates in appropriate treatment and skills-building programs.

The Inmate Skills Development initiative is being implemented at all institutions. The BOP is currently performing the initial assessment on all new arrivals, on 50 percent of high-

[1] We are able to release most inmates with a mental illness through a residential reentry center. However, there a number of severely mentally ill inmates who require a level of monitoring not currently available at any residential reentry center.

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security and medium-security inmates within 4 years of release, and 25 percent of low-security and minimum-security inmates within 4 years of release.

Conclusion

Thank you for holding this hearing and bringing attention to this important topic. The mentally ill in prison are a unique population that poses real challenges for our agency. We are doing a lot, particularly given the budget restrictions we have experienced. But more can be done and we continue to renew and refine our approaches to ensure we are meeting the needs of these inmates. I will be pleased to answer any questions the members of the Subcommittee may have.

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Leadership Conference on Civil Rights

STATEMENT OF

WADE HENDERSON, PRESIDENT & CEO
LEADERSHIP CONFERENCE ON CIVIL RIGHTS

COMMITTEE ON THE JUDICIARY

SUBCOMMITTEE ON HUMAN RIGHTS AND THE LAW
UNITED STATES SENATE

TUESDAY, SEPTEMBER 15, 2009

Chairman Durbin, Ranking Member Coburn, and Members of the Subcommittee, thank you for providing me the opportunity to share my views on the importance of incorporating human rights ideals and perspectives into the nation's civil rights dialogue. The Leadership Conference on Civil Rights strongly supports the Subcommittee's engagement on these issues.

I serve as President and CEO of the Leadership Conference on Civil Rights. The Leadership Conference is the oldest, largest, and most diverse civil and human rights coalition in the United States, consisting of more than 200 national organizations representing persons of color, women, children, organized labor, persons with disabilities, the elderly, gays and lesbians, and major religious groups.

For many years, the Leadership Conference on Civil Rights has been engaged in both domestic and international work to promote dignity, equality, and justice for all. We have recognized the importance of U.S. engagement in international human rights in many ways. We have coordinated NGO involvement in the work of the Organization for Security and Cooperation in Europe around combating Racial Discrimination, Anti-Semitism, Islamophobia, and related forms of Intolerance and participated in the preparatory meetings and NGO forum at the World Conference against Racism in Durban, South Africa in 2001. Most recently, we urged the U.S. Government to participate in the Durban Review Process and Durban Review Conference in Geneva, Switzerland. The Leadership Conference also advocated U.S. ratification of the Convention on the Elimination of Racial Discrimination (CERD) during the 1990s, and submitted shadow reports in response to the U.S. Government's reports in 2000[1] and

[1] Leadership Conference on Civil Rights and Lawyers Committee for Civil Rights Under Law, *American Dream? American Reality!: A Report on Race and Ethnicity and the Law in the United States* (2001)

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2007[2]. This level of international engagement has helped strengthen our work at home in significant ways. It also reaffirmed our belief that racism and related forms of intolerance must be fought throughout the world. Human rights are not merely a collection of international ethical standards set forth by the United Nations, but tools useful in illuminating persistent inequities.

Historically, the civil rights movement in the United States has been focused on strengthening and enforcing domestic laws to achieve equal opportunity here at home. However, within the longstanding tradition of the movement has been a vision of our domestic civil rights agenda as part of the larger global movement for human rights. Indeed, our civil rights movement in America drew inspiration from human rights ideals being recognized around the world. As Dr. King took inspiration from Ghandi, so too can domestic civil rights efforts today take inspiration from the international principles and treaties affirming basic human rights around the globe.

Although our country is young, the struggle for equality in the United States has been long. We have had many victories and countless setbacks. And through it all, our work has been rooted in and inspired by civil and human rights struggles around the world. As a country, we have traveled a great distance along the path of racial reconciliation toward the goal of social justice and cohesion. However, our racially-defined history of injustice still shapes today's realities. Racism and racial discrimination continue to impact the lives of Americans and the international community as a whole. While the manifestations may be different from one country to another, the problem is a collective one and it requires a collective solution. We are therefore very pleased that the United States has joined the Human Rights Council at the United Nations, has recently signed onto the International Convention on the Rights of Persons with Disabilities. We are also pleased that the Obama administration promised to push for Congress to ratify several international human rights treaties, most notably, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). We are hopeful that this renewed commitment with the world around human rights issues will result in greater progress both at home and around the globe.

But much work remains to be done to advance human rights and civil rights both at home and abroad. International human rights covenants can be used to encourage the U.S. government to focus on issues not redressable under U.S. law and to establish stronger remedies than are available under U.S. law.

Americans overwhelmingly recognize the importance of human rights. A 2007 survey by The Opportunity Agenda found that 80 percent of Americans believe that each person has certain basic rights and that the United States should "strive to uphold human rights in the U.S. because there are people being denied their human rights in our country." The public resoundingly agrees that equal access to public education (82 percent), equal opportunity regardless of race or gender (85 and 86 percent), a right to health care (72

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[2] Leadership Conference on Civil Rights, *American Dream? American Reality!: A Report on Race and Ethnicity and the Law in the United States* (January 2008). Available at: http://www.civilrights.org/publications/american-dream/ccrd-2007.pdf

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percent), and freedom from torture and fair treatment by the criminal justice system (83 percent) are, in fact, human rights. Over three quarters (77 percent) of Americans said that they would like the United States to work to advance and protect human rights.

These goals are still unmet. While we have made real progress, the finish line is still well in the distance.

The focus of this hearing is an important starting point for this conversation. According to the Bazelon Center for Mental Health Law, more than 16 percent of jail inmates have a mental illness and 70 percent of jail inmates with mental illnesses are incarcerated for nonviolent offenses.[3] The criminalization of the mentally ill means that people who need treatment the most are less likely to receive it because they are tracked into punitive jail settings.

In addition, our prisons and jails are the most racially segregated institutions in America. While African Americans and Latinos make up approximately 25 percent of the U.S. population, racial and ethnic minorities now make up more than 60 percent of the people in prison. For Black males in their twenties, 1 in every 8 is in prison or jail on any given day.[4] These trends have been intensified by the disproportionate impact of the so-called "war on drugs," with the result that three-fourths of all persons in prison for drug offenses are people of color. If current trends continue, one out of every three African-American males born today can expect to go to prison.

From criminalization of the mentally ill, to racial profiling, to discrimination in prosecution and sentencing, our criminal justice system is failing the minority community and, along the way, ruining the lives of countless numbers of African-American and Latino children and adults. Domestic perspectives have not been able to break this cycle, and the use of international principles and international treaties may provide new approaches and new solutions for this entrenched problem.

Other entrenched problems that our nation faces may also benefit from a broader and more international perspective. In the wake of World War II, Eleanor Roosevelt led an effort by a team of UN officials to articulate the most fundamental human needs in the Universal Declaration of Human Rights (UDHR). Those involved in drafting the document's principles did so with the intention of having those far-reaching ideals apply to all peoples around the globe equally, including those in the United States. The document incorporated in the UDHR included basic liberties found in the U.S. Bill of Rights, such as freedom of thought and religion, freedom from arbitrary arrest, and the principle of nondiscrimination. It also went further, affirming the right to emigrate, to marry, to have economic security, to receive equal pay for equal work, to organize, and to

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[3] Bazelon Center for Mental Health Law, "Fact Sheet #3 Individuals with Mental Illness in Jail and Prison." Available at http://www.bazelon.org/issues/criminalization/factsheets/criminal3.html (last accessed September 11, 2009)

[4] The Sentencing Project, *Reducing Racial Disparities in the Criminal Justice System: A Manual for Practitoners and Policy Makers* (2008). Available at: http://www.sentencingproject.org/doc/publications/rd_reducingracialdisparity.pdf

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be free from degrading treatment. Far from trying to supplant domestic law, the United States signed on to the UDHR in an effort to make our nation a more perfect union. Adopting a human rights framework can help combat the various forms of discrimination that currently exist in a number of our institutions.

In education, America remains largely segregated by race, and racial disparities track opportunity disparities in communities across the country. Too many of the schools in low-income and minority communities in America suffer from resource limitations that deny opportunities to their students. Their buildings are decaying. They are not wired for the Internet. The teachers often are not qualified for the subjects that they teach. And the classrooms are overcrowded. Together with their hardships at home, the inadequacies of public schools in communities across the country go a long way toward explaining why 50 percent of Black and Latino students in America drop out of high school.

As President Obama has made abundantly clear, health care in our nation is in crisis. More than 46 million Americans, including disproportionate numbers of African Americans and Latinos, are uninsured and millions more live in fear that their coverage will be cut back, the costs will be increased, or that they will lose their insurance when they lose their jobs. We need universal health coverage in America, beginning with every family with children at home. And we need to make sure that health care professionals and health care institutions are accessible to people in minority and low-income communities. A human rights perspective can be a useful lens through which to view this debate in order to transcend some of the obstacles to solving this problem that we now face.

We are plagued with other problems as well, including an immigration system that is broken and must be fixed; persistent poverty that threatens to swallow generations in un- or underemployment; and hate crimes targeted against vulnerable populations, undermining the safety, confidence, and productivity of its victims.

Our challenge going forward is to identify ways in which to solve these problems using all the tools at our disposal. A framework recognizing the integrity and dignity of every person will allow us to refocus the debates and find new solutions. As a nation, we must recognize the importance and value of the human rights perspective and join the international community in ratifying treaties and conventions that will provide additional tools and support for our efforts to ensure full and equal citizenship.

The following recommendations attempt to achieve that goal.

In an effort to create a more humane immigration system, the United States should ratify the United Nations International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, which protects migrants from exploitative working conditions and sexual and physical abuse. It should also sign the Convention against Enforced Disappearance, which prohibits the abduction and secret detention of any person by the state and a mechanism for obtaining reparation and compensation for victims. Vigorous enforcement of both treaties would provide

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additional protection for undocumented workers, curb abuses in the immigration detention facilities, and combat the scourge of human trafficking.

The United States should also ratify the Optional Protocol to the Convention against Torture (OPCAT), which prevents torture and other forms of ill-treatment by opening up detention facilities by encouraging regular visits to places of detention carried out by independent national and international bodies. The OPCAT goes beyond torture. It also affords rights to those living in our prisons, jails, immigration detention facilities, juvenile detention facilities, and psychiatric institutions by allowing them to complain about abuse. Given our overreliance on incarceration for people with mental illnesses, OPCAT would be instrumental in spotlighting certain systemic problems.

The Leadership Conference also urges President Barack Obama to issue an Executive Order resurrecting an Interagency Working Group on Human Rights. The Working Group will function as the coordinating body among federal agencies and departments for the promotion and implementation of human rights obligations in U.S. domestic policy.

And finally, the Leadership Conference endorses reforming the current U.S. Commission on Civil Rights so that it may serve once again as the conscience of the nation on civil rights issues. Among the reforms that must take place, the Commission's mandate and title must be amended to include human rights. Changing the commission's name to the United States Commission on Civil and Human Rights would reflect a more explicit obligation to examine U.S. compliance with these international treaties as part of its existing mandate to ensure compliance with civil rights laws and could help bolster the United States' leadership role in protecting human rights around the world.

Together, our goals for civil and human rights for all -- regardless of race, ethnicity, gender, disability, or sexual orientation – are more than dreams. They must define our future.

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Department of Justice

STATEMENT OF

MARY LOU LEARY
DEPUTY ASSISTANT ATTORNEY GENERAL
OFFICE OF JUSTICE PROGRAMS

BEFORE

SUBCOMMITTEE ON HUMAN RIGHTS AND THE LAW
COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE

AT A HEARING ENTITLED

"HUMAN RIGHTS AT HOME: MENTAL ILLNESS IN U.S. PRISONS AND JAILS"

PRESENTED

SEPTEMBER 15, 2009

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Hearing before
the Subcommittee on Human Rights and the Law
Committee on the Judiciary
United States Senate

Entitled
"Human Rights at Home: Mental Illness in U.S. Prisons and Jails"

September 15, 2009

Statement of
Mary Lou Leary
Deputy Assistant Attorney General
Office of Justice Programs

Mr. Chairman, Ranking Member Coburn and Members of the Subcommittee: I am pleased to have the opportunity to discuss the Department of Justice's (DOJ) efforts to improve the state and local criminal justice system's response to people with mental illnesses. We appreciate this Subcommittee's interest in this issue.

My name is Mary Lou Leary, and I am the Deputy Assistant Attorney General for the Office of Justice Programs (OJP) within the Department of Justice. OJP's mission is to provide leadership and services in grant administration and criminal justice policy development to support local, state and tribal justice strategies to achieve safer communities.

As the Subcommittee is well aware, many people entering this nation's criminal justice system are suffering from mental illnesses. According to a report from the Council of State Governments, funded, in part, by OJP's National Institute of Justice, 16.9 percent of the adults in a sample of local jails had a serious mental illness. That's

three to six times the rate of the general population. Also troubling is that while the serious mental illness rate was 14 percent for men, it was 31 percent for women. If these rates were applied to 13 million jail admissions reported in 2007, the study findings suggest that more than two million bookings of a person with a serious mental illness occur annually.

Many of the offenders with mental illnesses don't receive treatment. This is not only a disservice to the offenders and their families; it is a threat to public safety. Without treatment, these offender's conditions can worsen and they may pose a greater threat to themselves and others when they leave jail or prison.

To address this problem, OJP's Bureau of Justice Assistance (BJA) administers the Justice and Mental Health Collaboration Program (JMHCP) to help states, tribes and units of local government design and implement collaborative efforts between criminal justice and mental health systems. The program's goal is to improve access to effective treatment for people with mental illnesses involved with the justice system.

JMHCP grants can be used for a broad range of activities, including specialized law enforcement-based programs, mental health courts, mental health and substance abuse treatment for incarcerated offenders with mental illnesses, community reentry services, and cross-training of criminal justice and mental health personnel. The grants also allow for increased training of local law enforcement on how to identify and address encounters with people with mental illnesses. Each grantee is given the opportunity to

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tailor their responses to best fit their particular location and the needs of their target population.

Eligible JMHCP applicants include states, units of local government, federally recognized Indian tribes and tribal organizations. All JMHCP grants require a joint application from a mental health agency and unit of government responsible for criminal and/or juvenile justice activities. This underscores the collaborative nature of this grant, which is intended to bring the criminal justice and mental health systems together to improve outcomes for people with mental illnesses in the justice system. Grants can be used for planning, implementing or for expanding existing programs.

From Fiscal Year 2006 through Fiscal Year 2008, BJA has awarded 76 JMHCP grants totaling nearly $12 million to 32 states, the District of Columbia and Guam. Most of these grants supported programs for adults, with some funding efforts for juveniles and a few for efforts targeting both populations. Projects have also been funded to provide training and technical assistance to grantees and to provide services to those applicant communities that applied, but did not receive funding.

In just a short period of time we have already seen significant progress from the JMHCP grantees. A New York City JMHCP program offers an alternative to traditional incarceration that combines mental health treatment with community service. In the first six months of 2009, the program admitted 47 percent more people than in the previous

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six months. The program has also significantly increased the number of participants that were linked to long-term treatment services.

Another example is Cass County, North Dakota. In 2005, before the JMHCP grant, only 191 detainees were even referred for a psychological assessment and only 92 actually received one due to limited resources. In the first five months of 2009, with the JMHCP program in place, 550 detainees received an assessment. Of those people, 373 were referred for treatment and services, and 10 were transported for inpatient hospitalization or evaluation. Meanwhile, the state of Maine has used its JMHCP funds to move toward statewide inmate screening and assessment so that the most intensive interventions will be used for those who have the most impairments related to their mental illnesses and pose the highest risk to public safety.

We know that many people with mental illness cycle through the justice system, often for low-level crimes, without getting connected to needed mental health and other services. Encounters with law enforcement often play a critical role in whether or not people with mental illness continue to cycle in and out of jails and prisons. Law enforcement officers across the country are all too familiar with repeated calls for service involving situations where there are individuals that are exhibiting behaviors that indicate the presence of undiagnosed and diagnosed mental illness.

Many law enforcement officials across the country are partnering with local mental health advocates and mental health service providers to develop strategies to make

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it easier for law enforcement to connect people with mental illnesses to much needed services and to minimize the likelihood that they will cycle through the system. These programs, often referred to as Crisis Intervention Teams or Co-Responder Models, are eligible to receive funding under the JMHCP. Seven jurisdictions have used BJA funds to start or enhance law enforcement response programs for people with mental illness. In addition, BJA has partnered with the Council of State Governments on a number of publications that address law enforcement response to individuals with mental illnesses. These include *Essential Elements of Specialized Law Enforcement-Based Programs* and *Strategies for Effective Law Enforcement Training.*

OJP and other DOJ components have launched collaborative projects with the Department of Health and Human Services to find other ways to help state and local governments improve the response to people with mental illness involved in the criminal justice system. BJA joined with the National Institute of Corrections (NIC) and the Substance Abuse and Mental Health Services Administration to provide technical assistance to states to build on existing efforts and replicate them statewide. These partners worked with the GAINS Center and the Council of State Governments Justice Center to sponsor a national conference in 2009, "Smart Responses in Tough Times: Achieving Better Outcomes for People with Mental Illness Involved in the Justice System." Over 450 people attended the conference, including many representatives from our JMHCP grantees and applicants.

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BJA also partnered with the Council of State Governments Justice Center on a number of publications that address the criminal justice response to individuals with mental illnesses through mental health courts. These include *Improving Responses to People with Mental Illnesses: The Essential Elements of a Mental Health Court* and *Mental Health Courts: A Primer for Policymakers and Practitioners*. In addition, BJA has worked with the National Association of Counties on other related publications, *Reentry for Safer Communities, Effective County Practices in Jail to Community Transition Planning for Offenders with Mental Health and Substance Abuse Disorders* and *State and County Collaboration: Mental Health and the Criminal Justice System*. I am including these publications with my testimony.

Please be assured that our work and our commitment will continue. For Fiscal Year 2009, we will be awarding 43 JMHCP grants totaling nearly $8 million, with additional funding supporting training and technical assistance efforts. Also, many of the grants we will be awarding under the Second Chance Prisoner Reentry Initiative will support mental health treatment as part of comprehensive reentry efforts. In addition, we will continue to work with our partners within the Department of Justice and other federal agencies to explore new ways to help states and local communities improve mental health services for people in the criminal justice system.

Thank you for the opportunity to testify today. I welcome the chance to answer any questions you or other Members of the Subcommittee may have.

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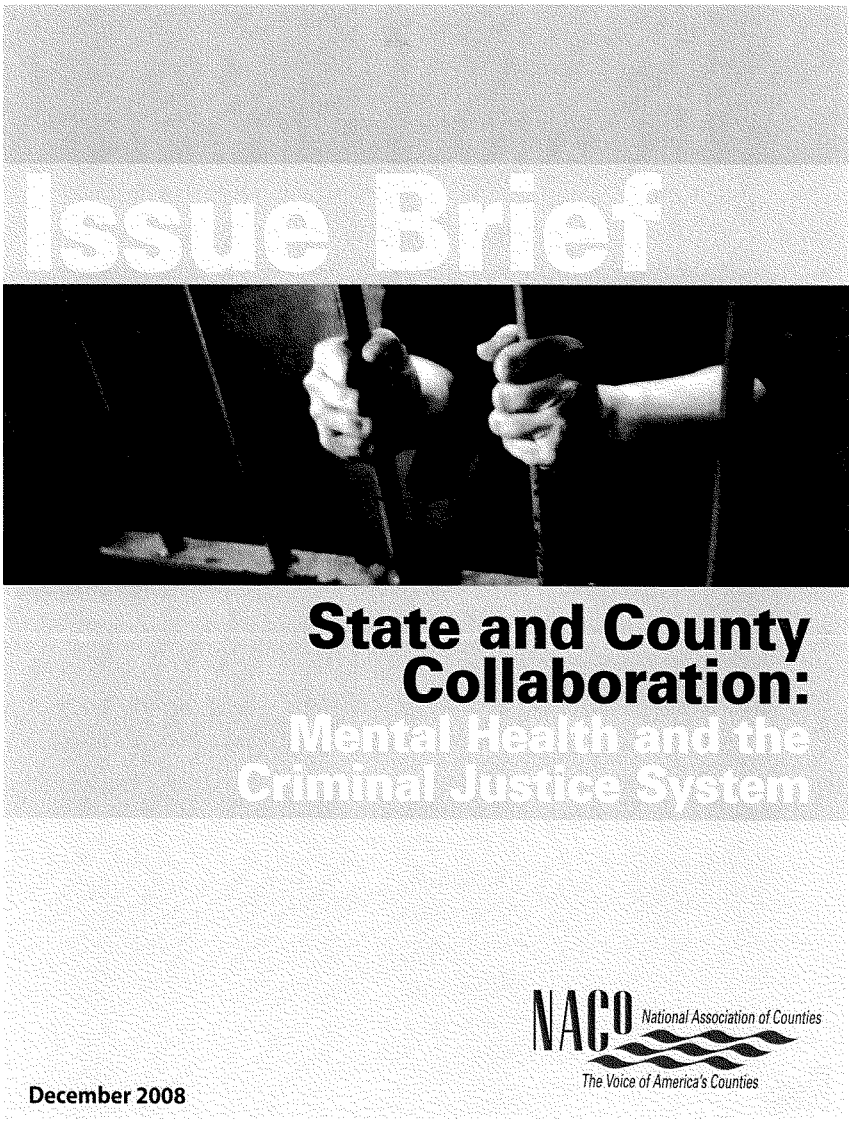
Issue Brief
State and County Collaboration:
Mental Health and the Criminal Justice System
NACo National Association of Counties
The Voice of America's Counties
December 2008

Issue Brief

State and County Collaboration:

Mental Health and the Criminal Justice System



Produced by the Community Services Division of the County Services Department

December 2008

NACo National Association of Counties
The Voice of America's Counties

About NACo – The Voice of America's Counties

The National Association of Counties (NACo) is the only national organization that represents county governments in the United States. Founded in 1935, NACo provides essential services to the nation's 3,066 counties. NACo advances issues with a unified voice before the federal government, improves the public's understanding of county government, assists counties in finding and sharing innovative solutions through education and research, and provides value-added services to save counties and taxpayers money. For more information about NACo, visit www.naco.org.

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Introduction

There is a disproportionate number of individuals with mental illness in the criminal justice system today, representing a mental health and criminal justice crisis that must be approached collaboratively. According to a 2006 Bureau of Justice Statistics report, more than half of all prison and jail inmates have a mental health problem.[1] Sixty- four percent of jail inmates are estimated to have a mental health problem compared to 56 percent of state prisoners (Figure 1). According to this same report, a quarter of both state and jail inmates who have a mental health problem have been incarcerated three or more times previously. This indicates that many of the individuals who are mentally ill in corrections today recidivate, which illustrates the difficulty and necessity of treating this population.

The criminal justice system has become increasingly overwhelmed with offenders who are mentally ill in the past decade due to deinstitutionalization which resulted in the release of thousands from psychiatric facilities. On account of this influx back into the community, many come into contact with the criminal justice system due to actions which are a result of their mental illness. Many end up being criminalized instead of receiving the treatment they need. Although this population can be best served with community-based treatment and services, the criminal justice system has been forced to care for individuals with mental illness despite often being ill-equipped to do so properly.[2]

Those who have mental health problems are often unable to access adequate services in the community. This may be due to lack of knowledge regarding available services, lack of funds, or a lack of capacity to access services. While the purpose of the criminal justice system is not to house individuals who are mentally ill, the high population of offenders with mental health needs represents an opportunity to provide access to treatment and other needed services. This requires a collaborative effort not only between the mental health and criminal justice systems, but ideally between levels of government. This special population of offenders with mental health needs requires a continuum of care in order to break the cycle of the revolving door of the criminal justice system.[3] In order to accomplish the goals of treatment and public safety through reduced recidivism, coordination between organizations and levels of government are required.

Since jails are locally operated facilities and prisons are maintained by the state, collaboration and coordination of services are necessary and have many benefits.[4] Continuing to jail and imprison individuals who are mentally ill is expensive. In 2005, local governments spent over $100 billion in corrections expenditures, while states spent about $60 billion (Figure 2). Coordination of resources represents opportunities for states and county governments to save money by reducing the amount of overlapping services. Collaboration also represents an opportunity among various organizations to combine services to allow for a continuum of care at all levels.[5]

Many state and county governments have begun to recognize the advantages of collaboration. The three states and local communities featured in this Issue Brief represent a range of collaborative efforts, including legislative efforts, a state-funded grant program with county-matched dollars, committee membership, and joint programming. All have made state and county collaborative efforts to reduce costs and improve public safety, programming, and the lives of offenders with mental health needs.



Those who have mental health problems are often unable to access adequate services in the community. This may be due to lack of knowledge regarding available services, lack of funds, or a lack of capacity to access services.

1 Bureau of Justice Statistics. 2006. Special Report on Mental Health Problems of Prison and Jail Inmates.
2 Bell, Maureen. "Facilitating Collaboration Between Correctional and Mental Health Systems." Corrections Today (2003). *http://findarticles.com/p/articles/mi_hb6399/is_/ai_n29062379.*
3 National Institute of Justice. 1999. Coordinating Community Services for Mentally Ill Offenders: Maryland's Community Criminal Justice Treatment Program, NCJ 175046.
4 Bureau of Justice Statistics. 2006. Special Report on Mental Health Problems of Prison and Jail Inmates.
5 National Institute of Justice. 1999. Coordinating Community Services for Mentally Ill Offenders: Maryland's Community Criminal Justice Treatment Program, NCJ 175046.

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Florida and the Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Program

Collaboration Through Legislation and a Grant Program

Florida has developed state and county collaboration through state legislation to create a grant program for local communities. Florida House Bill 1477 was approved by the Governor on June 19, 2007 and became effective July 1, 2007.[1] This bill created the Criminal Justice, Mental Health, and Substance Abuse Reinvestment Act and Grant Program within the Department of Children and Family Services (Figure 3). The purpose of the Reinvestment Grant Program is to provide funding to counties for programs that increase public safety by reducing recidivism, avoiding overspending on corrections by reducing the need for these services, and improving the success of treatment services. These programs focus on both juvenile and adult populations who have a mental illness, substance abuse disorder, or co-occurring mental health and substance abuse disorder. Individuals engaged in these initiatives are currently involved in the criminal justice system or are at risk of being so.[2]

Counties achieve these goals by receiving funding for a 1-year planning or 3-year implementation or expansion grant. The maximum grant award for a planning grant is $100,000, while the maximum grant award for the implementation or expansion grant is $1,000,000. This program is unique; the Act stipulates that in order for counties to receive state funding through this grant, they must commit to matching the funds dollar for dollar. The only exception lies with counties that are deemed "fiscally constrained;" those counties are obligated to a 50 percent match of state funds.[3] This program is significant because it begins a county and state collaboration through legislation and blended funding. The program encourages partnerships among the state and counties to address both juvenile and adult substance abuse and mental health needs.

As a result of HB 1477, 23 Florida counties have received grants from the state totaling roughly $9.6 million. Counties have matched these funds with a total of about $12.6 million for a grand total of around $22.2 million. All of the funds are focused on diverting those with substance abuse issues, mental health needs, or both (Figure 4). The state and county collaboration is not complete upon disbursement of funds to the counties. Per the passing of HB 1477, a Criminal Justice, Mental Health and Substance Abuse Policy Council has been created within the Florida Substance Abuse and Mental Health Corporation. This council works with counties that have received grant awards and identifies those which have planned, implemented, or expanded effective strategies for system change and reduced both recidivism and corrections costs. The council is tasked with disseminating this information throughout the state in order to increase awareness of effective strategies, thereby continuing the state and local collaboration.[4] For more information, please visit *www.samhcorp.org/home.htm*.

1 Florida House of Representatives. 2007. CS/CS/HB 1477- Forensic Mental Health. *www.myfloridahouse.gov/SECTIONS/Bills/billsdetail.aspx?BillId=36628.*

2 Florida Substance Abuse and Mental Health Corporation. Press Release. *www.samhcorp.org/pdf/News_Release_08-07-07.pdf*

3 Florida Substance Abuse and Mental Health Corporation. Fact Sheet. *www.samhcorp.org/pdf/Program_Fact_Sheet.pdf*

Utah and the Salt Lake County Criminal Justice Advisory Council (CJAC)

Collaboration Through Committees

Located in Utah, the Salt Lake County Criminal Justice Advisory Council (CJAC) was created as part of Salt Lake County's Criminal Justice Services Division. Although the group has become more formalized in the last seven years, CJAC was created over 15 years ago. The purpose of CJAC is to provide a venue for stakeholders at all levels to come together regarding criminal justice services and system change. CJAC is a leader in state and county collaboration through the mixed membership of the Council, as well as the mixed membership of their subcommittee, Span. Monthly meetings provide an opportunity to assess the criminal justice programs the group oversees and in turn recommend any changes. The 25 members of CJAC represent agencies and organizations at all levels, including city, county, and state.[5] Membership includes individuals from the following diverse agencies:[6]

- Law Enforcement Administrators and Directors
- Midvale City
- Salt Lake City Justice Court
- Salt Lake City Police Department
- Salt Lake City Prosecutor's Office
- Salt Lake County Criminal Justice Services
- Salt Lake County District Attorney's Office
- Salt Lake County Human Services
- Salt Lake County Justice Court
- Salt Lake County Mental Health
- Salt Lake County Sheriff's Office
- Salt Lake County Substance Abuse Services
- Salt Lake County Third District Court
- Salt Lake County Third District Juvenile Court
- Salt Lake Legal Defenders Association

4 Piekalkiewicz, Ellen. "Presentation on the CJMHSA Grant." Florida Substance Abuse and Mental Health Corporation. *www.samhcorp.org/RFA*

5 Salt Lake County Criminal Justice Advisory Council Membership. 2008. *www.cjac.slco.org/doctopdf/CJAC_Membership.pdf*

6 Salt Lake County Criminal Justice Advisory Council Agencies and Members. 2008. *www.cjac.slco.org/html/agencies.html*

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- Statewide Association of Prosecutors
- Taylorsville City Police Department
- Utah State House of Representatives
- Utah State Senate
- West Valley Justice Court

CJAC also has a subcommittee called the Span committee. The Span committee oversees additional programs including several that receive both county and state funding. The programs the Span committee oversees with blended funding are the expansion of the Third District Mental Health Court, the RIO Housing program, and specialized probation and parole for mental health cases. Span committee membership continues the collaboration exemplified by CJAC. Span committee members include individuals from ten county agencies, one federal agency, two city agencies, and three state agencies including the Utah Division of Substance Abuse and Mental Health. The collaborative nature of this subcommittee allows for information sharing among all stakeholders working with individuals who are mentally ill in the criminal justice system. This information sharing allows stakeholders to streamline resources, share ideas, and avoid overlapping resources. For more information, please visit *www.cjac.slco.org*.

Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) and Harris County

Collaboration Through Joint Programming

In 1987, Texas established the Texas Council on Offenders with Mental Impairments (TCOMI). Through legislation, Texas has been able to create a system that addresses all aspects of the juvenile and adult criminal justice systems for those with special needs. The Texas Legislature has recently exhibited its commitment to improving the criminal justice system by reauthorizing a $35 million dollar package for criminal justice and mental health collaboration and programs. The legislature furthermore changed the name of TCOMI to the Texas Correctional Office on Offenders with Medical or Mental Impairments, otherwise known as TCOOMMI.[7]

TCOOMMI is involved in important work in the criminal justice and mental health realm. TCOOMMI has studied the current mental health screening practices in Texas jails, it has established a statewide data network to identify current and former offenders with mental health needs, established a 60 day bed residential program for probationers with mental health needs, and expanded their jail diversion program to three additional counties.[8] TCOOMMI has also been working closely with Harris County to establish a community-based competency restoration pilot. It is this program that truly demonstrates TCOOMMI's commitment to state and county collaboration for offenders with mental health needs.

In 2003, the Rusk Diversion Project was created by TCOOMMI in partnership with Harris County Mental Health and Mental Retardation Authority (MHMRA), the Harris County Sheriff, and the Courts. The Harris County Rusk Diversion Project (Figure 5) is a community-based competency restoration project that was created to address the financial burden of committing incompetent defendants to the state hospital for restoration of competency. In the past, defendants who signified a mental health issue during their first court appearance were automatically sent for a competency evaluation at the state hospital. The cost of transporting individuals to the state hospital is high and oftentimes unnecessary. Several studies indicate that the majority of offenders who are mentally ill transferred to the state hospital were actually not in need of restoration.[9]

Instead of automatically being sent for a lengthy hospital stay, defendants are currently referred for psychiatric stabilization through this diversion project. A psychiatric review is completed at the first appearance in court if there is any question regarding mental stability. Each individual that is referred for a psychiatric evaluation is screened and sent to a psychiatrist, who then follows up with a re-evaluation 14 days after the initial treatment.

The goal of the project is to reduce the cost of lengthy hospital stays by aiming to identify defendants who can be restored to competency while remaining at the jail. Reducing transportation costs is not the only goal of the Rusk Diversion Project; another goal is to provide local treatment, thereby making family visitation more likely. Educating officers for the purpose of early identification and managing of offenders with mental health needs are additional goals of the program, as well as providing information to the courts regarding mental health conditions of inmates for the purpose of assisting with release and detention decisions. This information, combined with the continuous collaboration of the criminal justice and mental health systems, allows for the option of interventions to break the cycle of incarceration for this population.

There have been several program outcomes:[10]

- 74 percent (419) of defendants were served by the competency restoration project and diverted from state hospital commitments.
- The disposition of cases occurred faster due to the shorter amount of time defendants spent in the Rusk Diversion

7 Texas Department of Criminal Justice. 2005. The Biennial Report of the Texas Correctional Office on Offenders with Medical and Mental Impairments.

8 Texas Department of Criminal Justice. 2005. The Biennial Report of the Texas Correctional Office on Offenders with Medical and Mental Impairments.

9 Texas Department of Criminal Justice. 2005. The Biennial Report of the Texas Correctional Office on Offenders with Medical and Mental Impairments.

10 Texas Department of Criminal Justice. 2005. The Biennial Report of the Texas Correctional Office on Offenders with Medical and Mental Impairments.

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Project compared to the length of a state hospital commitment.

- Costs to the Sheriff's Department were reduced due to the decrease in state hospital admissions.

These program outcomes suggest that many offenders with mental health needs are being diverted from unnecessary lengthy hospital stays. This not only reduces costs, but cases are processed in a more timely manner as the defendants are able to stand trial earlier than if they had been admitted to the state hospital. The diversion program also allows for local treatment so family members can continue to be supportive and physically present in the offenders' lives. The money saved with this program can also be reinvested back into the criminal justice system by being applied to other mental health diversion programs or treatment services offered in the jail. Look for the 2009 Biennial Report for additional information on the state and county collaboration of Harris County's and TCOOMMI's Rusk Diversion Project. For more information, please visit *www.tdcj.state.tx.us*.

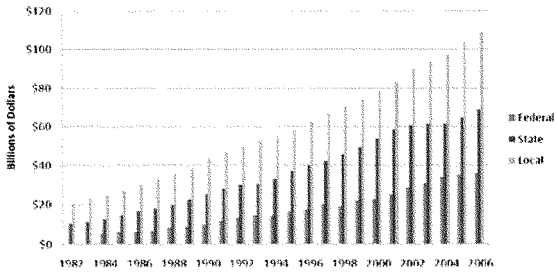
Figures

Figure 1: Percent of Inmates In Prisons or Jails Who Have a Mental Health Problem

Mental Health Problem	State Prison	Federal Prison	Local Jail
Any mental health problem	56	45	64
Recent history	24	14	21
Symptoms	49	40	60

Source: Bureau of Justice Statistics. 2006. Special Report on Mental Health Problems of Prison and Jail Inmates.

Figure 2: Criminal Justice Expenditures by Level of Government



Source: Bureau of Justice Statistics. 2008. *Justice Expenditure and Employment Extracts.*

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Figure 3: Results of the Creation of the Reinvestment Grant Program

- Requires Florida Substance Abuse and Mental Health Corporation to establish a statewide grant review committee;
- Authorizes counties to apply for a planning grant or an implementation or expansion grant;
- Creates the Criminal Justice, Mental Health and Substance Abuse Technical Assistance Center at the Florida Mental Health Institute, University of South Florida and;
- Creates the Criminal Justice, Mental Health and substance Abuse Policy Council within the Florida Substance Abuse and Mental Health Corporation.

Source: Florida Substance Abuse and Mental Health Corporation. Fact Sheet. *www.samhcorp.org/pdf/Program_Fact_Sheet.pdf*

Figure 4: Grant Allocations and Matching Funds in Florida as of August 26, 2008

County	Amount Awarded by the State	Matched Dollars from the County
Alachua	$999,000	$999,000
Broward	$991,368	$991,368
Charlotte	$60,190	$60,190
Citrus	$50,166	$50,166
Duval	$91,200	$93,319
Flagler	$40,447	$23,061
Hillsborough	$999,999	$1,000,000
Lake	$60,000	$60,000
Lee	$997,698	$2,030,473
Leon	$792,624	$890,469
Marion	$59,000	$68,587
Martin	$100,000	$100,000
Miami- Dade	$999,000	$999,000
Monroe	$92,568	$92,568
Nassau	$225,000	$225,000
Orange	$954,663	$2,476,788
Osceola	$87,500	$87,500
Palm Beach	$100,000	$100,000
Pinellas	$117,419	$117,419
Polk	$980,706	$1,021,530
St. Lucie	$688,576	$1,087,929
Sumter	$50,000	$25,000
Volusia	$65,300	$65,408
Totals	$9,602,424	$12,664,775

Source: Florida Substance Abuse and Mental Health Corporation. 2008. Cost Comparison by County. *www.samhcorp.org/RFA*

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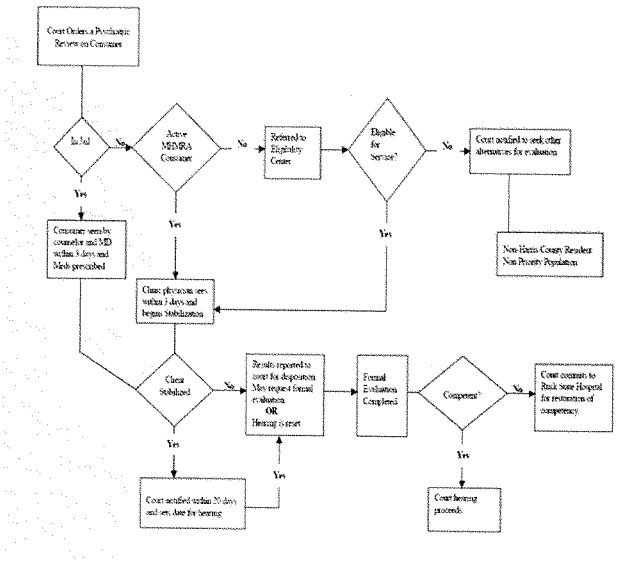
Figure 5: Diagram of the Rusk Diversion Project



Source: Texas Department of Criminal Justice. 2005. *The Biennial Report of the Texas Correctional Office on Offenders with Medical and Mental Impairments.*

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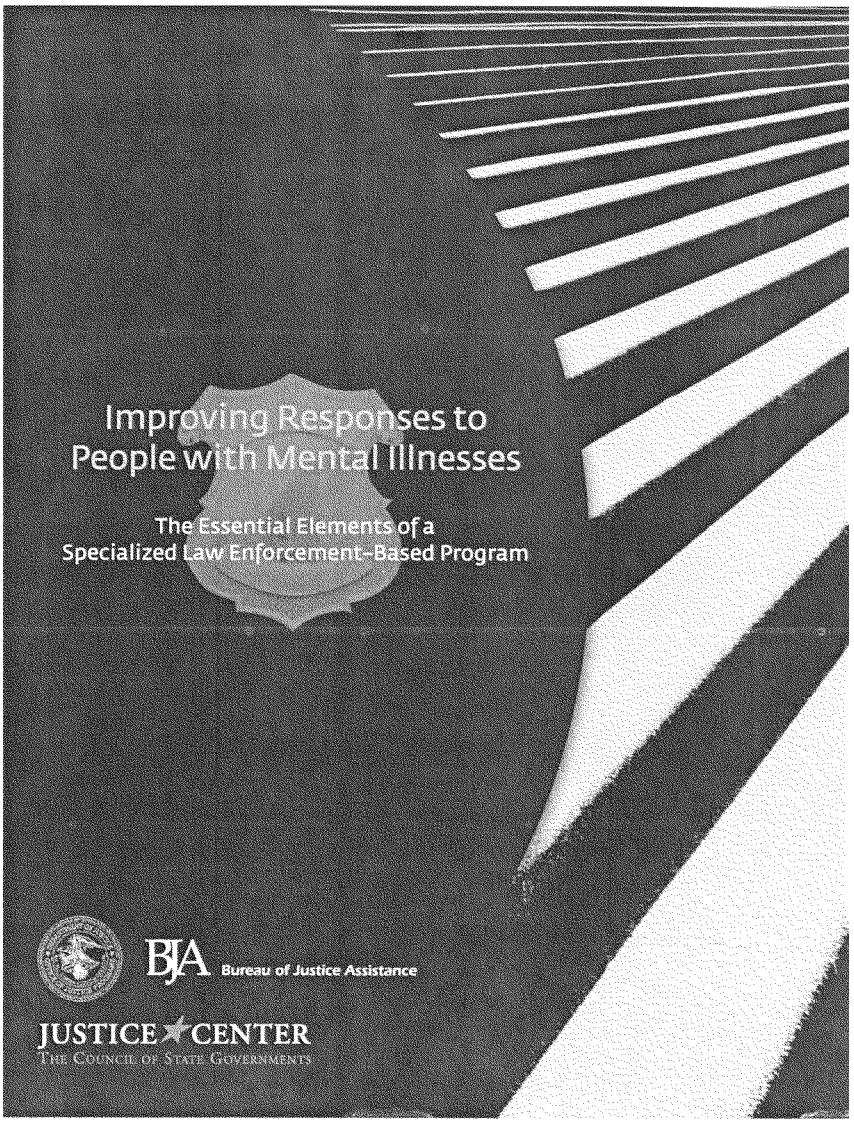
Improving Responses to
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The Essential Elements of a
Specialized Law Enforcement–Based Program
BJA Bureau of Justice Assistance
JUSTICE CENTER
The Council of State Governments

Improving Responses to People with Mental Illnesses

The Essential Elements of a Specialized Law Enforcement–Based Program

A report prepared by the
Council of State Governments Justice Center
in partnership with the Police Executive Research Forum

for the

Bureau of Justice Assistance
Office of Justice Programs
U.S. Department of Justice

Matt Schwarzfeld
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JUSTICE CENTER
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POLICE EXECUTIVE RESEARCH FORUM

BJA Bureau of Justice Assistance

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This report follows and builds on the format and scope of *The Essential Elements of a Mental Health Court*, published in 2008 with the support of BJA (available at www.consensusproject.org/mhcp/essential.elements.pdf). A similar document describing the elements of programs that bring together the corrections and mental health systems is in production at this writing and will be made available at www.consensusproject.org.

Council of State Governments Justice Center, New York 10005
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Thanks are also due to members of a project advisory group, listed alphabetically below.[1] A subset of the group (indicated by an asterisk) met in October 2005 and February 2006 to review earlier drafts of this document, and the entire advisory group convened in September 2006 to provide their insights on a more recent version of the document.

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- Sergeant Rick Schnell, *San Diego (Calif.) Police Department*
- Ms. Bonnie Sultan, CIT Technical Assistance Center Coordinator, *NAMI**
- Dr. Bruce Taylor, Director of Research, *Police Executive Research Forum*
- Representative John Tholl, Vice-Chair, *Criminal Justice and Public Safety Committee, New Hampshire House of Representatives*

1. Advisory Board members' titles and agency affiliations reflect the positions they held at the time of their involvement with the project.

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- Lieutenant Richard Wall, *Los Angeles (Calif.) Police Department*
- Lieutenant Michael Woody (ret.), Law Enforcement Liaison, *Ohio Criminal Justice Coordinating Center of Excellence**

A special thanks must be given to Council of State Governments Justice Center Director Mike Thompson and Health Systems and Services Policy Director Fred Osher for their insights in helping shape the scope and direction of this publication. In addition, the authors appreciate the ongoing support that the Police Executive Research Forum's Executive Director, Chuck Wexler, has provided.

Finally, the authors wish to express their gratitude to the nearly two hundred contributors who provided feedback in an August 2006 online Web forum. Far too many to name individually, these practitioners, policymakers, and advocates offered insights and suggestions that informed the authors and can be seen throughout these pages.

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Introduction

Law enforcement officers throughout the country regularly respond to calls for service that involve people with mental illnesses—often without needed supports, resources, or specialized training.[2] These encounters can have significant consequences for the officers, people with mental illnesses and their loved ones, the community, and the criminal justice system.[3] Although these encounters may constitute a relatively small number of an agency's total calls for service, they are among the most complex and time-consuming calls officers must address.[4] At these scenes, front-line officers must stabilize a potentially volatile situation, determine whether the person poses a danger to him- or herself or others, and effect an appropriate disposition that may require a wide range of community supports.

In the interests of safety and justice, officers typically take approximately 30 percent of people with mental illnesses they encounter into custody—for transport to either an emergency room, a mental health facility, or jail.[5] Officers resolve the remaining incidents informally, often only able to provide a short-term solution to a person's long-term needs. As a consequence, many law enforcement personnel respond to the same group of people with mental illnesses and the same locations repeatedly, straining limited resources and fostering a collective sense of frustration at the inability to prevent future encounters.[6]

In response, jurisdictions across the country are exploring strategies to improve the outcomes of these encounters and to provide a compassionate response that prioritizes treatment over incarceration when appropriate. These efforts took root in the late 1980s, when the crisis intervention team (CIT) and law enforcement–mental health co-response models, described in more detail below, first emerged. Since that time, hundreds of communities have implemented these programs; some have replicated the models, and others have adapted features to meet their jurisdiction's unique needs. Although this number represents only a small fraction of all U.S. communities, there are many indications that the level of interest in criminal justice–mental health collaborative initiatives is surging.[7]

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2. For the purposes of this document, "officer" refers to any law enforcement personnel with direct contact with the community; this includes sheriffs' deputies, state troopers, and other individuals with arrest powers.
3. The nation's prisons and jails hold unprecedented numbers of people with mental illnesses—many of whom came into contact with law enforcement as a result of behaviors related to their illness. For example, in 1999 the Los Angeles County Jail and New York's Rikers Island jail each held more people with mental illnesses than any psychiatric inpatient facility in the United States. The most recent data from the Bureau of Justice Statistics, U.S. Department of Justice, reveals that more than half of all prison and jail inmates reported that they had any one of a number of mental health symptoms. E. Fuller Torrey, "Reinventing Mental Health Care," *City Journal* 9 (1999):4; Doris J. James and Laura E. Glaze, *Mental Health Problems of Prison and Jail Inmates*, U.S. Department of Justice, Bureau of Justice Statistics, NCJ-213600 (Washington, D.C.: Bureau of Justice Statistics, 2006).
4. Recent data indicate that behaviors that appear to be the result of a mental illness are a factor in approximately 3–7 percent of all law enforcement calls for service. See Martha W. Deane, Henry J. Steadman, Randy Borum, Bonita M. Veysey, and Joseph P. Morrissey, "Emerging Partnerships between Mental Health and Law Enforcement," *Psychiatric Services* 50 (1) (1999): 99–101; Lodestar, *Los Angeles Police Department Consent Decree Mental Illness Project Final Report* (Los Angeles: Lodestar, 2002); Jennifer L.S. Teller, Mark R. Munetz, Karen M. Gil, and Christian Ritter, "Crisis Intervention Team Training for Police Officers Responding to Mental Disturbance Calls," *Psychiatric Services* 57 (2006): 232–37; William Terrill and Stephen Mastrofski, "Situational and Officer-Based Determinants of Police Coercion," *Justice Quarterly* 19 (2002): 215–48.
5. Linda Teplin, "Managing Disorder: Police Handling of the Mentally Ill," In *Mental Health and the Criminal Justice System*, ed. Linda Teplin. (Beverly Hills, CA: Sage Publications, 1984); Thomas M. Green, "Police as Frontline Mental Health Workers: The Decision to Arrest or Refer to Mental Health Agencies," *International Journal of Law and Psychiatry* 20 (1997): 469–86; Jennifer L.S. Teller, Mark R. Munetz, Karen M. Gil, and Christian Ritter, "Crisis Intervention Team Training for Police Officers Responding to Mental Disturbance Calls," *Psychiatric Services* 57 (2006): 232–37.
6. Thomas M. Green, "Police as Frontline Mental Health Workers: The Decision to Arrest or Refer to Mental Health Agencies," *International Journal of Law and Psychiatry* 20 (1997): 469–86; Gary Cordner, "People with Mental Illness," *Problem-Oriented Guides for Police Problem-Specific Guides Series*, 40, U.S. Department of Justice (Washington, D.C.: Office of Community Oriented Policing Services, 2006).
7. Federal interest in criminal justice–mental health initiatives is perhaps best illustrated by the broad bipartisan support for the Mentally Ill Offender Treatment and Crime Reduction Act of 2004 (MIOTCRA) and its subsequent appropriations. MIOTCRA facilitates collaboration among the criminal justice, juvenile justice, mental health treatment, and substance abuse systems in diverting individuals to treatment when appropriate. Among its allowable uses, MIOTCRA funds can support law enforcement training. For more information on MIOTCRA, see www.consensusproject.org/resources/government-affairs/fed-leg-MIOTCRA.

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Specialized Law Enforcement–Based Response Programs

This document focuses on specialized law enforcement–based response programs that meet three criteria: (1) they enhance traditional law enforcement roles to provide a new set of response options for frontline personnel that are tailored to the needs of people with mental illnesses; (2) when appropriate, they establish a link for these individuals to services in the community; and (3) they are based in law enforcement agencies with strong collaborative ties to mental health partners, other criminal justice agencies, and community members.[8]

Specialized law enforcement–based response programs include both the CIT and law enforcement–mental health co-responder models.

- The CIT model originated in the Memphis (Tenn.) Police Department and is therefore often called the Memphis Model. It was developed in response to a tragic incident in which a law enforcement officer used lethal force against a person with a mental illness. This model is designed to de-escalate tensions at the scene and to reduce the need for use of force during these types of encounters. To improve the likelihood of a safe and effective outcome, the CIT model includes training and deployment of self-selected officers to provide a first-response to the majority of incidents involving people with mental illnesses.
- The co-responder model was developed in Los Angeles County and implemented soon after in San Diego (Calif.). Leaders in those jurisdictions were concerned that they were unable to link people with mental illnesses to appropriate services or provide other effective and efficient responses. They identified limitations on officers' time and lack of awareness about both community mental health resources and the characteristics of individuals who need access to those services as major obstacles. They then developed an approach that pairs specially trained officers with mental health professionals to provide a joint secondary response to the scene.

About the Elements

As the growing number of interested communities grapple with implementing specialized law enforcement–based programs at the local level, there is a commensurate demand for more information on the key elements of promising programs. Several communities have tried to identify critical program elements, particularly for CIT initiatives, to promote consistency and quality.[9] Until this BJA-supported effort, however, there had been limited debate or agreement at the national level about which elements were essential to successfully implement any specialized law enforcement–based response program—regardless of the specific model.

This report articulates 10 essential elements for *any* specialized law enforcement–based response program. The elements are derived from recommendations made by a broad range of practitioners and other related experts to ensure they are practical and valuable (see the "Document Development" section, p. ix). They provide practitioners and policymakers with a common framework for program design and implementation that will promote positive outcomes while being sensitive to every jurisdiction's distinct needs and resources. Each element contains a short

8. Many communities also have developed teams of community mental health professionals, such as mobile crisis or assertive community treatment teams, to assist officers at the scene. While these models are undoubtedly a valuable resource for many communities and departments, they are not law enforcement–based and thus are not within the scope of this document. For further discussion of how law enforcement have collaborated with mental health mobile crisis teams, see www.uc.edu/criminaljustice/ProjectReports/MCT_Report.pdf. For more on how mental health agencies have tailored assertive community treatment teams to work with a justice-involved population, see www.gainscenter.samhsa.gov/text/ebp/Papers/ExtendingACTPaper.asp.

9. Most notably, promoters of the CIT model have recently formed a national group, the CIT National Organization (www.cit.memphis.edu/cno.html), to provide leadership and guidance to jurisdictions implementing CIT programs. Several members of the CIT National Organization also serve on the advisory board that has guided the development of this publication, to ensure complementary products. The National CIT Organization's guide describes critical elements of the CIT model using three categories: operational, ongoing, and sustaining elements. A draft of the guide is available at www.cit.memphis.edu/~cjus/dw.php?id=cjuscitdw01. In contrast, this document provides a framework for developing or enhancing elements of a specialized law enforcement–based response of *any* type.

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statement (in italics) describing criteria that specialized law enforcement–based response programs should meet to be effective, followed by several paragraphs explaining the element's importance and how its principles can be achieved.

The document reflects two key assumptions: First, each element depends on meaningful collaboration among professionals in the criminal justice and mental health systems. Although achieving the requisite level of collaboration is often difficult—particularly when faced with long-standing system barriers—successful partnerships are needed to carry out any of the elements. Second, law enforcement represents only the first of several criminal justice agencies with which people with mental illnesses may come in contact. Addressing problems raised by the large numbers of people with mental illnesses in the criminal justice system requires a comprehensive community- and systemwide strategy in which the law enforcement–based program plays only one part. The impact of a specialized law enforcement–based response program on jails, courts, the community-based mental health system, and the larger community must therefore be considered when planning and implementing the program.

The elements are meant to help guide individuals in communities that are interested in developing a law enforcement–based program or improving the organization and functions of an existing program. This document can be used as a practical planning tool for a specialized response at each stage of the process (e.g., designing the program, developing or enhancing policies and procedures, monitoring practices, and conducting evaluations). This report is meant to be a "living, breathing document" and thus will be updated or supplemented as specialized law enforcment–based programs mature, and to address new research studies that can provide a stronger base of knowledge about how these programs can best operate, their impact on the community and various affected systems, and the relative importance of the elements that form them.[10]

Document Development and Related Materials

The essential elements are based on information from a variety of sources, including interviews with law enforcement executives and officers, mental health professionals, advocates, and mental health consumers who have been engaged in these programs for many years, as well as a review of the scholarly literature. A panel of national experts guided early drafts of this document. It was then posted on a Web-based discussion forum through which hundreds of stakeholders reviewed it and provided feedback.[11] An advisory group of leading executives, practitioners, researchers, and other experts subsequently reviewed and discussed the comments and suggested revisions.

The Bureau of Justice Assistance (BJA), U.S. Department of Justice, is developing a series of resources for law enforcement practitioners and their community partners as part of BJA's Law Enforcement/Mental Health Partnership Program. This report serves as the centerpiece of this series. The *Improving Responses to People with Mental Illnesses* series includes a collection of resources that will complement the essential elements: a practical handbook on implementing effective training strategies; a monograph on tailoring law enforcement responses to the unique needs of the jurisdiction, which will include specific examples from the field; and Web-based information on statewide efforts to coordinate these law enforcement responses. Also available is an online database, the Criminal Justice/Mental Health Information Network, which includes profiles of local law enforcement responses to people with mental illnesses. This project is coordinated by the Council of State Governments Justice Center in partnership with the Police Executive Research Forum.

10. Updates to this document will be available at www.consensusproject.org/issue-areas/law-enforcement.

11. Throughout this document, the term "stakeholders" is used to describe the diverse group of individuals affected by law enforcement encounters with people with mental illnesses, such as criminal justice and mental health professionals; myriad other service providers, including substance abuse counselors and housing professionals; people with mental illnesses (sometimes referred to as "consumers") and their loved ones; crime victims; and other community representatives.

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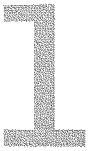
Ten Essential Elements



Collaborative Planning and Implementation

Organizations and individuals representing a wide range of disciplines and perspectives and with a strong interest in improving law enforcement encounters with people with mental illnesses work together in one or more groups to determine the response program's characteristics and guide implementation efforts.

Specialized responses to people with mental illnesses are an outgrowth of community policing and as such should reflect a partnership between a law enforcement agency and other stakeholder groups and individuals. Partners for the lead law enforcement agency should include mental health service providers, people with mental illnesses and their family members and loved ones, and mental health advocates. Based on the nature of the problem, additional partners could include other area law enforcement professionals; health and substance abuse treatment providers; housing officials and other service providers; hospital and emergency room administrators; crime victims; other criminal justice personnel such as prosecutors and jail administrators; elected officials; state, local, and private funders; and community representatives. Any stakeholder may initiate the planning for the specialized response, but to take root, the lead law enforcement agency must fully embrace the effort.

At the outset of the planning process, leaders from each of the stakeholder agencies who have operational decision-making authority and community representatives should come together as a multidisciplinary *planning committee.* This executive-level committee should examine the nature of the problem and help determine the program's objectives and design (see Element 2, Program Design), taking into consideration how the committee will relate to other criminal justice–mental health boards that may be in place or are in the process of being established. The planning committee also should provide a forum for developing grant applications and working with local and state officials. Although focused primarily on planning decisions, members should remain engaged during the implementation phase to provide ongoing leadership and support problem solving and design modifications throughout the life of the program.

Agency leaders on the planning committee also should designate appropriate staff to make up a *program coordination group* responsible for overseeing day-to-day activities. (In some jurisdictions, the two bodies may be the same—particularly those with small agencies, in rural areas, or with limited resources.) This coordination group should oversee officer training, measure the program's progress toward achieving stated goals, and resolve ongoing challenges to program effectiveness. The group also should serve to keep agency leaders and other policymakers informed of program costs, developments, and progress. Both groups' members should reflect the community's demographic composition.

To overcome challenges inherent in multidisciplinary collaboration, including staff turnover and changes in leadership, partnership and program policies should be institutionalized to the extent possible. Interagency memoranda of understanding (MOUs) can be developed to address key issues such as how each organization will commit resources and what information can be shared through identified mechanisms.

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2 Program Design

The planning committee designs a specialized law enforcement–based program to address the root causes of the problems that are impeding improved responses to people with mental illnesses and makes the most of available resources.

As a critical first step in the design process, the planning committee should develop a detailed understanding of the problems in its jurisdiction and identify all contributing factors. In this analysis, it is important to understand the driving force(s) behind current efforts to improve the law enforcement response. In some jurisdictions, law enforcement executives may become aware of the problem because of a tragic incident. In others, executives may realize there are operational challenges presented by particularly complex field encounters, such as the inordinate amount of time officers spend waiting for medical clearance in emergency rooms or the frequency with which officers repeatedly come in contact with the same individuals without an effective resolution.

The committee must examine the reasons why these incidents occur and other aspects of the problem that may not have been raised by the single high-profile incident. It should look at law enforcement data on calls for service, beat boundaries, feedback from officers, community survey data, and other sources of information. To enhance their understanding of root causes and available resources, committee members also should examine factors such as the community's inpatient and outpatient treatment options, crisis response services, ancillary services such as housing and substance abuse treatment, population, and geography. They also may want to talk to people in other jurisdictions who have grappled with limited community resources to see what alternatives are available to increase the reach of existing services.

The analysis of the problems and assessment of available and potential resources to address them should drive the short- and long-term goals of the program. For example, if the analysis reveals that a significant barrier to improving the law enforcement response is that officers lack the training to safely de-escalate situations involving people with mental illnesses, one program goal would be to correct this deficiency. If officers cannot efficiently link people to mental health treatments, another goal may be to revise and streamline processes for connecting to these services.

Once the program's purpose is defined, the committee must address personnel assignments and related considerations. The planning committee must decide whether some or all officers should be trained to stabilize and de-escalate situations involving people with mental illnesses in immediate response to the call for service. Should all officers receive some baseline training and others receive more extensive training? Should a subset of officers be trained to respond with a mental health professional? When considering the answers to questions like these, the committee should explore the practical implications of different staffing options and present them to the chief law enforcement executive or his or her designee on the committee. The committee also must help interpret the criteria for emergency mental health evaluation and decide how officers will access that service. These decisions will help the committee determine which additional skills and information the identified group of responders should receive in training.

If committee members, including representatives from policing, conclude that a subset of officers will respond to incidents involving people with mental illnesses, they should help the law enforcement executive determine how many officers are needed to cover all shifts and geographic districts. The committee also should develop personnel selection criteria and a process for identifying officers best suited for the challenges of this new role. In particular, planners should consider officers' ability to reorient from the more traditional method of gaining control by using an authoritative approach during a field contact to a nonadversarial, crisis-intervention style. To the extent possible, the selection process should be voluntary, yet selective.

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3 Specialized Training

All law enforcement personnel who respond to incidents in which an individual's mental illness appears to be a factor receive training to prepare for these encounters; those in specialized assignments receive more comprehensive training. Dispatchers, call takers, and other individuals in a support role receive training tailored to their needs.

Training must be provided to improve officers' responses to people with mental illnesses. Agencies may differ in the amount of training they offer: some will provide comprehensive training to all officers, some will provide this training only to a subset, and some will provide basic training to everyone in combination with more comprehensive training to a subset. At a minimum, a group of officers sufficient to cover all time shifts and geographic districts should receive extensive skills and knowledge training that builds on the more cursory information routinely given on this topic at recruit and in-service trainings.[12] The chief law enforcement executive should ensure that training is also provided to supervisory and support personnel, such as midlevel managers, field training officers, call takers, and dispatchers, who advance the specialized program's operations.

Planning and implementing a training initiative that supports the specialized program should be a collaborative effort between the law enforcement agency and stakeholders represented on the program coordination group. The coordination group should help guide training decisions, which include selecting content and techniques, ensuring the instruction is culturally competent, identifying and preparing trainers, and evaluating effectiveness. The group's multidisciplinary/multisystem composition helps make certain that the training initiative reflects an appropriate range of perspectives; members can identify mental health practitioners, consumers, and family members to provide some of the training instruction. Likewise, the group helps ensure quality by establishing a process for consistently reviewing and evaluating training and then modifying the curriculum based on the findings. The group can be particularly helpful in identifying resources to defray law enforcement agency costs.

Specialized training should, at a minimum, provide officers with an improved understanding of the following: mental illnesses and their impact on individuals, families, and communities; signs and symptoms of mental illnesses; stabilization and de-escalation techniques; disposition options; community resources; and legal issues. Trainers should provide sufficient opportunities for hands-on experiential learning, such as role play and group problem-solving exercises.

Training should address issues specific to the community in which it is being given. Mental health personnel and other stakeholders should be invited to participate in the specialized training to help improve cross-system understanding of agencies' roles and responsibilities, as well as to convey any requirements for accessing community-based services. Planners should brief any trainers outside law enforcement about effective techniques, language, and sensitivities to the law enforcement culture that will improve their connection with this audience. When possible, additional cross-training should be provided to improve the mental health professionals' understanding of law enforcement issues, such as ride-alongs and other opportunities to see policies translated into action.

12. For more information on various types of training opportunities for law enforcement personnel, see Council of State Governments, *Criminal Justice/Mental Health Consensus Project Report* (New York, N.Y.: Council of State Governments, 2002), www.consensusproject.org.

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4 Call-Taker and Dispatcher Protocols

Call takers and dispatchers identify critical information to direct calls to the appropriate responders, inform the law enforcement response, and record this information for analysis and as a reference for future calls for service.

When 911 or other call takers receive a request for service they suspect involves a person with a mental illness, they should gather descriptive information on the person's behavior; determine whether the individual appears to pose a danger to him- or herself or others; ascertain whether the person possesses or has access to weapons; and ask the caller about the person's history of mental health or substance abuse treatment, violence, or victimization. All call takers should receive training on how to collect the most useful information quickly. To supplement this training, members of the coordinating group with mental health backgrounds should develop a concise list of questions for call takers to have on hand when answering service requests that seem to involve someone with a mental illness.

Call takers and dispatchers must have an understanding of the purpose of the specialized program and how it works—particularly what types of calls for service should be directed to particular officers or teams. Dispatchers must be provided with up-to-date information on staffing patterns during all shifts and over all geographic areas that identify law enforcement or mental health responders designated to respond to calls that appear to involve a person with a mental illness.

The coordinating group should also provide these personnel with specific guidance on how to record information in the dispatch database about calls in which mental illness may be a factor. The information should be used for assessing procedures, informing future responses, and evaluating program outcomes (see Element 10 for more on how evaluations promote sustainability). Locations of repeat calls for service involving individuals with mental illnesses can be coded to help ensure that specially trained officers will be dispatched to respond to those locations in the future. Coding can help agencies ultimately reduce call and transport time, as well as potential injuries to all involved, by dispatching experienced officers. To protect community members' privacy, the notes made on these locations must never identify specific individuals and must be reviewed periodically to ensure accuracy (see Element 7 for more on confidentiality concerns). Responding officers should also validate and update this information when they clear a call to that location. All communications personnel and responding officers should be instructed to avoid using slang and pejorative language when describing individuals thought to have a mental illness.

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5 Stabilization, Observation, and Disposition

Specialized law enforcement responders de-escalate and observe the nature of incidents in which mental illness may be a factor using tactics focused on safety. Drawing on their understanding and knowledge of relevant laws and available resources, officers then determine the appropriate disposition.

Specialized law enforcement–based response programs are designed to resolve officers' encounters with people with mental illnesses safely and, when appropriate, link these individuals to mental health supports and services that reduce the chances for future interactions with the criminal justice system. The success of these programs is contingent on officers' using tactics that safely de-escalate situations involving someone who is behaving erratically or is in crisis. The high prevalence of trauma histories in this population requires the use of trauma-informed responses. In addition to de-escalating the incident, responding officers should assess whether a crime has been committed and observe the person's behavior within the given circumstances to determine if mental illness may be a factor. Officers should draw upon expertise acquired in specialized training and from their experiences to identify signs and symptoms of mental illness. Officers must ascertain whether the person appears to present a danger to him- or herself or others. To assist in this determination, officers may gather information from knowledgeable individuals at the scene, including mental health co-responders.

Officers must make disposition decisions based on their observations, information they gather at the scene, and their knowledge of community services and legal mandates. To assist officers in their decision making, the planning committee should develop clear guidelines that are consistent with the program's goals and governing authorities. For example, such programs might promote alternatives to incarceration for eligible individuals. If a person has come to the attention of law enforcement because of behaviors that appear to result from a mental illness and no serious crime has been committed, guidelines and protocols consistent with existing law should enable officers to divert the individual to mental health supports and services. When a serious crime has been committed, the person should be arrested.

To make these decisions, officers must be familiar with available community resources—particularly any 24-hour center that can receive individuals in mental health crises. Officers also must understand their state's criteria for involuntary emergency evaluation to make appropriate decisions regarding whether to detain and transport the person to a facility where he or she can undergo an emergency mental health evaluation. Officers must take into consideration both the individual's treatment needs and civil liberties and should pursue voluntary compliance with treatment whenever possible.

In the rare case when an incident involves barricaded individuals or de-escalation fails, responding officers will require additional support. Some agencies may equip officers who most frequently encounter people with mental illnesses with less-lethal weapons, so as to minimize injuries that could occur if there is a threat to safety and some use of force becomes necessary. Agencies should provide officers with additional training on the safe and appropriate deployment of these weapons and should establish protocols to guide officers in their decisions to use them. The planning committee also should develop protocols to make certain there is effective coordination during such incidents among specialized law enforcement responders, SWAT teams, and mental health professionals. Although agencies often are under pressure to resolve these situations quickly, it may be best, when there is no imminent threat of danger, to allow time for mental health personnel with expertise in crisis negotiation and law enforcement operations to communicate with the individual.

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6 Transportation and Custodial Transfer

Law enforcement responders transport and transfer custody of the person with a mental illness in a safe and sensitive manner that supports the individual's efficient access to mental health services and the officers' timely return to duty.

Law enforcement is authorized to provide transportation for people who are under arrest or who they believe meet the criteria for emergency evaluation (whether the evaluation is voluntary or involuntary). These individuals are in law enforcement custody, and rules and regulations regarding restraints in custodial situations apply.[13] Given the frequent history of traumatic experiences among people with mental illnesses, custodial restraints may create acute stress, which in turn may escalate their degree of agitation. Law enforcement executives, with input from other program planners, should review policies regarding restraints in custodial situations and balance considerations of officer and citizen safety with the impact of these controls on people with mental illnesses.

The planning committee should identify facilities that are capable of assuming custodial responsibility, are available at all times, and have personnel qualified to conduct a mental health evaluation.[14] Speedy custodial transfer is critical to the overall success of law enforcement responses. To enable officers to return quickly to their duties, staff in the receiving facility should efficiently and accurately obtain relevant law enforcement information. Protocols should ensure that medical clearance is achieved in a timely manner and that people brought by law enforcement are never turned away. If law enforcement responders determine that the person with a mental illness should be arrested and officers take the person to jail or lockup, then qualified staff should be available to screen the arrestee at intake for mental health status, medication needs, and suicide risk.

In noncustodial situations in which the person does not meet the criteria for emergency evaluation and is not under arrest—but officers determine he or she would benefit from services and support—officers should try to connect the individual with a friend or family member, peer support group, or treatment crisis center. Similarly, officers should seek to engage the services of the individual's current mental health provider or a mobile crisis team. In some jurisdictions, law enforcement may also collaborate with mental health professionals to help transport individuals to evaluation or treatment facilities.

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13. Law enforcement agencies generally define custody using a case law standard that can be described as whether or not a "reasonable person" would feel free to leave.
14. H. Steadman and colleagues have used the term "specialized crisis response site" (SCRS) to refer to such a facility. SCRSs are defined as "sites where officers can drop off individuals in psychiatric crisis and return to their regular patrol duties. These [prebooking diversion] programs identify detainees with mental disorders and work with diversion staff, community-based providers, and the courts to produce a mental health disposition in lieu of jail." They also can link individuals to substance abuse and other treatment. See H. Steadman, K. Stainbrook, P. Griffin, J. Draine, R. Dupont, and C. Horey, "A Specialized Crisis Response Site as a Core Element of Police-Based Diversion Programs," *Psychiatric Services* 52 (2001): 219–222.

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7 Information Exchange and Confidentiality

Law enforcement and mental health personnel have a well-designed procedure governing the release and exchange of information to facilitate necessary and appropriate communication while protecting the confidentiality of community members.

Law enforcement and mental health professionals should exchange information about people with mental illnesses who frequently come in contact with the justice system for many reasons: foremost among them, information sharing is essential to achieve desired outcomes by helping responders be more sensitive to individual needs, reduce injury, and enhance their ability to determine next steps. To facilitate an appropriate disposition decision, law enforcement officers should collaborate with mental health professionals to better understand the individual's mental health needs. Similarly, mental health providers working at receiving facilities can conduct a more effective mental health evaluation if law enforcement officers share their observations regarding the person's behavior at the scene. In addition to improving the outcomes of specific incidents, sharing information across systems will help program planners as they develop the program and its outcome measures.

The program's planning committee should carefully consider the type of information needed and existing barriers to its exchange and then develop procedures (and in some cases MOUs) to ensure that essential information is shared in an appropriate manner. These protocols should be reviewed during cross-training sessions, which will provide law enforcement and mental health professionals an opportunity to develop relationships with their counterparts and learn why they need certain information. Agency leaders also can explore the possibility of linking information systems to share certain information either on an ongoing or a one-time basis.[15]

Information should be shared in a way that protects individuals' confidentiality rights as mental health consumers and constitutional rights as potential defendants. The planning committee should determine which personnel have the authority to request and provide information about an individual's mental health and criminal history. In general, mental health records should be maintained by mental health professionals. Information exchanges should be limited strictly to what is needed to inform an appropriate incident response or disposition, and officers should focus on documenting observable behaviors only. All communications must, of course, comply with state and federal laws requiring the confidentiality of mental health records, such as the Health Insurance Portability and Accountability Act.[16] Cross-training should ensure that program staff understand relevant state and federal regulations about issues such as how medical information is released, secured, and retained.

Individuals with mental illnesses who have been in contact with a mental health agency should be offered an opportunity to provide consent in advance for mental health providers to share specified information with law enforcement authorities if an incident occurs (sometimes called an advance directive).[17] Individuals should be asked if an advance directive exists, and if so what the instructions are and who should be contacted to verify this information.

Officers can play an important role in exchanging information with family members and crime victims by providing explanations about criminal proceedings or diversion programs. They may inform the person with a mental illness and his or her family members about mental health treatment linkages and how to access other services or support groups, such as those related to substance use disorders. Law enforcement officers also can assist victims of crimes committed by people with mental illnesses by providing information about protective orders, victim support groups, and other services.

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15. The Bureau of Justice Assistance has supported groundbreaking advances that facilitate the electronic exchange of information between agencies. To learn more about efforts involving the development of national policies, practices, and technology capabilities that support effective and efficient information sharing, see www.it.ojp.gov.
16. For more information, see John Petrila, "Dispelling the Myths about Information Sharing between the Mental Health and Criminal Justice Systems," National GAINS Center for Systemic Change for Justice-Involved People with Mental Illness (February 2007).
17. For more information on psychiatric advance directives, see the National Resource Center on Psychiatric Advance Directives (NRC-PAD), at www.nrc-pad.org. NRC-PAD provides an overview, forms to complete psychiatric advance directives, links to state statutes, educational Web casts and discussion forums, and other resources.

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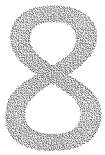

Treatment, Supports, and Services

Specialized law enforcement–based response programs connect individuals with mental illnesses to comprehensive and effective community-based treatment, supports, and services.

Law enforcement officers often are called to respond to incidents that are the manifestation of an untreated or inadequately treated mental illness. Specialized law enforcement–based responses provide an opportunity to link these individuals to community mental health supports and services that promote long-term wellness and reduce the chance of future negative encounters with officers.

When law enforcement responders bring individuals who are not under arrest to licensed mental health professionals at a receiving facility, staff there should be qualified to conduct a mental health evaluation; assess the contributions of mental illness, substance abuse, and other medical conditions to current behavior; and manage crisis situations. With their knowledge of available community-based treatment resources, mental health professionals can then link the individual to needed supports and services.

Individuals with mental illnesses often require an array of services and supports, which can include medications, counseling, substance abuse treatment, income supports and government entitlements, housing, crisis services, peer supports, case management, and inpatient treatment. Planners of the specialized response program should anticipate the treatment needs of the individuals with whom law enforcement will come in contact and work with service providers in the community to better ensure these needs can be met and coordinated.

Because many individuals with mental illnesses who come into contact with law enforcement have co-occurring substance use disorders, follow-up services will be most effective when delivered by providers with the capacity to integrate treatment approaches. Accordingly, the planning committee should consider how the program can help connect individuals with co-occurring disorders to integrated treatment and should advocate for greater access to this and other evidence-based practices.[18] Planners should pay special attention to the service needs of racial and ethnic minorities and women by making culturally competent and gender-sensitive services available to the extent possible.

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18. For our purposes here, evidence-based practices (EBPs) refer to mental health service interventions for which consistent scientific evidence demonstrates their ability to improve consumer outcomes. R. E. Drake, H. H. Goldman, H. S. Leff, A. F. Lehman, L. Dixon, K. T. Mueser, and W. C. Torrey, "Implementing Evidence-Based Practices in Routine Mental Health Service Settings," *Psychiatric Services* 52 (2001): 179–182. Other EBPs include assertive community treatment, psychotropic medications, supported employment, family psychoeducation, and illness self-management. For more information on the application of EBPs in forensic settings, see materials produced by the National GAINS Center at www.gainscenter.samhsa.gov/html/.

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9 Organizational Support

The law enforcement agency's policies, practices, and culture support the specialized response program and the personnel who further its goals.

Law enforcement leaders who recognize the value of a specialized response program to reduce repeat calls for service and produce better outcomes for people with mental illnesses must create an organizational structure to support it. Leadership cannot be limited to endorsing the program and authorizing staff training. Establishing that the response program is a high priority for the agency is essential and is best demonstrated through visible and practical changes in how the agency partners with the community and realigns internal processes.

Specifically, leaders should embrace new partners and foster a supportive culture through frequent messages about the value of this type of "real" policing work. Communications with officers at every level of the agency should stress the benefits of the response program. Officers should be encouraged to volunteer for the program's assignments when possible, rather than receive mandatory reassignment. Enlisting the support of supervisors and field training officers is critical to transforming how the program will be viewed by others in the agency. A program "champion" in a position of authority within the agency and with a demonstrated commitment to the specialized program should be identified to serve as the agency's representative on the coordination group and the program's representative within the agency.

Leaders should modify officers' performance evaluations to take into account the initiative's unique objectives. As a program designed to improve the safety of all those involved in an incident and to reduce the number of people inappropriately taken into custody, success should not be measured by the number of arrests. As with other successful law enforcement problem-solving efforts, personnel performance should be evaluated and rewarded based on officers' success collaborating with and making referrals to community partners, addressing the underlying causes of calls for service, and taking measures that reduce the need for force.[19] The law enforcement agency and planning committee should acknowledge these professionals' hard work through commendation ceremonies and other forms of recognition.

Agency leaders may need to adjust officers' schedules, obtain grants, or devote funds to specialized program training, create new positions dedicated to coordinating program activities and recruiting and screening responding officers, and revise deployment strategies to maximize the availability of trained law enforcement responders across shifts and geographic areas. Agencies may find it beneficial to develop a standard operating procedure to enumerate specific processes and roles and responsibilities within the program. In some jurisdictions, these issues will require close cooperation with labor unions.

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19. For more information on innovative personnel performance measures for community policing initiatives, see Mary Ann Wycoff and Timothy N. Oettmeier, *Evaluating Patrol Officer Performance under Community Policing: The Houston Experience*, U.S. Department of Justice (Washington, D.C.: National Institute of Justice, 1993).

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10 Program Evaluation and Sustainability

Data are collected and analyzed to help demonstrate the impact of and inform modifications to the program. Support for the program is continuously cultivated in the community and the law enforcement agency.

The planning committee should take steps early in the design process to ensure the program's long-term sustainability. Accordingly, the committee should identify performance measures based on program goals; these measures should consider quantitative data on key aspects of program operation, as well as qualitative data on officers' and community members' perceptions of the program. It may be helpful to aggregate baseline data before program implementation for later comparisons with new program information. To the extent possible, existing law enforcement and mental health agency data collection mechanisms should be adapted to accommodate the program's specific needs; planners may consider engaging a university partner to guide these data collection efforts. The planning committee should work with law enforcement and mental health agencies to ensure that the data are collected accurately and appropriately.

The data law enforcement personnel collect should focus on questions most critical to the program's success in achieving its goals, including the number of injuries and deaths to officers and civilians; officer response times; the number of incidents to which specially trained officers responded; the number of repeat calls for service; officers' disposition decisions, such as linking a person with services; and time required and method used for custodial transfer. Data should be used to refine program operations as needed, as well as review individual case outcomes and determine if follow-up by a mental health professional is warranted.

Program leaders should gauge the attitudes of community leaders, the media, key public officials, and other policymakers toward the program. It may be helpful to engage elected officials early in the process and keep them involved—from the initial kickoff through refunding and long-term implementation—to promote sustainability and desired legislation. The committee also should survey officers—both specialized responders and others—so that law enforcement leaders can better assess the program's usefulness to the entire department and address any concerns. Based on this information, the planning committee should determine the most effective way to promote the program's positive impact on the community, individuals, and agencies and respond to program shortcomings or high-profile tragic events.

While in-kind contributions from partners can go a long way toward offsetting certain program costs, planners should identify and cultivate long-term funding sources to cover costs that would otherwise fall to the law enforcement agency to absorb. Requests for funding should be based on clearly articulated program goals and, to the extent possible, should incorporate data demonstrating program outcomes.

Departments also should focus on sustaining internal support for the program, such as offering refresher training to help officers refine their skills and expand their knowledge base. To promote longer-term commitments from specialized officers, departments also should provide incentives and other organizational support for serving in the program.

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Conclusion

Many law enforcement agencies around the nation struggle to respond effectively to people with mental illnesses. Officers encounter these individuals when citizens call them to "do something" about the man exhibiting unusual behavior in front of their business, the woman sleeping on a park bench, or someone who is clearly in need of mental health services—whether or not a crime has been committed. Law enforcement professionals in many jurisdictions have lacked community-based support, guidance, and a clear framework for crafting a program to improve their response to people with mental illnesses.

But innovative solutions are at hand. Increasingly, law enforcement agencies of all sizes are implementing creative approaches despite scarce resources. The range of approaches in communities across the country reflects the realization that strategies must be tailored to each jurisdiction's unique needs. These agencies are engaged in problem solving with a range of partners from diverse disciplines and have access to a growing pool of programs and knowledge about promising practices. This publication outlines the essential elements of successful specialized law enforcement–based efforts that reflect this expanded knowledge base and experience to better guide practitioners initiating or enhancing their own programs.

The tone of the elements may suggest that these changes are easy to make. They are not. There are many challenges to these efforts, including politics, turf battles, competition for limited funding, lack of legal foundations for officers' actions, and scarce law enforcement and community mental health resources. Leaders in jurisdictions that have implemented a specialized response acknowledge that it takes commitment to overcome these obstacles, but agree that the costs—in dollars and human lives—are too high to sanction continuing with only more traditional law enforcement responses to people with mental illnesses. Their efforts have resulted in increased public safety and improved public health.

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The Council of State Governments (CSG) Justice Center is a national nonprofit organization serving policymakers at the local, state, and federal levels from all branches of government. The CSG Justice Center provides practical, nonpartisan advice and consensus-driven strategies, informed by available evidence, to increase public safety and strengthen communities. Read more at www.justicecenter.csg.org.

The CSG Justice Center also coordinates the Criminal Justice/Mental Health Consensus Project. This project is an unprecedented national effort to improve responses to people with mental illnesses who become involved in, or are at risk of involvement in, the criminal justice system. Read more at www.consensusproject.org.

The Police Executive Research Forum (PERF) is a national membership organization of progressive police executives from the largest city, county, and state law enforcement agencies. PERF is dedicated to improving policing and advancing professionalism through research and involvement in public policy debate. Read more at www.policeforum.org.



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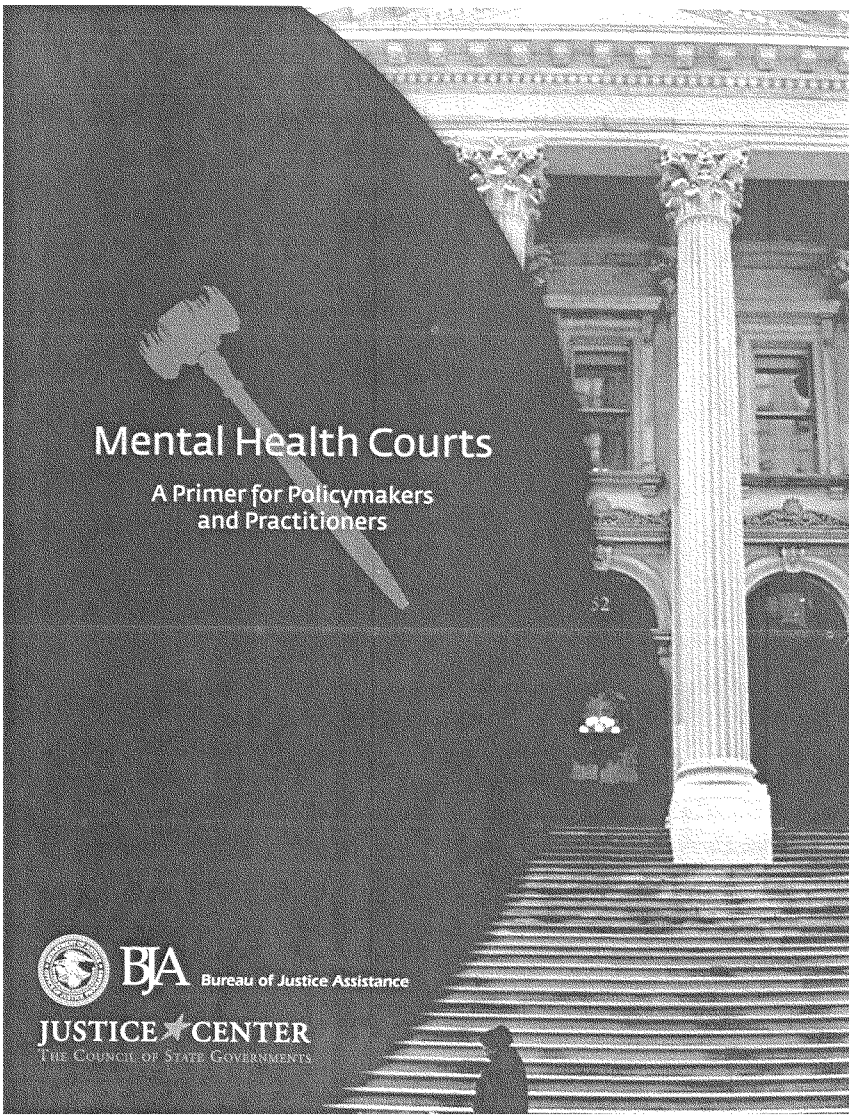
Mental Health Courts
A Primer for Policymakers and Practitioners
BJA Bureau of Justice Assistance
JUSTICE CENTER
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Mental Health Courts

A Primer for Policymakers and Practitioners

A report prepared by the
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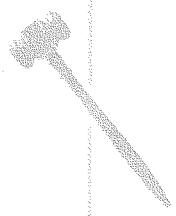

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Introduction

Mental health courts have spread rapidly across the country in the few years since their emergence. In the late 1990s only a handful of such courts were in operation; as of 2007, there were more than 175 in both large and small jurisdictions.[1]

If this recent surge in popularity is any indicator, many more communities will consider developing a mental health court in the coming years. This guide is intended to provide an introductory overview of this approach for policymakers, practitioners, and advocates, and to link interested readers to additional resources.

The guide addresses a series of commonly asked questions about mental health courts:

- Why mental health courts?
- What is a mental health court?
- What types of individuals participate in mental health courts?
- What does a mental health court look like?
- What are the goals of mental health courts?
- How are mental health courts different from drug courts?
- Are there any mental health courts for juveniles?
- What does the research say about mental health courts?
- What issues should be considered when planning or designing a mental health court?
- What resources can help communities develop mental health courts?

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Why Mental Health Courts?

Mental health courts are one of many initiatives launched in the past two decades to address the large numbers of people with mental illnesses involved in the criminal justice system. While the factors contributing to this problem are complicated and beyond the scope of this guide, the over-representation of people with mental illnesses in the criminal justice system has been well documented:[2]

- Prevalence estimates of serious mental illness in jails range from 7 to 16 percent, or rates four times higher for men and eight times higher for women than found in the general population.[3]
- A U.S. Department of Justice study from 1999 found that half of the inmates with mental illnesses reported three or more prior sentences.[4] Other research indicates that people with mental illnesses are more likely to be arrested than those without mental illnesses for similar crimes and stay in jail and prison longer than other inmates.[5]
- In 1999, the Los Angeles County Jail and New York's Rikers Island jail held more people with mental illnesses than the largest psychiatric inpatient facilities in the United States.[6]
- Nearly two-thirds of boys and three-quarters of girls detained in juvenile facilities were found to have at least one psychiatric disorder, with approximately 25 percent of these juveniles experiencing disorders so severe that their ability to function was significantly impaired.[7]

Without adequate treatment while incarcerated or linkage to community services upon release, many people with mental illnesses may cycle repeatedly through the justice system. This frequent involvement with the criminal justice system can be devastating for these individuals and their families and can also impact public safety and government spending. In response, jurisdictions have begun to explore a number of ways to address criminal justice/mental health issues, including mental health courts, law enforcement–based specialized response programs, postbooking jail diversion initiatives, specialized mental health probation and parole caseloads, and improved jail and prison transition planning protocols. All of these approaches rely on

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extensive collaboration among criminal justice, mental health, substance abuse, and related agencies to ensure public safety and public health goals.

Mental health courts serve a significant role within this collection of responses to the disproportionate number of people with mental illnesses in the justice system. Like drug courts and other "problem-solving courts," after which they are modeled, mental health courts move beyond the criminal court's traditional focus on case processing to address the root causes of behaviors that bring people before the court.* They work to improve outcomes for all parties, including individuals charged with crimes, victims, and communities.



*Drug courts have been particularly instrumental in paving the way for mental health courts. Some of the earliest mental health courts arose from drug courts seeking a more targeted approach to defendants with co-occurring substance use and mental health disorders.

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What Is a Mental Health Court?

Despite the recent expansion of mental health courts, there are not yet nationally accepted, specific criteria for what constitutes such a court. Although some initial research identified commonalities among early mental health courts, the degree of diversity among programs has made agreement on a core definition difficult.[8] Mental health courts vary widely in several aspects including target population, charge accepted (for example, misdemeanor versus felony), plea arrangement, intensity of supervision, program duration, and type of treatment available. Without a common definition, national surveys developed on mental health courts have relied primarily on self-reported information to identify existing programs.[9]

The working definition that follows distills the common characteristics shared by most mental health courts. The Justice Center worked with leaders in the field to also develop consensus on what these characteristics should look like and how they can be achieved, as documented in *The Essential Elements of a Mental Health Court.**

A Working Definition of a Mental Health Court

A mental health court is a specialized court docket for certain defendants with mental illnesses that substitutes a problem-solving model for traditional criminal court processing. Participants are identified through mental health screening and assessments and voluntarily participate in a judicially supervised treatment plan developed jointly by a team of court staff and mental health professionals. Incentives reward adherence to the treatment plan or other court conditions, nonadherence may be sanctioned, and success or graduation is defined according to predetermined criteria.[10]

*As the commonalities among mental health courts continue to emerge, practitioners, policymakers, researchers, and others have become interested in developing consensus not only on what a mental health court is but on what a mental health court should be. *The Essential Elements of a Mental Health Court* describes 10 key characteristics that experts and practitioners agree mental health courts should incorporate. Michael Thompson, Fred Osher, and Denise Tomasini-Joshi, *Improving Responses to People with Mental Illnesses: The Essential Elements of a Mental Health Court* (New York, NY: Council of State Governments Justice Center, 2008), www.consensusproject.org/mhcp/essential.elements.pdf.

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What Types of Individuals Participate in Mental Health Courts?

The majority of mental health court participants suffer from serious mental illnesses. Mental illness is a general term that includes a range of psychological disorders. A subset of serious mental illnesses is severe and persistent mental illness. This includes conditions that involve long-term and profound impairment of functioning—for example, schizophrenia, schizoaffective disorder, bipolar disorder (formerly called manic depression), severe depression, and anxiety disorders. In addition to describing level of functioning, most states also use criteria for "severe and persistent" to prioritize access to public mental health services.

Some mental health courts accept individuals with a broader array of disabling conditions than mental illness alone. While developmental disabilities, traumatic brain injuries, and dementias are not included in federal statutory and regulatory definitions of serious mental illness, they may be the cause of behavioral problems that result in criminal justice contact and may also co-occur with serious mental illnesses. Each mental health court determines how flexible to be on eligibility requirements and, when screening an individual who does not precisely fit standard criteria, whether to accept participants on a case-by-case basis. Working with individuals who have needs that fall outside the typical mental health service continuum requires additional partnerships with other community agencies, and so acceptance decisions are based, in part, on an individual's ability to benefit from a court intervention given these clinical and system capacity considerations. All individuals must be competent before agreeing to participate in the program.

Although addictive disorders are considered mental illnesses and are included in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, their diagnosis, treatment interventions, and providers differ from those for nonaddictive mental illnesses. Nevertheless, the majority of people with mental illnesses involved with the criminal justice system—approximately three out of four—also suffer from a co-occurring substance use disorder.[11] As a result, mental health courts must address this population and treat both mental health and substance use disorders in a comprehensive and integrated fashion. The vast majority of mental health courts accept individuals with co-occurring disorders, and some courts even seek out this population, but few mental health courts accept defendants whose only mental disorders are related to substance use.

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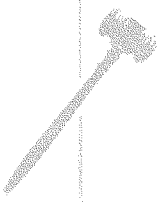
The prevailing belief in the scientific community is that mental disorders, both addictive and nonaddictive, are neurobiological diseases of the brain, outside the willful control of individuals. People with mental illnesses cannot simply decide to change the functioning of their brain. As with physical illnesses, it is believed that mental disorders are caused by the interplay of biological, psychological, and social factors. This acknowledged lack of control contributes to the belief that mental health courts, which rely on treatment and flexible terms of participation rather than the traditional adversarial system, represent a more just way for courts to adjudicate cases involving people with mental illnesses. Nevertheless, entering a mental health court does not negate individuals' responsibility for their actions. Mental health courts promote accountability by helping participants understand their public duties and by connecting them to their communities.



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What Does a Mental Health Court Look Like?

The enormous variability in mental health court design and operation has led some observers to note that "if you have seen one mental health court, you have seen one mental health court." Nevertheless, while great variety exists, mental health courts share several core characteristics. What follows is a description of one mental health court in action that reflects some of these central features, the "essential elements."

Every Wednesday afternoon, County Courthouse Room 13 assumes a mental health docket. The courtroom team (judge, defense attorney, prosecutor, probation officer, court coordinator, and case manager) has already met for several hours to discuss the people who will be appearing that day.



The first individuals before the bench are those entering the court for the first time. They have already undergone basic screening for program eligibility, had their mental health needs assessed, and been given a description of the mental health court program. The judge explains why they have been offered the opportunity to participate and describes the court's procedures. She asks if they want to enter the program and whether they fully understand the terms of participation. Those who agree to participate (the majority) are welcomed into the court.

After the new participants have been admitted, the court proceeds with status hearings for current program participants. The judge inquires about their treatment regimens, and publicly congratulates those who received positive reviews from their case managers and probation officers at the staff meeting. One participant receives a certificate for completing the second of four phases of the court program. The judge hands down sanctions of varying severity to individuals who have missed treatment appointments—tailored to the needs of each participant. The judge also informs several participants that certain privileges they had hoped to obtain will be withheld because of their misconduct over the past two weeks. Throughout the status hearings, conversation remains informal and individualized, often relaxed. Observers unfamiliar with mental health court procedures may be uncertain of what they are witnessing, but they will be sure of one thing: this is not a typical courtroom.

In the following days, the mental health court team will work to develop a service plan for each new participant to connect him or her quickly to community-based mental health treatment and other supports. Those individuals who have declined to participate will return to the original, traditional court docket.

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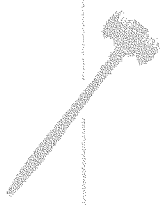
What Are the Goals of Mental Health Courts?

At their heart, mental health courts represent a response to the influx of people with mental illnesses into the criminal justice system. They seek to use the authority of the court to encourage defendants with mental illnesses to engage in treatment and to adhere to medication regimens to avoid violating conditions of supervision or committing new crimes. Unlike some programs that divert individuals from the justice system and merely refer them to community service providers, mental health courts can mandate adherence to the treatment services prescribed, and the prospect of having charges reduced or dismissed provides participants with additional incentives.



Communities start mental health courts with the hope that effective treatment will prevent participants' future involvement in the criminal justice system and will better serve both the individual and the community than does traditional criminal case processing. Within this framework, mental health court planners and staff cite specific program goals, which usually fall into these categories:

- Increased public safety for communities—by reducing criminal activity and lowering the high recidivism rates for people with mental illnesses who become involved in the criminal justice system
- Increased treatment engagement by participants—by brokering comprehensive services and supports, rewarding adherence to treatment plans, and sanctioning nonadherence
- Improved quality of life for participants—by ensuring that program participants are connected to needed community-based treatments, housing, and other services that encourage recovery
- More effective use of resources for sponsoring jurisdictions—by reducing repeated contacts between people with mental illnesses and the criminal justice system and by providing treatment in the community when appropriate, where it is more effective and less costly than in correctional institutions

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How Are Mental Health Courts Different from Drug Courts?

Drug courts are the best known and most widespread of the various problem-solving court models and have in many ways served as a prototype from which mental health courts have evolved. The high rate of co-occurring mental health and substance use disorders among individuals in the criminal justice system also suggests significant overlap in the target populations of these related court programs. In fact, in some jurisdictions, the inability of the local drug court to effectively manage individuals with serious mental illnesses precipitated the development of a mental health court.

Important differences remain in the principles and operation of drug courts and mental health courts; mental health courts are not merely drug courts for people with mental illnesses.[12] Although little research has been conducted comparing drug courts and mental health courts, it is already clear that jurisdictions interested in building on the experiences of their drug courts to develop a mental health court will need to adapt the model in significant ways to accommodate individuals with mental illnesses.

The majority of the differences listed below stem from the fact that mental illness, unlike drug use, is, in and of itself, not a crime; mental health courts admit participants with a wide range of charges, while drug courts focus on drug-related offenses. Also, whereas drug courts concentrate on addiction, mental health courts must accommodate a number of different mental illnesses, and so there is greater variability among treatment plans and monitoring requirements for participants than in drug courts.

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Key Differences between Drug Courts and Mental Health Courts

PROGRAM COMPONENT	DRUG COURTS . . .	MENTAL HEALTH COURTS . . .
Charges accepted	Focus on offenders charged with drug-related crimes	Include a wide array of charges
Monitoring	Rely on urinalysis or other types of drug testing to monitor compliance	Do not have an equivalent test available to determine whether a person with a mental illness is adhering to treatment conditions
Treatment plan	Make treatment plans structured and routinized; apply sanctioning grid in response to noncompliance, culminating with brief jail sentence	Ensure that treatment plans are individualized and flexible; adjust treatment plans in response to nonadherence along with applying sanctions; rely more on incentives; use jail less frequently
Role of advocates	Feature only minimal involvement from advocacy community	Have been promoted heavily by some mental health advocates, who are often involved in the operation of specific programs; other mental health advocates have raised concerns about mental health courts, either in general or in terms of their design
Service delivery	Often establish independent treatment programs, within the courts' jurisdiction, for their participants	Usually contract with community agencies; require more resources to coordinate services for participants
Expectations of participants	Require sobriety, education, employment, self-sufficiency, payment of court fees; some charge participation fees	Recognize that even in recovery, participants are often unable to work or take classes and require ongoing case management and multiple supports; few charge a fee for participation

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Are There Any Mental Health Courts for Juveniles?

The development of mental health courts for juveniles began several years after the emergence of adult programs. In 2001 Santa Clara, California, became the first jurisdiction to use this strategy to address the large numbers of youth with mental health needs involved with the juvenile justice system.[13] A number of other juvenile mental health courts have since been catalogued, and as of 2007 the National Center for Mental Health and Juvenile Justice (NCMHJJ) had identified 18 juvenile mental health courts in operation. An additional 20 jurisdictions indicated they were either considering or actively planning a juvenile mental health court.[14] The small number of juvenile mental health courts does not in any way reflect an infrequency of mental illnesses among youth in the juvenile justice system. In fact, the percentage of individuals with mental illnesses is just as significant in the juvenile justice system as in the adult system, if not more so.

Given that the juvenile mental health courts have developed more slowly than adult mental health courts, less is known about their operation and effectiveness. NCMHJJ's study of juvenile mental health courts has revealed that many different models exist; nevertheless, like adult courts, several themes characterize these courts:

- They work best when part of a larger comprehensive plan that incorporates other elements, such as diversion and treatment, to address the mental health needs of these youth.
- The majority use a postadjudication model, although several function at the preadjudication stage.
- Most juvenile mental health courts accept youth who have committed either felonies or misdemeanors; however, many have broad discretion in determining whether to include youth who have committed very serious felonies.
- They vary on which mental health diagnoses to focus on when identifying participants, with some accepting youth with any mental health disorder, others including only youth with certain serious disorders, and still others concentrating on youth with co-occurring mental health and substance use disorders.[15]

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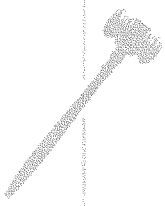
Juvenile mental health courts offer many of the same benefits as adult programs. They also confront many of the same operational problems, but because of their participants' status as minors, juvenile mental health courts also must address an additional layer of challenges and tasks. These include identifying developmental issues that affect cognition, behavior, and the potential effectiveness of mental health treatment; working with parents and guardians; and involving a larger number of other systems, including the education and foster care systems.



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What Does the Research Say about Mental Health Courts?

Research on mental health courts can be divided into two main types: studies assessing court operations (process evaluations) and studies assessing court effectiveness (outcome evaluations). Given the short tenure of most mental health courts, the greatest volume of research examines court operations and the way in which participants flow through the various programs.

Process evaluations

Process evaluations completed as of 2007 confirm that all mental health courts have some commonalities, but there are also some important differences. One of the few comparative studies, which looked at seven mental health courts' operations, found there were differences between early mental health courts and more recently developed ones, deemed "second-generation courts."[16] According to this study, while procedures varied greatly from court to court, the newer courts were more likely to share these elements:

- They consider defendants charged with felonies, as opposed to only misdemeanors, for acceptance into the program.
- They allow only postplea program enrollment, which means that the time from jail admission to program enrollment is usually longer.
- They rely more heavily on criminal justice staff, as opposed to community treatment providers, to monitor and supervise participants.
- They use jail more regularly to sanction nonadherence to court orders.[17]

These findings were published in 2004, and since then many of the "first-generation" courts have expanded the charges and pleas they accept. It is also not uncommon for new courts that would be labeled as second generation to begin as misdemeanor programs. Nevertheless, these general trends illustrate that as mental health courts become more commonplace and accepted, planning groups have more opportunities to focus on higher-risk populations than when mental health courts first emerged.

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Outcome evaluations

In addition to describing mental health court operations generally, several studies have evaluated individual mental health courts and their impact on a range of participant and system outcomes. Their findings suggest the following:

- Mental health court participation resulted in comparatively fewer new bookings into jail and greater numbers of treatment episodes compared with the period prior to program participation.[18]
- Participants were significantly less likely to incur new charges or be arrested than a comparison group of individuals with mental illnesses who did not enter the mental health court program.[19]
- Participation increased the frequency of treatment services, as compared with involvement in traditional criminal court.[20]
- Mental health court participants improved their independent functioning and decreased their substance use compared with individuals who received treatment through the traditional court process.[21]
- Participants spent fewer days in jail than their counterparts in the traditional court system.[22]
- Mental health court participants reported more favorable interactions with the judge and perceived that they were treated with greater fairness and respect than in traditional court.[23]

Researchers have also begun to explore the fiscal impact of mental health courts. A recent study by the RAND Corporation assessed the Allegheny County Mental Health Court in Pennsylvania.[24] The study found that the program did not result in substantial added costs, at least in the short term, over traditional court processing for individuals with serious mental illnesses. The findings also suggested that over the longer term, the mental health court may actually result in net savings for the government.*

In assessing the impact of mental health courts, it is important to note that these findings draw on a handful of studies, many of which look at individual programs and so cannot be generalized. Furthermore, research has not yet explored how changes in a mental health court's program elements or procedures affect outcomes. A comparative study of outcomes across different mental health courts has yet to be completed.[25]

*This savings projection is based on an analysis of the anticipated costs associated with incarceration and utilization of the most expensive mental health treatment (hospitalization) and the expectation that mental health court participation would reduce both of the above.

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What Issues Should Be Considered When Planning or Designing a Mental Health Court?

Fueled by emerging data on the utility of mental health courts, the popularity of problem-solving courts in general, and the desire to respond to a deep-rooted social problem, jurisdictions will likely continue to launch mental health courts in the coming years. Policymakers and practitioners interested in establishing or enhancing mental health courts should consider some important issues related to the formation and design of these courts.

Practicality in local context

Mental health courts may be impractical in some jurisdictions, either because of jurisdiction size and insufficient staff and resources or because of local resistance to problem-solving courts.[26] Accordingly, communities considering the development of a mental health court should also investigate the array of other court-based strategies being employed across the country, including postbooking jail diversion programs, specialized dockets within existing court structures, mental health–specific probation caseloads, and improved training for court personnel.

Limited data

As the previous section indicates, while only limited research has been completed, the available studies indicate that mental health courts may have more positive outcomes for people with mental illnesses than traditional criminal court processing. More research is nevertheless needed to compare different mental health court practices and evaluate outcomes across programs. Jurisdictions planning a mental health court should build data collection and evaluation into their program operations, so that the court will eventually be able to conduct its own basic data analyses.

Effect on overall service capacity

Though mental health courts have arisen in part because of the inadequate treatment services and resources in community mental health systems, implementing a program does not usually result in expanded service capacity.

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Instead, mental health court staff work within the existing framework of local resources and treatment providers. As a result, if mental health courts are effective in linking their participants with services, they can actually reduce the availability of treatment options for people with mental illnesses outside the criminal justice system. To avoid disadvantaging individuals in the community, therefore, mental health court administrators, other criminal justice professionals, and mental health and substance use treatment providers should ensure the availability of services for all people with mental illnesses and work collaboratively to fill gaps in the treatment system.

Need for a continuum of response strategies

Some communities have developed mental health courts without considering alternatives across the criminal justice continuum. In these communities mental health courts might be viewed as the only strategy needed to improve outcomes for people with mental illnesses in the justice system, when in fact no single initiative can address the driving factors behind this problem. Focusing solely on mental health courts can also lead to a lack of coordination with law enforcement–based diversion programs, drug courts, reentry programs, and other initiatives at the intersection of the criminal justice, mental health, and substance use systems. Without cooperation among different criminal justice/mental health programs, limited resources cannot be shared and efforts may be duplicated. To avoid these pitfalls, policymakers and practitioners should work together to coordinate responses to their shared clientele.

Integration with traditional case processing

Regardless of their effectiveness, mental health courts alone cannot respond to the vast numbers of people with mental illnesses who enter the criminal justice system. Traditional court officials must adopt the principles and policies at the core of mental health courts to ensure that these approaches are not limited to the small number of individuals who enter specially tailored programs. Accordingly, traditional court judges and administrators should strive toward three goals: making training available to all court personnel on mental health issues; integrating mental health information into pretrial and presentence reports and responses to violations of community supervision conditions; and improving collaboration among all criminal justice agencies and mental health and substance use treatment systems.

Design considerations

Many complex issues related to mental health court design and implementation deserve greater scrutiny. For example, mental health court practitioners and observers differ on the types of participants mental health courts should

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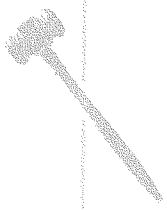
accept, the plea agreements courts should offer, appropriate program length, and how program success should be measured. Readers interested in these issues should consult this guide's companion document, *A Guide to Mental Health Court Design and Implementation* (www.consensusproject.org/mhcp/info/mhresources/pubs).



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What Resources Can Help Communities Develop Mental Health Courts?

Jurisdictions interested in developing a mental health court can benefit from a range of resources and documents offering support.

Federal grant support

Although many mental health courts emerged as community-level responses to locally identified problems, they have also been supported at the federal level.

- *Justice and Mental Health Collaboration Program*

  In 2004, Congress authorized the creation of the Justice and Mental Health Collaboration Program (JMHCP).[27] This program strives to increase public safety by facilitating collaboration among the criminal justice, juvenile justice, mental health treatment, and substance use systems and to improve access to effective treatment for people with mental illnesses involved with the criminal justice system.

  The JMHCP does not exclusively support mental health courts; nevertheless, of the 27 grantees selected in 2006 and the 26 selected in 2007, approximately one-third have focused on court-related initiatives. Congress appropriated $5 million for both 2006 and 2007 and increased appropriations to $10 million for the program in 2008.

  The JMHCP is administered by the Bureau of Justice Assistance (BJA).[28] At this writing, technical assistance is provided to the grantees by the Justice Center, as well as the Pretrial Justice Institute and the National Association of Counties (NACO).[29]

  To learn more about the JMHCP and grantees, see www.consensusproject.org/jmhcp.

- *Targeted Capacity Expansion Program*

  In addition to funds from criminal justice agencies, mental health courts have also received support from federal health agencies, namely, the Substance Abuse and Mental Health Services Administration (SAMHSA).

  Since 2005, SAMHSA has supported several mental health courts directly through its Targeted Capacity Expansion (TCE) program.[30] The

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Technical Assistance and Policy Analysis (TAPA) Center for Jail Diversion provides technical assistance to TCE grantees.[31]

State grant support

Several states have developed broad programmatic support to address the prevalence of people with mental illnesses in the criminal justice system. As with the JMHCP, these grant dollars can be used for mental health courts. Such programs can be found in California and Florida, and many states are considering similar proposals.

- *Mentally Ill Offender Crime Reduction Grant Program (California)*

  The California Mentally Ill Offender Crime Reduction (MIOCR) program seeks to (1) support the implementation and evaluation of county efforts to increase access to community-based services and supports, (2) facilitate successful transitions from incarceration to the community, and (3) reduce recidivism among both adults and juveniles with mental illnesses involved with the criminal justice system.

  In 2006, 44 grants were awarded to 28 different counties, totaling $44.6 million. Many of these counties have used the funding to plan or improve mental health court programs. Nearly $30 million was appropriated for MIOCR in 2007. For more information, see www.cdcr.ca.gov/Divisions_Boards/CSA/CPP/Grants/MIOCR/MIOCRG.html.

- *Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Program (Florida)*

  In 2007, the Florida Substance Abuse and Mental Health Corporation announced the availability of $3.8 million under the newly created Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Program. In 2008, planning or implementation grants were given to counties to develop initiatives to improve public safety, avoid an increase in spending on criminal and juvenile justice, and better connect individuals with mental health or substance use disorders who are involved with the criminal justice system to treatment. More information can be found at www.samhcorp.org/RFA/index.htm.

In addition to federal and state grants, a number of other resources are available to jurisdictions interested in planning a mental health court.

BJA mental health court learning sites

Besides its work with the Justice and Mental Health Collaboration Program, BJA has designated five mental health courts as learning sites to provide a

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peer support network for local and state officials interested in planning a new—or improving upon an existing—mental health court:

- Akron Municipal Mental Health Court (Ohio)
- Bonneville County Mental Health Court (Idaho)
- Bronx County Mental Health Court (New York)
- Dougherty Superior Court (Georgia)
- Washoe County Mental Health Court (Nevada)

These courts serve as a resource for jurisdictions across the country looking to develop or refine their approach to individuals with mental illnesses. Since each mental health court has a unique set of policies and procedures, the learning sites program allows jurisdictions to observe different models and the flexibility needed to tailor a program to a specific community. The learning sites also work with the Justice Center, the technical assistance provider for this program, to assess and improve their own court operations and to develop tools for the mental health court field.

The five learning sites are indeed representative of the great variability in mental health court models. For example, the Bronx County Mental Health Court started with only felony charges and began accepting misdemeanors in 2007, whereas the Akron Municipal Mental Health Court has continually focused on misdemeanor charges. Similarly, the Bonneville County Mental Health Court serves a rural jurisdiction and averages approximately 35 participants at a time, whereas the Washoe County Mental Health Court—located in a more urban area—has an estimated 200 people under its supervision at a given time. As a dual mental health court and drug court, the Dougherty Superior Court uses a different program model than all of the other learning sites. Interested jurisdictions are encouraged to visit the learning site most similar to the program model envisioned or to contact several or all of the courts to compare their models and processes.[32]

Policy guides

As part of the Mental Health Court Program and with support from BJA, the Justice Center has produced a number of practical policy guides to aid mental health courts across the country. The following publications explore in more depth a number of issues and lessons presented in this primer. They can be found at www.consensusproject.org/mhcp/info/mhresources/pubs.[33]

- *The Essential Elements of a Mental Health Court*
- *A Guide to Mental Health Court Design and Implementation*
- *A Guide to Collecting Mental Health Court Outcome Data*
- *Navigating the Mental Health Maze*

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Web resources

The Consensus Project website, which the Justice Center maintains, is a helpful place to begin exploring criminal justice/mental health issues or gathering information on mental health courts. The homepage can be found at www.consensusproject.org, and the following web pages also provide relevant information.

- *Consensus Project Report*

  The landmark *Criminal Justice/Mental Health Consensus Project* report, a comprehensive discussion of the involvement of people with mental illnesses in the criminal justice system, from before arrest to after reentry from prison or jail, is available at www.consensusproject.org/the_report. A chapter of the report has been dedicated to issues that must be considered when looking at possible court-based strategies.

- *Mental Health Court Web Page*

  Within the Consensus Project website, the Justice Center maintains a page specifically for mental health courts, www.consensusproject.org/mhcp/. Many of the publications described above can be found on this page, as well as information on the learning sites and other relevant materials and websites.

- *Criminal Justice/Mental Health Information Network*

  A number of relevant mental health court resources can be found on the Criminal Justice/Mental Health Information Network (InfoNet) website, www.cjmh-infonet.org, an online database that provides a comprehensive inventory of collaborative criminal justice/mental health activity across the country and serves as a platform for peer-to-peer networking.

  At this writing, the InfoNet contains approximately 175 mental health court profiles, which are added to the site once a court fills out a survey about its program. Viewers can sort by type of program (in addition to courts, the InfoNet contains information on law enforcement, corrections, and community support programs) or by state to find the mental health courts closest to them. Users can also get a sense of the type of model these courts follow, the participants and charges they accept, and how long they have been up and running. The InfoNet also contains information on mental health court research, as well as relevant media articles.[34]

- *JMHCP Web Page*

  Grantees and nongrantees alike can find useful resources on the JMHCP web page, www.consensusproject.org/jmhcp. JMHCP provides access to

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grantee snapshots and technical assistance resources, as well as links to detailed program profiles for each grantee represented on the InfoNet.

- *Center for Court Innovation Website*

  The Center for Court Innovation, which helps courts and criminal justice agencies aid victims, reduce crime, and improve public trust in criminal justice, has worked extensively with mental health courts. Relevant publications are available on its website, www.courtinnovation.org.

- *National Center for State Courts Website*

  The National Center for State Courts (NCSC) strives to improve the administration of justice through leadership and service to state courts and courts around the world. The NCSC website contains a number of materials for specialty courts, including mental health courts, which can be found at www.ncsconline.org.

- *National Drug Court Institute Website*

  Readers interested in learning more about drug courts should visit the website of the National Drug Court Institute (NDCI), www.ndci.org. NDCI promotes education, research, and scholarships for drug court and other court-based intervention programs.

- *National GAINS Center Website*

  The National GAINS Center works to collect and disseminate information about effective mental health and substance abuse services for people with co-occurring disorders involved with the justice system. Within the GAINS Center, the TAPA Center for Jail Diversion focuses on policies related to jail diversion, and both GAINS and TAPA resources can be found at www.gainscenter.samhsa.gov.

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Notes

1. The Justice Center catalogues mental health court programs on its Criminal Justice/Mental Health Information Network (InfoNet) website: www.cjmh-infonet.org.

2. For a comprehensive discussion, see the *Criminal Justice/Mental Health Consensus Project* report (New York, NY: Council of State Governments, 2002).

3. Paula M. Ditton, *Special Report: Mental Health and Treatment of Inmates and Probationers* (Washington, DC: U.S. Department of Justice, 1999). *The Prevalence of Co-occurring Mental and Substance Use Disorders in Jails* (Delmar, NY: National GAINS Center, 2002). Revised Spring 2004. L. Teplin, K. Abram, and G. McClelland, "Prevalence of Psychiatric Disorders among Incarcerated Women: Pretrial Jail Detainees," *Archives of General Psychiatry* 53 (1996): 505–512. A study released by the Bureau of Justice Statistics in 2006 (*Mental Health Problems of Prison and Jail Inmates*) found that more than half of all prison and jail inmates studied reported having mental health "problems," a measure that had not been used previously.

4. Paula M. Ditton, *Special Report: Mental Health and Treatment of Inmates and Probationers* (Washington, DC: U.S. Department of Justice, 1999), www.ojp.usdoj.gov/bjs/pub/pdf/mhtip.pdf.

5. Linda Teplin, *Keeping the Peace: Police Discretion and Mentally Ill Persons* (Washington, DC: U.S. Department of Justice, 2000). Fox Butterfield, "Asylums behind Bars: A Special Report: Prisons Replace Hospitals for the Nation's Mentally Ill," *New York Times*, March 5, 1998, section A, p.1.

6. E. F. Torrey, "Reinventing Mental Health Care," *City Journal* 9, no. 4 (1999), www.city-journal.org/html/9_4_a5.html.

7. L. Teplin, K. Abram, G. McClelland, M. Dulcan, and A. Mericle, "Psychiatric Disorders in Youth in Juvenile Detention," *Archives of General Psychiatry* 59 (2002): 1133–1143. Jennie L. Shufelt and Joseph J. Cocozza, *Youth with Mental Health Disorders in the Juvenile Justice System: Results from a Multi-state, Multi-system Prevalence Study* (Delmar, NY: National Center for Mental Health and Juvenile Justice, 2006).

8. John Goldkamp and Cheryl Irons-Guynn, "Emerging Judicial Strategies for the Mentally Ill in the Criminal Caseload: Mental Health Courts in Fort Lauderdale, Seattle, San Bernardino, and Anchorage" (Washington, DC: U.S. Department of Justice, 2000). Henry J. Steadman, Susan Davidson, and Collie Brown, "Mental Health Courts: Their Promise and Unanswered Questions," *Psychiatric Services* 52 (2001): 457–458.

9. The Council of State Governments Justice Center, with support from the National Alliance on Mental Illness and the National GAINS Center, developed three annual surveys on mental health courts between 2004 and 2006.

10. Adapted by Henry J. Steadman from Henry J. Steadman, Susan Davidson, and Collie Brown, "Mental Health Courts," *Psychiatric Services* 52 (2001): 457–458.

11. Linda Teplin and Karen Abram, "Co-occurring Disorders among Mentally Ill Jail Detainees: Implications for Public Policy," *American Psychologist* 46, no. 10 (1991): 1036–1045.

12. John Petrila, Norman G. Poythress, Annette McGaha, and Roger A. Boothroyd, "Preliminary Observations from an Evaluation of the Broward County Mental Health Court," *Court Review* (Winter 2001): 14–22.

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13. Joseph J. Cocozza and Jennie L. Shufelt, *Juvenile Mental Health Courts: An Emerging Strategy* (Washington, DC: National Center for Mental Health and Juvenile Justice, 2006).

14. Ibid., with updated numbers from personal correspondence with Jennie Shufelt, September 5, 2007.

15. Ibid.

16. A. Redlich, H. Steadman, J. Monahan, J. Petrila, and P. Griffin, "The Second Generation of Mental Health Courts," *Psychology, Public Policy, and Law* (2004): 527–538.

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18. E. Trupin, H. Richards, D. Werthheimer, and C. Bruschi, *Seattle Municipal Court, Mental Health Court: Evaluation Report* (Seattle, WA: City of Seattle, 2001). M. J. Cosden, J. Ellens, J. Schnell, and Y. Yamini-Diout, *Evaluation of the Santa Barbara County Mental Health Treatment Court with Intensive Case Management* (Santa Barbara, CA: Gevirtz Graduate School of Education, 2004). H. A. Herinckx, S. C. Swart, S. M. Ama, C. D. Dolezal, and S. King, "Rearrest and Linkage to Mental Health Services among Clients of the Clark County Mental Health Court Program," *Psychiatric Services* 56 (2005): 853–857.

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20. R. Boothroyd, N. Poythress, A. McGaha, and J. Petrila, "The Broward Mental Health Court: Process, Outcomes, and Service Utilization," *International Journal of Law and Psychiatry* 26 (2002): 55–71.

21. M. Cosden, J. Ellens, J. Schnell, Y. Yasmeen, and M. Wolfe, "Evaluation of a Mental Health Treatment Court with Assertive Community Treatment," *Behavioral Sciences and the Law* 21 (2003): 415–427.

22. Boothroyd, Poythress, McGaha, and Petrila, "The Broward Mental Health Court."

23. Ibid.

24. M. Susan Ridgely et al., *Justice, Treatment, and Cost: An Evaluation of the Fiscal Impact of Allegheny County Mental Health Court* (Santa Monica, CA: RAND Corporation, 2007).

25. At this writing, Policy Research Associates is working on such a study, which is being funded by the John D. and Catherine T. MacArthur Foundation and is projected to be published in 2010.

26. For information on how to build political support and assess whether mental health courts are appropriate for a community, see the Criminal Justice/Mental Health Consensus Project's *Essential Elements of a Mental Health Court* (www.consensusproject.org/mhcp/info/mhresources/pubs).

27. The Justice and Mental Health Collaboration Program was authorized through the Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA). This program replaced the Mental Health Court Program, which funded 37 mental health court initiatives over the course of 2002–2004.

28. BJA is a component of the Office of Justice Programs, U.S. Department of Justice, and the former administrator of the Mental Health Court Program. BJA provides leadership, funding, training, and technical assistance to states, local governments, and other justice and prevention agencies to reduce crime, violence, and drug abuse and improve the functioning of the criminal justice system.

29. The Justice Center coordinates the Criminal Justice/Mental Health Consensus Project, a national effort to help local, state, and federal policymakers and criminal justice and mental health professionals improve the response to people with mental illnesses involved in the criminal justice system. Through the Consensus Project, the Justice Center works closely with

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BJA on a number of criminal justice/mental health issues and served as the technical assistance provider for the Mental Health Court Program. For more information on the Consensus Project and technical assistance opportunities, see www.consensusproject.org. For more information on the Pretrial Justice Institute and NACO, see their respective websites: www.pretrial.org and www.naco.com.

30. SAMHSA originally coordinated the TCE Jail Diversion Program with BJA's Mental Health Court Program and helped to provide technical assistance to the grantees, but mental health courts were not eligible to apply directly for TCE grants until 2005. The TCE program is intended to expand the community's ability to provide a comprehensive, integrated response to substance use treatment capacity issues and to improve the quality of services.

31. For more information on TAPA, see www.gainscenter.samhsa.gov/html/tapa/cmhs/role.asp.

32. For more information on BJA mental health court learning sites, see www.consensusproject.org/mhcp/.

33. Hard copies of all of these policy guides (except for *Essential Elements*) can be requested from the Justice Center.

34. The Justice Center coordinates the InfoNet and developed it with assistance from key partners, namely, the National GAINS Center, the National Alliance on Mental Illness (NAMI), and the Police Executive Research Forum (PERF). The InfoNet is made possible through the support of BJA, National Institute of Corrections (NIC), Office for Victims of Crime (OVC), SAMHSA, the Center for Mental Health Services (CMHS), and the John D. and Catherine T. MacArthur Foundation.

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The Bureau of Justice Assistance, Office of Justice Programs, U.S. Department of Justice, provides leadership training, technical assistance, and information to local criminal justice agencies to make America's communities safer. Read more at www.ojp.usdoj.gov/BJA/.

The Council of State Governments Justice Center is a national nonprofit organization serving policymakers at the local, state, and federal levels from all branches of government. The Justice Center provides practical, nonpartisan advice and consensus-driven strategies, informed by available evidence, to increase public safety and strengthen communities. Read more at www.justicecenter.csg.org.

The Criminal Justice/Mental Health Consensus Project is an unprecedented national effort coordinated by the Justice Center to improve responses to people with mental illnesses who become involved in, or are at risk of involvement in, the criminal justice system. Read more at www.consensusproject.org.


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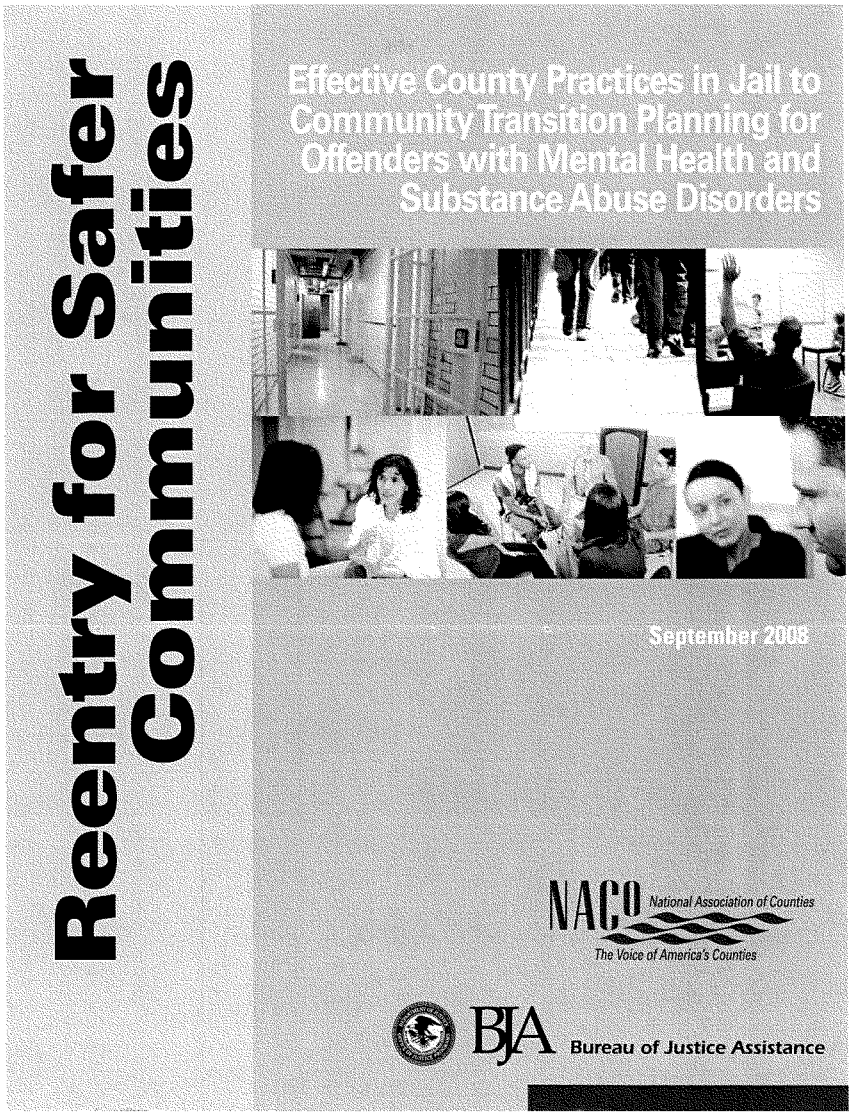
Reentry for Safer Communities
Effective County Practices in Jail to Community Transition Planning for Offenders with Mental Health and Substance Abuse Disorders
September 2008
NACO National Association of Counties
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Reentry for Safer Communities

Effective County Practices in Jail to Community Transition Planning for Offenders with Mental Health and Substance Abuse Disorders

A Publication of the Community Services Division of the County Services Department

September 2008

BJA Bureau of Justice Assistance

NACo National Association of Counties
The Voice of America's Counties

About NACo – The Voice of America's Counties

The National Association of Counties (NACo) is the only national organization that represents county governments in the United States. Founded in 1935, NACo provides essential services to the nation's 3,066 counties. NACo advances issues with a unified voice before the federal government, improves the public's understanding of county government, assists counties in finding and sharing innovative solutions through education and research, and provides value-added services to save counties and taxpayers money. For more information about NACo, visit www.naco.org.

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Introduction

In an effort to reduce recidivism and properly address individuals with co-occurring disorders, there has been an emergence of collaborative reentry practices at the county level. These system practices set out to provide interventions that will improve the chances of a successful reintegration into the community for offenders leaving jails. Because jails are locally run and operated and there is such a variance in population and resources in each community, there are many different ways to approach the creation of an effective transition strategy.

This publication is designed for county elected officials, administrators and staff, social service and community providers, local law enforcement, jail and corrections professionals, and other relevant members of the community who are interested in reentry options for offenders with mental health and substance abuse disorders. In most cases, the county board of commissioners is responsible for the jail operating budget; therefore, these local officials are key policymakers in advancing successful reentry practices.

Background

In counties across the country, jails have become our nation's de facto mental health providers. Increasingly overcrowded jails compounded by high rates of mental illness and substance abuse disorders among inmate populations have left community mental health providers unable to meet the demand for mental health services, while county jails struggle with their new role as the primary providers of care to mentally ill offenders. More Americans receive mental health treatment in prisons or jails than in hospitals or treatment centers. The Los Angeles County Jail and New York City's Riker's Island have become our country's largest psychiatric facilities, holding more people with mental illness than the largest psychiatric inpatient facility in any hospital.[1]

There are 3,365 local jails that admit and release an estimated 12 million people annually.[2] A majority of individuals stay in jail less than a month, some for just a couple of hours before they are released. With 73 percent of jail inmates having been previously sentenced to probation or incarceration, it is clear that recidivism is playing a major role in the core population of jails across the country.[3]

The numbers of individuals with mental illnesses cycling through our nation's jails represent an acute crisis of public health and safety, resulting in steep costs to county jails, criminal justice agencies, and the individuals themselves. Because differing criteria are used to determine mental health problems or mental illness, estimates of its prevalence in correctional populations tend to vary.

- The U.S. Bureau of Justice Statistics estimated in 2006 that 24 percent of jail inmates and 15 percent of state prisoners suffered from a serious mental illness, resulting in approximately two million mentally ill individuals admitted to county jails annually. [4]
- The same report found that up to 64 percent of jail inmates suffered from "mental health problems," a rate much higher than the approximately 10 percent of adults in America who suffer from mental health disorders. [5]
- The Center for Mental Health Services' National GAINS Center estimates that 72 percent of persons with mental illness admitted to county jails also meet the clinical criteria for co-occurring mental health and substance abuse disorders. [6]

A co-occurring disorder, also called a dual diagnosis, occurs when an individual has both mental health and substance abuse treatment needs. The overwhelmingly disproportionate rates of mental illness and co-occurring substance abuse disorders among inmate populations have placed additional pressures on overcrowded, overextended, and under-funded county systems.

Benefits of Reentry

This publication focuses on defining the essential components of effective transition planning for this population and showcases studies of promising county practices from across the country. These examples demonstrate that successful reentry practices can:

- Enhance public safety through reducing offender's risk to the community upon release
- Demonstrate cost-savings through a decrease in incarceration and in a wide array of government programs
- Improve the quality of life of individuals suffering from mental health and substance abuse issues
- Promotes safe, orderly, and secure correctional institutions

Analysis conducted by the Urban Institute indicates that regardless of the cost environment or offender population, a modest, publicly funded reentry program could generate considerable net benefits to the community. The study showed that only small reductions in recidivism rates were necessary for public agencies to recover their initial investment in the reentry program; for some counties, less than a percentage point drop in recidivism would initiate cost-savings.[7]

The Urban Institute also conducted an evaluation of the Maryland Re-entry Partnership, which provides transition planning for offenders leaving prison through community-based case management. The evaluation found that with just a 5 percent drop in re-arrest rates exhibited by the program that the state saw a cost savings of $7.2 million, returning a benefit of about $3 for every dollar of cost associated with the program.[8] This research shows the value of prevented costs to potential crime victims and to public agencies that can result from reentry programs. However, these studies are not able to measure the possible decrease in health costs and benefits to the individuals exiting jail and their families.

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There are several points at which a person suffering from a co-occurring disorder can come into contact with the criminal justice system. The National Gains Center for People with Co-occurring Disorders in the Justice System has developed the "Sequential Intercept Model," a conceptual tool to illustrate the interface between the criminal justice and mental health systems. The Sequential Intercept Model outlines five points, or "intercepts," at which the criminal justice and mental health systems interact:[9]

1) Law enforcement and emergency services
2) Initial detention and initial hearings
3) Jail, courts, forensic evaluations, and forensic commitments
4) Reentry from jails, state prisons, and forensic hospitalization
5) Community corrections and community support services

This model can be seen as a series of filters (see Figure 1) in which the intercepts represent different opportunities to intervene to prevent the cycling in and out of the criminal justice system that occurs with mentally ill individuals who often have co-occurring substance abuse disorders. This model has proven to be an effective tool for localities in developing promising practices that provide services designed to help these individuals transition back into the community. The ultimate aim is to reduce rates of recidivism and improve public health and safety by ending the unnecessary incarceration of individuals with mental illness.

Components of Effective Transition Planning for Individuals with Co-occurring Disorders

Developing a transition plan for individuals with co-occurring disorders and linking them to the proper treatment and services in the community upon release from incarceration is integral to reducing the rate of return of these individuals to the criminal justice system.

This publication will focus on local promising practices that address the final two intercepts of the Sequential Intercept Model: (4) reentry from jails, state prisons, and forensic hospitalization and (5) community corrections and community support services.

Role of NACo

In April 2005, the National Association of Counties (NACo) and the U.S. Department of Justice, Bureau of Justice Assistance convened a "Reentry Focus Group," which included experts from both the criminal justice and mental health fields. The group focused on the issue of transition planning, from jail to the community, of individuals who suffer from co-occurring mental health and substance abuse disorders. Representatives from federal, state, local, private, and nonprofit agencies (a list of all the organizations represented is included in the Acknowledgements) met to discuss the key components of model county practices in transitioning jailed persons with co-occurring disorders to the community as well as to identify possible model sites across the country.

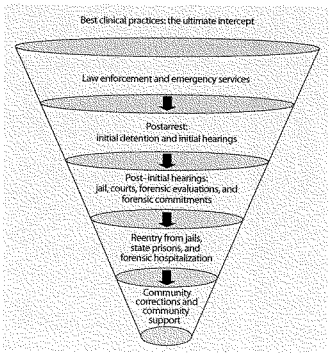
The Reentry Focus Group identified and defined five major characteristics of promising practices in local transition planning:

1) Collaboration - At the forefront of any successful reentry program is a strong collaborative structure between criminal justice and mental health agencies in the community. No single community organization is solely responsible for facilitating reentry practices, it requires partnerships across jurisdictional boundaries. Information sharing between partnering organizations in this process and offering collaborative/individual case management with aid from groups like local law enforcement, the jails, community mental health providers, faith-based organizations, probation and parole, and other social service providers is critical in establishing an effective transition from jail back into the community.
2) Access to Benefits – An important component to reentry for offenders with co-occurring disorders is ensuring access to benefits such as social securities income/ social securities disability income and Medicare/Medicaid prior to release so that individuals can access medication, health care, housing, food, and employment opportunities.

   When individuals are charged with a crime and incarcerated, they lose all access to federal benefits such as Medicare/Medicaid and Social Security. This often results in a burden on county governments, as locals are left to pay for medical care of jail inmates even if they have yet to be convicted of a crime. When they are released from jail, the reinstatement of these benefits can be difficult to navigate and can cause a significant lag before these services are readily available again.
3) Sustainability – A characteristic of any promising prac-

Figure 1: The Sequential Intercept Model Viewed as a Series of Filters

Source: Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness, Psychiatric Services, 2006.



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tice is sustainability. The program needs to surpass a temporary status, locate consistent funding, develop performance measures, and become common practice in the locality.

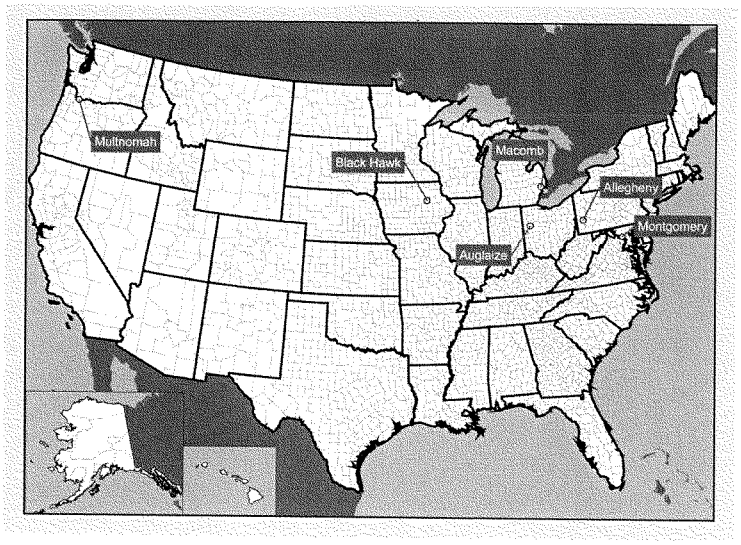
4) Cultural/Gender Components – Sensitivity to ethnicity, culture, and gender is integral in addressing the reentry of individuals with co-occurring disorders. Offering gender-specific programming as part of their treatment plan is important in properly addressing these offenders leaving jail.
5) Community Linkages – The final piece of the reentry process is connecting the offender to the appropriate services and support in the community to ensure the individual does not cycle back into the criminal justice system. This includes family reunification, access to housing, employment, transportation, and general aftercare and follow-up as part of the transition plan.

Having established these criteria, NACo sent out a "Call for Nominations" to solicit examples of model sites that exhibit these essential elements. Based on the nominated programs NACo received and on the recommendations that emerged from the Reentry Focus Group, six models were selected for further review. NACo program staff then conducted an intensive study, which included on-site visits to each selected county to meet with county elected officials, key staff, and other partner stakeholders.

This publication, based on the national study by NACo, features six effective practices for transition planning for incarcerated individuals with co-occurring disorders. These sites represent rural, suburban, and urban counties in different regions of the country (see Figure 2). These programs differ in the focal points of their reentry efforts, but exhibit strong partnerships between the jail and the community, treatment and transition planning within the jail, and some level of follow-up after release. The six sites are:

1) Allegheny County, Pennsylvania
2) Auglaize County, Ohio
3) Black Hawk County, Iowa
4) Macomb County, Michigan
5) Montgomery County, Maryland
6) Multnomah County, Oregon

Figure 2: Jail to Community Transition Planning Model Sites



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Six model county programs

Allegheny County, Pennsylvania
Allegheny County Jail Collaborative

Allegheny County is an urban county with well over one million residents; the county seat is Pittsburgh. The Allegheny County Jail, located in downtown Pittsburgh, holds about 2,500 inmates and usually receives over 25,000 offenders a year to serve sentences or await trial. On an average day, approximately 100 arrestees come through the Intake Department. Additionally, the jail receives inmates from Constables, federal authorities, and Sheriff's Deputies. With the number of permanent releases being slightly less than admissions, the population of the jail has been steadily growing over the past decade.[10]

The Allegheny County Jail Collaborative (ACJC) has been a joint effort between the Allegheny County Jail (ACJ), the Allegheny County Department of Human Services (DHS), and the Allegheny County Health Department (ACHD) since 2000. The Collaborative was established at this time to address public safety, recidivism, successful reintegration, and duplication of services throughout government agencies within the county. In particular a County Executive had raised concerns that the county was duplicating services and could reduce recidivism and increase public safety by forming a collaborative body to work on these issues.

The Collaborative focuses on comprehensive reentry planning that includes family reunification, housing, substance abuse and mental health treatment, employment, and community engagement. This group has utilized screening tools to identify the needs of inmates and to develop creative solutions to address these needs. The Collaborative has built an infrastructure specifically to provide the supports and services to fill the gaps and remove the barriers that relate to the high rate of recidivism. The partners of the Collaborative meet monthly and work to plan all in-jail, transitional, and post-release services.

Collaboration

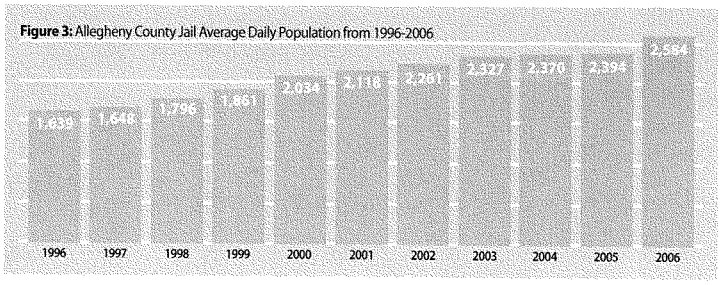
The ACJC partners meet monthly with departmental management as well as representatives from the court, probation/parole, and an evaluation team. The evaluation team is composed of academic staff from the University of Pittsburgh - School of Social Work and Center for Race and Social Problems staff who keep statistics and measuring the results of the Collaborative.

The Collaborative's partnership formed several committees to focus on certain aspects of the reentry process. The Allegheny County Reintegration Advisory Committee is a group of community-and jail-based service providers and ex-offenders who meet monthly to discuss barriers and solutions to the unified reintegration efforts in Allegheny County. The concerns and recommendations of this group are sent to the County Collaborative Management Team for review.

Access to Benefits

The Collaborative begins reentry planning as soon as an individual enters the jail. Inmates are screened upon intake and referred to jail-based programs and treatments such as GED preparation and testing, job training, life-skills class, mental health treatment, and in-patient substance abuse. Allegheny County Forensic Services works with the county jail, the District Courts, Service Coordination Units, and other community providers to assist these offenders with co-occurring mental health and substance abuse disorders prior to their preliminary hearing. They provide coverage at jail intake for processing involuntary or emergency commitments, divert the appropriate individuals from incarceration or extended jail stays, and create and present service plans to the court.

Figure 3: Allegheny County Jail Average Daily Population from 1996-2006



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Several programs inside the Allegheny County Jail provide reintegration supports and services to inmates. Intensive case management during incarceration and after release involves building a service plan with the inmate along with service providers and court officials, coordinating services and applying for medical assistance inside the jail, and beginning to facilitate supports for release. The intensive case management is also responsible for contacting any pre-existing community supports, spiritual supports, or family members to include in the transition planning.

The Collaborative has built an infrastructure specifically to provide the supports and services to fill the gaps and remove the necessary barriers that directly relate to lowering the rate of recidivism in Allegheny County. ACJC has implemented reintegration programs, drug and alcohol treatment, GED programs, a "Three Quarter Way House" that acts as a hybrid of a halfway house and transitional housing, and the intensive programs that the county provides such as mental health forensics, Narcotics Anonymous (NA) and Alcoholics Anonymous (AA), and HIV/AIDS prevention and education. Forensic Services also runs the Community Reintegration of Offenders with Mental Illness and Drug Abuse (CROMISA) initiative, a separate facility that provides a therapeutic community for men who suffer from co-occurring disorders and are on probation or parole.

Sustainability

ACJC receives funding from numerous different sources including federal, state, and local agencies, and private foundations. ACJC receives funding support from the Pennsylvania Commission on Crime and Delinquency and other state resources; locally, from the Allegheny County Department of Human Services; and from five different foundations located in the county. Attending the monthly meetings of ACJC and its subcommittees has become common practice for the contributing organizations.

Gender/Cultural Components

The Collaborative manages 18 service providers within the Allegheny County Jail. Many of these providers offer gender-specific treatment programs. Zoar is a service provider that focuses on female inmates. The Community Reintegration of Offenders with Mental Illness and Substance Abuse (CROMISA) initiative is a separate facility working only with male offenders. The Three Quarter Way House is for male offenders and the county is working on the creation of one for women. Both Goodwill and Strength, Inc. work with men and women on reintegration projects.

Community Linkages

A major focus of ACJC is family reunification. In 2003, the Pittsburgh Child Guidance Foundation commissioned a study on the children of incarcerated parents in Allegheny County. The study found that 7,000 children in every zip code and school district in the county have a parent in jail or prison. The study also found that these children were significantly more likely than their peers to fail out of school, suffer emotional distress, commit serious delinquent acts, and be incarcerated themselves as adults.[11]



Figure 4: Allegheny County Jail
Source: Allegheny County Bureau of Corrections, 2006 Annual Report

In response to these findings, Lydia's Place, Inc., in partnership with the Allegheny County Bureau of Corrections, the Pittsburgh Child Guidance Foundation, by 100 other community organizations and individuals, is creating a Family Activity Center in the lobby of the Allegheny County Jail. The Center will assist families waiting to visit loved ones who are incarcerated as well as help keep the link between the incarcerated individuals and their family when they leave jail. Allegheny County has also been addressing this issue by working with the Urban Institute's Children of Incarcerated Parents Project.

Upon release from jail, a majority of individuals follow their transition plan and receive treatment, live in alternate housing in the Collaborative's Three Quarter Way House, transitional housing, or their own home. The intensive case manager follows the individual for up to a year after release to assist with family reunification, employment, housing, legal matters, transportation, child support issues, and obtaining logistical items such as a driver's license or other photo identification.

Results

A researcher from the University of Pittsburgh has been collecting data on the effectiveness of the Collaborative and conducting interviews with ex-offenders in a three-year study to show the benefit to public safety, to improve individual's lives, and save taxpayer dollars. The preliminary findings show an overall 15 percent reduction in recidivism compared to the rate before the Collaborative was established. The Collaborative is also working with Carnegie Mellon University to analyze the needs of the recidivating population and the communities most affected in the process.

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Auglaize County, Ohio
Auglaize County Transition Program

Auglaize County is a rural county of just over 46,000 residents, located in Western Ohio. The Auglaize County Transition (ACT) Program is a joint project of the Auglaize County Sheriff's Office and the Community Connection for Ohio Offenders, a private, non-profit agency focusing on reentry services throughout Ohio. Although some aspects of ACT have been in place for a number of years, the program formally began in 2003. ACT takes a reentry case management approach to reducing crime in the community.

The Auglaize County Correctional Center is a 72-bed facility that holds pre-trial, pre-sentenced, and sentenced inmates for up to 18 months. The facility receives approximately 1,200 inmates a year, half of whom will be released within 72 hours. Of the 600 remaining inmates, about 200 actively participate in the correctional center's programming every year.

Collaboration

The ACT Program created an interdisciplinary collaboration board of partners called the Reentry Case Management Team. This team meets monthly and is composed of a number of organizations throughout the community:

1) Auglaize County Sheriff's Office
2) Auglaize County Municipal Court
3) Auglaize County Probation Department
4) Auglaize County Department of Jobs and Services
5) Community Connection for Ohio Offenders
6) Lutheran Social Services
7) ASTOP (a local substance abuse provider)
8) Mercy Unlimited (a faith-based outreach group)
9) Tri-County Mental Health and Recovery Services Board (Allen, Auglaize, and Hardin counties)
10) St. Mary's School District Adult Basic Education/ GED Program
11) Auglaize County Community Corrections Planning Board
12) Westwood Behavioral Center (a local mental health provider)
13) Ohio Adult Parole Authority

The ACT Program uses a case manager as the primary staff manager in coordinating transition plans for the inmates. In addition, a facility classification team- consisting of the case manager, the facility commander, the staff sergeant, one corrections officer from each shift, the mental health/chemical dependency counselor, and two individuals from the Ohio Department of Job and Family Services- meet monthly to review the list of inmates and discuss issues and treatment options for individual offenders.

Auglaize County Commissioner Douglas Spencer commented, "If I had to sum up why this program is a success in one word, it would be collaboration. Getting all these groups involved as partners in this program is really what has made it so effective."

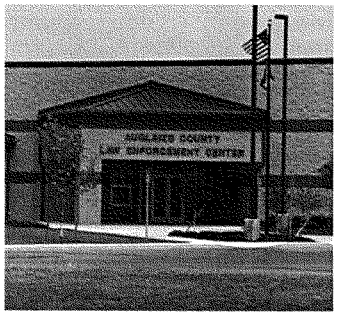

Figure 5: Auglaize County Jail
Source: Staff Sergeant Charles Fuerstenau, Auglaize County Jail

Access to Benefits

All inmates are screened upon intake to the jail for any possible mental health or substance abuse disorders. The Mental Health and Recovery Services Board of Allen, Auglaize and Hardin counties provides a therapist certified for dual diagnosis assessments to administer a full and formal assessment for any inmates exhibiting mental health or substance abuse disorders. From this point, the ACT Program uses a case manager to link inmates to the appropriate services, both inside the jail and in the community upon release.

Substance abusing individuals are directed into a chemical dependency program, which includes Moral Reconation Therapy (MRT), a 12-step/chapter substance abuse treatment program, and individual and group therapy. Inmates with mental health issues or who are suffering from co-occurring disorders are routed into the chemical dependency program when appropriate and are seen by the facility therapist for individual and group programming. The mental health and chemical dependency programs are provided through an agreement with the Mental Health and Recovery Services Board of Allen, Auglaize, and Hardin counties. The Sheriff also contracts with Westwood Behavioral, a local provider, of mental health counseling for individuals who are not residents of one of the three counties served by this board.

The case manager also can admit inmates into the facility's GED program. Since 1999, over 80 individuals have received a GED while incarcerated; 14 received their GED in 2006 alone. The program has a 100 percent success rate, with individuals passing the GED exam, not necessarily on their first attempt, but in completing the program before they are released from jail. The case manager also facilitates an anger management group for inmates. The case manager works closely with the local adult probation and parole authorities to incorporate treatment programming into the conditions of release for offenders who have post-release control in their transition plan.

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Sustainability

The ACT Program is funded by a Justice Assistance Grant from the Ohio Office of Criminal Justice Services, the inmate telephone fund, and the profit from the facility commissary fund. The facility commissary fund is composed of food sales and other miscellaneous items. The inmate telephone fund was established through an arrangement with a local phone company wherein the jail receives revenue from all inmate phone calls. This inmate commissary fund provides enough funding to sustain all of the alternative services that the jail provides its inmates.

Gender/Cultural Components

The Auglaize County Jail is designed to have 11 beds for female inmates, but has experienced an influx of female offenders recently. ACT has responded by offering gender-specific programming.

Community Linkages

A majority of ACT's services are offered inside the jail facility while the inmate is incarcerated. The case manager works closely with local adult probation and parole to work on transition plans for persons exiting the jail and remains an important contact after individuals are released. The case manager also coordinates with an employment specialist provided through the Ohio Department of Job and Family Services to help ex-offenders obtain a job and appropriate housing immediately after their release. Joe Lynch, jail administrator at the facility says that ACT is "grassroots crime prevention at the local level."

The ACT Program has brought community groups together and worked with inmates with mental health or substance abuse needs to provide the appropriate services and improve their chances of becoming more productive citizens. Staff Sergeant Charles M. Fuerstenau of the ACT Program remarked on the effect of the program, "I used to think if someone came back into the jail after having been previously incarcerated that the program had failed. Now I realize that you have to measure your progress in terms of improving the lives of the entire community."

Results

Since the program was put in place in 2003, the jail has seen an 80 percent drop in incidents of violence within the facility. Also, the work release program at the facility has generated $385,000 in income since its inception. The Ohio Department of Health has funded a $20,000 evaluation of the ACT Program by a criminal justice professor from the University of Texas at San Antonio and a professor from Tiffin University (Ohio) who was formerly the director of the Ohio Bureau of Adult Detention. They hope to produce statistically significant results from the past three years they have been monitoring the effort.

Black Hawk County, Iowa Mental Health Assessment and Jail Diversion Program

Black Hawk County has a population of approximately 120,000 people living predominately in the Waterloo/Cedar Falls region. The jail averages 250 inmates with approximately 28 percent taking psychiatric medications. The Black Hawk County Jail was experiencing constant overcrowding, and in 2004 the county's Department of Correctional Services received funding from the Central Point of Coordination (CPC) office, which oversees local mental health spending in the county, to address this population.

The Department of Correctional Services, with input from various community organizations including the county attorney's office, put together the Mental Health Assessment and Jail Diversion Program. The goal was to establish a structured means of screening and early intervention for individuals with mental health issues and to pursue the best possible supervision/treatment options for mentally ill offenders coming back into the community.

The Mental Health Assessment and Jail Diversion Program is based on the Substance Abuse and Mental Health Services Administration's (SAMHSA) "APIC Model" which includes the following components:

Assess

Assess the inmate's clinical and social needs and public safety risks

Plan

Plan for the treatment and services required to address the inmate's needs

Identify

Identify required community and correctional programs responsible for post-release services

Coordinate

Coordinate the transition plan to ensure implementation and avoid gaps in care with community-based services[12]

Collaboration

The Mental Health Assessment and Jail Diversion Program is a collaborative effort among the Department of Correctional Services, the Sheriff's Office, the county attorney's office, the public defender, the local courts system, the mental health center, Pathways Behavioral Services (mental health professionals working within the jail), and other community agencies in and around Black Hawk County. In 2004, the Department of Correctional Services hired a Community Treatment Coordinator who has been integral in coordinating the organizations and agencies involved in this program.

Upon the inception of the program, the county decided to place the Community Treatment Coordinator within the Department of Correctional Services. The connection between the mental health community and an offender's parole or probation added accountability, which helped gain support from judges in the local court system. There are weekly meetings with the Sheriff's Office, the County Attorney, Pathways Be-

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havioral Services and the Community Treatment Coordinator to discuss and plan for releases from the Black Hawk County Jail.

Access to Benefits

The Mental Health Assessment and Jail Diversion Program provides the opportunity for identified mentally ill inmates in the Black Hawk County Jail to be screened and provided assistance in establishing a transition plan. Referrals for inmates to enter this program come from a variety of sources, including jail staff, probation/parole officers, the Mental Health Center, the offender and their family, public defender/county attorney, case managers, and other involved community agencies.

The Community Treatment Coordinator provides assessment, referral to the appropriate services, and works to facilitate the transition plan for these individuals. The Department of Correctional Services partners with Black Hawk Grundy Mental Health and Pathways Behavioral Services to offer the referral option of gender-specific services in the Dually Diagnosed Program for Men and the Women's Co-Occurring Disorder Program at the county's Residential Correctional Facility. The partners make every effort to get medication to those inmates in need.

Sustainability

The Mental Health Assessment and Jail Diversion Program began with a grant from Black Hawk County's CPC, an office that assists with referrals and placement to appropriate service providers in the community. The program quickly produced results for the community, and the county has been very supportive of the program by providing funding.

Gender/Cultural Components

The Department of Correctional Services offers two gender-specific programs for treating individuals with co-occurring disorders: the Dually Diagnosed Program for Men and the Women's Co-Occurring Disorder Program. Both programs incorporate an integrated treatment approach by addressing both the mental health and substance abuse disorders. Simultaneously, in the same setting, cross-trained staff from mental health, substance abuse, and correctional services work together to provide the services.

The Dually Diagnosed Program for Men, a 16-bed residential facility for male offenders with co-occurring issues, was established by the county in 1998. Clients participate in treatment during a six to twelve month period, and continue to receive case management, individual counseling, and group therapy services following their discharge from the facility. Two respite beds are set aside in the residential facility for clients encountering difficulty adjusting to their release while under the program's continuing care supervision.

The Women's Co-Occurring Disorder Program began in 2003 and has many similarities to the men's dual diagnosis program. A number of these female offenders spend time in the Waterloo Residential Correctional Facility as a condition of their probation or on work-release status. The overall goal of both these programs is to provide gender-specific treatment programs so that offenders can establish law-abiding lifestyles with a stabilized mental condition free of chemical dependency.

Community Linkages

The Community Treatment Coordinator works with Probation/Parole Officers in coordinating the transition of the offender back into the community. They focus on connecting the individuals with access to medications, housing options, finances, and employment. A unique feature of Black Hawk County's program is the Community Accountability Board, a group composed of various agencies and individuals from the community who have a vested interest in persons with mental illness. The board assists the Department of Correctional Services and the correctional consumers in reviewing potential program participants, developing comprehensive treatment plans, and identifying what needs to be done to have the greatest chance for a successful community transition. The Department of Correctional Services is trying to secure funding to hire an outreach worker whose duties would be based solely on narrowing gaps in aftercare when offenders are released from jail.

Results

The Community Treatment Coordinator position has also enabled the Mental Health Assessment and Jail Diversion Program to track data and show the community results in improving public safety, improving people's lives, and saving money.

Based on 34 months of data (i.e., since inception of program)

- 415 men and women assessed
- 282 men = 68%
- 133 women = 32%
- 74% (309 people) were transitioned successfully into the community/diverted from jail and prison
- Re-arrest rate is 26%
- Surveyed 10 specific individuals in the program and estimated cost savings over $54,500

Based on the average stay in jail, data from November, 2006

A neighboring county, Dubuque, is using Black Hawk County's program as a model in developing its own jail diversion and transition planning efforts. As Sara Carter, the Community Treatment Coordinator, commented, "We have gotten to the point we are not just reacting to the problem, but we have put some planning into how to ease overcrowding in the jails, treat mentally ill individuals appropriately, and increase awareness of the issue throughout the community."

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Macomb County, Michigan
Dual Diagnosis & Mental Health Jail Reduction Programs

Macomb County is the third largest county in Michigan, with a population of over 800,000. The largely suburban county is within metropolitan Detroit, covers 482 square miles, and is the fastest growing county in the state. The Macomb County Jail houses over 1,438 adult men and women; approximately 14 percent have mental health issues. Seventy percent of those identified as having mental health issues were incarcerated for non-violent crimes and 80 percent also have substance abuse issues.

Macomb County Community Corrections operates two programs for offenders with mental health and substance abuse issues: the Dual Diagnosis Program and the Mental Health Jail Reduction Program. The Dual Diagnosis Program has been working to address the needs of those with mild to moderate mental illness both in and outside the Macomb County Jail since October 2001. In response to a growing need for earlier, more intensive intervention for individuals suffering from co-occurring disorders in the jail, the Mental Health Reduction Program began in 2004.

Collaboration

The Dual Diagnosis and Mental Health Jail Reduction Programs are run by Macomb County Community Corrections, a county department that develops and maintains community-based alternatives to incarceration for non-violent offenders aimed at relieving prison and jail overcrowding. Community Corrections administers these programs in coordination with the Community Mental Health Department and works to build the community collaboration necessary to help meet the needs of the co-occurring population in the Macomb County Jail.

The group's Advisory Board includes a circuit court judge, a district court judge, a prosecuting attorney, a defense attorney, the county sheriff, chief of police, representatives from the chamber of commerce, the county's office of substance abuse, Community Mental Health, and members of the public. Community Corrections has a number of both formal and informal agreements with organizations throughout the community to assist the program's clients. These include a partnership of more than two dozen local human services agencies that have pledged to provide resources including health care, education, vocational training, family counseling, childcare, and transportation to populations with mental illness. Macomb County Commissioner Joan Flynn remarks, "Macomb County has been encouraging collaboration; that's what makes these programs work."

Access to Benefits

Macomb County Community Corrections works to place non-violent offenders into community supervision, rather than jail or prison, to free up corrections space for more serious offenders. Through the Dual Diagnosis and Mental Health Jail Reduction Programs rehabilitative and monitoring options include substance abuse inpatient and outpatient treatment, daily reporting services, urine testing, community service work, cognitive restructuring, and pre-trial release supervision.

The Dual Diagnosis Program is designed to fill the gap between release from incarceration and the inductions of community services by providing treatment and case management. Participants can be felons or misdemeanants who have a primary diagnosis of substance abuse and a secondary diagnosis of a mental health disorder. Before the existence of the Dual Diagnosis Program, it was difficult to place individuals with co-occurring disorders in treatment programs, because of the complexities of dealing with the combinations of issues. Emergency psychiatric evaluations and medications are provided to participants while they wait for their federal benefits and an appointment with a community mental health provider.

The Mental Health Jail Reduction Program, established in 2004, was designed to reduce the jail population by diverting non-violent, less severe mentally ill inmates who previously would not have been eligible for community-based programs. Those who participate in the program are chosen based on specific eligibility criteria. They are then assessed and screened for appropriateness for the program. A request is made to the courts for early release from jail into various residential facilities or intensive outpatient treatment. While involved in this program, the offender is seen by a contracted psychiatrist, provided with medication, and given assistance with housing and transportation costs.

Both of these programs focus on the needs of those with mild to moderate mental illness previously ineligible for placement through the Macomb County's Community Mental Health Department. The Community Mental Health Department has funding to address the remaining offenders with severe and persistent mental illness with secondary substance abuse issues. Community Corrections has two staff whose jobs are primarily transition planning. In addition, Community Mental Health has two case managers assigned to the jail for this purpose.



Figure 6: Macomb County Advisory Board
Source: Linda Verville, Assistant Director, Macomb County Corrections

Sustainability

The Dual Diagnosis program began with funding through the Bureau of Justice Assistance and is currently being financed by Macomb County. The Mental Health Jail Reduction Program is funded through the Michigan State Office of Community Corrections. The Macomb County Board of Commissioners has put on hold plans for a jail expansion project that would

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cost upwards of $93 million and is currently investing in the jail diversion programs to address the needs of this growing population.

Gender/Cultural Components

The Dual Diagnosis and Jail Reduction Programs fund a women's treatment facility, called the Home of New Vision, for long-term dual diagnosis treatment and transition back into the community. This provides specialized residential treatment that can address the gender specialized needs of the co-occurring population. Group services include a 12-week Women's Empowerment Series designed for survivors of domestic violence, as well as other open support groups.

Community Linkages

Once an individual is leaving jail or residential treatment, Community Corrections addresses the lag in time between the release from jail and the intake process at community agencies. In this crucial period, the programs fund necessary psychological evaluations, prescription medications, housing assistance, transportation, and other basic needs.

The coordinator meets with the offender to review the individualized plan and make appointments for community case management meetings before the offender is released from jail. After release, the coordinator meets with the client for employment screenings, health care eligibility screenings, long-term housing options, and enrollment into outpatient treatment programs or other services identified by the initial needs assessment. Community Corrections works with the local Michigan Works! Office and the state's workforce development association to coordinate employment and training options.

Communication with treatment and service providers is ongoing. The Program Coordinator updates the probation department and the courts on progress and compliance. Substance abuse testing is part of the treatment plan to ensure compliance. The average time in the program is between seven and twelve months.

Results

Throughout 2006, 111 individuals went through the full transition planning program, were released from jail, and provided case management and individualized treatment and services. The average reduction in jail stay for these individuals is estimated to be 78 days. By reducing their incarceration time, the county estimates it saves 10,400 jail bed days for a cost savings of $733,200.[13]

With a reduction in recidivism and extending the time for re-arrest, if it does occur, additional jail beds are saved in the long term. Documented outcomes from the programs indicate that the average time between incarcerations before program intervention for this population was 128 days; after completing the program, the time was extended to 309 days. Macomb County Commissioner Keith Rengert says, "These programs are proving to be effective not only in saving the county money, but in helping people improve their lives."

Montgomery County, Maryland Pre-Release and Reentry Services Division

Montgomery County is a large suburban county of over 870,000 residents, located just north of Washington, DC. The Montgomery County Department of Correction and Rehabilitation oversees four major operational divisions:

1) The Pre-Release Center (PRC)– a pre-release facility that holds an average of 172 inmates and coordinates with an average of 50 offenders in home confinement.
2) The Correctional Facility – a jail with a capacity of 1,029 inmates.
3) The Detention Center – responsible for intake and processing of offenders with a capacity of 200 inmates.
4) The Pre-Trial Services Unit – a pre-trial community supervision program of about 1,500 defendants a year.

The Pre-Release and Reentry Services Division (PRRS) coordinates the PRC, a complex of four correctional units, each operated by a separate staff treatment team: a co-ed unit, two men's units, and an honor's unit. The first stand-alone PRC was opened in 1972. The program was expanded over the years and in 1990 the PRRS developed a highly structured non-residential pre-release component. The PRC is a highly structured residential work release and treatment facility for up to 177 male and female offenders, and offers a comprehensive array of services that provide offenders and their families an opportunity to address problems, make lifestyle changes, and manage the issues of reentry as offenders begin their return to the community.

The PRRS serves local, state, and federal offenders who are within 12 months of release and are primarily returning to Montgomery County. PRRS works closely with the offender's family in designing the transition plan and PRRS staff provide intensive case management, employment services, and treatment planning. The program conducts a thorough screening and assessment of individuals before they are deemed eligible to participate.

Collaboration

The PRRS works closely with the Montgomery County Department of Health and Human Services, the courts, local employers, housing agencies, the local faith community, the Maryland State Division of Corrections, and the federal Bureau of Prisons. PRRS partners with the Department of Health and Human Services in designing treatment plans for individuals with co-occurring disorders or mental health services. The Archdiocese of Washington's Welcome Home Program and St. James Aftercare Ministries offer mentoring services and the Montgomery County Housing Opportunity Commission and other faith-based organizations provide offenders with federally subsidized housing.

Access to Benefits

PRRS staff screen individuals weekly in each of Montgomery County's detention facilities. Referrals are typically received from defense and prosecuting attorneys, judges, probation agents, case managers within the Maryland Division of Corrections, and community corrections officials within

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the federal Bureau of Prisons. At the time of initial screening, each case undergoes a thorough review to determine if an offender is best served by residential services through the PRC, non-residential through the home confinement program, or a combination of both.

PRRS provides a comprehensive array of services including:

- Individualized assessment and treatment planning
- The intensive Job Readiness and Retention Program, job counseling, and placement
- Comprehensive substance abuse and addiction services, education, counseling, relapse prevention planning, and Twelve Step programming
- Work-release or educational release
- Individual, group, and family counseling
- Community-based therapy
- Life Skills seminars

Sustainability

Montgomery County fully funds PRRS. The program operates under the premise that public safety is enhanced when individuals are released through the PRC rather than through the jail. Residents of the PRC provide support for their families and save money for their release by obtaining employment. Residents also pay 20 percent of their salaries for room and board, which generates over $250,000 for the county annually.

Gender/Cultural Components

Programming in the PRC includes gender-specific treatment through the TAMAR Program, which stands for Trauma, Addictions, Mental health And Recovery. TAMAR is a voluntary trauma treatment and education program for women and men. The TAMAR Program is in place in eight counties throughout the state of Maryland, offering trauma treatment centers within the detention centers as well as peer support groups within the community. The program also offers connection to community agencies providing mental health, substance abuse, and social and domestic violence services.

Community Linkages

The PRRS Division has a strong work-release program in which individuals are assigned a Work Release Coordinator whose primary functions are to assist in finding long-term employment, provide vocational guidance and counseling, facilitate the Job Readiness/Retention Seminar, and ensure that their clients maintain positive performance and accountability at work. The Work Release Coordinators are engaged in community outreach with local businesses, prospective employers, and vocational training programs.

Case managers help individuals suffering from co-occurring disorders link up with the proper community based mental health and substance abuse treatment. They also work with the offender's family member designated as their "sponsor" to ensure the offender is having a smooth transition back into the community. PRRS will provide the sponsor information on enabling, limit-setting, domestic violence, and family roles. Sponsors are seen as an integral part of the reentry process.

Results

PRRS collects data and demographic information on individuals successfully released from PRRS; jail beds saved; cost savings; and percentage released with employment, housing, and other appropriate services.

In 2006, PRRS:

- Managed almost 30 percent of all locally sentenced inmates in the corrections system in Montgomery County
- Served 624 individuals, and 83 percent successfully completed the program.
- Collected $400,000 in program fees. Program participants paid over $200,000 for family and child support and $30,000 in federal taxes.
- Saw 99 percent of program participants released with housing.
- Saw 88 percent of program participants were released with employment.

Multnomah County, Oregon
Transition Services Unit

Multnomah County is an urban county of over 660,000 containing the city of Portland. Multnomah County contains two operating jails: the Multnomah County Detention Center, a 676-bed maximum security adult facility in downtown Portland, and the Multnomah County Inverness Jail, a 1,014 bed medium security facility in the Northeast part of the city.

The Transition Services Unit (TSU), established in 2001, provides a comprehensive system of services designed to prepare, equip, and sustain offenders upon their release from jail or prison. The TSU conducts reach-in visits of inmates who are going to be released from state prisons back into Multnomah County. The program is responsible for linking recently released offenders to services, including pre-release planning, case coordination, housing, transportation, and medical and benefit assistance. The TSU provides transition planning services up to 120 days prior to release from prison or jail and 90 to 180 days post-incarceration.

The Department of Community Justice, a county agency in Multnomah County, runs the TSU. The program works on the "housing first" model and coordinates with Multnomah County and the city of Portland's 10-year plan to end homelessness. TSU's primary focus is on offenders with special needs, including those with mental, developmental, and physical disabilities; the elderly; and predatory sex offenders. TSU services cover a daily average of 35 recently released offenders from jail or prison, helping them to:

1) Locate and access safe and suitable housing
2) Identify and make an initial appointment for medical and/or mental health and substance abuse treatment
3) Receive medication assistance
4) Make first appointment for federal and state benefits
5) Receive employment referrals
6) Receive clothing
7) Receive case coordination parole/probation and connect to other service providers

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Collaboration

The Department of Community Justice coordinates the TSU in and works with a number of community, state, and federal agencies and organizations.

TSU's Housing Services has contracts with six local housing providers and provides contracted/subsidy housing for individuals transitioning back into the community. The Department of Community Justice partners with Cascadia Behavioral Healthcare, a local treatment provider, to provide treatment for individuals suffering from co-occurring disorders.

Multnomah County also runs a Public Safety Coordinating Council where committees make recommendations on various criminal justice and mental health concerns. Multnomah County Commissioner Lisa Naito remarks, "A regular organizational meeting with all the appropriate stakeholders is a necessary first step. The Public Safety Coordinating Council is the foundational structure of Multnomah County's efforts; it's where the action stems from."

Access to Benefits

The TSU coordinates the Joint Access to Benefits (JAB) Program, a collaborative effort that helps offenders qualify for federal disability benefits that cover mental health services, psychiatric medications, and other care. This is a joint project among the Multnomah County Sheriff's Office, Multnomah County Aging and Disability Services, Social Security Administration, and Oregon Department of Corrections. The goal of the JAB Program is to initiate the application for Social Security benefits as early as possible after release so persons leaving jail can receive benefits as soon as possible in order to ensure stable housing and medication assistance.

Individuals with co-occurring disorders are connected with Cascadia Behavioral Healthcare before their release. A 30 day supply of medication is provided for individuals leaving prison and a 14-day supply for those exiting jail. The TSU also has available 20 slots a month to cover no charge offenders exiting prison or jail a full 12 months of coverage for medical services and insurance.

Snapshot of Special Needs for TSU Clients	
Mental Health	35%
Sex Offenders	51%
Offenders with Violent Histories	19%
Developmental Disabilities	6%
Medical Disabilities	11%
Alcohol and Drug Issues	78%

The Multnomah County Department of Community Justice also operates the Londer Learning Center, designed to enhance community safety by helping offenders develop literacy skills. The center collaborates with local treatment centers, courts, corrections counselors, and parole/probation officers to provide educational services for adults out of jail or prison, but on some form of community supervision.

Sustainability

The TSU is funded primarily by Multnomah County, with additional funding from the Oregon Department of Corrections. The Multnomah County Board of Commissioners has been supportive of the TSU program and has made the services the TSU offers common practice in the county.

Gender/Cultural Components

Multnomah County's Day Reporting Center is a highly structured, non-residential program that offers supervision and access to services while stressing accountability and community safety. The Day Reporting Center offers 90 to 120 days of intensive case management for offenders coming out of jail or prison. The Focus on Reentry (FOR) program offers a number of gender-specific groups; cognitive restructuring and life skills groups; and relapse prevention, education, and emotional management services. The FOR program works in 12 gender-specific sessions, and on the 13th session they bring in the appropriate community linkages for the individual.

Community Linkages

TSU works extensively in providing housing support for offenders transitioning back into the community. The program provides contracted/subsidy housing for a monthly average of 329 offenders who have no other resources or support. Multnomah County has contracts with local housing providers and also operates facilities like the Medford Building. The Medford Building- a co-operative effort of Multnomah County and Central City Concern, a non-profit group working to provide solutions to homelessness in Portland- houses male and female offenders released from substance abuse treatment programs and who currently undergoing outpatient treatment as well as indigent, post-prison parolees and probationers.

TSU works with the Day Reporting Center to form a hub of services for released offenders from jail or prison, including:

- Drug and alcohol assessments, referrals, and services
- Cognitive restructuring and life skills groups
- Case management
- Random urinalysis
- Employment services
- Referrals for education and GED testing
- Mental health services

Results

TSU corroborates research that finds that offenders who have access to supportive services and housing upon leaving incarceration are less likely to recidivate and more likely to find employment.

- TSU receives approximately 2,265 clients a month.
- TSU data also shows 78 percent of high-risk, high-need offenders were able to move into stable housing, obtain employment, complete their GED and/or obtain entitlements.

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National Association of Counties

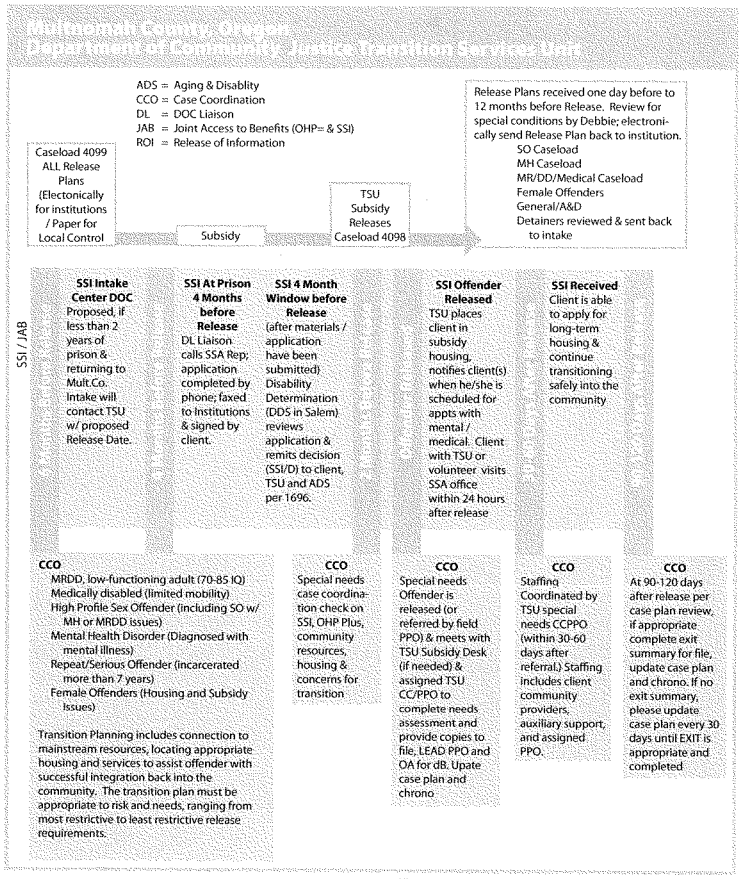

Figure 7: Diagram of the Transition Services Unit Services

Reentry for Safer Communities

Endnotes

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[13] Macomb County Community Corrections estimates that with 100 participants multiplied by 104 days (the average stay in jail for individuals with co-occurring disorders) multiplied by $70.30 (the daily cost of incarceration in the Macomb County Jail) they save $733,200 a year in jail costs.

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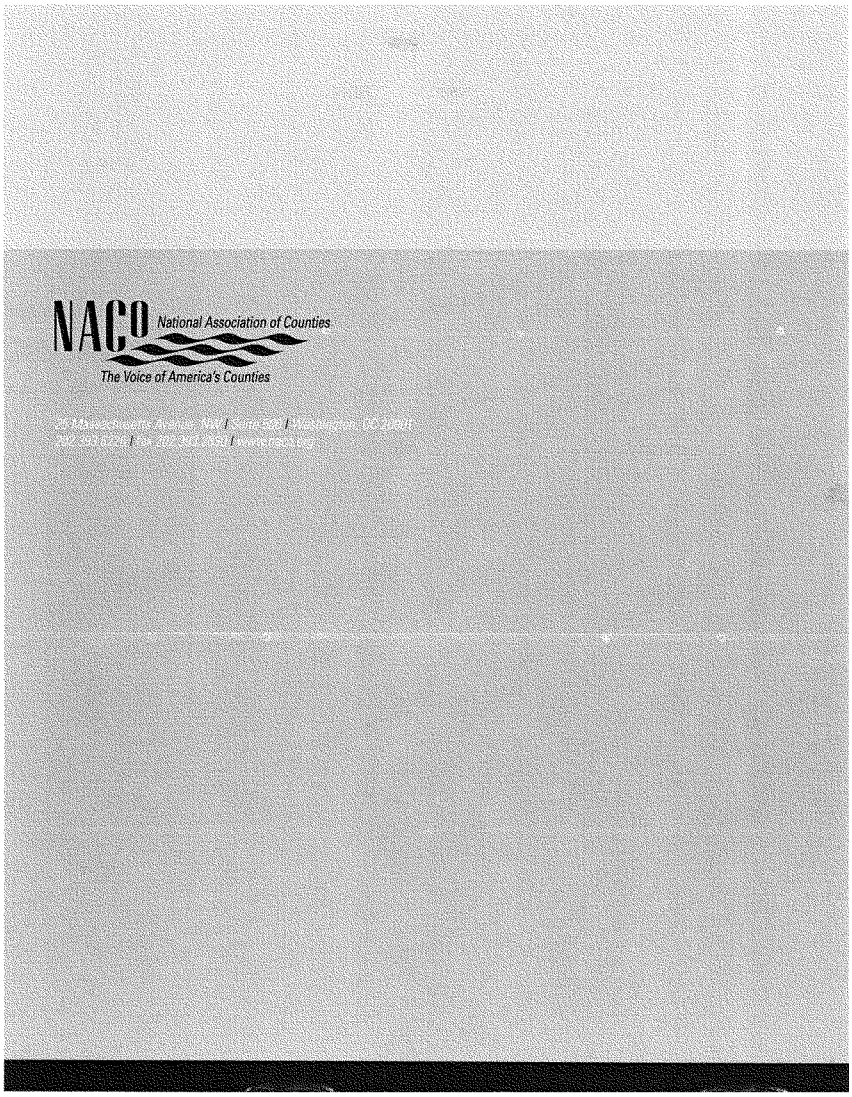

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U.S. Senate Judiciary
Subcommittee on Human Rights and the Law
Incarceration and Persons with Mental Illness
September 15, 2009

Background

Good afternoon Mr. Chairman and members of the Committee. My name is Gary Maynard, and I serve as Secretary of the Maryland Department of Public Safety and Correctional Services. I am here today to offer testimony regarding incarcerated populations with mental illness.

I have been involved in corrections for 39 years, working in five states and the Federal Bureau of Prisons. Early in my career I served as a prison psychologist, rose through the ranks of management, was a warden on two occasions, and eventually served as the head of corrections in four of those states. I am the Immediate Past President of the American Correctional Association and am an active member of both the Association of State Correctional Administrators and Maryland Correctional Administrators Association, and over the years have maintained communication with the American Jail Association – all of these organizations support the testimony I will offer today.

The Problem

Nationally, the population of inmates possessing mental health issues is growing at a dramatic rate in both our prison and jail populations. This comes in part as a result of the depopulation of state-operated mental health hospitals in the late 1960's which over the past several decades have closed their doors, seeking to treat these individuals with new, inexpensive medications designed to enable those with mental illness to live and function within the community. An article reported in Psychiatric Quarterly by Lamb and Weinberger stated that, "the putative trans-institutionalizing of persons with mental illness from mental institutions to correctional institutions was seen as a direct result of under-funded mental health policies and a fragmented community-based service system, in combination with more restrictive civil-commitment criteria."

Though we understand the intent behind treatment involving a comprehensive community network of support and services, the results have been an increase in criminal activity within this population. Our prisons and jails have become this country's de facto psychiatric hospitals as our population of mentally ill inmates has far surpassed the number residing in psychiatric hospitals. In 1959, nearly 559,000 mentally ill patients were housed in state mental hospitals. A 2003 study conducted by Human Rights Watch reported that there are now fewer than 80,000 people in mental hospitals and over 2.5 million housed in our criminal justice system, a figure that has quadrupled during that same time.

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According to the American Jail Association (AJA) in 2008, there were more than 650,000 bookings into the more than 3,300 jails in the United States that involved persons with some degree of mental illness. A study presented by the Council of State Governments Justice Center's Consensus Project this past summer evaluated over 20,000 adults entering five local jails. Researchers were able to document the presence of serious mental illness in 14.5% of the male and 31% of the female population, accounting for almost 17% of the incoming population. The report also cited a 1999 Bureau of Justice Statistics study which surveyed our jail population and found that 16.3% reported having spent the night in a mental hospital or the presence of a "mental condition." The same question was asked in 2006 inquiring of our jail population if they had a "mental health problem," and a staggering 64% reported that they met these criteria.

It has become clear that these individuals are not receiving sufficient treatment in the community. According to the Center for Therapeutic Justice, the average length of stay in jail for a mentally ill person is five times greater than an inmate lacking diagnosed mental illness. As an example, cases of Schizophrenia are four to five times higher within our prisons and jails than within comparable demographic groups in the community. Reports have indicated that individuals with some type of mental illness have much higher rates of recidivism.

A 2005 report by the Bureau of Justice Statistics entitled "Mental Health Problems of Prison and Jail Inmates" reports that in 2005 more than half of the prison and jail population had mental health issues. These estimates represented 56% of state prisoners, 45% of federal prisoners, and 64% of jail inmates. The high rate of mentally ill offenders more than likely stems from the fact that they present more frequently to law enforcement. It is estimated that contact rates with police agencies lie in the 69 to 83 percent range while arrest records for this population could range anywhere from 18 to 40 percent. One of the primary factors relates to substance abuse, where studies have shown that as many as 85% of inmates have some type of substance abuse problems that further mask mental illness. Law enforcement often lacks the training and education necessary to arrest and book a person with a mental diagnosis. This places the public's safety at risk, not to mention the officer and the offender.

The same is true for correctional staff who must work with a growing population on a daily basis to maintain the safety and security of our institutions. Contact with mentally ill inmates is one of the top three contributors to injury to corrections staff. Mentally ill inmates tend to have higher than average rates of disciplinary infractions. A study in Washington found that while mentally ill inmates made up only 18.7 percent of the prison population, they accounted for 41 percent of the reported infractions. Many of these individuals are placed on disciplinary segregation to protect staff and other offenders, a necessary precaution within a correctional setting. However, this type of confinement is particularly difficult for mentally ill inmates because of the potential for limited medical care. Additionally, this type of isolation causes idleness which could be

psychologically destructive and detrimental to their eventual transition back to the community.

Corrections' Response

So what can we do? Please know that corrections professionals do not believe in abandoning this population. Ideally, these individuals would have an opportunity to receive treatment within the mental health system, but we know that this will not always be an option. We understand that many of these individuals will break the law and be sentenced to our prisons and jails. It is inherent in our obligation to protect the public's safety and that of our staff and inmates that we must invest in methodologies that seek to care for and treat this population.

Leadership has been provided by the American Correctional Association (ACA) and the Association of State Correctional Administrators (ASCA), who have developed policy and standards to provide guidance for the treatment of mentally ill offenders. The provision of a continuum of services both in the community and during incarceration is vital for the mentally ill offender population.

For those who have been incarcerated, it starts with a good assessment at the front door as part of the intake/reception process in order to get a sense of the individual's mental health needs. In corrections, so much of what we do regarding identifying who has a mental illness relies on a self-report by the inmate. Many staff are trained in motivational interviewing techniques and work to get as much accurate information from the inmate as possible. Staff focus on how we ask questions and rely on a variety of screening and assessment instruments at our disposal. A successful example of this has been implemented by the Montgomery County Department of Corrections and Rehabilitation in Maryland, which has a comprehensive screening, triage, and referral process for services that is overseen by public mental health professionals.

The Association of State Correctional Administrators (ASCA) has helped in the development of two independently developed mental health screens – one by Dr Fred Osher and the other by Dr Robert Trestman – to quickly identify those who may be mentally ill or suicidal. Steps must be taken to develop and implement related strategies, including a policy on recognition, prevention, and treatment methods.

A second method to improve identification at intake is to rely on technology. Maryland has an information technology agreement with the Baltimore Mental Health System where arrest data is shared with the mental health agency on a daily basis, and it is run against the roster of those receiving public mental health care. The data cross check allows both the institution and the provider to know where the patient is. It further enables coordination in order to ensure continuity of care, including appropriate medication, counseling, and other interventions.

While persons are incarcerated, we must ensure quality care – with both counseling and medication. Corrections relies on the expertise of mental health professionals to work within our population; however, many agencies lack adequate staffing levels to fully address the needs of this growing population. We must recognize that within the criminal justice population virtually all of the mentally ill have a dual diagnosis – they have the co-occurring mental illness and addiction, as well as an anti-social personality disorder. States and local corrections departments have initiated a number of effective strategies aimed at this population. For example, in Pennsylvania, a Department of Corrections psychologist works with program staff six months prior to release to assist in the reintegration of mentally ill offenders returning to one of their local jurisdictions. In Minnesota, discharge planners seek out community providers who have worked with a mentally ill offender in the past and ask them to collaborate with reentry planning. In Wisconsin, advocates from the Community Support Program work with these offenders to manage entitlement claims, and Wisconsin Department of Corrections staff work with inmates to file applications for Medicaid benefits.

Without proper coordination to address co-occurring disorders, the inmate will most assuredly resort to street drugs in order to self-medicate rather than attempt to navigate the maze for public mental health treatment. To prevent this, many states and localities have adopted successful practices. In Cook County, Illinois, the Adult Probation Department's Mental Health Unit employs probation officers with a background in mental health to help clients access disability benefits upon release. And in Texas health services agencies share information on individuals receiving health related services. Both examples are designed to enhance a continuum of care.

In working with this population it is important not only to provide proper treatment during incarceration but also to develop an effective plan that will integrate these individuals back into our communities with sufficient access to vital resources. Collaborative efforts across the nation have been established to work with the community to provide comprehensive reentry planning, including family reunification, housing, employment, community engagement, and mental health and substance abuse treatment.

Solutions

There are three viable strategies to address this complex issue – funding, coordination, and federal leadership.

While funding cannot be the only solution, it has to be a part of the equation. The Mentally Ill Offender Act, signed into law in 2004, has been a resource to some agencies across the country; however, due to limited funding levels it has not made a meaningful, lasting impact. In 2006, 250 grant applications were submitted for funding; however, only 11% were funded, for a total of $5 million. The same was true in 2007 and 2008, with only 11% of the applications receiving funding in each year.

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Corrections agencies need both the funding and technical assistance necessary to build meaningful collaborative partnerships with the public health system on behalf of the incarcerated mentally ill. As we have shifted our focus to preparing offenders for the inevitable transition from prison to the community, mental health services must be part of that. Funding must be increased to support the original vision offered decades ago that was characterized by the depopulation of mental health facilities for enhanced community care – a comprehensive network of support and services to treat the mentally ill in their communities. This network can serve to not only stem the flow of mentally ill into the jails and prisons but also as a resource for those reentering our communities.

The Mental Health Association has spearheaded an effort in Maryland that we are proud to be a part of. The Maryland Department of Public Safety and Correctional Services, the Department of Health and Mental Hygiene, representatives of local detention centers, representatives of local health departments, and the United Healthcare Association have formed the Mental Health and Criminal Justice Partnership. By working together, legislation has been passed to assure that mentally ill inmates being released from State incarceration receive thirty days worth of medication on release. By working together, local health departments have accepted responsibility for release planning six to nine months in advance of inmates being released. This is a problem that will only be addressed by those behind prison fences and those in the community working together. This is a promising practice in coordination that could be modeled by other states.

Finally, defining a clear role and mission at the federal level on behalf of this population could further address this issue. Using correctional education as an example, the Federal Department of Education has made providing basic education services to inmates a part of its mission. Perhaps the Substance Abuse and Mental Health Services Administration could take the lead in working with corrections and public health agencies across the country to provide help to supplement funding for medication in prison, provide consistent protocols, guidance and training for staff, and assist in the coordination of reentry services. Many of these elements may exist to some degree, but they must be coordinated and specifically targeted to meet the unique needs of the population.

However, given the complexity of the population, perhaps the best strategy would be a blend of the options that I presented – funding, coordination, and federal support. I can attest to the willingness of corrections leaders across the country who stand ready to work toward these objectives.

Thank you.

Written Statement of

Mental Health America

Before the

U.S. Senate Committee on the Judiciary

Subcommittee on Human Rights and the Law

On

Human Rights at Home: Mental Illness in

U.S. Prisons and Jails

September 15, 2009

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Broken Promises

From Psychiatric Institutions to Confinement – What Happened to Life in the Community?

The Surgeon General's sentinel Mental Health Report of 1999 called attention to the fact that no family has been untouched by mental illness. Mental Health America (MHA), the nation's oldest and leading nonprofit dedicated to helping all people live mentally healthier lives, initiated a recovery movement on behalf of those families and consumers in 1909. In fact, Mental Health America (formerly National Mental Health Association) was recognized in the Surgeon General's report as the leader of the movement in the middle of the 20th century from institutionalized care to community-based care or *deinstitutionalization.* When the doors to state psychiatric institutions started to close, the promise was to shift the emphasis to community-based care. However, this promise was broken and instead of community-based care, the plight of individuals with mental health conditions has shifted to yet another set of institutions – jails and prisons.

The epidemiological snapshot of the high number of individuals with mental illnesses in confinement is upsetting and unambiguous. As the findings of the recently enacted Mentally Ill Offender Treatment and Crime Reduction Reauthorization and Improvement Act (MIOTCRA; P.L. 110-416) reveal: (1) Communities nationwide are struggling to respond to the high numbers of people with mental illnesses involved at all points in the criminal justice system; (2) A 1999 study by the Department of Justice estimated that 16 percent of people incarcerated in prisons and jails in the United States, which is more than 300,000 people, suffer from mental illnesses; (3) Los Angeles County and New York City's jails are today the largest providers of mental health services in the United States; and (4) State prisoners with a mental health problem are twice as likely as those without a mental health problem to have been homeless in the year before their arrest. The rate of serious mental illnesses for individuals in jail or prison is nearly three to four times that of the general US population. In addition, the Bureau of Justice Statistics reported that since midyear 2005 more than half of all prison and jail inmates had a mental health problem.

Mental health problems among the population of persons in the nation's jails and prisons are serious and growing. In New York State, a five-year study of persons in the mental health and correctional systems established that men who were involved with the public mental health system were four times as likely to be jailed as men in the general population. Another published report on a New York City jail found that the average length of stay for a mentally ill inmate was 215 days, as opposed to 42 days for all other inmates. The Los Angeles County Jail, Cook County Jail in Chicago and New York City's Riker's Island "each hold more people with mental illness on any given day than any hospital in the United States." The Los Angeles County Jail has for a number of years been declared to be the largest mental health facility in the country. In an era of deinstitutionalization, jails and prisons have become *de facto* mental health treatment facilities.

People with mental and substance use conditions in jails and prisons have complex and challenging needs. Almost 75 percent have co-occurring mental health and substance use disorders. Homelessness is widespread in the mental health community as well. Inmates with mental health conditions are twice as likely to have experienced homelessness in the year prior to

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arrest compared to inmates not diagnosed with mental illness. Half of the inmates with mental health conditions in prison were incarcerated for committing non violent crimes. Many have been incarcerated for minor offenses such as trespassing, disorderly conduct and other symptoms of untreated mental illness.

The large number of persons with mental health and substance use conditions in the criminal justice system has enormous fiscal, public safety, health and human costs. MHA supports diverting individuals with mental and substance use conditions away from jails and prisons and toward more appropriate and culturally competent community-based mental health care has emerged as an important component of national, state and local strategies to provide effective mental health care; to enhance public safety by making jail and prison space available for violent offenders; to provide judges and prosecutors with alternatives to incarceration; to provide specialty training to law enforcement and probation personnel to deal effectively with mental health and substance use issues; and to reduce the social cost of providing inappropriate mental health services or no services at all.

The escalating prevalence of individuals with mental illness in confinement calls for new and alternative solutions. The success of diversion programs in communities across the country is generating genuine excitement and hope that real progress can be made in meeting the challenge of criminalization and reducing the toll it exacts on these individuals, their families, service agencies and the criminal justice system. There is an appropriate role for the U.S. Congress to advance strategies that include diversion, improving services and supports during confinement, and generating discharge plans that ensure a successful transition to the community. These programs and policies are especially critical for juveniles.

Mental Health America supports maximum diversion from the criminal justice system for all persons accused of crimes for whom voluntary mental health or substance use treatment is a reasonable alternative to confinement or other criminal sanctions. Diversion programs have been heralded for their potential benefits to the diverted persons, the criminal justice system and the community. MHA urges the utilization of diversion programs at the earliest possible phase of the criminal process, preferably before booking or arraignment. Conversely, MHA supports minimizing the use or threat or use of criminal sanctions to compel mental health treatment. These principles apply with equal force to adults and juveniles.

Another critical issue for individuals with a mental or substance use condition is that of coercion. With a deeper understanding of the role of recovery in the successful treatment of mental health or substance use problems, MHA is wary of the expanded use of the criminal justice system, with its increased focus on persons with mental illness, as a substitute for voluntary community-based treatment that mental health advocates have consistently sought. The sense of dependency and helplessness that comes from linking treatment to incarceration is at the core of the need for effective diversion.

Mental Health America recognizes that the development of diversion programs involves negotiation between the mental health system, law enforcement officers, public defenders, prosecutors, court personnel and others in the criminal justice system. Each community must reach consensus on the type of diversion program appropriate for that community and the

severity of offenses that may disqualify offenders from participation in the program. However, the principal consideration should be assuring that careful consideration is given to diversion of persons with serious mental and substance use conditions despite their charges, which may be more reflective of stigma than the real severity of the offence.

There are two major kinds of jail diversion programs: pre-arrest and post-arrest. Pre-arrest strategies typically focus on the law enforcement officers that are often the first point of contact with persons with mental or substance use conditions in crisis. Since their initial interactions with persons with mental or substance use conditions are so critical to determining the situation's outcome (i.e., whether or not an individual is to be jailed), pre-arrest jail diversion strategies rely heavily on helping police become knowledgeable regarding the nature of mental and substance use conditions, provide tools to de-escalate crisis situations and provide options for treatment alternatives to incarceration that are available in the community.

Examples of pre-arrest strategies include: police training to recognize the signs of mental illness and substance use; deployment of a mobile crisis response team that provide assistance and support to police and the individual; and transportation to treatment rather than jail. Culturally competency is a critical component of such training, to avoid the unequal treatment that comes from stereotyping racial and cultural groups.

Post-booking diversion programs are the more common type of jail diversion program in the United States. After formal charges have been filed, post-booking programs screen individuals to determine the presence of mental or substance use conditions; negotiate with prosecutors, attorneys, courts and mental health providers to dispose of the case without additional jail time; and link the individual with mental health treatment as a condition of a reduction in charges, deferred prosecution or dismissal.

Mental health courts are an example of a post-booking jail diversion program. Mental health courts hear cases involving persons with mental health conditions who have been charged with non-violent crimes. They divert these individuals away from jail or prison by negotiating a treatment program that might include group or day services, psychotropic medication, case management or inpatient hospitalization in order to restore defendants to stable functioning in their communities.

Studies show that diversion of persons with mental and substance use conditions accused of misdemeanor crimes into appropriate, community-based mental health treatment programs allows for better long-term results for offenders. A collaborative program between the U.S. federal prison system and community healthcare providers in Baltimore was studied for recidivism among released inmates. This is one of the few studies that looked at both pre- and post-booking recidivism. The rate of violation of probation, parole, or supervision was 19% after participation in a diversion program while this same group of offenders had a violation rate of 56% before their current release. Researchers believe this result is attributed in part to the close working relationship between the clinical team and the probation officer as well as clinicians being able to gain a better understanding of the community supervision system. This new cooperation between the contracting agencies would allow all treatment options to be exhausted before sanctions are deemed necessary. A more recent study has reiterated this

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finding and shown that program participants incurred less jail days, hospital days, and number of arrests post-program participation compared to one year prior to arrest.

Mental Health America believes that successfully completed pre-booking and/or post-booking diversion programs should provide for dismissal of criminal charges. In the case of post-booking diversion, jeopardy of re-involvement in the criminal justice system should be limited in accordance with the criminal justice standards in that jurisdiction. As a guideline, conditions of deferred prosecution, deferred sentence or probation ordinarily should not exceed one year.

Timely and accurate mental health screening and evaluation is the single most critical element in a successful diversion program. More treatment resources are desperately needed. Communities must develop services that meet the needs of mental health and substance use consumers. In addition to significant increases in public investment, services must be integrated across public and private agencies. Individual treatment plans should be focused on consumer recovery and choice and should include: mental and physical healthcare, case management, appropriate housing, supportive education, integrated substance abuse treatment, and psychosocial services, in the least restrictive environment possible.

These tools (eg, screening, treatment and discharge plans) are particularly critical with juveniles because children and adolescents with emotional disorders are especially vulnerable in jails or prisons. Overcrowding often contributes to inadequacy of mental health services and to ineffective classification and separation of classes of persons confined. It can both increase vulnerability and exacerbate emotional disorders. Young people who suffer from acute mental disorders or who are actively suicidal should be placed in or transferred to appropriate medical or mental health units or facilities and returned to general population only with medical clearance.

Diversion programs also require the development of community coalitions, including but not limited to partnerships between criminal justice, mental health and substance abuse treatment agencies. Criminal justice and corrections agencies should be encouraged to develop new sources of funding to expand diversion programs. Coalitions should also be reflective of the diverse make-up of the community. Joint mobile outreach services such as crisis intervention teams are a key element in successful partnering between mental health, substance abuse treatment and law enforcement agencies, with effective diversion to an appropriate treatment plan the critical measure of success. Consumers of mental health and substance abuse services and family members affected by mental illness or substance use need to be included in such coalitions to assure that the real barriers to effective mental health and substance abuse treatment in that community are addressed. These community coalitions need to reach out to all criminal justice system personnel to ensure that comprehensive culturally competent training is provided at all levels to deal with issues of mental illness and substance use, wherever and whenever they occur.

NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

LINDA ROSENBERG, MSW WILLIAM H. KYLES, MA, MPA

TESTIMONY

Submitted on behalf of National Council for Community Behavioral Healthcare

"Human Rights at Home: Mental Illness in U.S. Prisons and Jails"

Senate Judiciary Committee

Subcommittee on Human Rights and the Law

September 15, 2009

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Mental Illness and Addiction among Justice Involved Individuals

The National Council for Community Behavioral Healthcare would like to thank Senator Durbin and the Committee for convening the hearing entitled, "Human Rights at Home: Mental Illness in U.S. Prisons and Jails." The National Council welcomes the opportunity to comment on the urgent need to address the overwhelming number of individuals under criminal justice supervision who are in need of care for a mental illness and/or substance use disorder. The National Council represents 1,600 Community Behavioral Health Centers and other safety net community-based agencies. Collectively, they serve over 6 million low-income children and adults with mental health and addiction disorders nationwide, many of whom are justice-involved individuals.

Background

There are more than 2.2 million people held in federal and state prisons or in local jails in the United States. The U.S. Department of Justice estimated in 2005 that more than half of all individuals in both prison and jail had a mental health problem and that in 2002 more than two thirds of inmates in jail were dependent on or abusing alcohol or drugs. Each year, more than 1.1 million people diagnosed with mental illnesses are arrested and booked into jails in the United States. Roughly three-quarters of these individuals also experience co-occurring substance use disorders, which increase their likelihood of becoming involved in the justice system. On any given day, between 300,000 and 400,000 people with mental illnesses are incarcerated in jails and prisons across the United States, and more than 500,000 people with mental illnesses are under correctional control in the community.[i]

As the number of individuals with criminal records in the United States continues to rise, there is a proportionate increase in the number who have mental health and/or substance use disorders. In many cases, the reason for their arrest is associated with "their lack of income and their unmet need for services, such as mental health and addiction treatment, and supports, such as housing and employment that are essential to life in the community."[ii] The National Council is concerned with this alarming trend and

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urges the Congress and Administration to support policy initiatives that ensure that individuals with mental illness and substance use disorders are diverted from incarceration when appropriate and linked with healthcare and support services before release in order to assist their re-entry into the community and to reduce recidivism. Such policy initiatives include funding for the Second Chance Act and the Mentally Ill Offender Treatment Crime Reduction Act. Critical programs targeted at treatment for justice involved individuals also reside within the Department of Health and Human Service's Substance Abuse and Mental Health Services Administration (SAMHSA) and expanded resources for SAMHSA programs, including the Substance Abuse Prevention and Treatment Block Grant and the Mental Health Services Block Grant, would significantly expand treatment availability.

Implications of Benefit Disenrollment for Incarcerated Individuals with Mental Illness

Incarcerated individuals with mental illness have higher rates of homelessness, unemployment, past physical and sexual abuse, and substance abuse and dependency than those without mental problems.[iii] Individuals returning to communities upon release from jail and prison face numerous barriers to successful transition including limited access to subsidized housing, job prospects, educational opportunities, and health insurance. Many individuals with criminal records do not have access to employer-based health insurance through work and must rely on public funding for medical care.

Corrections facilities spend substantial amounts of money to provide mental health services and medications to incarcerated persons, yet due to a lack of coordination, many are released without access to services in the community, compromising their recovery. For newly released inmates seeking medical coverage, applications for Medicaid enrollment can take up to 3 to 5 months for approval. As a result, the released person is likely to enter the community without access to mental health and addiction services for 90 days or more, increasing the risk of relapse, re-hospitalization, and recidivism.[iv]

Medicaid coverage upon release increases the likelihood of persons with mental illness receiving continuity of care. A study conducted by Morrissey et al. (2006) found that persons enrolled in Medicaid upon release are more likely "[...] to receive services more quickly, and to receive more days of service than those without Medicaid in the 90 days after their release from jail." In a second study, Morrissey et al. (2007) found that inmates with mental illness who are enrolled in Medicaid at the time of release have fewer detentions in the following year than those released without enrollment in Medicaid, thus indicating reduced recidivism rates.[v]

Federal policy has encouraged states to suspend SSI and Medicaid benefits during incarceration, yet many states continue to terminate eligibility for these programs. Clearly, this discrepancy needs to be addressed in order to ensure that incarcerated individuals receive federal benefits and are able to access the necessary services the day they leave jail or prison. As permitted by federal policy, the National Council urges that legislation be adopted by states to suspend, rather than terminate, the Medicaid benefits of eligible individuals during incarceration. To implement legislation successfully, state governments and local correctional facilities need to work in partnership to integrate their systems and communicate effectively to ensure individuals have access to benefits when released. In the interim, state and local agencies should work with correctional facilities to identify those who are eligible upon release, quickly reinstate benefit eligibility, and utilize strategies to ensure continuous care.

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Court-Involved Youth

Many youth who come into contact with the juvenile justice system suffer from mental health and substance abuse problems and addiction. According to the National Institute on Drug Abuse, from 1986 to 1996, drug-related juvenile incarcerations increased nearly threefold. Studies have documented that there is significant overlap between the populations of youth served by community mental health agencies and youth in contact with the community's juvenile court. In 2000, among adolescents detained for offenses, 56 percent of boys and 40 percent of girls tested positive for drug use. Alarmingly, the number of youth incarcerated within the adult population of 2.2 million is increasing. A recent brief authored by the National Council on Crime and Delinquency (NCCD) showed a significant increase over the past decade of youth entering the adult criminal justice system, specifically adult jails. Today, one in 10 youth incarcerated in the U.S. are admitted to an adult prison or jail.

Mental health and substance abuse services must be provided to young people under community supervision and those in secure settings in order to help them achieve success. We strongly recommend swift passage of S. 678, the Juvenile Justice and Delinquency Prevention Reauthorization Act of 2009, because it strengthens and updates critical components of the Juvenile Justice Delinquency and Prevention Act (JJDPA), which has been protecting youth across the nation for over 30 years. Additionally, S. 678 makes meaningful improvements that expand several of the core protections and other areas contained in the bill, including strengthening emphasis on the need for mental health and substance abuse services for young people in the juvenile justice system.

Strategies to Support Continuity of Care for Court-involved Adults and Youth

Several strategies can be employed to ensure continuity of care for court-involved adults and youth with mental health and substance use disorders. These include, but are not limited to:

- **Suspension of eligibility instead of termination:** As suggested previously, state Medicaid policy could allow incarcerated individuals—where applicable by Federal law—to maintain Medicaid eligibility, to ensure continuity of care. Released individuals would then be able to go directly to a Medicaid provider, demonstrate eligibility, and receive services, without interrupting access to medications and other treatment. This is the most desirable approach since it does not require that a new application be filed and benefits can be restored with minimal delay.

- **Pre-release planning:** For those whose benefits were terminated or who were not previously enrolled, a desirable option is to ensure that an application for Medicaid, SSI and other benefits are submitted well in advance of release (at least 1 to 3 months prior) so that assistance is available upon release. A variety of Federal, state, and local funds and grants support enrollment in public programs as part of the discharge planning process. Pre-release planning varies by the length of an individual's incarceration period, the size of the correctional facility, and the resources available. Planning programs can include ensuring that the individual has identification cards (i.e. for Medicaid), a supply of medications, and community resource supports (i.e. food stamps, cash assistance, and housing) upon release. Co-locating relevant specialized staff (i.e. trained social workers) or local Social Security Administration staff at the institution to facilitate the process is advisable. A case study from Texas indicates that having a single agency with

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responsibility for discharge planning (especially assisting with benefit enrollment) is most effective.

- **Diversion programs.** These programs divert individuals with mental illness and/or substance use disorders to community-based services as an alternative to incarceration to prevent them from cycling in and out of the criminal justice system and their community services. Providing appropriate services and addressing the complex needs of diverted individuals enables them to live successfully in the community, thereby reducing the risk of homelessness, recidivism, and institutionalization.

- **Re-Entry Programs.** These programs are designed to connect individuals released from incarceration with supports and services that foster effective integration into the community. Evidence-based programs are comprehensive in nature and include a range of services designed to reduce recidivism, particularly pre-release programs, mental health and drug treatment, transitional housing support, and vocational training/placement.

Additional Programs of Importance:

- **Forensic Intensive Case Management (FICM)** is designed for justice-involved people with multiple and complex needs and features services provided when and where they are needed. FICM focuses on brokering rather than providing services directly, making it less expensive than ACT. For a brokered service model to be effective, communities must have adequate and accessible services to which individuals can be linked. What makes these services "forensic" is "criminal justice savvy," that is, providers understand the criminal justice system and the predicaments of their clients involvement in it.[vi]

- **Supportive Housing** is permanent, affordable housing linked to a broad range of supportive services, including treatment for mental and substance use disorders. Supportive housing can significantly decrease the chance of recidivism to jails and prisons and is less costly on a daily basis than jail or prison. Unfortunately, affordable housing is in short supply in many communities, and individuals with drug-related offenses often have trouble securing public housing assistance. Housing for justice-involved individuals must balance the needs for supervision and the provision of social services.[vii]

- **Peer Support Services** can expand the continuum of services available to people with mental and substance use disorders and may help them engage in treatment. Forensic peer specialists bring real-world experience with multiple service systems and an ability to relate one-on-one to people struggling to reclaim their lives. The practice of consumer-driven care—as exemplified by the involvement of mental health consumers in service design, delivery, and evaluation—is at the heart of a transformed mental health system.

Over the past 50 years we have gone from institutionalizing people with mental illnesses, often in subhuman conditions, to incarcerating them at unprecedented and appalling rates—putting recovery out of reach for millions of Americans. Clearly, jails and prisons were never intended as a community's primary setting to provide acute care services to individuals experiencing serious mental illnesses. In most

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cases they are ill equipped to do so. We must move toward a day when people with mental and substance use disorders receive the effective community-based interventions they need and deserve, and jails and prisons no longer are forced to serve as primary, de facto treatment facilities.[viii]

Thank you for your attention to this important issue. Please feel free to contact Alexa Eggleston, Director of Public Policy, at alexae@thenationalcouncil.org, 202-684-7457 ext 243, or Chuck Ingoglia, Vice President of Policy, chuckI@thenationalcouncil.org , 202-684-7457 ext 249 if you have any questions about the information presented in this document or would like to receive additional information about the National Council for Community Behavioral Healthcare.

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[i] Ending an American Tragedy: Addressing the Needs of Justice-Involved People with Mental Illnesses and Co-Occurring Disorders. National Leadership Forum on Behavioral Health/Criminal Justice Services, September, 2009. Available online at www.thenationalcouncil.org.

[ii] The Bazelon Center for Mental Health Law. (2001). For people with serious mental illnesses: Finding the key to successful transition from jail to community. Washington, D.C.

[iii] *Id at 1.*

[iv] Issue Brief: Continuity of Care for Justice Involved Individuals with Mental Illness, available online at http://www.thenationalcouncil.org/galleries/policy-file/Continuity%20of%20benefits%20for%20justice%20involved%20individuals%20with%20MI.pdf

[v] *Id at 1.*

[vi] *Id.*

[vii] *Id.*

[viii] *Id.*

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National Council on Disability

An independent federal agency making recommendations to the President and Congress
to enhance the quality of life for all Americans with disabilities and their families.

September 21, 2009

Subcommittee on Human Rights and the Law
Senate Committee on the Judiciary
Washington, DC 20510

Dear Chairman Durbin and Ranking Member Coburn:

I am pleased to write to you on behalf of the National Council on Disability (NCD), an independent federal agency, to provide policy recommendations regarding youth with disabilities who are involved in the juvenile justice system in order to be considered part of the record for the Subcommittee's September 15, 2009 hearing entitled "Human Rights at Home: Mental Illness in U.S. Prisons and Jails."

During the hearing's opening remarks, Chairman Durbin highlighted the prevalence of mental illness in juvenile facilities in Cook County, which is true of the nation as a whole. A significant percentage of youth detained in correctional facilities each year has serious mental disabilities and a commensurately large percentage has addictive disorders. Many have education-related disabilities and are eligible for special education and related services.

Several years ago, NCD undertook a report entitled "Addressing the Needs of Youth with Disabilities in the Juvenile Justice System: The Current Status of Evidence-Based Research" in recognition that children and youth with disabilities had increasingly become overrepresented in the juvenile justice system. While the report is several years old, many of its findings and recommendations are still very much timely and relevant. Following this cover letter, we offer summary excerpts from the report to be considered part of the record for the Subcommittee's September 15, 2009 hearing entitled "Human Rights at Home: Mental Illness in U.S. Prisons and Jails."

NCD is composed of 15 members, appointed by the President, with the consent of the U.S. Senate, and a staff that supports the Council's work. The purpose of NCD is to promote policies, programs, practices, and procedures that guarantee equal opportunity for all individuals with disabilities, and that empower individuals with disabilities – including youth – to achieve economic self-sufficiency, independent living, and integration into all aspects of society. To accomplish this, we gather stakeholder input, review federal programs and legislation, and provide advice to the President, Congress and governmental agencies. Much of this advice comes in the form of timely reports and papers NCD releases throughout each year.

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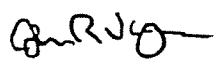
If you have any questions about this submission, please contact NCD Executive Director Michael Collins by phone at (202) 272-2004, or email at mcollins@ncd.gov. On behalf of NCD, thank you for your leadership in focusing attention on this important topic. I also thank you for the opportunity to submit this statement for the record.

Respectfully,



John R. Vaughn
Chairperson

National Council on Disability

An independent federal agency making recommendations to the President and Congress
to enhance the quality of life for all Americans with disabilities and their families.

Addressing the Needs of Youth with Disabilities in the Juvenile Justice System: The Current Status of Evidence-Based Research

National Council on Disability
May 1, 2003

Read the full report at:
http://www.ncd.gov/newsroom/publications/2003/juvenile.htm

Major Findings

- Any challenges to implementing disability law in schools are magnified in the juvenile justice system, where there is little understanding of disabilities or disability law and where few resources exist to adequately address the needs of youth with disabilities.
- Most sources suggest that many schools are not providing legally required services to youth with disabilities. The needs/services gap appears to be even greater in the juvenile justice system, where the primary focus is on sanctioning youth for their delinquent behavior, not on providing services. Systematic, empirical documentation of these gaps does not currently exist or is not readily available.
- There are many opportunities for improving both research and practice. However, the existence of such opportunities by themselves is insufficient to result in a change in the levels and quality of programming and enforcement of juvenile justice and disability law.
- Some research and anecdotal evidence suggests that as schools have become more restrictive and punitive (e.g., zero tolerance approaches to misbehavior), they have increasingly pushed greater numbers of youth with disabilities into the juvenile justice system. Many observers speculate that the failure of many schools to fully and consistently implement federal law, especially the Individuals with Disabilities Education Act, has contributed to this process.
- Few local, state, or national organizations maintain consistent or reliable records of the types and levels of services or funding of programs that focus on youth with disabilities who are at risk of entering or involved in the juvenile justice system.
- Despite calls for significant prevention and early intervention efforts in schools and the juvenile justice system, there is little evidence that such efforts are widespread. The absence is notable because research suggests that such programming may be the only effective method for reducing the involvement of youth with disabilities in the juvenile justice system, especially in the "deeper end" of the system (e.g., correctional facilities).

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- Racial/ethnic minorities, including Native American youth, are overrepresented at most stages of the juvenile justice system and among the population of youth with disabilities. Yet, there is little evidence that juvenile justice systems are providing appropriate disability-related programming for this population, or that they have developed culturally appropriate approaches for these youth.
- A range of increasingly popular intervention strategies and trends exists in schools and the juvenile justice system. Although some explicitly focus on youth with disabilities, many more diffusely focus on youth with behavioral problems. The more popular disability and delinquency intervention strategies and trends include positive behavioral support treatment; alternative education; diversion from the juvenile justice system; restorative justice; specialized youth courts; and greater intra- and interagency information-sharing.
- Researchers have not systematically identified and assessed interventions or practices that focus primarily on youth with disabilities who are at risk of delinquency or are involved in the juvenile justice system. As a result, there remains little scientific basis for recommending specific programs for these youth.

Major Recommendations

- Identify a range of strategies to enforce and promote compliance with federal disability law as it relates to children and youth with disabilities who are at-risk of delinquency. The strategies should include those that increase effective programming for youth with disabilities in schools and in juvenile justice settings.
- Increase funding and/or resources to schools and the juvenile justice system to ensure that youth with disabilities receive appropriate services.
- Designate a single federal agency whose sole focus is to ensure that the rights and needs of youth with disabilities entering or in the juvenile justice system are addressed. The Coordinating Council on Juvenile Justice and Delinquency Prevention and the President's Task Force on Disadvantaged Youth may be well-suited to provide the direction and leadership to address this gap by helping to create a national commission focused explicitly on youth with disabilities at risk of entering or already in the juvenile justice system.
- Conduct research that focuses on establishing the true prevalence of youth with disabilities of different types among at-risk populations in schools and across all stages of the juvenile justice system; the needs/services gap, including compliance with disability law; the causes of overrepresentation, where it exists, of youth with disabilities in the juvenile justice system, especially correctional facilities; and effective systems-level and program-level approaches, including federal laws, for addressing the needs of these youth, including particular attention to the types of programming most effective for youth from diverse racial/ethnic and cultural backgrounds.
- Undertake a comprehensive assessment to determine what programs and policies are most effective in schools, communities, and the juvenile justice system. At the same time, ensure that there is a balanced approach to funding diverse programs and policies, coupled with evaluation research studies of their effectiveness. Such an approach will ensure that a more definitive body of knowledge can develop to determine "what works" and for whom.

Conclusions

Knowledge Gaps

There is a tremendous gap in empirically based knowledge about children and youth with disabilities, especially those who are either at risk of delinquency or involved in the juvenile justice system. This gap covers a wide spectrum of largely unanswered questions involving distinct sets of policy issues. These issues range from the potentially conflicting philosophies underlying existing laws to what is known about effective prevention, intervention, and delinquency management strategies and efforts to ensure that the rights and needs of children and youth with disabilities are addressed.

Weakness of Existing Research

The bulk of research on the children and youth of focus in this report--those with disabilities who are at risk of delinquency or involved in the juvenile justice system--provides a relatively weak foundation for drawing sound empirical generalizations. For example, one of the only relatively well-studied issues relating to this population is the prevalence of disabilities among incarcerated youth. NCD's research suggests that disabilities, especially learning disabilities and serious emotional disorders, are far more common among incarcerated youth than among youth in schools. Yet this research, too, suffers from inconsistent definitions and measurements. In addition, it provides a weak foundation for making generalizations about youth in other parts of the juvenile justice system, including probation, parole, and nonsecure residential treatment facilities. These problems are even more endemic in the other areas covered in this report.

Research Needed

This report has many implications for research and policies focused on children and youth with disabilities who are at risk of delinquency or justice system involvement or who are already involved in the juvenile justice system. The challenges are numerous, but in almost all instances the need for more and better research is clear. Which areas should be prioritized must ultimately be determined by policymakers and practitioners. Clearly, a more complete and accurate portrait of the kinds of disabilities present among youth referred to the juvenile justice system is needed. At the same time, research is needed on the extent to which youth with disabilities are having their needs addressed at all stages of the juvenile justice system. Research is needed as well on effective programming. Which areas require greater attention can be determined only by the priorities of specific stakeholders (e.g., schools, probation departments, correctional facilities, communities). However, advances in knowledge in any of these areas likely will contribute to a greater ability to decrease delinquency among children and youth with disabilities, to ensure that the needs of these children and youth are effectively addressed, and to enhance positive physical, mental, educational, and other life outcomes among this population.



Written Statement

of the

National Disability Rights Network

U.S. Senate Committee on the Judiciary

Subcommittee on Human Rights and the Law

hearing

"Human Rights at Home: Mental Illness in U.S. Prisons & Jails"

September 15, 2009

The National Disability Rights Network, on behalf of the federally-mandated Protection and Advocacy (P&A) System, thanks you for holding this critically important hearing about prisoners with mental illness in U.S. prisons and jails.

Congress created the national P&A System as an independent, external oversight system for facilities where individuals with disabilities can be found, including correctional facilities.[1] Because individuals with severe mental illness who are involuntarily confined in locked facilities are particularly vulnerable to abuse, Congress conferred on P&A agencies the right to access correctional facilities to monitor conditions of confinement and investigate incidents of probable abuse.

The National Disability Rights Network (NDRN) is a nonprofit membership organization for the P&A System, created by Congress in the 1970's to protect the rights of all individuals with disabilities and their families.[2] With a P&A agency in every state, the District of Columbia, and five U.S. Territories,[3] the P&A System seeks to uncover and eliminate the maltreatment of individuals with disabilities and ensure compliance with laws designed to protect their rights, including prisoners with mental illness confined in correctional facilities.

A. Abusive conditions and practices in correctional facilities -- prisoners with psychiatric disabilities.

We share your concerns about the harmful use of isolation for incarcerated persons with mental illness. Not only does isolation have no therapeutic or helpful benefit for prisoners who exhibit behavior challenges associated with an untreated or improperly treated serious emotional disturbance, isolation inflicts serious physical and psychological damage. P&A agencies have documented all too often the maltreatment of prisoners with severe mental illness who are confined in administrative and disciplinary segregation units for 24 hours a day, where they are deprived of essential mental health treatment and services resulting in unnecessary psychological harm and physical injuries, suicides and deaths.

Prisoners who have a psychiatric disability often exhibit behavioral challenges related to their illness. However, prisons and jails are too quick to label these individuals as antisocial and "bad" rather than seriously mentally ill and in need of services. When placed in maximum security units, all prisoners exhibit symptoms such as massive anxiety, acute confusion, paranoia, concentration and memory problems, and aggressive or self-destructive behaviors. Prisoners who have psychiatric disabilities and are prone to psychotic episodes are also likely to develop these symptoms – however,

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[1] The history of the P&A System and the eight federal grant programs that fund it is available on NDRN's website: http://bit.ly/OdeN2.

[2] Additional information about NDRN and the P&A/CAP system is available online: http://bit.ly/2fCsvD.

[3] The name and contact information for each of the 57 P&A agencies is available by using the "Choose your State" dropdown list on NDRN's website: http://www.ndrn.org/index.htm

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for them this can result in a psychotic breakdown.[4] The failure to provide these prisoners with the mental health treatment and services that are needed to function on par with prisoners who are not living with mental illness, constitutes disability discrimination of the highest magnitude.

We are also concerned about the use of mechanical restraint devices to "manage" the behavior of prisoners with serious psychiatric disabilities. Restraint chairs, four point restraints and related devices have no therapeutic value for such prisoners, and inflict emotional agony for many of them – particularly those in a psychotic state. Many prisoners have died or suffered lasting physical and psychiatric damage while restrained in such devices. At least one court has found the use of these devices in such circumstances as constituting torture.[5]

P&A monitoring in prisons and jails throughout the country has documented a systemic lack of access to appropriate mental health services and treatment in correctional facilities, and violations of standards of basic human rights.[6] This includes, but is not limited to:

- Lock-up facilities with little or no mental health treatment;
- Denial of necessary medications, prescribing wrong medications, overmedicating to chemically "restrain" prisoners, and improper administration of medications;
- Lack of appropriate mental health facilities, and a significantly inadequate number of in-patient beds;
- An inadequate number of corrections officers, and providing line staff with inadequate training for managing prisoners with mental illness;
- Insufficient mental health staff to treat the growing number of prisoners with mental illnesses;

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[4] *Walker v. State,* 316 Mont. 103, 68 P.2d 872 (2003). *See also,* Stuart Grassian, "The Psychiatric Effects of Solitary Confinement" in *Journal of Law & Policy,* Vol. 22:325 (2006).

[5] In *Hadix v Caruso*, 461 F.Supp.2d 574 (W.D. Mich., 2006) , Judge Richard Enslen reviewed recent deaths of prisoners with mental illness. One who had a history of bipolar disorder died after spending 5 days in a segregation cell laying naked in four-point restraints for disobedience (which expert testimony established to be the result of being floridly psychotic) during a heat wave. With regard to mechanical restraints, the Court reviewed Supreme Court 8th Amendment jurisprudence, and found the punitive use of mechanical restraints to be comparable to pillory and constituting "torture" (deliberate, systematic or wanton administration of cruel, inhumane, and degrading punishment during imprisonment or detainment).

[6] For an example of a prison system rife with constitutional deficiencies, see: *Tolerating Failure: The State of Health Care and Mental Health Care Delivery in the Michigan Department of Corrections* (Dec. 2007), available at: http://bit.ly/2LsGZZ.

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- Isolation of prisoners with psychiatric illnesses from human contact which exacerbates their conditions and creates a cycle of dangerous behavior; and

- Conditions of extreme isolation on Supermax units that both cause and exacerbate mental illness, and conditions on a mental health unit that are designed to mimic the conditions at the Supermax to minimize malingering which similarly exacerbates the prisoners' mental illness.

P&As have documented other abusive practices inflicted on persons with mental illness in contact with the criminal justice system:

- The unnecessary incarceration of persons with mental illness due to the failure of law enforcement officers to make reasonable accommodations with respect to decisions to arrest or incarcerate them, and the lack of crisis intervention services as an alternative to incarceration.

- Denial of treatment and services for seriously mentally ill defendants languishing in jails for excessive periods of time while on a waiting list for bed space in forensic facilities that evaluate competency to stand trial and/or provide restorative treatment for those found incompetent to stand trial.

- The frequent problem of successful suicide attempts while individuals are confined in jail despite the facility being amply aware of these prisoners' histories of mental illness and suicide ideation. One man with a history of suicide attempts by drug overdose was able to commit suicide by overdose of a prescription medication administered by jail personnel. In another incident a jail had been warned that a prisoner had made a recent suicide attempt and wanted to kill himself, but the jail nonetheless released him to the general population and the next day he jumped from the second story to his death.

- The absence of continuity of care while in the prison system, especially when prisoners are transferred between facilities (from jail to prison, between prisons, or from prison back to jail). Medical records often do not accompany prisoners, and are not transmitted in a timely fashion.

- The release of prisoners with mental illness back into the community without arrangements to access necessary medications and mental health services; their illnesses left untreated, they often relapse into psychosis.

B. Recommendations to Congress

In order to address the inhumane and unconstitutional conditions of confinement inflicted on prisoners with psychiatric disabilities, we recommend the following to Congress.

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- Create a **Criminal Justice Protection & Advocacy Program** to supplement the existing resources of P&A agencies so they can expand their oversight of prisons and jails (*see* Part C, *below*).

- Enact S.714, the ***National Criminal Justice Commission Act of 2009***, which would establish a commission to study the entirety of the American criminal justice system and make recommendations for system-wide overhaul.

- Support the development of national standards regarding the treatment, services, staffing and best practices for handling prisoners with psychiatric disabilities, including: mechanisms to keep prisoners with mental illness from being transferred to Supermax units; controls on the practice of arbitrarily changing medications; limits on the use of disciplinary tactics and the practice of disciplining prisoners for behaviors associated with mental illness (e.g. self-harming behaviors); restrictions on the use of mechanical restraints for prisoners with mental illness except when ordered by a doctor as part of a course of treatment, and then for the least amount of time necessary with continuous monitoring; requirements for reasonable out-of-cell time and programming; and adequate suicide prevention protocols.

- Provide incentives for the creation of additional "special needs" beds for prisoners with severe mental illness needing in-patient care.

- Reform the Prison Abuse Remedies Arc (the "PLRA") in order to increase access to the courts for prisoners to file lawsuits seeking to correct unconstitutional conditions of confinement.[7]

C. The need for independent oversight over correctional facilities.

In June 2006, after more than a year of study and several well-attended public hearings, the **Commission on Safety and Abuse in America's Prisons** released an important report, entitled ***Confronting Confinement,*** about violence and abuse in prisons and jails. [8] One of its recommendations is increased oversight and accountability in correctional facilities. In addition to the need for each state to create an independent agency to monitor correctional facilities, the Commission understands the need to build a national system for independent, non-governmental oversight.

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[7] For information about the need to re-introduce and pass the *Prison Abuse Remedies Act of 2007* (H.R. 4109), see Human Rights Watch statement in support: http://bit.ly/3X2rwa.

[8] The Commission's co-chairs are former U.S. Attorney General Nicholas Katzenbach and John J. Gibbons, former Chief Judge of the Third Circuit Court of Appeals. The 21-member, nonpartisan panel includes "respected civic leaders with experience in the administration of justice and law enforcement, seasoned corrections professionals, advocates for the rights of prisoners, former prisoners, and members of the religious community." Information about the Commission and the report are available on the Commission's website: http://bit.ly/4tmNZa.

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Building on the existing P&A system is a cost-effective approach to increasing non-governmental oversight of prisons and jails. Creating and funding a Criminal Justice P&A (CJ P&A) Program taps into the existing national P&A System, a well-established, network in every state and U.S. territory, with a proven track record for more than 30 years.[9]

P&As have unique federally-mandated authority to access correctional facilities to monitor and investigate conditions and practices. The largest cross-disability network in the nation, the P&A System brings independence, disability expertise, experience, and knowledge of evidence-based practices.

The increasing number of prisoners with disabilities, including psychiatric disabilities, creates urgency to providing funding for P&A agencies to expand their oversight in prisons and jails. All P&As have an interest in and commitment to doing this work but cite lack of funding and resources as the primary barrier. Formula grants for P&A criminal justice advocacy will meet this need.

With funding to engage in this work, P&As will tailor their activities to the unique needs and issues in their jurisdictions. The range of potential P&A activities includes:

- √ **Monitoring and oversight**: Identifying dangerous conditions and practices that place prisoners with disabilities at risk of harm, and advocacy for reforms to correct dangerous conditions and practices.

- √ **Consulting with correctional facilities**. Providing training for facility staff on the rights of prisoners with disabilities under federal and state law, and how to recognize the signs and symptoms of disabilities. Consulting with facilities about making appropriate accommodations under the Americans with Disabilities Act (ADA), and providing special education services for prisoners with disabilities entitled to services under the Individuals with Disabilities Education Act (IDEA).

- √ **Discharge planning advocacy:** Promoting the reintegration of prisoners with mental illness into their communities with the services and supports they need to be successful (e.g.., education, employment, health and mental health care) and reduce recidivism. This includes assistance with reactivating or initiating Social Security benefits and access to Medicaid.

[9] There also is a need for a national Juvenile Justice (JJ) P&A Program which appropriately can be included in the Reauthorization of the Juvenile Justice and Delinquency Prevention Act (JJDPA). Frequently Answered Questions about the need for a JJ P&A Program is posted on NDRN's website: http://www.ndrn.org/issues/jj/faq.htm

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CONCLUSION

Identifying and appropriately meeting the treatment and service needs of prisoners with psychiatric disabilities is a win-win solution for prisoners and correctional facilities. It decreases self-harming behaviors, suicides, and deaths. Decreasing challenging behaviors of mentally ill prisoners reduces injuries to them and to correctional staff. It also reduces staff turnover and increases staff morale. The facility also lowers its risk of liability for injuries, suicides, and deaths. Improved discharge planning reduces recidivism, and increases public safety. Ultimately the financial savings from reduced injuries, staff turnover, and liability can be used to provide treatment and services.

Creating a national Criminal Justice P&A Program is a cost-effect approach to increasing non-government oversight of jails and prisons by an existing, independent national network that has disability expertise, monitoring experience, a federally-mandated authority to access prisons and prisoners, and a proven track record of systems reform.

Thank you for this opportunity to share this information, and for the Committee's leadership in increasing awareness of these vitally important issues.

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What happens inside jails and prisons does not stay inside jails and prisons. It comes home with prisoners after they are released and with corrections officers at the end of each day's shift.

We must create safe and productive conditions of confinement not only because it is the right thing to do, but because it influences the safety, health, and prosperity of us all.

Confronting Confinement, A Report of the Commission on Safety and Abuse in America's Prisons (2006)

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THE NEW YORKER

ANNALS OF HUMAN RIGHTS

HELLHOLE

The United States holds tens of thousands of inmates in long-term solitary confinement. Is this torture?

by Atul Gawande

MARCH 30, 2009



Human beings are social creatures. We are social not just in the trivial sense that we like company, and not just in the obvious sense that we each depend on others. We are social in a more elemental way: simply to exist as a normal human being requires interaction with other people.

Children provide the clearest demonstration of this fact, although it was slow to be accepted. Well into the nineteen-fifties, psychologists were encouraging parents to give children *less* attention and affection, in order to encourage independence. Then Harry Harlow, a professor of psychology at the University of Wisconsin at Madison, produced a series of influential studies involving baby rhesus monkeys.

He happened upon the findings in the mid-fifties, when he decided to save money for his primate-research laboratory by breeding his own lab monkeys instead of importing them from India. Because he didn't know how to raise infant monkeys, he cared for them the way hospitals of the era cared for human infants—in nurseries, with plenty of food, warm blankets, some toys, and in isolation from other infants to prevent the spread of infection. The monkeys grew up sturdy, disease-free, and larger than those from the wild. Yet they were also profoundly disturbed, given to staring blankly and rocking in place for long periods, circling their cages repetitively, and mutilating themselves.

At first, Harlow and his graduate students couldn't figure out what the problem was. They considered factors such as diet, patterns of light exposure, even the antibiotics they used. Then, as Deborah Blum recounts in a fascinating biography of Harlow, "Love at Goon Park," one of his researchers noticed how tightly the monkeys clung to their soft blankets. Harlow wondered whether what the monkeys were missing in their Isolettes was a mother. So, in an odd experiment, he gave them an artificial one.

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In the studies, one artificial mother was a doll made of terry cloth; the other was made of wire. He placed a warming device inside the dolls to make them seem more comforting. The babies, Harlow discovered, largely ignored the wire mother. But they became deeply attached to the cloth mother. They caressed it. They slept curled up on it. They ran to it when frightened. They refused replacements: they wanted only "their" mother. If sharp spikes were made to randomly thrust out of the mother's body when the rhesus babies held it, they waited patiently for the spikes to recede and returned to clutching it. No matter how tightly they clung to the surrogate mothers, however, the monkeys remained psychologically abnormal.

In a later study on the effect of total isolation from birth, the researchers found that the test monkeys, upon being released into a group of ordinary monkeys, "usually go into a state of emotional shock, characterized by . . . autistic self-clutching and rocking." Harlow noted, "One of six monkeys isolated for three months refused to eat after release and died five days later." After several weeks in the company of other monkeys, most of them adjusted—but not those who had been isolated for longer periods. "Twelve months of isolation almost obliterated the animals socially," Harlow wrote. They became permanently withdrawn, and they lived as outcasts—regularly set upon, as if inviting abuse.

The research made Harlow famous (and infamous, too—revulsion at his work helped spur the animal-rights movement). Other psychologists produced evidence of similarly deep and sustained damage in neglected and orphaned children. Hospitals were made to open up their nurseries to parents. And it became widely accepted that children require nurturing human beings not just for food and protection but also for the normal functioning of their brains.

We have been hesitant to apply these lessons to adults. Adults, after all, are fully formed, independent beings, with internal strengths and knowledge to draw upon. We wouldn't have anything like a child's dependence on other people, right? Yet it seems that we do. We don't have a lot of monkey experiments to call upon here. But mankind has produced tens of thousands of human ones, including in our prison system. And the picture that has emerged is profoundly unsettling.

Among our most benign experiments are those with people who voluntarily isolate themselves for extended periods. Long-distance solo sailors, for instance, commit themselves to months at sea. They face all manner of physical terrors: thrashing storms, fifty-foot waves, leaks, illness. Yet, for many, the single most overwhelming difficulty they report is the "soul-destroying loneliness," as one sailor called it. Astronauts have to be screened for their ability to tolerate long stretches in tightly confined isolation, and they come to depend on radio and video communications for social contact.

The problem of isolation goes beyond ordinary loneliness, however. Consider what we've learned from hostages who have been held in solitary confinement—from the journalist Terry Anderson, for example, whose extraordinary memoir, "Den of Lions," recounts his seven years as a hostage of Hezbollah in Lebanon.

Anderson was the chief Middle East correspondent for the Associated Press when, on March 16, 1985, three bearded men forced him from his car in Beirut at gunpoint. He was pushed into a Mercedes sedan, covered head to toe with a heavy blanket, and made to crouch head down in the footwell behind the front seat. His captors drove him to a garage, pulled him out of the car, put a hood over his head, and bound his wrists and ankles with tape. For half an hour, they grilled him for the names of other Americans in Beirut, but he gave no names and they did not beat him or press him further. They threw him in the trunk of the car, drove him to another building, and put him in what would be the first of a succession of cells across Lebanon. He was soon placed in what seemed to be a dusty closet, large enough for only a mattress. Blindfolded, he could make out the distant sounds of other hostages. (One was William Buckley, the C.I.A. station chief who was kidnapped and tortured repeatedly until he weakened and died.) Peering around his blindfold, Anderson could see a bare light bulb dangling from the ceiling. He received three unpalatable meals a day—usually a sandwich of bread and cheese, or cold rice with canned vegetables, or soup. He had a bottle to urinate in and was allotted one five- to ten-minute trip each day to a rotting bathroom to empty his bowels and wash with water at a dirty sink. Otherwise, the only reprieve from isolation came when the guards made short visits to bark at him for breaking a rule or to threaten him, sometimes with a gun at his temple.

He missed people terribly, especially his fiancée and his family. He was despondent and depressed. Then, with time, he began to feel something more. He felt himself disintegrating. It was as if his brain were grinding down. A month into his confinement, he recalled in his memoir, "The mind is a blank. Jesus, I always thought I was smart. Where are all the things I learned, the books I read, the poems I memorized? There's nothing there, just a formless, gray-black misery. My mind's gone dead. God, help me."

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He was stiff from lying in bed day and night, yet tired all the time. He dozed off and on constantly, sleeping twelve hours a day. He craved activity of almost any kind. He would watch the daylight wax and wane on the ceiling, or roaches creep slowly up the wall. He had a Bible and tried to read, but he often found that he lacked the concentration to do so. He observed himself becoming neurotically possessive about his little space, at times putting his life in jeopardy by flying into a rage if a guard happened to step on his bed. He brooded incessantly, thinking back on all the mistakes he'd made in life, his regrets, his offenses against God and family.

His captors moved him every few months. For unpredictable stretches of time, he was granted the salvation of a companion—sometimes he shared a cell with as many as four other hostages—and he noticed that his thinking recovered rapidly when this occurred. He could read and concentrate longer, avoid hallucinations, and better control his emotions. "I would rather have had the worst companion than no companion at all," he noted.

In September, 1986, after several months of sharing a cell with another hostage, Anderson was, for no apparent reason, returned to solitary confinement, this time in a six-by-six-foot cell, with no windows, and light from only a flickering fluorescent lamp in an outside corridor. The guards refused to say how long he would be there. After a few weeks, he felt his mind slipping away again.

"I find myself trembling sometimes for no reason," he wrote. "I'm afraid I'm beginning to lose my mind, to lose control completely."

One day, three years into his ordeal, he snapped. He walked over to a wall and began beating his forehead against it, dozens of times. His head was smashed and bleeding before the guards were able to stop him.

Some hostages fared worse. Anderson told the story of Frank Reed, a fifty-four-year-old American private-school director who was taken hostage and held in solitary confinement for four months before being put in with Anderson. By then, Reed had become severely withdrawn. He lay motionless for hours facing a wall, semi-catatonic. He could not follow the guards' simplest instructions. This invited abuse from them, in much the same way that once isolated rhesus monkeys seemed to invite abuse from the colony. Released after three and a half years, Reed ultimately required admission to a psychiatric hospital.

"It's an awful thing, solitary," John McCain wrote of his five and a half years as a prisoner of war in Vietnam—more than two years of it spent in isolation in a fifteen-by-fifteen-foot cell, unable to communicate with other P.O.W.s except by tap code, secreted notes, or by speaking into an enamel cup pressed against the wall. "It crushes your spirit and weakens your resistance more effectively than any other form of mistreatment." And this comes from a man who was beaten regularly; denied adequate medical treatment for two broken arms, a broken leg, and chronic dysentery; and tortured to the point of having an arm broken again. A U.S. military study of almost a hundred and fifty naval aviators returned from imprisonment in Vietnam, many of whom were treated even worse than McCain, reported that they found social isolation to be as torturous and agonizing as any physical abuse they suffered.

And what happened to them *was* physical. EEG studies going back to the nineteen-sixties have shown diffuse slowing of brain waves in prisoners after a week or more of solitary confinement. In 1992, fifty-seven prisoners of war, released after an average of six months in detention camps in the former Yugoslavia, were examined using EEG-like tests. The recordings revealed brain abnormalities months afterward; the most severe were found in prisoners who had endured either head trauma sufficient to render them unconscious or, yes, solitary confinement. Without sustained social interaction, the human brain may become as impaired as one that has incurred a traumatic injury.

On December 4, 1991, Terry Anderson was released from captivity. He had been the last and the longest-held American hostage in Lebanon. I spoke to Keron Fletcher, a former British military psychiatrist who had been on the receiving team for Anderson and many other hostages, and followed them for years afterward. Initially, Fletcher said, everyone experiences the pure elation of being able to see and talk to people again, especially family and friends. They can't get enough of other people, and talk almost non-stop for hours. They are optimistic and hopeful. But, afterward, normal sleeping and eating patterns prove difficult to reëstablish. Some have lost their sense of time. For weeks, they have trouble managing the sensations and emotional complexities of their freedom.

For the first few months after his release, Anderson said when I reached him by phone recently, "it was just kind of a fog." He had done many television interviews at the time. "And if you look at me in the pictures? Look at my eyes. You can tell. I look drugged."

Most hostages survived their ordeal, Fletcher said, although relationships, marriages, and careers were often lost. Some found, as John McCain did, that the experience even strengthened them. Yet none saw solitary confinement as

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anything less than torture. This presents us with an awkward question: If prolonged isolation is—as research and experience have confirmed for decades—so objectively horrifying, so intrinsically cruel, how did we end up with a prison system that may subject more of our own citizens to it than any other country in history has?

Recently, I met a man who had spent more than five years in isolation at a prison in the Boston suburb of Walpole, Massachusetts, not far from my home. Bobby Dellelo was, to say the least, no Terry Anderson or John McCain. Brought up in the run-down neighborhoods of Boston's West End, in the nineteen-forties, he was caught burglarizing a shoe store at the age of ten. At thirteen, he recalls, he was nabbed while robbing a Jordan Marsh department store. (He and his friends learned to hide out in stores at closing time, steal their merchandise, and then break out during the night.) The remainder of his childhood was spent mostly in the state reform school. That was where he learned how to fight, how to hot-wire a car with a piece of foil, how to pick locks, and how to make a zip gun using a snapped-off automobile radio antenna, which, in those days, was just thick enough to barrel a .22-calibre bullet. Released upon turning eighteen, Dellelo returned to stealing. Usually, he stole from office buildings at night. But some of the people he hung out with did stickups, and, together with one of them, he held up a liquor store in Dorchester.

"What a disaster that thing was," he recalls, laughing. They put the store's owner and the customers in a walk-in refrigerator at gunpoint, took their wallets, and went to rob the register. But more customers came in. So they robbed them and put them in the refrigerator, too. Then still more customers arrived, the refrigerator got full, and the whole thing turned into a circus. Dellelo and his partner finally escaped. But one of the customers identified him to the police. By the time he was caught, Dellelo had been fingered for robbing the Commander Hotel in Cambridge as well. He served a year for the first conviction and two and a half years for the second.

Three months after his release, in 1963, at the age of twenty, he and a friend tried to rob the Kopelman jewelry store, in downtown Boston. But an alarm went off before they got their hands on anything. They separated and ran. The friend shot and killed an off-duty policeman while trying to escape, then killed himself. Dellelo was convicted of first-degree murder and sentenced to life in prison. He ended up serving forty years. Five years and one month were spent in isolation.

The criteria for the isolation of prisoners vary by state but typically include not only violent infractions but also violation of prison rules or association with gang members. The imposition of long-term isolation—which can be for months or years—is ultimately at the discretion of prison administrators. One former prisoner I spoke to, for example, recalled being put in solitary confinement for petty annoyances like refusing to get out of the shower quickly enough. Bobby Dellelo was put there for escaping.

It was an elaborate scheme. He had a partner, who picked the lock to a supervisor's office and got hold of the information manual for the microwave-detection system that patrolled a grassy no man's land between the prison and the road. They studied the manual long enough to learn how to circumvent the system and returned it. On Halloween Sunday, 1993, they had friends stage a fight in the prison yard. With all the guards in the towers looking at the fight through binoculars, the two men tipped a picnic table up against a twelve-foot wall and climbed it like a ladder. Beyond it, they scaled a sixteen-foot fence. To get over the razor wire on top, they used a Z-shaped tool they'd improvised from locker handles. They dropped down into the no man's land and followed an invisible path that they'd calculated the microwave system would not detect. No alarm sounded. They went over one more fence, walked around a parking lot, picked their way through some woods, and emerged onto a four-lane road. After a short walk to a convenience store, they called a taxi from a telephone booth and rolled away before anyone knew they were gone.

They lasted twenty-four days on the outside. Eventually, somebody ratted them out, and the police captured them on the day before Thanksgiving, at the house of a friend in Cambridge. The prison administration gave Dellelo five years in the Departmental Disciplinary Unit of the Walpole prison, its hundred-and-twenty-four-cell super-maximum segregation unit.

Wearing ankle bracelets, handcuffs, and a belly chain, Dellelo was marched into a thirteen-by-eight-foot off-white cell. A four-inch-thick concrete bed slab jutted out from the wall opposite the door. A smaller slab protruding from a side wall provided a desk. A cylindrical concrete block in the floor served as a seat. On the remaining wall was a toilet and a metal sink. He was given four sheets, four towels, a blanket, a bedroll, a toothbrush, toilet paper, a tall clear plastic cup, a bar of soap, seven white T-shirts, seven pairs of boxer shorts, seven pairs of socks, plastic slippers, a pad of paper, and a ballpoint pen. A speaker with a microphone was mounted on the door. Cells used for solitary confinement are often windowless, but this one had a ribbonlike window that was seven inches wide and five feet tall.

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The electrically controlled door was solid steel, with a seven-inch-by-twenty-eight-inch aperture and two wickets—little door slots, one at ankle height and one at waist height, for shackling him whenever he was let out and for passing him meal trays.

As in other supermaxes—facilities designed to isolate prisoners from social contact—Dellelo was confined to his cell for at least twenty-three hours a day and permitted out only for a shower or for recreation in an outdoor cage that he estimated to be fifty feet long and five feet wide, known as "the dog kennel." He could talk to other prisoners through the steel door of his cell, and during recreation if a prisoner was in an adjacent cage. He made a kind of fishing line for passing notes to adjacent cells by unwinding the elastic from his boxer shorts, though it was contraband and would be confiscated. Prisoners could receive mail and as many as ten reading items. They were allowed one phone call the first month and could earn up to four calls and four visits per month if they followed the rules, but there could be no physical contact with anyone, except when guards forcibly restrained them. Some supermaxes even use food as punishment, serving the prisoners nutra-loaf, an unpalatable food brick that contains just enough nutrition for survival. Dellelo was spared this. The rules also permitted him to have a radio after thirty days, and, after sixty days, a thirteen-inch black-and-white television.

"This is going to be a piece of cake," Dellelo recalls thinking when the door closed behind him. Whereas many American supermax prisoners—and most P.O.W.s and hostages—have no idea when they might get out, he knew exactly how long he was going to be there. He drew a calendar on his pad of paper to start counting down the days. He would get a radio and a TV. He could read. No one was going to bother him. And, as his elaborate escape plan showed, he could be patient. "This is their sophisticated security?" he said to himself. "They don't know what they're doing."

After a few months without regular social contact, however, his experience proved no different from that of the P.O.W.s or hostages, or the majority of isolated prisoners whom researchers have studied: he started to lose his mind. He talked to himself. He paced back and forth compulsively, shuffling along the same six-foot path for hours on end. Soon, he was having panic attacks, screaming for help. He hallucinated that the colors on the walls were changing. He became enraged by routine noises—the sound of doors opening as the guards made their hourly checks, the sounds of inmates in nearby cells. After a year or so, he was hearing voices on the television talking directly to him. He put the television under his bed, and rarely took it out again.

One of the paradoxes of solitary confinement is that, as starved as people become for companionship, the experience typically leaves them unfit for social interaction. Once, Dellelo was allowed to have an in-person meeting with his lawyer, and he simply couldn't handle it. After so many months in which his primary human contact had been an occasional phone call or brief conversations with an inmate down the tier, shouted through steel doors at the top of their lungs, he found himself unable to carry on a face-to-face conversation. He had trouble following both words and hand gestures and couldn't generate them himself. When he realized this, he succumbed to a full-blown panic attack.

Craig Haney, a psychology professor at the University of California at Santa Cruz, received rare permission to study a hundred randomly selected inmates at California's Pelican Bay supermax, and noted a number of phenomena. First, after months or years of complete isolation, many prisoners "begin to lose the ability to initiate behavior of any kind—to organize their own lives around activity and purpose," he writes. "Chronic apathy, lethargy, depression, and despair often result. . . . In extreme cases, prisoners may literally stop behaving," becoming essentially catatonic.

Second, almost ninety per cent of these prisoners had difficulties with "irrational anger," compared with just three per cent of the general population.* Haney attributed this to the extreme restriction, the totality of control, and the extended absence of any opportunity for happiness or joy. Many prisoners in solitary become consumed with revenge fantasies.

"There were some guards in D.D.U. who were decent guys," Dellelo told me. They didn't trash his room when he was let out for a shower, or try to trip him when escorting him in chains, or write him up for contraband if he kept food or a salt packet from a meal in his cell. "But some of them were evil, evil pricks." One correctional officer became a particular obsession. Dellelo spent hours imagining cutting his head off and rolling it down the tier. "I mean, I know this is insane thinking," he says now. Even at the time, he added, "I had a fear in the background—like how much of this am I going to be able to let go? How much is this going to affect who I am?"

He was right to worry. Everyone's identity is socially created: it's through your relationships that you understand yourself as a mother or a father, a teacher or an accountant, a hero or a villain. But, after years of isolation, many prisoners change in another way that Haney observed. They begin to see themselves primarily as combatants in the

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world, people whose identity is rooted in thwarting prison control.

As a matter of self-preservation, this may not be a bad thing. According to the Navy P.O.W. researchers, the instinct to fight back against the enemy constituted the most important coping mechanism for the prisoners they studied. Resistance was often their sole means of maintaining a sense of purpose, and so their sanity. Yet resistance is precisely what we wish to destroy in our supermax prisoners. As Haney observed in a review of research findings, prisoners in solitary confinement must be able to withstand the experience in order to be allowed to return to the highly social world of mainline prison or free society. Perversely, then, the prisoners who can't handle profound isolation are the ones who are forced to remain in it. "And those who have adapted," Haney writes, "are prime candidates for release to a social world to which they may be incapable of ever fully readjusting."

Dellelo eventually found a way to resist that would not prolong his ordeal. He fought his battle through the courts, filing motion after motion in an effort to get his conviction overturned. He became so good at submitting his claims that he obtained a paralegal certificate along the way. And, after forty years in prison, and more than five years in solitary, he got his first-degree-homicide conviction reduced to manslaughter. On November 19, 2003, he was freed.

Bobby Dellelo is sixty-seven years old now. He lives on Social Security in a Cambridge efficiency apartment that is about four times larger than his cell. He still seems to be adjusting to the world outside. He lives alone. To the extent that he is out in society, it is, in large measure, as a combatant. He works for prisoners' rights at the American Friends Service Committee. He also does occasional work assisting prisoners with their legal cases. Sitting at his kitchen table, he showed me how to pick a padlock—you know, just in case I ever find myself in trouble.

But it was impossible to talk to him about his time in isolation without seeing that it was fundamentally no different from the isolation that Terry Anderson and John McCain had endured. Whether in Walpole or Beirut or Hanoi, all human beings experience isolation as torture.

The main argument for using long-term isolation in prisons is that it provides discipline and prevents violence. When inmates refuse to follow the rules—when they escape, deal drugs, or attack other inmates and corrections officers—wardens must be able to punish and contain the misconduct. Presumably, less stringent measures haven't worked, or the behavior would not have occurred. And it's legitimate to incapacitate violent aggressors for the safety of others. So, advocates say, isolation is a necessary evil, and those who don't recognize this are dangerously naïve.

The argument makes intuitive sense. If the worst of the worst are removed from the general prison population and put in isolation, you'd expect there to be markedly fewer inmate shankings and attacks on corrections officers. But the evidence doesn't bear this out. Perhaps the most careful inquiry into whether supermax prisons decrease violence and disorder was a 2003 analysis examining the experience in three states—Arizona, Illinois, and Minnesota—following the opening of their supermax prisons. The study found that levels of inmate-on-inmate violence were unchanged, and that levels of inmate-on-staff violence changed unpredictably, rising in Arizona, falling in Illinois, and holding steady in Minnesota.

Prison violence, it turns out, is not simply an issue of a few belligerents. In the past thirty years, the United States has quadrupled its incarceration rate but not its prison space. Work and education programs have been cancelled, out of a belief that the pursuit of rehabilitation is pointless. The result has been unprecedented overcrowding, along with unprecedented idleness—a nice formula for violence. Remove a few prisoners to solitary confinement, and the violence doesn't change. So you remove some more, and still nothing happens. Before long, you find yourself in the position we are in today. The United States now has five per cent of the world's population, twenty-five per cent of its prisoners, and probably the vast majority of prisoners who are in long-term solitary confinement.

It wasn't always like this. The wide-scale use of isolation is, almost exclusively, a phenomenon of the past twenty years. In 1890, the United States Supreme Court came close to declaring the punishment to be unconstitutional. Writing for the majority in the case of a Colorado murderer who had been held in isolation for a month, Justice Samuel Miller noted that experience had revealed "serious objections" to solitary confinement:

> A considerable number of the prisoners fell, after even a short confinement, into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane; others, still, committed suicide; while those who stood the ordeal better were not generally reformed, and in most cases did not recover sufficient mental activity to be of any subsequent service to the community.

Prolonged isolation was used sparingly, if at all, by most American prisons for almost a century. Our first supermax—our first institution specifically designed for mass solitary confinement—was not established until 1983, in

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Marion, Illinois. In 1995, a federal court reviewing California's first supermax admitted that the conditions "hover on the edge of what is humanly tolerable for those with normal resilience." But it did not rule them to be unconstitutionally cruel or unusual, except in cases of mental illness. The prison's supermax conditions, the court stated, did not pose "a sufficiently high risk to all inmates of incurring a serious mental illness." In other words, there could be no legal objection to its routine use, given that the isolation didn't make *everyone* crazy. The ruling seemed to fit the public mood. By the end of the nineteen-nineties, some sixty supermax institutions had opened across the country. And new solitary-confinement units were established within nearly all of our ordinary maximum-security prisons.

The number of prisoners in these facilities has since risen to extraordinary levels. America now holds at least twenty-five thousand inmates in isolation in supermax prisons. An additional fifty to eighty thousand are kept in restrictive segregation units, many of them in isolation, too, although the government does not release these figures. By 1999, the practice had grown to the point that Arizona, Colorado, Maine, Nebraska, Nevada, Rhode Island, and Virginia kept between five and eight per cent of their prison population in isolation, and, by 2003, New York had joined them as well. Mississippi alone held eighteen hundred prisoners in supermax—twelve per cent of its prisoners over all. At the same time, other states had just a tiny fraction of their inmates in solitary confinement. In 1999, for example, Indiana had eighty-five supermax beds; Georgia had only ten. Neither of these two states can be described as being soft on crime.

Advocates of solitary confinement are left with a single argument for subjecting thousands of people to years of isolation: What else are we supposed to do? How else are we to deal with the violent, the disruptive, the prisoners who are just too dangerous to be housed with others?

As it happens, only a subset of prisoners currently locked away for long periods of isolation would be considered truly dangerous. Many are escapees or suspected gang members; many others are in solitary for nonviolent breaches of prison rules. Still, there are some highly dangerous and violent prisoners who pose a serious challenge to prison discipline and safety. In August, I met a man named Robert Felton, who had spent fourteen and a half years in isolation in the Illinois state correctional system. He is now thirty-six years old. He grew up in the predominantly black housing projects of Danville, Illinois, and had been a force of mayhem from the time he was a child.

His crimes were mainly impulsive, rather than planned. The first time he was arrested was at the age of eleven, when he and a relative broke into a house to steal some Atari video games. A year later, he was sent to state reform school after he and a friend broke into an abandoned building and made off with paint cans, irons, and other property that they hardly knew what to do with. In reform school, he got into fights and screamed obscenities at the staff. When the staff tried to discipline him by taking away his recreation or his television privileges, his behavior worsened. He tore a pillar out of the ceiling, a sink and mirrors off the wall, doors off their hinges. He was put in a special cell, stripped of nearly everything. When he began attacking counsellors, the authorities transferred him to the maximum-security juvenile facility at Joliet, where he continued to misbehave.

Felton wasn't a sociopath. He made friends easily. He was close to his family, and missed them deeply. He took no pleasure in hurting others. Psychiatric evaluations turned up little more than attention-deficit disorder. But he had a terrible temper, a tendency to escalate rather than to defuse confrontations, and, by the time he was released, just before turning eighteen, he had achieved only a ninth-grade education.

Within months of returning home, he was arrested again. He had walked into a Danville sports bar and ordered a beer. The barman took his ten-dollar bill.

"Then he says, 'Naw, man, you can't get no beer. You're underage,' " Felton recounts. "I says, 'Well, give me my ten dollars back.' He says, 'You ain't getting shit. Get the hell out of here.' "

Felton stood his ground. The bartender had a pocket knife on the counter. "And, when he went for it, I went for it," Felton told me. "When I grabbed the knife first, I turned around and spinned on him. I said, 'You think you're gonna cut me, man? You gotta be fucked up.' "

The barman had put the ten-dollar bill in a Royal Crown bag behind the counter. Felton grabbed the bag and ran out the back door. He forgot his car keys on the counter, though. So he went back to get the keys—"the stupid keys," he now says ruefully—and in the fight that ensued he left the barman severely injured and bleeding. The police caught Felton fleeing in his car. He was convicted of armed robbery, aggravated unlawful restraint, and aggravated battery, and served fifteen years in prison.

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He was eventually sent to the Stateville Correctional Center, a maximum-security facility in Joliet. Inside the overflowing prison, he got into vicious fights over insults and the like. About three months into his term, during a shakedown following the murder of an inmate, prison officials turned up a makeshift knife in his cell. (He denies that it was his.) They gave him a year in isolation. He was a danger, and he had to be taught a lesson. But it was a lesson that he seemed incapable of learning.

Felton's Stateville isolation cell had gray walls, a solid steel door, no window, no clock, and a light that was kept on twenty-four hours a day. As soon as he was shut in, he became claustrophobic and had a panic attack. Like Dellelo, Anderson, and McCain, he was soon pacing back and forth, talking to himself, studying the insects crawling around his cell, reliving past events from childhood, sleeping for as much as sixteen hours a day. But, unlike them, he lacked the inner resources to cope with his situation.

Many prisoners find survival in physical exercise, prayer, or plans for escape. Many carry out elaborate mental exercises, building entire houses in their heads, board by board, nail by nail, from the ground up, or memorizing team rosters for a baseball season. McCain recreated in his mind movies he'd seen. Anderson reconstructed complete novels from memory. Yuri Nosenko, a K.G.B. defector whom the C.I.A. wrongly accused of being a double agent and held for three years in total isolation (no reading material, no news, no human contact except with interrogators) in a closet-size concrete cell near Williamsburg, Virginia, made chess sets from threads and a calendar from lint (only to have them discovered and swept away).

But Felton would just yell, "Guard! Guard! Guard! Guard! Guard!," or bang his cup on the toilet, for hours. He could spend whole days hallucinating that he was in another world, that he was a child at home in Danville, playing in the streets, having conversations with imaginary people. Small cruelties that others somehow bore in quiet fury—getting no meal tray, for example—sent him into a rage. Despite being restrained with handcuffs, ankle shackles, and a belly chain whenever he was taken out, he managed to assault the staff at least three times. He threw his food through the door slot. He set his cell on fire by tearing his mattress apart, wrapping the stuffing in a sheet, popping his light bulb, and using the exposed wires to set the whole thing ablaze. He did this so many times that the walls of his cell were black with soot.

After each offense, prison officials extended his sentence in isolation. Still, he wouldn't stop. He began flooding his cell, by stuffing the door crack with socks, plugging the toilet, and flushing until the water was a couple of feet deep. Then he'd pull out the socks and the whole wing would flood with wastewater.

"Flooding the cell was the last option for me," Felton told me. "It was when I had nothing else I could do. You know, they took everything out of my cell, and all I had left was toilet water. I'd sit there and I'd say, 'Well, let me see what I can do with this toilet water.' "

Felton was not allowed out again for fourteen and a half years. He spent almost his entire prison term, from 1990 to 2005, in isolation. In March, 1998, he was among the first inmates to be moved to Tamms, a new, high-tech supermax facility in southern Illinois.

"At Tamms, man, it was like a lab," he says. Contact even with guards was tightly reduced. Cutoff valves meant that he couldn't flood his cell. He had little ability to force a response—negative or positive—from a human being. And, with that gone, he began to deteriorate further. He ceased showering, changing his clothes, brushing his teeth. His teeth rotted and ten had to be pulled. He began throwing his feces around his cell. He became psychotic.

It is unclear how many prisoners in solitary confinement become psychotic. Stuart Grassian, a Boston psychiatrist, has interviewed more than two hundred prisoners in solitary confinement. In one in-depth study, prepared for a legal challenge of prisoner-isolation practices, he concluded that about a third developed acute psychosis with hallucinations. The markers of vulnerability that he observed in his interviews were signs of cognitive dysfunction—a history of seizures, serious mental illness, mental retardation, illiteracy, or, as in Felton's case, a diagnosis such as attention-deficit hyperactivity disorder, signalling difficulty with impulse control. In the prisoners Grassian saw, about a third had these vulnerabilities, and these were the prisoners whom solitary confinement had made psychotic. They were simply not cognitively equipped to endure it without mental breakdowns.

A psychiatrist tried giving Felton anti-psychotic medication. Mostly, it made him sleep—sometimes twenty-four hours at a stretch, he said. Twice he attempted suicide. The first time, he hanged himself in a noose made from a sheet. The second time, he took a single staple from a legal newspaper and managed to slash the radial artery in his left wrist with it. In both instances, he was taken to a local emergency room for a few hours, patched up, and sent back to prison.

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Is there an alternative? Consider what other countries do. Britain, for example, has had its share of serial killers, homicidal rapists, and prisoners who have taken hostages and repeatedly assaulted staff. The British also fought a seemingly unending war in Northern Ireland, which brought them hundreds of Irish Republican Army prisoners committed to violent resistance. The authorities resorted to a harshly punitive approach to control, including, in the mid-seventies, extensive use of solitary confinement. But the violence in prisons remained unchanged, the costs were phenomenal (in the United States, they reach more than fifty thousand dollars a year per inmate), and the public outcry became intolerable. British authorities therefore looked for another approach.

Beginning in the nineteen-eighties, they gradually adopted a strategy that focussed on preventing prison violence rather than on delivering an ever more brutal series of punishments for it. The approach starts with the simple observation that prisoners who are unmanageable in one setting often behave perfectly reasonably in another. This suggested that violence might, to a critical extent, be a function of the conditions of incarceration. The British noticed that problem prisoners were usually people for whom avoiding humiliation and saving face were fundamental and instinctive. When conditions maximized humiliation and confrontation, every interaction escalated into a trial of strength. Violence became a predictable consequence.

So the British decided to give their most dangerous prisoners more control, rather than less. They reduced isolation and offered them opportunities for work, education, and special programming to increase social ties and skills. The prisoners were housed in small, stable units of fewer than ten people in individual cells, to avoid conditions of social chaos and unpredictability. In these reformed "Close Supervision Centres," prisoners could receive mental-health treatment and earn rights for more exercise, more phone calls, "contact visits," and even access to cooking facilities. They were allowed to air grievances. And the government set up an independent body of inspectors to track the results and enable adjustments based on the data.

The results have been impressive. The use of long-term isolation in England is now negligible. In all of England, there are now fewer prisoners in "extreme custody" than there are in the state of Maine. And the other countries of Europe have, with a similar focus on small units and violence prevention, achieved a similar outcome.

In this country, in June of 2006, a bipartisan national task force, the Commission on Safety and Abuse in America's Prisons, released its recommendations after a yearlong investigation. It called for ending long-term isolation of prisoners. Beyond about ten days, the report noted, practically no benefits can be found and the harm is clear—not just for inmates but for the public as well. Most prisoners in long-term isolation are returned to society, after all. And evidence from a number of studies has shown that supermax conditions—in which prisoners have virtually no social interactions and are given no programmatic support—make it highly likely that they will commit more crimes when they are released. Instead, the report said, we should follow the preventive approaches used in European countries.

The recommendations went nowhere, of course. Whatever the evidence in its favor, people simply did not believe in the treatment.

I spoke to a state-prison commissioner who wished to remain unidentified. He was a veteran of the system, having been either a prison warden or a commissioner in several states across the country for more than twenty years. He has publicly defended the use of long-term isolation everywhere that he has worked. Nonetheless, he said, he would remove most prisoners from long-term isolation units if he could and provide programming for the mental illnesses that many of them have.

"Prolonged isolation is not going to serve anyone's best interest," he told me. He still thought that prisons needed the option of isolation. "A bad violation should, I think, land you there for about ninety days, but it should not go beyond that."

He is apparently not alone among prison officials. Over the years, he has come to know commissioners in nearly every state in the country. "I believe that today you'll probably find that two-thirds or three-fourths of the heads of correctional agencies will largely share the position that I articulated with you," he said.

Commissioners are not powerless. They could eliminate prolonged isolation with the stroke of a pen. So, I asked, why haven't they? He told me what happened when he tried to move just one prisoner out of isolation. Legislators called for him to be fired and threatened to withhold basic funding. Corrections officers called members of the crime victim's family and told them that he'd gone soft on crime. Hostile stories appeared in the tabloids. It is pointless for commissioners to act unilaterally, he said, without a change in public opinion.

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This past year, both the Republican and the Democratic Presidential candidates came out firmly for banning torture and closing the facility in Guantánamo Bay, where hundreds of prisoners have been held in years-long isolation. Neither Barack Obama nor John McCain, however, addressed the question of whether prolonged solitary confinement is torture. For a Presidential candidate, no less than for the prison commissioner, this would have been political suicide. The simple truth is that public sentiment in America is the reason that solitary confinement has exploded in this country, even as other Western nations have taken steps to reduce it. This is the dark side of American exceptionalism. With little concern or demurral, we have consigned tens of thousands of our own citizens to conditions that horrified our highest court a century ago. Our willingness to discard these standards for American prisoners made it easy to discard the Geneva Conventions prohibiting similar treatment of foreign prisoners of war, to the detriment of America's moral stature in the world. In much the same way that a previous generation of Americans countenanced legalized segregation, ours has countenanced legalized torture. And there is no clearer manifestation of this than our routine use of solitary confinement—on our own people, in our own communities, in a supermax prison, for example, that is a thirty-minute drive from my door.

Robert Felton drifted in and out of acute psychosis for much of his solitary confinement. Eventually, however, he found an unexpected resource. One day, while he was at Tamms, he was given a new defense lawyer, and, whatever expertise this lawyer provided, the more important thing was genuine human contact. He visited regularly, and sent Felton books. Although some were rejected by the authorities and Felton was restricted to a few at a time, he devoured those he was permitted. "I liked political books," he says. " 'From Beirut to Jerusalem,' Winston Churchill, Noam Chomsky."

That small amount of contact was a lifeline. Felton corresponded with the lawyer about what he was reading. The lawyer helped him get his G.E.D. and a paralegal certificate through a correspondence course, and he taught Felton how to advocate for himself. Felton began writing letters to politicians and prison officials explaining the misery of his situation, opposing supermax isolation, and asking for a chance to return to the general prison population. (The Illinois Department of Corrections would not comment on Felton's case, but a spokesman stated that "Tamms houses the most disruptive, violent, and problematic inmates.") Felton was persuasive enough that Senator Paul Simon, of Illinois, wrote him back and, one day, even visited him. Simon asked the director of the State Department of Corrections, Donald Snyder, Jr., to give consideration to Felton's objections. But Snyder didn't budge. If there was anyone whom Felton fantasized about taking revenge upon, it was Snyder. Felton continued to file request after request. But the answer was always no.

On July 12, 2005, at the age of thirty-three, Felton was finally released. He hadn't socialized with another person since entering Tamms, at the age of twenty-five. Before his release, he was given one month in the general prison population to get used to people. It wasn't enough. Upon returning to society, he found that he had trouble in crowds. At a party of well-wishers, the volume of social stimulation overwhelmed him and he panicked, headed for a bathroom, and locked himself in. He stayed at his mother's house and kept mostly to himself.

For the first year, he had to wear an ankle bracelet and was allowed to leave home only for work. His first job was at a Papa John's restaurant, delivering pizzas. He next found work at the Model Star Laundry Service, doing pressing. This was a steady job, and he began to settle down. He fell in love with a waitress named Brittany. They moved into a three-room house that her grandmother lent them, and got engaged. Brittany became pregnant.

This is not a story with a happy ending. Felton lost his job with the laundry service. He went to work for a tree-cutting business; a few months later, it went under. Meanwhile, he and Brittany had had a second child. She had found work as a certified nursing assistant, but her income wasn't nearly enough. So he took a job forty miles away, at Plastipak, the plastics manufacturer, where he made seven-fifty an hour inspecting Gatorade bottles and Crisco containers as they came out of the stamping machines. Then his twenty-year-old Firebird died. The bus he had to take ran erratically, and he was fired for repeated tardiness.

When I visited Felton in Danville last August, he and Brittany were upbeat about their prospects. She was working extra shifts at a nursing home, and he was taking care of their children, ages one and two. He had also applied to a six-month training program for heating and air-conditioning technicians.

"I could make twenty dollars an hour after graduation," he said.

"He's a good man," Brittany told me, taking his arm and giving him a kiss.

But he was out of work. They were chronically short of money. It was hard to be optimistic about Felton's

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prospects. And, indeed, six weeks after we met, he was arrested for breaking into a car dealership and stealing a Dodge Charger. He pleaded guilty and, in January, began serving a seven-year sentence.

Before I left town—when there was still a glimmer of hope for him—we went out for lunch at his favorite place, a Mexican restaurant called La Potosina. Over enchiladas and Cokes, we talked about his family, Danville, the economy, and, of course, his time in prison. The strangest story had turned up in the news, he said. Donald Snyder, Jr., the state prison director who had refused to let him out of solitary confinement, had been arrested, convicted, and sentenced to two years in prison for taking fifty thousand dollars in payoffs from lobbyists.

"Two years in prison," Felton marvelled. "He could end up right where I used to be."

I asked him, "If he wrote to you, asking if you would release him from solitary, what would you do?"

Felton didn't hesitate for a second. "If he wrote to me to let him out, I'd let him out," he said.

This surprised me. I expected anger, vindictiveness, a desire for retribution. "You'd let him out?" I said.

"I'd let him out," he said, and he put his fork down to make the point. "I wouldn't wish solitary confinement on anybody. Not even him." ♦

*Correction, April 6, 2009: Three per cent of the general population had difficulties with "irrational anger," not three per cent of prisoners in the general population, as originally stated.

ILLUSTRATION: BRAD HOLLAND

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Director Randle Testimony before the U.S. Senate Committee on the Judiciary
Subcommittee on Human Rights and the Law
Sept. 15, 2009
10:00 a.m.
Room 226 - Dirksen Senate Office Building.

Introduction:

Mr. Chairman and members of the Subcommittee,

Thank you for the opportunity to speak to the important issues surrounding offenders with diagnosed mental illnesses. My name is Michael Randle and I am the Director of the Illinois Department of Corrections. Prior to my appointment in Illinois, I served as the assistant director of the Ohio Department of Rehabilitation and Correction. In conjunction with the Department of Mental Health, I had oversight responsibility for the Community Linkage Program, which was charged with providing continuity of mental health care to mentally ill persons entering and leaving the prison system.

The issue of mental illness in our prisons and jails is both complex and pervasive. In fact, a recent study conducted by the Bureau of Justice statistics reported that up to 16 percent of the jail and prison population is afflicted with mental illness, which is approximately four (4) times higher for men and eight (8) times higher for women than in the population at large. This disproportionate representation is primarily resultant from policies that have shifted the emphasis from community-based treatment of the at-risk population and priorities that have diverted resources away from treatment providers.

In recognition of these problems, Congress enacted the Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA) in 2004. This Act created the Justice and Mental Health Collaboration Program (JMHCP) to help states and counties design and implement collaborative efforts between the criminal justice community and mental health treatment providers. While the Act authorized $50 million to be granted toward these efforts, only $21.5 million has been appropriated between fiscal years 2006-2009. Due in part to this lack of funding, coupled with record deficits, states and counties have found themselves in dire circumstances with respect to treatment and management of the mentally ill.

The Ohio Experience: Community Linkage Program

In 1995, the State of Ohio created the Community Linkage Program, which was designed to facilitate mental health care for persons entering or leaving the prison system by assisting in policy development, providing information sharing, monitoring outcomes, and providing problem-solving assistance. The program was borne from two concurrent events:

In 1994 the National Coalition for the Mentally Ill in the Criminal Justice System sponsored a policy meeting of teams of interdisciplinary experts from multiple states to

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examine ways and make recommendations to better manage offenders in the criminal justice system with mental health issues, and; the *Dunn vs. Voinivich* lawsuit, which resulted in a consent decree that mandated changes in the delivery of services to offenders with mental illness.

In essence, the program was created as a result of recognized and demonstrated need, and of legal necessity. At its core, the program is designed to bridge the gap between state and local criminal justice and mental health services; it provides a consistent, sustained "link" between these entities from the moment the offender enters the criminal justice system to the time that the offender re-enters the community. The program emphasizes and is designed around the following goals:

- Provide continuity of mental health care for offenders entering and leaving prison
- Reduce recidivism
- Reduce decompensation rates of offenders to avoid hospitalization
- Enhance information sharing across the applicable service delivery systems
- Facilitate problem-solving between corrections and mental health systems to enhance access to community mental health services
- Enhance public safety via intensive re-entry mental health services

Since the inception of this program, the State of Ohio has become a model for other states in formulation of policy regarding treatment of mentally ill offenders. In 2005, PBS produced an award-winning feature entitled "*Frontline: The New Asylum,*" which focused on questions surrounding "why" the mentally ill were in the prison system versus psychiatric hospitals, as well as recommended solutions to the problem. The PBS feature received The Robert F. Kennedy Journalism Award Grand Prize. Within the feature, Dr. Fred Cohen (who led a court-appointed panel of experts overseeing the consent decree, and issued the final progress report), noted that "the mental health system set up by the Ohio Department of Rehabilitation and Correction is unsurpassed by any other prison system in the country." Additionally, several other states have worked with Ohio to learn and adopt its principles and practices to better manage these offenders.

Status of Services in Illinois:

Like other states, Illinois prisons and jails are facing crisis levels of mentally ill offenders. Recent figures indicate that between 20-25 percent of the inmate population in Illinois are carried on the mental health caseload, with 12 percent requiring psychotropic medication. This large caseload, along with fiscal challenges and inadequate community resources, has created difficulties with managing offenders while incarcerated, as well as difficulty in providing re-entry services.

The Illinois Department of Corrections has historically issued a 14-day supply of psychotropic drugs to such offenders upon release. Unfortunately, it usually takes months for such offenders to acquire access to the mental health services that they need; this gap from access to services can and does lead to decompensation and often

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recidivism. In light of this, the department has begun to initiate a linkage program that will provide continuity of care for these offenders throughout incarceration and re-entry.

Upon notification that a mentally ill inmate is within 180 days of his or her projected release date, mental health professionals review the inmate's diagnosis, list of medications, need for follow-up services, community treatment provider information, and any additional information necessary for continuity of care during the re-entry process.

However, before a mentally ill inmate is released back into the community, it is imperative to prepare the inmate as well as possible to navigate the challenges that the inmate will face upon re-entry and strategies to facilitate community service linkage. To that end, the Office of Mental Health is preparing to implement a multi-week re-entry program to help prepare mentally ill inmates, who are being released or discharged from the Illinois Department of Corrections.

This program will consist of four phases (Orientation, Education, Referrals, and Readiness Evaluation), during which mentally ill inmates (and their families and caregivers, where applicable) will:

- process their feelings and concerns about being released;
- be provided with information specific to their mental health diagnoses and medications;
- be educated as to their right to privacy and the provider's responsibility to ensure that their mental health information is protected;
- discuss the importance of getting consents signed prior to release, review their psychotropic medication needs and discuss all issues relative to such, including the need and way to set up appointments with a mental health professional and psychiatrist in the community;
- and be provided with community resources.

These inmates will also be educated as to:

- how to access mental health treatment,
- how to cope with system barriers,
- how to access housing, job, social, and care assistance services;
- and how to build and strengthen family and community alliances.

Should a post-incarceration placement in a community mental health setting be necessary, assistance will be provided. Each inmate will have a discharge plan individually tailored to meet the inmate's mental health re-entry needs.

In addition to the pre-release planning of a mentally ill offender, the Illinois Department of Corrections is currently working with the Illinois Department of Human Services' Division of Mental Health on a continuity of care program for mentally ill offenders. This program is in its initial planning stages and is currently referred to as the "Continuity of Care Path (CoCPath) Program." CoCPath is intended to provide intensive

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case management outreach support services to inmates with serious mental illness, such as bipolar disorders, schizophrenia, psychosis and major depression.

To qualify for the services, an inmate must be homeless or at risk for homelessness. Upon the Illinois Department of Corrections' referral, an Illinois Department of Human Services provider will follow the inmate for mental health, housing, social security benefits, and crisis intervention services to help the inmate gain resources and supports in the community following the inmate's release from the Illinois Department of Corrections.

With regard to offenders that qualify for Medicaid, the department has worked with interest groups and the state legislature in advocating Senate Bill 231. This bill would facilitate continuity of Medicaid eligibility for offenders during and after their incarceration. With its passage, it will help ensure that such offenders have access to the medical and mental health and pharmacological services that they need.

Conclusion:

As director, I recognize that the challenges of providing proper care for mentally ill offenders while protecting them from themselves and the community will be ongoing. At both the national and state levels, we have made significant progress in recognizing and dealing with this issue. However, more needs to be done.

It is my charge to ensure that the Illinois Department of Corrections is doing everything that it can to address this issue. I intend to tap the expertise of my mental health staff, to work with other agencies to provide seamless treatment for offenders, and to provide linkage with community providers. Using the resources that are at our disposal, the agency will continue to provide the best care for these offenders that it possibly can provide.

Having said that, I also recognize that our agency is but one cog in the wheel of offender treatment. Our state will need additional resources in order to provide the full complement of services for mentally ill offenders.

Resources will be needed to:

- train law enforcement officers, who are often the first contact, as to how to deal with mentally ill offenders,
- to assist the courts and counties with diversion programs such as Mental Health Courts, state planning and implementation grants,
- and monies that assist in the provision of linkage programs for offenders.

With the passage of the Mentally Ill Offender Treatment and Crime Reduction Act, we have a vehicle to help provide these services. I respectfully ask that you fuel this vehicle, and fully fund the program.

Thank you very much for allowing me to come before the committee.

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THE REBECCA PROJECT FOR HUMAN RIGHTS

Health Safety and Dignity for Vulnerable Families

Statement for the Record
The Rebecca Project for Human Rights

"Human Rights at Home: Mental Illness in U.S. Prisons and Jails "
U.S. Senate Judiciary Committee
Subcommittee on Human Rights and the Law.
September 15, 2009

Submitted by:
Malika Saada Saar
Executive Director
Kathleen Shakira Washington
Policy Director
Rebecca Project for Human Rights

The Rebecca Project for Human Rights is honored by the opportunity to submit written testimony

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for the "Human Rights at Home: Mental Illness in U.S. Prisons and Jails " hearing held by the Senate Judiciary Committee Subcommittee on Human Rights and the Law. The Rebecca Project for Human Rights is a national legal and policy organization that advocates for public policy reform, justice and dignity for vulnerable families. The Rebecca Project strives to reform child welfare, criminal justice, and substance abuse policies that impact the lives of vulnerable families. We frame the pervasiveness of violence against women and girls, the draconian conditions that too often characterize maternal incarceration, and the dearth of access to health and healing for mothers and their children, as fundamental human rights violations.

The Rebecca Project applauds the subcommittee's leadership in addressing mental health issues suffered by the incarcerated. We are especially concerned about the condition of women and girls involved in the criminal justice system. Our written testimony lays out the distinct pathways to incarceration for women and girls, adult and juvenile correctional systems that disregard the distinct and gendered mental health disorders presented by female incarceration, and the profound dearth of mental health, trauma-based services and alternative programs for women and girls.

WOMEN AND MOTHERS' PATHWAYS TO INCARCERATION

Twenty-five years ago, the presence of women—especially mothers—was an aberration in the criminal justice system. That was before the war on drugs. Since 1986, following the introduction of mandatory sentencing to the federal drug laws in the mid 1980s, and its adoption by many states at about the same time, the number of women in prison has risen 400%, according to a recent Department of Justice report, "Survey of State Prison Inmates"; for black women, the figure is 800 percent.[1] In fact, beginning in 1990, the annual rate of growth of the female inmate population has outpaced the average increase in the number of male inmates.[2] Women offenders comprise seven percent of the federally incarcerated population and 58.8 percent of them are mothers to minor children. [3]

The pathway to incarceration for women and mother offenders is shaped by gendered violence and trauma. The National Council on Crime and Delinquency (NCCD) in a study of 151 adult women incarcerated in California, Florida, and Connecticut state prisons found that over 92 percent had experienced one or multiple forms of abuse, and that "a history of violent abuse is one of the most universally shared characteristics of women in prison."[4] 48-88% of women inmates experienced sexual or physical abuse before coming to prison, and suffer from post-traumatic stress disorder.[5]

It is well established that women subject to sexual violence are more vulnerable to substance abuse. Incarcerated mothers with histories of sexual violence are also suffering from untreated addiction. Indeed, untreated addiction is a leading reason for

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[1] Bureau of Justice Statistics., U.S.Dep't of Justice, ncj 175688, Women Offenders 1(Lawrence A. Greenfield&Tracy L. Snell eds.,1999) [hereinafter Women Offenders].
[2] Federal Bureau of Prison Quick Facts(updated Dec.31, 1999).
[3] Bureau of Justice Statistics., U.S.Dep't of Justice, ncj 175688, Women Offenders 1(Lawrence A. Greenfield&Tracy L. Snell eds.,1999) at 7.
[4] Leslie Acoca and James Austin, National Council On Crime and Delinq., Report, *The Hidden Crisis: Women In Prison* (1996).
[5] Amnesty International, Women In Prison: A Fact Sheet (August 2005).

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female incarceration. The most recent statistics indicate that substance abuse is responsible for the incarceration of 72 percent of federal female prisoners. [6] Additionally, eighty seven percent of women in federal prisons report struggling with issues of drug abuse.[7]

MENTAL ILLNESS AND INCARCERATED WOMEN AND MOTHERS

Women and mother offenders' narratives of sexual victimization and trauma also reveal serious histories of mental disorders, often precipitated by the violence done to them. Hence, significant numbers of incarcerated women and mothers suffer from mental illness. Yet, there are minimal programs and services for female offenders struggling with mental health disorders.

In 1999 the UN Special Rapporteur recognized:

"In many of the facilities visited by the Special Rapporteur, there was a woeful lack of care for women with mental illnesses. Except for Bedford Hills in New York, none of the prisons was equipped to deal with large-scale mental health problems. In light of recent trends towards deinstitutionalization, women with mental illnesses are increasingly being found in prisons. This makes the lack of such services particularly problematic. Furthermore, mentally ill women are at high risk of sexual abuse in custodial settings. Consequently, it is imperative that prisons have adequate facilities to meet the needs and ensure the protection of such women."[8]

In April 2009, the American Bar Association Corrections Committee report found:

"The increased presence of women in prisons and jails does not merely expand the number of people under custodial supervision; women also have a unique mental health profile and require different services compared with men. For example, incarcerated women have higher rates of mental illness than male inmates – research indicates that approximately fifty percent of women in the criminal justice system have experienced sexual and physical trauma at some point in their lives."[9]

Despite the higher rates of mental illness suffered by incarcerated women and mothers, their shared histories of sexual violence and trauma, and co-occurring untreated addictions, the basic mental health needs of female offenders are marginalized. In the federal prison system, the Bureau of Prisons (BOP) has yet to implement a comprehensive, gender-specific program for female offenders suffering from mental health disorders. There is only one 500-hour gender specific Residential Drug Abuse Treatment Program at Hazelton, West Virginia for female offenders with untreated

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[6] Bureau of Justice Statistics., U.S.Dep't of Justice, ncj 175688, Women Offenders 1(Lawrence A. Greenfield&Tracy L. Snell eds.,1999) at 7.

[8] U.N. Econ. & Soc. Council, supra note 9, at ¶ 67.

[9] Rebecca Engel & Emily Stirba, Sarah Mehta, Report on Custodial Policies and Their Effects on Incarcerated Women (Apr. 2, 2009) (citing Bureau of Justice Stat., U.S. Dept. of Justice, Profile of Jail Inmates 1996 (Apr. 1998), http://www.ojp.usdoj.gov/bjs/pub/pdf/pji96.pdf).

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addiction issues.

ABSENCE OF ALTERNATIVE SENTENCING FOR INCARCERATED MOTHERS

When mothers are incarcerated, their children are either placed in foster care or kinship care. During the period of incarceration, it is a struggle for incarcerated mothers to maintain an abiding connection to their children. Women's prisons are often located in rural areas far from the cities in which the majority of inmates lived, making it difficult to maintain contact with their children and jeopardizing the prospects of successful reunification. A national study found that more than half of the children of women prisoners did not visit their mothers while they were in prison. Over 60 percent of the children, who did not visit, lived more than 100 miles from the prison where their mothers were incarcerated. [10] Incarcerated mothers with children in foster care are often unable to meet court-mandated family reunification requirements for contact and visitation with their children, and consequently lose their parental rights.

The children left behind from maternal incarceration are vulnerable to suffering from attachments disorders, are more likely to experience substance use disorders, engage in criminal activity, manifest sexually promiscuous behavior, and dangerously lag behind in educational development and achievement.[11] Children of incarcerated mothers labor under their own sentences, their own punishment of being taken from their mothers.

Alternative sentencing to community based programs permit mothers and their children to maintain the important mother-child relationship, within the context of health and healing for the family. Since most incarcerated mothers are first-time, nonviolent offenders, who ought to have been served by the public health system, it is optimal to facilitate mother's return to the community and attachment to her child within the community.

Unfortunately, the Bureau of Prisons has not demonstrated any leadership in establishing an alternative, community-based program for incarcerated mothers and their children.

The only alternative program available to a limited number of mothers is MINT (Mothers and Infants Nurturing Together (MINT). A select few pregnant offenders can give birth to their babies during the period of incarceration and then be transferred to one of the seven MINT locations where the mothers can spend several months before and after their child is born. [12]

Research demonstrates that prison nursery programs yield effective outcomes for mothers and their children. Mothers who participate in prison nursery programs show lower rates of recidivism. Moreover, the mother-child bond is preserved during a formative and critical time in an infant's development, and the emotional and

[10] LESLIE ACOCA AND JAMES AUSTIN, NATIONAL COUNCIL ON CRIME AND DELINQ., REPORT, *THE HIDDEN CRISIS: WOMEN IN PRISON* (1996).

[11] Women in Prison Project of Correctional Association of New York, When "Free" Means Losing Your Mother: the Collision of Child Welfare and the Incarceration of Women in New York State, 9 (February 2006).

[12] http://www.bop.gov/inmate_programs/female.jsp.

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financial costs of foster care involvement are avoided.[13]

The Bureau should be directed to expand the MINT program beyond three months, to 18 months at all seven sites, and implement immediately the pilot program for an in-house nursery that BOP promised to initiate in June 2007.

CURRENT STATUS OF GIRLS IN THE JUVENILE JUSTICE SYSTEM

The past two decades has witnessed a decline in the number of youth involved in the juvenile justice system. Data has shown that between 1994 and 2003, overall juvenile arrest rates declined by 18%.[14] However, the proportion of female juvenile offenders has steadily increased with an unprecedented number of girls entering the juvenile justice system. In 2007, female offenders accounted for 29% of the 2.18 million juvenile arrests[15] - a dramatic increase from 2001 when girls accounted for 19% of detained youth.[16] Further, when comparing girls' involvement in the criminal justice system to that of boys, between 1985 and 2002, the overall delinquency caseload for females increased by 92% compared to only 29% for males.[17]

Most often juvenile female offenders are arrested for status offenses. Status offenses are "noncriminal offenses" or offenses that are illegal for underage persons, but not for adults.[18] Such offenses include curfew violations, incorrigible or ungovernable behavior, running away, truancy, and underage drinking.[19] While current legislation prohibits the detainment of youth arrested for status offenses, far too often the practice of "bootstrapping," violations of court orders based on the original status offense, and lack of alternatives to detention faced by most courts often result in detainment of female juvenile offenders. For example, in 2005 only 15% of all arrest of female juveniles involved physical violence (e.g., violent crimes – 3% and simple assault – 12%) with status offenses (e.g., running away, liquor laws, curfew violations, and loitering) and property crimes accounting for the remaining 85% of arrest.[20] Further, girls disproportionately represented 58% of all runaway arrest even though they only accounted for 29% of all detained youth.[21] Last, recent investigations into the causes of increasing rates of female juvenile arrest has found that rates of crime among female juvenile populations are not increasing, but girls are being arrested more often due to

[13] Lorie Smith Goshin & Mary Woods Byrne, Converging Streams of Opportunity for Prison Nursery Programs in the United States, 48 J. OFFENDER REHABILITATION 271, 275 (2009).

[14] Snyder, Howard N., and Sickmund, Melissa. (2006) Juvenile Offenders and Victims: 2006 National Report. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.
[15] OJJDP. Statistical Briefing Book. 2007 (Accessed 9/4/09. http://ojjdp.ncjrs.org/crime/qa05101.asp?qaDate=2007.)
[16] Sherman FT. 13 Pathways to Juvenile Detention Reform: Detention Reform and Girls – challenges and solutions. The Annie E. Casey Foundation, Baltimore, MD. 2005.
[17] OJJDP, 2007.
[18] Legal Dictionary. Accessed 9/09. http://miscellaneous.legaldictionaries.org/SBB-Glossary/Status_offense.
[19] Legal Dictionary, 2009.
[20] Federal Bureau of Investigation. Uniform Crime Reports for the United States: 2005. Washington, DC: U.S. Government Printing Office. 2005.
[21] Federal Bureau of Investigation, 2005

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stricter, no-tolerance policies and practices of schools, the police, social welfare agencies, and the juvenile justice system.[22]

PATHWAYS OF FEMALE ADOLESCENTS TO DETENTION

There are a variety of characteristics associated with youth who are involved in the juvenile justice system including school failure and family stress and chaos.[23] However, one characteristic or factor that is distinct and most salient for girls is that of sexual and physical abuse. While it is estimated that approximately 73% of all girls involved in the juvenile justice system report histories of extreme sexual and physical abuse, various studies have reported findings as high as, if not higher, than 90%.[24] For example, a California based study found that 92% of the girls interviewed had suffered some form of abuse. Of this group, 81% of the girls had been physically abused and 56% reported one or more forms of sexual abuse.[25] Further, a study conducted by the Oregon Social Learning Center on chronically delinquent girls found that the average age of first sexual encounter among girls was approximately 6 years of age and that 78% of girls had documented histories of physical abuse as compare to 3% of boys.[26]

When considering policies and programs that address youth involved in the juvenile justice system, it is imperative that such decisions take into account the high rates of trauma due to physical and sexual abuse among adolescent female offenders. There is a wealth of information suggesting that exposure to traumatic events may be linked to delinquent behavior and that delinquent acts may be a direct or indirect reflection of past victimization.[27] For example, a longitudinal study found that girls and women with histories of childhood abuse or neglect were 73% more likely than females without abuse histories to be arrested for property, alcohol, drug, and misdemeanor offenses such as disorderly conduct, curfew violations, or loitering.[28] Studies have found that youth who were victims of sexual abuse coupled with physical abuse and neglect were more likely to run away from home than children who experienced other forms of maltreatment[29] - with estimates of that between 33–75% of girls who are in runaway homes or in the juvenile justice system were victims of sexual violence.[30] Further, girls hurt by sexual violence are 3 times more likely to develop psychiatric disorders or alcohol/drug abusing behaviors in adulthood, compared to girls who are not sexually abused.[31] Studies have found that 75% of girls involved with the juvenile justice system report

[22] Goodkind S, Ng I, Sarri RC. The impact of sexual abuse in the lives of young women involved or at risk of involvement with the juvenile justice system. Violence Against Women, 2009. 12(5):456-477.
[23] Sherman FT, 2005.
[24] Sherman FT, 2005.
[25] Acoca L, Dedel K. No Place to hide: Understanding and Meeting the Needs of Girls in the California Juvenile Justice System. National Council on Crime and Delinquency, San Francisco, CA, 1998.
[26] Chamberlain P. The Miltideminsional Treatment Foster Care Model: Research and Community-Based Services. Presented at the 2nd National Training Conference on Juvenile Detention Reform. Portland, Oregon: Annie E. Casey Foundation, Jan. 24-26, 2002.
[27] Caufman E, Feldman SS, Waterman J, Steiner H. Posttramatic Stress Disoder Among Female Juvenile Offenders. Journal of the American Academy of Child Adolescent Psychiatry. 1998. 37(11):1209-1216.
[28] Sherman FT, 2005.
[29] Widom CS. Victims of childhood sexual abuse – later criminal consequences. NIJ Research in Brief. Mar. 1995:1-8.
[30] Shelden RG. Female delinquency and the juvenile justice system: Part I – Delinquency among girls. University of Nevada – Las Vegas, Las Vegas, NV. 2004; 1-28.
[31] Day A, Thurlow K, Woolliscroft J. Working with childhood sexual abuse: A survey of mental health professions. Child Abuse & Neglect. 2003. 27: 191-198.

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being regular users of alcohol and/or drugs, with another 34% being diagnosed with a substance abuse disorder.[32]

Once detained, many girls suffer further victimization. The 2006 National Report of the Office of Juvenile Justice and Delinquency Prevention reported that there were 2,821 allegations of youth-on-youth (59%) and staff-on-youth (41%) acts of sexual violence in juvenile facilities in 2004. Within the youth-on-youth incidents, 2 of every 3 were nonconsensual sexual acts and within the staff-on-youth incidents, 3 of every 4 were staff sexual misconducts.[33] Of these allegations, girls made up only 11% of the state-operated facilities population, but accounted for 34% of the victims of sexual violence in these facilities[34] and in local or privately owned facilities, girls made up only 17% of the total population, but accounted for 37% of the victims of sexual violence.[35]

While these numbers are daunting, it is important to remember that sexual and physical abuse often goes unreported or underreported. [36] Given this fact, one can only assume that current statistics regarding the extent of physical and sexual abuse of girls involved in the juvenile justice system are more than likely an underestimation of the actual rates among this vulnerable population.

MENTAL HEALTH AND VICTIMIZATION OF GIRLS IN THE JUVENILE JUSTICE SYSTEM

It has been estimated that one in five adolescents involved in the juvenile justice system has a serious mental health problem.[37] For females involved in the juvenile justice system, the estimated prevalence of mental health disorders has been reported as high as 84% - a rate similar to that of physical and sexual abuse among detained female juveniles.[38] In one study of detained youth in Cook County from 1995 to 1998, study outcomes found that girls had higher rates of psychiatric disorders and rates of depression and anxiety, with anxiety disorders being particularly high among girls participating in the study.[39] Further, the Oregon Social Learning Center found that over three-quarters of adolescent female study participants met the criteria for three or more DSM IV Aix 1 diagnoses.[40]

This data is significant in that numerous studies have found that exposure to trauma effects girls differently than boys. Studies have found that among those who are exposed to trauma, females are more likely than males to develop mental health

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[32] Riehman KS. Adolescent girls in the juvenile justice system issues for treatment. <Web access: www.womenandchildren.treatment.org/media/presentations/d-4/Riehman.ppt.>
[33] Snyder HN, Sickmund M. Juvenile Offenders and Victims: 2006 National Report. US Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention, Washington, DC. 2006: 1-242.
[34] Snyder HN, Sickmund M, 2006.
[35] Snyder HN, Sickmund M, 2006.
[36] Biden Jr. JR. What about the girls? The role of the federal government in addressing the rise in female juvenile offenders. Stanford Law and Policy Review. 2003. 29.
[37] Cocozza JJ, Skowyra K. Youth with mental health disorders: Issues and emerging responses. Juvenile Justice. 2000. 8(1):3-13.
[38] Wrath C, Ybarra M, Holden EW, Manteuffel B, Santiago R, Leaf P. Female offenders referred for community-based mental health service as compared to other service-referred youth: correlates of conviction. J. of Adolescence. 2003. 26:45-61.
[39] Sherman FT, 2005.
[40] Cauffman E, 1998.

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problems as a result of this exposure.[41] In particular, female juvenile delinquents are six times more likely than male juvenile delinquents to suffer from posttraumatic stress disorder at the point of detention and at some time in their lives than the general population.[42]

Left untreated mental health disorders, such as depression and posttraumatic stress are expressed through a variety of behaviors that include suicidal tendencies, phobic/avoidant behaviors, affective numbing, nightmares, and repetitive/inappropriate sexual behaviors.[43] Trauma has also been associated with a variety of other anti-social behaviors that place victims at increased risk for detention. Data has suggested that youth exposed to trauma are more "emotionally overactive" and more likely to engage in coercive and noncompliant behaviors and will display a variety of emotions that are associated with problem behavior including lack of empathy, impulsivity, anger, acting-out, resistance to treatment, and high risk sexual behavior.[44]

An example of the impact of trauma on the lives of girls is exemplified in a study that examined the relationship between gender, trauma, delinquency and mental health in a cohort of delinquent offenders. Of the 96 participating females in the study, 74% of the girls reported being "badly hurt or in danger of being hurt", 76% reported "witnessing someone severely injured or killed" and 60% reported "being raped or in danger of being raped." This study also found that boys were more likely to be traumatized as observers of violence as compared to girls who were more likely to be traumatized as direct victims, and participating girls were 50% more likely to exhibit current symptoms of posttraumatic stress as compared to boys participating in the study.[45]

While detention is often viewed as a protective measure for troubled youth, most often conditions of detainment exacerbate untreated mental health issues. There have been numerous reports as well as lawsuits that have shed a glaring light on the deplorable conditions under which detained youth are required to reside. The most comprehensive national study on the conditions of juvenile detention facilities titled *Conditions of Confinement: Juvenile Detention and Corrections Facilities* (1994) noted the existing deficiencies in the system that included inadequate living space due to overcrowding, lack of appropriate security, the lack of basic personal hygiene supplies, the use of restraints and isolation, as well as emotional, physical and sexual abuses by staff and detainees.[46] Lawsuits have also focused specifically on the failure to provide "adequate medical and mental healthcare, including screening, emergency services, and ongoing services, as well as allegations of insufficient staffing, poor staff qualifications and lack of training, and inadequate protection for youth at risk of suicide."[47]

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[41] Cauffman E, 1998.
[42] Cauffman E, 1998.
[43] Deblinger E, McLeer SV, Atkins AS, Ralphe D, Foa E. Post-traumatic Stress in Sexually Abused, Physically abused and Nonabused Children. Child Abuse & Neglect. 1999. 13:403-408.
[44] Smith DK, Leve LD, Chamberlain P. Adolescent girls' offending and health-risking sexual behavior: The predictive role of trauma. Child Maltreatment. 2006 Nov. 11(4):346-353.
[45] Cauffman E, 1998.
[46] Burrell S. Chapter 6: Pathways to Juvenile Detention Reform – Improving conditions of confinement in secure juvenile detention centers. Annie E. Casey Foundation. Baltimore, MD. 2005.
[47] Burrell S. 2005.

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Since the 1990s, a number of actions have been taken to address the dearth of mental health services provided through the juvenile justice system. For example, the National Commission on Correctional Health Care (NCCHC) published standards of care for juvenile facilities, the Office on Juvenile Justice and Delinquency Prevention (OJJDP) conducted a survey of juvenile justice facilities to assess the extent to which facilities were meeting treatment standards, and standardized screening instruments and protocols have been developed. However, as noted in a recent report by the Annie E. Casey Foundation,

> "Though research identifies extensive mental health needs among detained and incarcerated girls, few girls' detention units address girls' mental health comprehensively and appropriately. Adequate mental health screening is not common, nor is mental health treatment, and temporary detention is disruptive to community mental health treatment and to treatment through medication."[48]

ALTERNATIVES TO DETENTION FOR FEMALE ADOLESCENTS

In a recent report published by the Justice Policy Institute, it was estimated that states spend approximately $5.7 billion each year to detain and imprison youth.[49] Further, this report noted that several states such as California, Illinois, Ohio, New York and Pennsylvania are turning to more effective yet less expensive alternatives to detention as a solution to escalating cost associated with youth delinquency and to address the growing body of evidence regarding the detrimental long-term effects of detainment and incarceration of youth. For example, in Ohio, outcome measures of the "RECLAIM Ohio" program has found a 42% decline in the number of youth committed to secure state care and "for every dollar spent on the RECLAIM program, the state save(d) $11 to $45 in commitment and processing cost, depending on the risk level of the youth."[50]

Given that the majority of girls enter the juvenile justice system for non-violent, status offenses, that between 70-90% of girls have a history of extreme victimization, and that upwards to 80% suffer from mental health disorders, alternatives to detainment would be a safe and cost effective alternative to the detainment of girls involved in the juvenile justice system. As a minimum, these programs should incorporate the following elements to be considered gender-responsive:[51]

- **Comprehensive** – weaving family, community and systems together for girls;
- **Safe** – promoting healing from trauma caused by physical and psychological abuse;
- **Empowering** – addressing needs while encouraging leadership and the development of girls' strengths;
- **Community and Family Focused** – based in the community, fostering health family relationships and sustainable community connections; and

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[48] Sherman FT. 2005.
[49] Justice Policy Institute. The cost of confinement: Why good juvenile justice policies make good fiscal sense. May 2009. Washington, DC. www.justicepolicy.org
[50] Justice Policy Institute, 2009.
[51] Sherman FT, 2005.

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- **Relational** – supporting continuous, positive relationships for girls with older women, family, and peers.

Examples of programs that are gender-responsive, trauma-informed and strength-based include the following:

- PACE Center for Girls (FL)
- Center for Young Women's Development (CA)
- Crittenton Foundation (National)
- Girls Mentoring and Education Services (NY)
- Wings for Life (TX)
- Multidimensional Treatment Foster Care (OR)
- Hawai'i Girl Court (HI)

Unfortunately, these strength-based, gender-specific, trauma-responsive programs are severely limited in capacity, relegating girls to the juvenile justice system as a default approach. The phenomenon of girls in detention by default, especially girls with serious mental health disorders precipitated by sexual violence, because of the absence of alternative strength-based, gender-specific, and trauma-responsive programs is unacceptable. The Rebecca Project for Human Rights therefore urges for the scaling up of these programs as a needed and effective alternative to the senseless detention of vulnerable girls.

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rights ★ working ★ group

Statement of the Rights Working Group
Hearing on "Human Rights at Home: Mental Illness in U.S. Prisons and Jails"
Of the Senate Subcommittee on Human Rights and the Law
September 15, 2009

In 2007, the Rights Working Group welcomed the establishment of the Human Rights Subcommittee of the Senate Judiciary Committee. This committee recognizes the critical importance of international law and human rights in the protection of civil rights and civil liberties. Under the guidance of Senators Durbin and Coburn, this committee sits at the critical nexus between U.S. and international law as it applies to situations of human rights violations both in the U.S. and around the world.

In the last two years, the committee has looked at crucial issues such as the law of genocide, corporate responsibility in the extraction of natural resources, human trafficking and child soldiers. The Human Rights Subcommittee is uniquely situated to investigate these pressing human rights issues that cross borders and affect both the U.S. and the global community. The Rights Working Group is pleased to see that the Human Rights Committee is now turning its attention to domestic issues, recognizing that human rights is not just a foreign issue by holding the hearing titled "Human Rights at Home: Mental Illness in U.S. Prisons and Jails."

International human rights law is clear – when a government decides to deprive someone of their liberty, that government is responsible for ensuring that all of that person's health care needs are met, including mental health needs. Not only does the proper care need to be available to those in detention, no one should be detained in conditions that cause their mental health to deteriorate. Mental illness in U.S. prisons is a growing problem that affects not only convicted criminals but also immigration detainees. More than half of the people currently being detained by the Immigration and Customs Enforcement agency of the Department of Homeland Security are housed in state and local prisons, often being co-mingled with the convicted populations. This problem is especially acute when torture survivors and asylum seekers who arrive in the U.S. already traumatized and suffering from Post-Traumatic Stress Disorder are then placed in jails and prisons ill-equipped to handle their mental health needs.

The Rights Working Group expresses its sincere hope that this is just the first of many hearings that examine human rights in the United States. Historically, the United States has played an integral role in creating many of the human rights mechanisms that laid the foundation for modern day human rights norms and laws. Yet in the past, it has not applied those mechanisms and frameworks inward. The Rights Working Group encourages the Committee to continue this trend. In particular, we urge the Senate Judiciary Committee to consider reforming the U.S. Civil Rights Commission to become a Civil and Human Rights Commission, ensuring that the human rights of those within the United States are recognized and protected. The establishment of a reformed Civil and Human Rights Commission would be a strong step toward restoring the United States' historic role as a leader on human rights, signaling a renewed commitment to strengthening international human rights protections both inside and outside of the United States.

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Statement for the Record
University Legal Services
"Human Rights at Home: Mental Illness in U.S. Prisons and Jails"
U.S. Senate Judiciary Committee
Subcommittee on Human Rights and the Law.
September 15, 2009

Submitted by:
Gretchen Rohr
Director, *DC Jail Advocacy Project*
University Legal Services
Washington, DC

UNIVERSITY LEGAL SERVICES, INC.
Protection and Advocacy Program
for the District of Columbia

September 15, 2009

Senate Judiciary Committee
Subcommittee on Human Rights and the Law

We are pleased that under Senator Durbin's leadership the Senate Judiciary Subcommittee on Human Rights and the Law is convening a hearing focusing on mental illness in U.S. prisons. This memo is offered to provide the Subcommittee with an outline of three key issues that concern those we represent, DC residents with psychiatric disabilities within the Federal Bureau of Prisons.

University Legal Services is 40 year old nonprofit providing a range of disability rights legal protection and housing counseling for historically disadvantaged individuals in the District of Columbia. Our criminal justice initiative, entitled the *DC Jail Advocacy Project*, operates under federal mandate to protect incarcerated individuals with psychiatric disabilities from abuse and neglect. The Project aims to reduce the rates of incarceration of people with mental illness and remove barriers to their successful community reentry. We utilize a multidisciplinary approach by incorporating legal advocacy and peer education and promoting systemic reforms that offer treatment alternatives to incarceration.

The following are three issues that we repeatedly encounter in our representation of DC residents with mental illness incarcerated within the Federal Bureau of Prisons.

1. Individuals with serious and persistent mental illnesses are more likely to be charged with disciplinary violations. Even minor infractions can lead to longer terms of incarceration.

2. Disciplinary infractions, as minor as yelling or refusing to leave a cell, can result in use of force and restraint causing physical injury and isolation spurring further deterioration of mental health.

3. Individuals, with even the most serious and persistent mental illnesses, are not provided with pre-release discharge planning that ensures continuity of mental health care upon release.

Individuals with serious and persistent mental illnesses are more likely receive disciplinaries that impact the length of their sentence.
According to the Bureau of Justice Statistics 2006, people with mental illness are twice as likely than those without to be charged with rule violations in federal prison or local jail.

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In 2000 in Pennsylvania, 16 percent of all releasees served their maximum sentence. People with mental illness were twice as likely as others to serve their maximum sentence; people with a serious mental illness were three times as likely to "max out." [Council of State Governments].

ULS encounters illustrations of these statistics in our regular contact with incarcerated men and women. Here is one example:

- We represent a young man with a co-occurring mental health disorder and intellectual disability in the BOP (he has a full scale IQ of 59). Due to these combined disabilities, he struggles with poor impulse control and extreme anxiety. We originally met with him in April 2009, a week after his release from the BOP while he was staying at a local halfway house without any connection with treatment providers. Before adequate services were secured to address his intellectual disability, he was sent directly back to the BOP after making threats to staff at the halfway house. He was due for release in August 2009, but because of disciplinary infractions within the facility, his release has been postponed twice.

In order to address an apparently disproportionate number of infractions within this population, we suggest the FBOP perform analysis to determine if there are distinct differences in the number and types of infractions caused by people with Axis I mental health disorders. Results of the assessment, along with evaluation of best practices in state systems, would support FBOP developing new policies and practices that can increase institutional safety and reduce infractions while accommodating disability needs. Perhaps BOP should incorporate their qualified mental health staff in the disciplinary determination process. Most importantly, BOP must conduct closer oversight of contracted halfway houses to ensure they are providing critical disability accommodations and supports for individuals under their care and ensuring they are not sent back to prison for exhibiting behaviors in response to denial of necessary mental health treatment.

Disciplinary infractions can result in use of force and restraint causing physical injury and isolation.

One individual with a diagnosis of schizoaffective disorder contacted our office because he states he spent several months in and out of four-point restraints. One period, he states lasted 8 straight days in hard four-point restraints without the opportunity to use the toilet, despite the BOP program policy that requires periodic reviews every 2 hours to determine if the restrained person is calm and to allow the person to use the toilet. These allegations appear to expose BOP's use of four-point restraints for excessive periods of time and for the purpose of punishment which is contrary to BOP policy.

Particularly troubling, was a complaint by the same individual that on one occasion, BOP staff's use of a chemical agent and weapon resulted in serious trauma to his testicles with

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bleeding. Yet, instead of immediate transfer to the hospital, he was again restrained for an entire day before being afforded appropriate medical treatment.

ULS has not completed an investigation into the allegations—but a preliminary review of the medical records confirms that the complainant was not brought to the emergency room for almost 36 hours after the event which caused testicular fracture and hematoma requiring surgery. Our review of records also confirm that at least one conflict that arose between the individual and correctional staff occurred because of his refusal to discuss private matters with the therapist cell-front and his request for a private space. The prison staff noted that a private meeting with the therapist could not be offered for possibly 24 hours.

ULS urges BOP to prohibit "cell-front" therapy in accordance with the NCCHC Standard MC-A-09 which requires mental health services to be conducted in private and carried out in a manner designed to encourage the patient's subsequent use of services."

ULS recommends stronger enforcement of current BOP program statements and ACA Standards -4190 and 4191 that prohibit use of restraints for punishment and for periods longer than 2 hours without meaningful evaluation that the risk of harm has passed.

BOP and local facilities do not provide pre-release discharge planning that ensures continuity of mental health care upon release.

According to the DC Department of Corrections, 22% of the individuals who process through the jail have a serious mental illness (a diagnosis of schizophrenia, major depression, PTSD or bipolar disorder). Our parole authority estimates that 2,500 DC residents are released from the BOP each year. Yet, there is no program statement or policy in place that requires BOP staff contact community mental health providers to obtain appointments or coordinate with them to prepare individualized transition plans. Mental health providers in DC complain that they are not notified in advance when their consumers are going to be 'dropped' by the BOP at a local shelter. DC's community supervision agency, CSOSA, is charged with referring individuals needing mental health service connection to the Department of Mental Health. Yet this usually occurs *after* release and only for those under supervision. DMH reports that in a 7 month period in 2008, they received only seven referrals from CSOSA to develop service connection for individuals *prior* to their release from prison.

In addition, the BOP system does not consistently pursue benefits applications pre-release for individuals with disabilities, despite a federal regulation that encourages pre-release agreements between the Social Security Administration and prisons. Examples of the lack of pre-release planning:

- We met with a gentleman last month who has schizophrenia and was released from prison after 25 years. Despite his active engagement with mental health services while inside, the staff did not make any contacts with local mental health providers before his release. Halfway house staff provided him with an address to

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> a location to complete mental health service intake, yet every time he left he would get lost or confused and was fearful of venturing out on his own. Once he was connected with an advocate from ULS, he was escorted to the clinic and obtained an appointment almost 2 months after his release. In the interim, ULS helped him obtain medication to sustain him until his appointment with the psychiatrist. Without interventions by ULS, this gentleman may have fallen through the cracks and never connected with the treatment necessary to keep him out of prison. He now is facing release from the halfway house in November and is worried that he will not have any plan for housing because his mental health provider has not been given enough advance time to prepare and help him apply for supportive housing options.

University Legal Services recognizes the need for earlier halfway house placement for individuals needing complex transition planning support and urges immediate implementation of the Second Chance Act which mandates consideration of halfway house placement for individuals as early as 1 year prior to release. Similarly, ULS supports greater consideration of currently under-utilized home-based supervision for those who may benefit from intense wrap-around supports like Assertive Community Treatment during their transition back to the community.

ULS recommends BOP's system-wide implementation of current federal regulations that support pre-release coordination with the Social Security Administration to reduce bureaucratic delays in processing social security income applications. Useful training is available for correctional staff, including Policy Research Associates' *Stepping Stones to Recovery* training for case managers assisting people apply for SSI/SSDI benefits.

ULS also supports the suspension rather than termination of Medicaid benefits during periods of incarceration to allow expedited restoration during individuals' transition to community mental health care.

Conclusion

Thank you for the opportunity to submit written remarks on the rights of people with mental illness in US prisons, particularly those subject to our protection and advocacy authority within the District of Columbia. If you wish to learn more information about our advocacy for incarcerated men, women and youth with mental illness visit our website at www.uls-dc.org.

Best regards,
/s
Gretchen Rohr, Esq.
Director, *DC Jail Advocacy Project*
University Legal Services

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Testimony for the Senate Committee on the Judiciary,
Subcommittee Human Rights and the Law
"Human Rights at Home: Mental Illness in U.S. Prisons and Jails"
September 15, 2009
By the Coalition to Stop Abuse and Violence Everywhere (SAVE Coalition)

The Coalition to Stop Abuse and Violence Everywhere (SAVE Coalition) is a broad, non-partisan group of organizations and individuals dedicated to protecting the U.S. prison and jail population from violence and abuse. The SAVE Coalition includes faith-based organizations; legal organizations; policy institutes; advocacy organizations for rape survivors, children, and the mentally ill; and others. *See* Exhibit A, List of SAVE Coalition Members and Mission Statement. Our members have long been involved with issues surrounding the treatment of incarcerated persons with mental illness and we would like to thank the Subcommittee for holding a hearing on this important issue. The intersection of the Prison Litigation Reform Act (PLRA) and mental illness in prisons is our particular concern today. The PLRA was enacted in 1996 purportedly to reduce frivolous litigation by prisoners, but in practice many of its provisions undermine prisoners' ability to protect their Constitutional rights and to pursue remedies for meritorious claims in federal courts.

The PLRA, while afflicting all prisoners, acutely injures inmates with mental illness. In particular, the PLRA requirement of exhaustion of administrative remedies regardless of the fairness or accessibility of the administrative system makes it exceedingly difficult for prisoners with mental illness to make their claims in court. Furthermore, the PLRA's application to youths in detention is especially onerous for the many mentally ill children in our nation's jails, prisons and juvenile detention centers. In order to provide adequate protections for prisoners with mental illness, Congress should amend the PLRA's exhaustion requirement and exempt juveniles from the provisions of the Act.

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I. The PLRA Undermines Legal Protections for Mentally Ill Prisoners and Juveniles.

Although the announced purpose of PLRA was to reduce frivolous litigation by prisoners, in reality, the PLRA makes it almost impossible for most prisoners to file any civil rights claims, regardless of the merits. The PLRA has been extremely damaging to prisoners' rights in this country and the courts' ability to undertake their essential function of holding prisons and jails accountable to the Constitution. This was not the original intent of Congress. Indeed, one of the law's sponsors, Representative Charles T. Canady (R-FL) stated that PLRA "will not impede meritorious claims by inmates but will greatly discourage claims that are without merit." But after thirteen years of experience, we now know that the PLRA often slams the court house doors in victims' faces. It is clear that the PLRA keeps countless serious claims from reaching the courts—including claims of physical and sexual abuse, indifference to inmate on inmate rape, gross mistreatment of confined juveniles, and markedly deficient medical and mental health treatment. The PLRA effectively prevents courts from exercising their role of protecting constitutional rights for some of the most vulnerable Americans.

A. The PLRA's Exhaustion Requirement (42 U.S.C. § 1997e(a)) Creates Insurmountable Barriers for Prisoners with Mental Illness.

The PLRA requires prisoners to exhaust "such administrative remedies as are available," which means that prisoners must complete the prison's internal administrative grievance process before filing suit. The stated purpose behind this requirement is the hope that many disputes will be resolved before they get to court. The Supreme Court has held that this requires "proper exhaustion," *i.e.*, "compliance with an agency's deadlines and other critical procedural rules."[i]

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Over the past thirteen years, hundreds, even thousands, of claims of serious and unconstitutional abuse of prisoners have been forever barred for lack of "proper exhaustion,"[ii] with no inquiry into the truth of the prisoner's substantive claims.[iii] Prisoners – many of whom have little education, read poorly or not at all,[iv] or have mental illness or mental retardation[v] – are ill-equipped to comply with technical rules under short deadlines and without the assistance of legal counsel. Unlike most federal administrative remedies, prison and jail grievance systems tend to have extremely short deadlines, mostly 30 days or less, many as short as a week or two.[vi] Further, many prison grievance systems have unclear rules[vii] or are inconsistently administered,[viii] and some prisoners are subjected to misinformation[ix] or even threats by prison staff[x] that impede them from exhausting properly. Some prisoners' grievances simply disappear.[xi] In a remarkable number of cases, prisoners receive no response whatsoever to their grievances,[xii] and prison officials have gotten many cases dismissed by arguing that the prisoner failed to appeal the officials' *failure* to respond.[xiii] Moreover, under PLRA, there is no exception for immediate threats to health or safety.[xiv] The result is that prisoner litigation has turned into a game of "gotcha"[xv] in which correctional system lawyers and the federal courts scour the record for mistakes in exhausting, while the merits are forgotten,[xvi] often on the most hair-splitting of grounds.[xvii]

The requirement to exhaust all administrative remedies bars many meritorious and serious cases of constitutional violations. But this requirement is especially problematic for prisoners with mental illness. Though the PLRA requires exhaustion of administrative remedies, it does not set any standards or put any limit on the administrative systems themselves. As a result, many correctional systems and institutions have developed highly complex, multi-step processes with short deadlines and hyper-technical rules. These processes are difficult for

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anyone to understand, but they are frequently impossible for prisoners with mental illness to manage accurately, or at all. For example, a Pennsylvania prisoner filed a grievance claiming he was harassed by officers. He made several spelling and grammatical errors in his grievance form. His grievance was denied due to these errors, and he was told in writing to "Please resubmit when spelled & punctuated correctly." Though some mentally ill inmates may be appointed guardians ad litem to make litigation decisions for them once their case actually gets to court, those same prisoners are not entitled to any assistance navigating the byzantine administrative remedy systems in correctional facilities that determines whether or not they can seek protection from the courts in the first place.

Complicating this situation even further is the fact that many of the rights violations prisoners suffer in correctional facilities arise from or cause acute psychotic breaks or periods of decompensation which can then make it impossible for a mentally ill prisoner to navigate his/her facility's grievance process. Moreover, because many facilities have a lengthy administrative process, prisoners with mental illness may often be subject to periods of months where they are forced to go without mental healthcare and cannot seek an injunction to compel treatment because they have not exhausted their administrative remedies. It is also well established that inmates with mental illness are more frequently sent to segregation units and spend more time in segregation and under lock-down conditions than other inmates. This is often due to the inability of prisoners with mental illness to function in a correctional environment, especially where they have little access to proper mental health treatment. Lack of medication or mental healthcare causes them to "act out," resulting in disciplinary charges that lead to placement in solitary confinement and solitary confinement-like disciplinary housing. Once in a segregation unit, prisoners with mental illness often experience further dramatic decompensation in their mental

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status. Moreover, it can be even more difficult to comply with administrative procedures while in segregation or solitary confinement because access to basic writing utensils and the administrative forms themselves can be restricted. It is also frequently the case that mentally ill prisoners fear that correctional officers or medical staff will withhold medication and treatment as retaliation for making an administrative complaint.

The PLRA's exhaustion requirement creates unnecessary and unjust hurdles for all prisoners, but it disparately impacts the most vulnerable of prisoners, like the mentally ill. The purpose and value of exhaustion can be preserved, however, while bypassing the problems of the present exhaustion rule, by simply requiring that claims be presented to responsible prison officials before filing suit. Where a prisoner has not done so, the court should stay the case for up to 90 days and return it to prison officials for whatever administrative consideration they deem appropriate. Some cases will be resolved; those that are not will go forward, and the courts' time will not be wasted on satellite litigation about the adequacy of the prisoner's grievances.

The SAVE Coalition calls on Congress to amend the requirement for exhaustion of administrative remedies to require prisoners to present their claims to responsible prison officials before filing suit, and, if they fail to do so, require the court to stay the case for up to 90 days and return it to prison officials to provide them the opportunity to resolve the complaint administratively. (Amend 42 U.S.C. § 1997e(a).)

B. The PLRA's Application to Incarcerated Children, Especially Mentally Ill Children, Increases Their Vulnerability to Rape and Other Forms of Abuse.

Congress should also be particularly concerned about the application of the PLRA to confined juveniles. Juveniles tend to be the most vulnerable of confined persons and the most

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likely to suffer abuse. Applying the PLRA to juveniles serves neither the goals of the Act nor the welfare of our country's children. The PLRA was designed to reduce the number of frivolous prisoner lawsuits reaching the courts. But juveniles do not file frivolous lawsuits. They generally lack the literacy skills, knowledge of the court system, and access to legal materials that would be needed to engage in any type of litigation.

The PLRA has negatively impacted incarcerated youth generally, but a few provisions in particular have proven especially troublesome for juveniles, especially mentally ill youth. Most prominent among them is the exhaustion requirement, which holds that a prisoner must exhaust all administrative remedies at his or her facility before filing a lawsuit in federal court. In order to satisfy this requirement, youth must navigate convoluted grievance systems and comply with often challenging rules regarding deadlines, the necessary content of complaints, and appeals processes. Many youth either do not know of or do not understand the grievance systems in their facilities, and many more fear retaliation for filing grievances. For mentally ill youth, the challenge of exhausting administrative procedures is even more acute. As a result, this provision effectively undermines the rights of incarcerated youth by denying them any access to the federal courts and the oversight and accountability of prison officials that the courts provide.

The PLRA has also created special problems for incarcerated youth subject to sexual abuse. Unfortunately, because mentally ill children are the most vulnerable in detention, they are also the most likely to be victimized and the least likely to speak out. Naturally, the power imbalance inherent in prison leaves incarcerated people, and especially children, concerned about experiencing retaliation if they file grievances. This means that many prisoners, including youth, will not take part in the grievance system because they fear its consequences. This problem has played out in especially sinister ways for detained youth. For example, children

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detained by the Texas Youth Commission (TYC) were subject to rampant sexual abuse by staff for years and could not safely complain because many times the perpetrators themselves held the key to the complaint box. No child in TYC could hope to overcome the constraints of PLRA, leaving children with nowhere to go for help and the courts powerless to intervene. Once the scandal broke and the Texas legislature stepped in, detained children and their parents were able to come forward and over 1,000 complaints of sexual abuse have now been alleged.[xviii] But such atrocities should never have happened.

Unfortunately, the tragedy in TYC is not an isolated incident. Other cases amply illustrate the barriers children face in seeking protection from the courts because of PLRA. In *Minix v. Pazera*, for example, corrections staff allowed the rape and repeated assault of a child detainee. But the boy's lawsuit was thrown out of court because he did not file a formal grievance, even though he feared further abuse if he reported the incidents, and even though his mother repeatedly contacted prison and juvenile court officials to try to get them to stop the abuse. To satisfy the PLRA's exhaustion requirement, the boy would have had to file his formal grievance within 48 hours of being violently attacked. 2005 WL 1799538, 2005 U.S. Dist. LEXIS 10913 (N.D. Ind. July 27, 2005).

Because of the PLRA, federal courts frequently cannot protect vulnerable incarcerated children, especially mentally ill children, from rape and other forms of abuse.

The SAVE Coalition calls on Congress to protect mentally ill children by exempting juveniles from the PLRA. (Amend 18 U.S.C. § 3626(g), 42 U.S.C. § 1997e(h), 28 U.S.C. § 1915(h), 28 U.S.C. § 1915A(c).)

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For further information on efforts to reform the PLRA, go to www.savecoalition.org.

[i] *Woodford v. Ngo*, 548 U.S. 81, 90-91, 126 S.Ct. 2378, 2386 (2006). This "proper exhaustion" rule contrasts sharply with the treatment of other civil rights litigants in federal court. Concerning the administrative filing requirement of Title VII of the Civil Rights Act of 1964, the Court said that "technicalities are particularly inappropriate in a statutory scheme in which laymen, unassisted by trained lawyers initiate the process," *Love v. Pullman*, 404 U.S. 522, 526 (1972), and it refused to allow violation of a state administrative time limit to bar the litigant from proceeding in federal court.

A more recent Supreme Court decision concerning the exhaustion requirement was decided in the prisoners' favor. *See Jones v. Bock*, 549 U.S. 199 (2007). However, that decision addressed several extreme interpretations of the PLRA adopted in the Court of Appeals for the Sixth Circuit, which required prisoners to plead exhaustion in their complaints with specificity and documentary support and to have named all the defendants in their lawsuits in their prison grievance. That court also required "total exhaustion," meaning that if any aspect of the prisoner's complaint (including the naming of a defendant) had not been exhausted, the entire complaint must be dismissed. The Supreme Court's correction of these aberrant rules did not cure the problems discussed in this report.

[ii] Dismissal for non-exhaustion is usually without prejudice, meaning that in theory the prisoner can exhaust the claim properly and return to court. *See, e.g., Berry v. Kerik*, 366 F.3d 85, 87-88 (2d Cir. 2004). Reality is more like *Catch-22*: by the time a case is dismissed for a mistake in exhaustion, the brief time limit for filing a grievance will inevitably have passed, so under the "proper exhaustion" rule, the prisoner can never satisfy the exhaustion requirement. Regan v. Frank, 2007 WL 106537 at *4-5 (D.Haw., Jan. 9, 2007). (Some prison systems have provisions for late grievances at officials' discretion, but that discretion often is not exercised in favor of prisoners, particularly those who clearly are seeking to sue prison personnel.)

[iii] *See, e.g., Minix v. Pazera*, 2005 WL 1799538 at *4 (N.D.Ind., July 27, 2005) (dismissing for non-exhaustion because the 15-year-old prisoner, who had been repeatedly beaten and raped, did not file a grievance, even though his mother had made repeated complaints to numerous officials while the abuse was ongoing); *Gerrard v. Daley*, 2000 WL 34229777 (W.D.Wis., July 24, 2000), *subsequent determination*, 2000 WL 34231492 (W.D.Wis. Aug. 21, 2000) (dismissing for non-exhaustion the claim of a prisoner who was denied testing for symptoms of cancer until the disease had become terminal because his complaint to the director of the bureau of health services, pursuant to Wis. Admin. Code § DOC 310.08(4), did not comply with the inmate grievance policy specified in Wis. Admin. Code § DOC 310.04).

[iv] The National Center for Education Statistics reported in 1994 that seven out of ten prisoners perform at the lowest literacy levels. Karl O. Haigler et al., U.S. Dept. of Educ., Literacy Behind Prison Walls: Profiles of the Prison Population from the National Adult Literacy Survey xviii, 17- 19 (1994) (available at http://nces.ed.gov/pubsearch/pubsinfo.asp?pubid=94102).

[v] Prisoners with mental illness are subject to the same exhaustion requirement as other prisoners. *See Williams v. Kennedy*, 2006 WL 18314 at *2 (S.D.Tex., Jan. 4, 2006) (dismissing despite prisoner's claim he didn't know of the exhaustion requirement and a prior brain injury made it difficult for him to remember things); *Bakker v. Kuhnes*, 2004 WL 1092287 (N.D.Iowa, May 14, 2004) (rejecting plaintiff's argument that his medication doses were so high they "prohibited him from being of sound mind to draft a grievance"; noting that he failed to submit a grievance after his medication was corrected, and he filed other grievances during the relevant period).

Another court addressing a claim by a prisoner with mental illness also felt constrained to dismiss for non-exhaustion. It did direct prison officials to appoint someone to assist the plaintiff in exhausting. *Ullrich v. Idaho*, 2006 WL 288384 at *3 (D.Idaho, Feb. 6, 2006). However, it is not clear that a court has the power to direct such relief in a case that must be dismissed. In any case, such an order would likely be ineffectual, since the prisoner's claim would almost always be time-barred under the short deadlines characteristic of prison grievance systems.

We note that there is very little law on this subject despite the well-known concentration of persons with mental illness in prison. It is likely that many prisoners with mental illness are not capable of adequately framing an

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argument that their mental condition has prevented them from strictly complying with grievance procedures as the Supreme Court has directed.

[vi] *Woodford v. Ngo*, 548 U.S. 81, 126 S.Ct. 2378, 2389 (2006). The Court noted that the 15-day deadline the plaintiff missed is not unusual; grievance deadlines are typically 14 to 30 days according to the United States and even shorter according to the plaintiff. *Woodford*, 126 S.Ct. at 2389. The dissenting opinion cited a case from a juvenile facility involving a *48-hour* time limit. *Id.* at 2403, citing *Minix v. Pazera*, 2005 WL 1799538 at *2 (N.D.Ind., July 27, 2005).

[vii] Even prison officials sometimes can't get their own rules straight. In *Giano v. Goord*, 380 F.3d 670 (2d Cir. 2004), New York State prison officials argued that the plaintiff's claim that evidence in a disciplinary hearing had been falsified was not exhausted by appealing his disciplinary conviction, but that he should have filed a separate grievance on the subject. The court held that the plaintiff had shown special circumstances justifying his failure to exhaust, since any misunderstanding he had of the rule was entirely reasonable. In a later case presenting the same fact situation under the same rules, prison officials made precisely the opposite argument, claiming that a prisoner who had filed a separate grievance about false disciplinary charges should instead have pursued his claims through a disciplinary appeal. *Larkins v. Selsky*, 2006 WL 3548959 at *9 (S.D.N.Y., Dec. 6, 2006). In the years after *Giano*, the prison system did nothing to clarify its rules to distinguish between the scope of disciplinary appeals and that of grievances. *See also Westefer v. Snyder*, 422 F.3d 570, 580 (7th Cir. 2005) (observing prison policies did not "clearly identif[y]" the proper administrative remedy and there was no "clear route" to administrative review of certain decisions); *Abney v. McGinnis*, 380 F.3d 663, 668-69 (2d Cir. 2004) (noting the lack of instruction in the grievance rules for instances where a favorable grievance decision is not carried out).

[viii] *Brownell v. Krom*, 446 F.3d 305, 311-12 (2d Cir. 2006) (citing prison officials' erroneous advice that the plaintiff's lost property was not the responsibility of the prison he had been transferred to, which resulted in a failure to investigate; a prison official's advice to abandon his property claim and pursue a grievance instead, resulting in loss of the ability to appeal the property claim; and the lack of any apparent provision in the grievance system for raising newly discovered facts in a previously filed grievance); *Warren v. Purcell*, 2004 WL 1970642 at *6 (S.D.N.Y. Sept. 3, 2004) (noting 'baffling' grievance response that left prisoner with no clue what to do next); *Kendall v. Kittles*, 2004 WL 1752818 at *2 (S.D.N.Y., Aug. 4, 2004) (noting that Grievance Coordinator's affidavit said that plaintiff needed a physician's authorization to grieve medical concerns; no such requirement appears in the New York City grievance policy); *Livingston v. Piskor*, 215 F.R.D. 84, 86-87 (W.D.N.Y. 2003) (noting evidence that grievance personnel, contrary to policy, refused to process grievances where a disciplinary report had been filed); *Casanova v. Dubois*, 2002 WL 1613715 at *6 (D.Mass., July 22, 2002) (finding that, contrary to written policy, practice was "to treat complaints of alleged civil rights abuses by staff as 'not grievable'"), *remanded on other grounds*, 304 F.3d 75 (1st Cir. 2002).

[ix] *See Jackson v. District of Columbia*, 254 F.3d 262, 269-70 (D.C.Cir. 2001) (holding that a plaintiff who complained to three prison officials and was told by the warden to "file it in the court" had not exhausted); *Yousef v. Reno*, 254 F.3d 1214, 1221-22 (10th Cir. 2001) (holding that plaintiff who was confused by prison officials' erroneous representations about the powers of the grievance system was still required to exhaust); *Chelette v. Harris*, 229 F.3d 684, 688 (8th Cir. 2000) (holding that a plaintiff who complained to the warden and was told the warden would take care of his problem, but the warden didn't, was not excused from exhausting the grievance system), cert. denied, 531 U.S. 1156 (2001); *Mendez v. Herring*, 2005 WL 3273555 at *2 (D.Ariz., Nov. 29, 2005) (dismissing claim of a prisoner who said staff told him his rape complaint was not grievable, since futility is not an excuse); *U.S. v. Ali*, 396 F.Supp.2d 703, 707 (E.D.Va. 2005) (holding that a prisoner who received a response that "[a]s these issues are addressed by your attys [sic] and the government you will be informed" and did not appeal failed to exhaust); *Thomas v. New York State Dep't of Correctional Services*, 2003 WL 22671540 at *3-4 (S.D.N.Y., Nov. 10, 2003) (dismissing case where prison staff told the prisoner a grievance was not necessary; this was "bad advice, not prevention or obstruction," and the prisoner did not make sufficient efforts to exhaust).

In other cases, the courts have allowed claims to go forward where prisoners were misled. *See, e.g., Brown v. Croak*, 312 F.3d 109, 112-13 (3d Cir. 2002) (holding that if security officials told the plaintiff to wait for completion of an investigation before grieving, and then never informed him of its completion, the grievance system was unavailable to him); *Scott v. California Supreme Court*, 2006 WL 2460737 at *7 (E.D.Cal., Aug. 23, 2006) (holding that a prisoner who had relied on officials' misinformation and sought relief in state court had exhausted,

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notwithstanding officials' subsequent issuance of an untimely decision which he did not appeal); *Beltran v. O'Mara*, 405 F.Supp.2d 140, 154 (D.N.H. 2005) (holding, where a grievance was rejected on the ground that incidents which were the subject of disciplinary proceedings could not be grieved, "a reasonable inmate in [the plaintiff's] position" would believe the grievance process was not an available remedy and his claims should be raised in the disciplinary process), *on reconsideration*, 2006 WL 240558 (D.N.H., Jan. 31, 2006); *O'Connor v. Featherston*, 2003 WL 554752 at *2-3 (S.D.N.Y., Feb. 27, 2003) (holding allegation that prison Superintendent told a prisoner to complain via the Inspector General rather than the grievance procedure presented triable factual issues).

[x] There is a well-known pattern in American prisons of threats and retaliation against prisoners who file grievances and complaints. *See Dannenberg v. Valadez*, 338 F.3d 1070, 1071-72 (9th Cir. 2003) (noting jury verdict for plaintiff on claim of retaliation for assisting another prisoner with litigation); *Walker v. Bain*, 257 F.3d 660, 663-64 (6th Cir. 2001) (noting jury verdict for plaintiff whose legal papers were confiscated in retaliation for filing grievances), cert. denied, 535 U.S. 1095 (2002); *Gomez v. Vernon*, 255 F.3d 1118 (9th Cir.) (affirming injunction protecting prisoners who were the subject of retaliation for filing grievances and for litigation), *cert. denied*, 534 U.S. 1066 (2001); *Trobaugh v. Hall*, 176 F.3d 1087 (8th Cir. 1999) (directing award of compensatory damages to prisoner placed in isolation for filing grievances); *Hines v. Gomez*, 108 F.3d 265 (9th Cir. 1997) (affirming jury verdict for plaintiff subjected to retaliation for filing grievances), cert. denied, 524 U.S. 936 (1998); *Cassels v. Stalder*, 342 F.Supp.2d 555, 564-67 (M.D.La. 2004) (striking down disciplinary conviction for "spreading rumors" of prisoner whose mother had publicized his medical care complaint on the Internet); *Atkinson v. Way*, 2004 WL 1631377 (D.Del., July 19, 2004) (upholding jury verdict for plaintiff subjected to retaliation for filing lawsuit); *Tate v. Dragovich*, 2003 WL 21978141 (E.D.Pa., Aug. 14, 2003) (upholding jury verdict against prison official who retaliated against plaintiff for filing grievances); *Hunter v. Heath*, 95 F.Supp.2d 1140 (D.Or. 2000) (noting prisoner's acknowledged firing from legal assistant job for sending "kyte" (officially sanctioned informal complaint) to the Superintendent of Security concerning the confiscation of a prisoner's legal papers), *rev'd on other grounds*, 26 Fed.Appx. 754, 2002 WL 112564 (9th Cir. 2002); *Maurer v. Patterson*, 197 F.R.D. 244 (S.D.N.Y. 2000) (upholding jury verdict for plaintiff who was subjected to retaliatory disciplinary charge for complaining about operation of grievance program); *Gaston v. Coughlin*, 81 F.Supp.2d 381 (N.D.N.Y. 1999) (awarding damages for trumped-up disciplinary charge made in retaliation for prisoner's complaining about state law violations in mess hall work hours), on reconsideration, 102 F.Supp.2d 81 (N.D.N.Y. 2000); *Alnutt v. Cleary*, 27 F.Supp.2d 395, 397-98 (W.D.N.Y. 1998) (noting jury verdict for plaintiff who was subject to verbal harassment, assault, and false disciplinary charges in retaliation for his work as an Inmate Grievance Resolution Committee representative).

There have been mixed results from the courts in cases involving claims of failure to exhaust because of threats or intimidation. Some courts have simply dismissed such claims. *See, e.g., Enright v. Heine*, 2006 WL 2594485 at *2 (D.Mont., Sept. 11, 2006) ("Even a prisoner's fear of retaliatory action could not excuse her from pursuing administrative remedies."); *Broom v. Engler*, 2005 WL 3454657 at *3 (W.D.Mich., Dec. 16, 2005) (stating, where plaintiff recounted threats he received, "[t]he PLRA does not excuse exhaustion for a prisoner . . . who is afraid to complain"). Others have held that retaliation and threats can make a remedy unavailable or excuse the failure to exhaust. *See, e.g., Hemphill v. New York*, 380 F.3d 680, 688 (2d Cir. 2004); *accord, Kaba v. Stepp*, 458 F.3d 678, 684-86 (7th Cir. 2006). But even where courts hold the latter view, it will ultimately be a prisoner's word against that of prison staff members who will be accused of covert misconduct to which there are unlikely to be witnesses.

[xi] *See Dole v. Chandler*, 438 F.3d 804, 811-12 (7th Cir. 2006) (holding a prisoner had exhausted when he did everything necessary to exhaust but his grievance simply disappeared, and he received no instructions as to what if anything to do about it).

[xii] *See*, for example, these cases, which courts have allowed to go forward in spite of the protracted failure by prison officials to respond to grievances or appeals. *Brown v. Koenigsmann*, 2003 WL 22232884 at *4 (S.D.N.Y., Sept. 29, 2003); *accord, Levi v. Briley*, 2006 WL 2161788 at *3 (N.D.Ill., July 28, 2006) (declining to dismiss where the prisoner had waited two years for a final decision); *Jones v. Blanas*, 2005 WL 1868826 at *3 (E.D.Cal., Aug. 3, 2005); *White v. Briley*, 2005 WL 1651170 at *6 (N.D.Ill., July 1, 2005); *Casarez v. Mars*, 2003 WL 21369255 at *6 (E.D.Mich., June 11, 2003) (holding that prison officials' lack of response to a Step III grievance did not mean failure to exhaust); *John v. N.Y.C. Dept. of Corrections*, 183 F.Supp.2d 619, 625 (S.D.N.Y. 2002) (rejecting argument, three years after grievance appeal, that plaintiff must continue waiting for a decision).

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This response by the courts is far from universal. Some courts have stated categorically that exhaustion is not completed until the prisoner receives a decision, even if the prisoner has taken all necessary steps to exhaust. *See Petrusch v. Oliloushi*, 2005 WL 2420352 at *4 (W.D.N.Y., Sept. 30, 2005) (dictum); *Rodriguez v. Hahn*, 209 F.Supp.2d 344, 347-48 (S.D.N.Y. 2002). That view would let prison officials keep prisoners out of court just by failing to decide grievances. Other courts have said that exhaustion is complete once the time for a decision on the final appeal has passed. *See, e.g., Powe v. Ennis*, 177 F.3d 393, 394 (5th Cir. 1999). However, that view is not necessarily followed in practice. In *Wyatt v. Doe*, 2006 WL 1407636 at *1 (S.D.Tex., May 19, 2006), the court said that a prisoner whose grievance had remained "under exhaustion" for eight months and whose appeal had been ignored "[did] not establish that the investigation has been delayed unreasonably," even though the grievance process in Texas is supposed to be completed within 90 days. *See Pugh v. Braneff*, 2006 WL 1408392 at *2 (E.D.Tex., May 19, 2006). In *Ford v. Johnson*, 362 F.3d 395, 400 (7th Cir. 2004), a federal appeals court held that the prisoner had failed to exhaust where he had waited six months for a final decision in a system where decisions are supposed to be rendered within 60 days "whenever possible." *See also Mendez v. Artuz*, 2002 WL 313796 at *2 (S.D.N.Y., Feb. 27, 2002) (dismissing for non-exhaustion where a prisoner's grievance appeal had not been initially processed as a result of "administrative oversight").

Some grievance systems do not even have deadlines for responses, so the prisoner must engage in guesswork as to whether enough time has passed that the court will think he has waited long enough. *See Olmsted v. Cooney*, 2005 WL 233817 at *2 (D.Or., Jan. 31, 2005) (holding prisoner who waited seven weeks after filing last appeal was not shown to have failed to exhaust); *Thompson v. Koneny*, 2005 WL 1378832 at *5 (E.D.Mich., May 4, 2005) (holding that a decision delayed six and a half months was not "timely" and case could not be dismissed for non-exhaustion where prisoner filed after five and a half months); *McNeal v. Cook County Sheriff's Dep't*, 282 F.Supp.2d 865, 868 n.3 (N.D.Ill. 2003) (holding that 11 months is long enough, citing cases holding that seven months is long enough and one month is not).

[xiii] *See Cox v. Mayer*, 332 F.3d 422, 425 n.2 (6th Cir. 2003); *Donahue v. Bennett*, 2004 WL 1875019 at *6 n.12 (W.D.N.Y., Aug. 17, 2004); *Bailey v. Sheahan*, 2003 WL 21479068 at *3 (N.D.Ill., June 20, 2003); *Sims v. Blot*, 2003 WL 21738766 at * 3 (S.D.N.Y., July 25, 2003); *Larry v. Byno*, 2003 WL 1797843 at *2 n.3 (N.D.N.Y., Apr. 4, 2003) ("This Court's decision should not be seen as condoning" the failure to follow procedure by not rendering a decision); *Harvey v. City of Philadelphia*, 253 F.Supp.2d 827, 830 (E.D.Pa. 2003) (holding that failure to use a procedure permitting sending a grievance directly to the Commissioner if the prisoner believes he is being denied access to the process was a failure to exhaust); *Croswell v. McCoy*, 2003 WL 962534 at *4 (N.D.N.Y., Mar. 11, 2003); *Mendoza v. Goord*, 2002 WL 31654855 at *3 (S.D.N.Y., Nov. 21, 2002) (dismissing for failure to appeal a non-response even though the plaintiff "tried many avenues to seek relief from prison authorities"); *Petty v. Goord*, 2002 WL 31458240 at *4 (S.D.N.Y., Nov. 4, 2002); *Graham v. Cochran*, 2002 WL 31132874 (S.D.N.Y., Sept. 25, 2002); *Reyes v. Punzal*, 206 F.Supp.2d 431, 432-33 (W.D.N.Y.2002); *Martinez v. Dr. Williams R.*, 186 F.Supp.2d 353, 357 (S.D.N.Y. 2002); *Saunders v. Goord*, 2002 WL 1751341 at *3 (S.D.N.Y., July 29, 2002); *Jorss v. Vanknocker*, 2001 WL 823771 at *2 (N.D.Cal., July 19, 2001), aff'd, 44 Fed.Appx. 273, 2002 WL 1891412 (9th Cir. 2002); *Smith v. Stubblefield*, 30 F.Supp.2d at 1174; *Morgan v. Arizona Dept. of Corrections*, 976 F.Supp. 892, 895 (D.Ariz. 1997).

[xiv] *See, e.g. Jones v. Oaks Correctional Facility Health Services*, 2005 WL 3312562 at *2 (W.D.Mich., Dec. 7, 2005) (stating even a case that presents imminent danger of serious physical harm must be exhausted); *Calderon v. Anderson*, 2005 WL 2277398 at *5 (S.D.W.Va., Sept. 19, 2005) (stating exhaustion was required despite the prisoner's claim of "life-or-death situation"); *Drabovskiy v. U.S.*, 2005 WL 1322550 at *2 (E.D.Ky., June 2, 2005) ("To the extent the plaintiff's motion for emergency appeal is intended to be a request for the Court to forgive the exhaustion requirement necessary [sic], he provides no factual or legal grounds therefor."); *Joseph v. Jocson*, 2004 WL 2203298 at *1 (D.Or., Sept. 29, 2004) ("Plaintiff contends he should not be required to exhaust available remedies because delay may result in irreparable harm. Exhaustion is mandatory.") While one court has suggested that preliminary relief may be granted pending exhaustion, *see Jackson v. District of Columbia*, 254 F.3d 262, 267-68 (D.C.Cir. 2001), we are not aware of cases in which that argument has actually been applied. One court did decline to dismiss for non-exhaustion where the prisoner was shortly to be executed and exhaustion was not complete. *Evans v. Saar*, 412 F.Supp.2d 519, 527 (D.Md. 2006).

[xv] In addition to cases cited in the previous notes, another example of PLRA "gotcha" is cases where prisoners fail to exhaust out of fear or other justifiable circumstances, and courts then hold that they should have filed grievances

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when those conditions ceased to apply—even though, given the short deadlines for prison grievances, the grievance filing deadlines would generally have long passed and their grievances would be untimely. The result of a prisoner's failure to appreciate this point, as with other failures to exhaust, is dismissal of the prisoner's case, however meritorious it might be. A good illustration is the acknowledged pattern of physical abuse of prisoners by staff at the Rogers State Prison in Georgia, which resulted in the termination of a number of employees and lesser discipline to others, as well as a "series of prisoner-beating cases" in the federal district court. *See Priester v. Rich*, 457 F.Supp.2d 1369, 1371 & n.1 (S.D.Ga. 2006). In one of these cases, the plaintiff said he did not file a grievance because of his fear of violent retaliation, but the court said he should have filed a grievance when conditions changed, i.e., the administration was replaced and several officers were suspended and eventually terminated. *Stanley v. Rich*, 2006 WL 1549114 at *3 (S.D.Ga., June 1, 2006). Similarly, in *Langford v. Rich*, 2006 WL 1549120 at *2 (S.D.Ga., June 1, 2006), a prisoner who complained of threats of retaliation at Rogers should have filed an out-of-time grievance upon being transferred to another prison. Although these prisoners' claims were dismissed without prejudice, as a practical matter they would be unable to exhaust and then refile their claims under the "proper exhaustion" rule of *Woodford v. Ngo*, *supra,* because any new attempt to exhaust would be untimely. *Accord*, *Hemingway v. Lantz*, 2006 WL 1237010 at *2 (D.N.H., May 5, 2006) (holding a prisoner who said he did not grieve for fear of staff retribution should have done so once transferred to the "safety" of another state); *Haroon v. California Dept. of Corrections and Rehabilitation*, 2006 WL 1097444 at *3 (E.D.Cal., Apr. 26, 2006) (holding that a prisoner who was in a coma during the usual time limit should have filed afterwards), *report and recommendation adopted*, 2006 WL 1629123 (E.D.Cal., June 9, 2006); *Isaac v. Nix*, 2006 WL 861642 at *4 (N.D.Ga., Mar. 30, 2006) (holding prisoner who said he couldn't get grievance forms within a five-day time limit should have filed a grievance within five days of getting the forms); *Brazier v. Maricopa County Sheriff's Office*, 2006 WL 753157 at *4 (D.Ariz., Mar. 22, 2006) (holding that a prisoner who was physically traumatized and unable to file a grievance within the 48-hour time limit was required to exhaust them later, even untimely), *reconsideration denied*, 2006 WL 1455569 (D.Ariz., May 22, 2006); *Ming Ching Jin v. Hense*, 2005 WL 3080969 at *3 (E.D.Cal., Nov. 15, 2005) (holding a prisoner informed that there was no record of his appeal was obliged to take steps to pursue the appeal), *report and recommendation adopted*, 2006 WL 177424 (E.D.Cal., Jan. 20, 2006).

[xvi] As one court put it, once suit is filed, "the defendants in hindsight can use any deviation by the prisoner to argue that he or she has not complied with 42 U.S.C. § 1997e(a) responsibilities." *Ouellette v. Maine State Prison*, 2006 WL 173639 at *3 n.2 (D.Me., Jan. 23, 2006), *aff'd*, 2006 WL 348315 (D.Me., Feb. 14, 2006). Other courts have expressed similar concerns. *See, e.g.*, *Campbell v. Chaves*, 402 F.Supp.2d 1101, 1106 n.3 (D.Ariz. 2005) (noting danger that grievance systems might become "a series of stalling tactics, and dead-ends without resolution"); *LaFauci v. New Hampshire Dept. of Corrections*, 2005 WL 419691 at *14 (D.N.H., Feb. 23, 2005) ("While proper compliance with the grievance system makes sound administrative sense, the procedures themselves, and the directions given to inmates seeking to follow those procedures, should not be traps designed to hamstring legitimate grievances."); *Rhames v. Federal Bureau of Prisons*, 2002 WL 1268005 at *5 (S.D.N.Y., June 6, 2002) ("While it is important that prisoners comply with administrative procedures designed by the Bureau of Prisons, rather than using any they might think sufficient, . . . it is equally important that form not create a snare of forfeiture for a prisoner seeking redress for perceived violations of his constitutional rights.").

[xvii] For example, in *Marshall v. Knight*, 2006 WL 3714713 (N.D.Ind. Dec 14, 2006), the prisoner said he had been subject to adverse disciplinary and classification action in retaliation for constitutionally protected activity. He did not file a grievance because the grievance system excludes disciplinary and classification matters. However, the defendants said, and the court agreed, that his claim was really about retaliation, not about classification and discipline, and he should have filed a grievance. Mr. Marshall's case was dismissed because he followed a common-sense interpretation of the prison's own grievance policy, and as noted, any attempt to exhaust after the dismissal would have been untimely.

[xviii] *See, e.g.*, Sylvia Moreno, *In Texas, Scandals Rock Juvenile Justice System: Hundreds to Be Released as State Looks at Abuse Allegations and Sentencing Policies*, WASH. POST, Apr. 5, 2007, at A3.

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Testimony for the Senate Committee on the Judiciary,
Subcommittee Human Rights and the Law
"Human Rights at Home: Mental Illness in U.S. Prisons and Jails"
September 15, 2009
By the Coalition to Stop Abuse and Violence Everywhere
(SAVE Coalition)

EXHIBIT A

Coalition to Stop Abuse and Violence Everywhere (SAVE Coalition)

Mission Statement:

The SAVE Coalition is a group of organizations and individuals dedicated to protecting the U.S. prison, jail and youth detention population--a group that is increasingly vulnerable to violence and abuse since the 1996 enactment of the Prison Litigation Reform Act (PLRA). Members of the SAVE Coalition have studied the impact of the PLRA and developed proposed reforms to the law that do not interfere with its stated purpose: to reduce frivolous litigation by prisoners. Among the groups most adversely affected by the restrictions imposed by the PLRA are juveniles, who could never be considered "frivolous" litigators in the first place. The SAVE Coalition's proposed reforms seek to preserve the rule of law in America's jails, prisons, and youth detention centers and to protect adult and juvenile prisoners from rape, assault, denials of religious freedom, and other constitutional violations by fixing the unintended consequences of the PLRA.

SAVE Coalition members include:

United Methodist Church, General Board of Church and Society

Juvenile Law Center

ACLU

Human Rights Watch

American Bar Association

Drug Policy Alliance

Legal Aid Society of NY

The Sentencing Project

Open Society Institute

Penal Reform International

Just Detention International

Prison Legal News

Washington Lawyers' Committee for Civil Rights and Urban Affairs, DC Prisoners' Project

Public Justice Center

CURE International

Prison Law Office

Private Corrections Institute

AdvoCare, Inc.

PA. Institutional Law Project

Other supporters include:

Chase Riveland, former Director of the Colorado and Washington Dept. of Corrections

Pan Nolan, Prison Fellowship

Joseph Lehman, former Director of the Pennsylvania, Maine and Washington Dept. of Corrections

Dave Keene, Chairman of the American Conservative Union

For more information on the SAVE Coalition, please visit
www.savecoalition.org
or contact Amy Fettig, SAVE Coalition Coordinator,
202/548-6608, afettig@npp-aclu.org.

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Statement to the Judiciary Committee's Subcommittee on Human Rights and the Law

On September 15, 2009, the Senate Judiciary Committee's Subcommittee on Human Rights and the Law, chaired by Senator Dick Durbin (D-IL), heard testimony from representatives from the U.S. Department of Justice, corrections leaders, and providers of community-based services about the challenges associated with providing quality mental health care to the large number of people with mental illness who are incarcerated in prisons and jails across the United States. It is no secret that America's prisons and jails have become *de facto* mental hospitals. Yet, most correctional administrators are the first to admit that the institutions they run are not therapeutic environments and too often lack the resources needed to serve this population.

In 2006, the Vera Institute of Justice's Commission on Safety and Abuse in America's Prisons published its final report, *Confronting Confinement*, which recommended, among other things, improving the quality of mental health care in prisons and jails, increasing linkages to community services that can serve mentally ill prisoners, and reducing the number of incarcerated people with mental illness. The Commission's report described strong models for achieving these goals, such as the screening, diversion, and treatment program at the jail in Montgomery County, Maryland, and intermediate care programs in the New York State prison system. Yet, the report also acknowledged that most prisons and jails face a tremendous burden in meeting this need, which is exacerbated by an inadequate supply of community-based services and a lackluster broader commitment to treating mental illness in community and hospital settings. These concerns were echoed by witnesses at the September 15th hearing, and Vera supports the subcommittee's effort to draw attention to this crisis.

Among the most troubling trends explored by Vera's Commission and raised at the subcommittee hearing is correctional facilities' increased use of long-term segregated housing for prisoners whose behavior poses challenges for facility mangers. Too often, this practice can result in individuals spending weeks, months, or even years in isolated conditions. Having taken great pains to explore and analyze research on this practice and consult with leading psychiatric experts, the Commission concluded that this type of long-term segregation is detrimental to mental health and can be devastating for people with pre-existing mental illnesses.

However, there is considerable resistance to reversing the trend. Corrections administrators are understandably concerned about their ability to manage overcrowded facilities without being able to permanently remove from the general population prisoners who they deem to be trouble-makers. Yet this practice places prisoners with histories of mental illness, who often have great difficulty adhering to institutional rules, at particular risk. The conditions associated with segregation can cause serious mental deterioration among people with no previous history of mental illness; among those who do have a history of mental illness they are known to cause psychosis.

To date, there has not been a sufficient investment in exploring alternatives to segregation, nor have corrections departments been provided with the resources and incentives needed to adopt existing alternatives. Yet, a handful of states and counties have taken dramatic steps to reduce the numbers of prisoners they hold in long-term segregation and to improve conditions

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for those who are in segregation. For example, the state prison systems in Mississippi and Ohio, and the jail in Hampden County, Massachusetts, have significantly reduced the numbers of prisoners they have in long-term segregation and have worked to mitigate the isolating conditions for those who remain in segregation. Their efforts and efforts like this should be studied and their outcomes for both institutional and public safety better understood. Vera is researching alternatives to the overuse of long-term segregation by looking at these reform initiatives and others, with the goal of encouraging jurisdictions to adopt the most promising alternatives.

A great deal more needs to be learned about not only the impact of isolation on the individual, but also the impact of the large-scale use of long-term segregation on public safety. Existing evidence already suggests, for example, that prisoners released directly from supermax confinement are more likely to commit crimes than those with identical criminal histories released from general prison populations. More research is needed to understand this phenomenon, as well as to learn who is living in isolated conditions in prisons and jails, why they are there, and the impact these conditions have on both their mental health and the public's long-term safety.

The Vera Institute of Justice is heartened by this subcommittee's clear concern about these issues. We encourage further exploration of them, and would gladly serve as a resource as the subcommittee moves forward.

Alex Busansky
Director
Washington, DC Office
Vera Institute of Justice



Statement for the Record
Witness Justice

"Human Rights at Home: Mental Illness in U.S. Prisons and Jails"
U.S. Senate Judiciary Committee
Subcommittee on Human Rights and the Law.
September 22, 2009

Submitted by:
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Violence: Trauma is the Common Denominator, Healing is the Common Goal
Addressing the Escalating Public Health Crisis With Integrated Trauma-Informed Solutions

Whether they emerge from the shadow of sexual abuse, the wake of a hurricane, the rubble of a terrorist attack, or the smoke of combat, survivors of traumatic events all have one thing in common — picking up the pieces of a life shattered by violence. Trauma, especially when left untreated, has a devastating impact on the victim's physical, mental, and emotional wellbeing.

But the problem is not just a private one. Like the shock wave from a bomb blast, the consequences of untreated trauma radiate far beyond an individual ground zero, inflicting damage throughout our society. The affects can be felt from our hospitals and prisons to our schools and businesses — costing our nation billions of dollars annually. With more Americans serving in Iraq and Afghanistan, increasing acts of terrorism, rising crime and the lingering aftermath of hurricanes Katrina and Rita, we face a growing public health crisis caused by trauma that touches us all.

The vast scope and scale of this issue demands our urgent attention. Yet this crisis remains neglected by elected officials, policy makers, and a majority of citizens, due to the lack of public education, awareness, and support for an integrated "trauma-informed" approach to assisting the spectrum of survivors.

Solutions exist, as outlined below, following an examination of what trauma is, its human and social costs, the science behind traumatic behavior, and models of therapy. Fortunately, developments in addressing and healing from psychological trauma offer successful methods of coping to those who suffer from natural or man-made violent experiences.

And since trauma is the common denominator of violence and disaster victims, then healing is the common goal we all must share for the sake of our country's public health and welfare.

What is Trauma?
Everyone feels "stressed out" at times by seemingly overwhelming situations or has faced some distressful events common to human beings — a fender bender, loss of a job, or death of a loved one. Stress is a part of life.

But trauma from a violent event goes far beyond the average mental, emotional, or physical strain of daily living, leaving the victim with a deeper "silent" wound. For those individuals, the trauma isn't just part of life, it changes life as it was once known.

The American Psychiatric Association's *Diagnostic and Statistical Manual* (DSM-IV) defines a "traumatic event" as one in which a person experiences, witnesses, or is confronted with actual

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or threatened death or serious injury, or threat to the physical integrity of oneself or others. A person's response to trauma often includes intense fear, helplessness, or sheer horror.[1] Trauma can result from experiences that are "private" (e.g. sexual assault, domestic violence, child abuse/neglect, witnessing interpersonal violence) or more "public" (e.g. war, terrorism, natural disasters).

Medical researchers, sociologists, and healthcare professionals increasingly recognize trauma as a significant factor in a wide range of health, behavioral health, and social problems.[2 3] Trauma resulting from prolonged or repeated exposures to violent events can be the most severe.[4]

Clearly, different individuals react to trauma in their own way, depending on the nature of and circumstances surrounding their traumatic experiences. For example, trauma associated with repeated childhood physical or sexual abuse can become a central defining characteristic to a survivor's identity, impacting nearly every aspect of his or her life. Regardless of its cause, trauma is a central mental health concern and a "common denominator" for violence and disaster victims.

The Human Cost

Trauma can have severe negative impacts on a person's physical and emotional state. The most common experiences include flashbacks, emotional numbness and withdrawal, nightmares and insomnia, mood swings, grief, guilt, distrust, and a lack of physical or sexual intimacy. Trauma has been linked to hallucinations and delusions, depression, suicidal tendencies, chronic anxiety and fatigue, hostility, hypersensitivity, eating disorders such as anorexia or obesity, and other obsessive behaviors.[5]

Victims are at a much higher risk for co-occurring mental health disorders and substance abuse, violence victimization and perpetration, self-injury, and a host of other coping mechanisms which themselves have devastating human, social, and economic costs. Trauma has been linked to social, emotional, and cognitive impairments, disease, disability, serious social problems, and premature death.[6]

In fact, between 51 percent and 98 percent of public mental health clients diagnosed with severe mental illness have trauma histories,[7] and prevalence rates within substance abuse treatment programs and other social services are similar.[8] In children, trauma may be incorrectly diagnosed as depression, attention deficit hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), conduct disorder, generalized anxiety disorder, separation anxiety disorder, and reactive attachment disorder.[9 10] Adults also encounter similar misdiagnosis and obstacles in having their trauma experiences understood and addressed.

The Adverse Childhood Experiences (ACE) study, which examined the health and social effects of traumatic childhood experiences over the lifespan of 18,000 participants, demonstrated that trauma is far more prevalent than previously recognized, that the impacts of trauma are cumulative, and that unaddressed trauma underlies a wide range of problems. Chronic medical conditions such as heart disease, cancer, lung and liver disease, skeletal fractures, and HIV-AIDS plague many trauma survivors. Also, a host of social ills from homelessness, prostitution, delinquency and criminal behavior, to the failure to finish school or an inability to hold a job,

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stem from the effects of a traumatic event [11 12 13] Fractured relationships and support systems also greatly impact the survivor and their ability to heal.

The Public Price Tag of Untreated Trauma

When undiagnosed and untreated trauma manifests itself as civic problems, we all foot the bill. It can significantly increase the use of health care and behavioral health services, as well as boosts incarceration rates and increases the need for victim compensation and services. For instance, we know that more than 40% of women on welfare were sexually abused as children.[14] So taxpayers then pick up the tab for the greater reliance on public resources such as Medicare, Medicaid, and other welfare programs, plus the strain on the law enforcement, court, victim service, and prison systems. Meanwhile trauma costs business and the American economy in decreased productivity and unemployment payments.

And the financial burden to society is staggering. The economic expenditures of untreated trauma-related alcohol and drug abuse alone were estimated at $160.7 billion in 2000.[15] The estimated cost to society of child abuse and neglect is $94 billion per year, or $258 million per day.[16] For child abuse survivors, long-term psychiatric and medical health care costs are estimated at $100 billion per year.[17] Lost productivity from violence accounted for $64.4 billion annually, with another $5.6 billion spent in medical care.[18]

A Multiplier Effect: Disasters

Research on the consequences of recent public disasters, including the 1995 Oklahoma City bombing, the 2002 Challenger disaster, the September 11, 2001 terrorist attacks, and hurricanes Katrina and Rita illustrates that disasters can induce severe and long-term trauma, particularly in those with prior histories of mental health problems, addiction, or trauma.[19 20 21] All disaster victims are likely to experience some form of trauma. While many disaster survivors "recover" from grief and shock after a few months, 25 percent to 30 percent of those directly affected may develop full-blown Post-traumatic Stress Disorder (PTSD),[22 23] with the surfacing of increased substance abuse, child abuse taking place months later. Domestic violence incidents can increase 30 percent to 50 percent within three to six months following a disaster in those communities affected.[24]

People with severe mental illness, addictions, and previous histories of trauma are particularly vulnerable to the psychological impact of disasters.[25 26] People with prior exposure to domestic violence (including physical or sexual abuse) in childhood or adulthood have significantly heightened susceptibility to severe and chronic PTSD following exposure to any type of traumatic event.[27 28 29] Similarly, refugees who had been previously traumatized in their native countries and who had been diagnosed with PTSD are at risk.[30]

For those with previous trauma histories, PTSD symptoms, and/or substance abuse problems, trauma symptoms can actually *increase* with time following a disaster. Often they are able to maintain stability during the initial crisis, but after the immediate crisis passes, they may re-experience thoughts, emotions, symptoms, and anxiety levels like those associated with their previous traumas, causing a kind of "relapse," increased demand on mental health services, and increased suicide rates.[31 32]

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New Discoveries in the Science of Traumatic Behavior

Especially when experienced in childhood, trauma produces neurobiological impacts on the brain, causing dysfunction in the hippocampus, amygdala, medial prefrontal cortex, and other limbic structures.[33] [34] When confronted with danger, the brain moves from a normal "information-processing" state to a survival-oriented, reactive "alarm state." Trauma causes the body's nervous system to experience an extreme adrenaline rush, intense fear, problems processing information, and a severe reduction or shutdown of cognitive capacities, leading to confusion and a sense of defeat.

If there are insufficient biological or social resources to assist in coping, the "alarm state" may persist even when the immediate danger has passed, and this can lead to PTSD. Excessive and repeated stress causes the release of chemicals that disrupt brain architecture by impairing cell growth and interfering with the formation of healthy neural circuits. When trauma occurs repeatedly, permanent changes in the brain can occur, compromising core mental, emotional, and social functioning -- and resulting in a brain that is focused on simply surviving trauma.[35]

However, recent research suggests post-traumatic stress is not a permanent neuropsychological condition, but rather a functional and largely reversible distortion in the multi-dimensional pathways that meld the mind and body. These discoveries, together with a range of new therapy approaches, are opening new perspectives on healing,[36] and new treatments are being explored within this context.[37]

Steps on the Road to Recovery

Today, the healing journey includes a variety of models and programs offering greater opportunities to trauma victims for health and wellness. Treatment may range from very trauma-specific interventions, to peer support, or to more proactive efforts, such as teaching resilience and coping skills as part of high school health education.

Trauma-specific interventions are just that — treatment especially designed to address the consequences of trauma in the individual and assist in healing. Such programs generally acknowledge the survivor's need to be respected, informed, included, connected, safe, and hopeful regarding their own recovery. Thus, key components involve listening, education, reassurance, and a healing environment. These models recognize the interrelation between trauma and its symptoms (substance abuse, easting disorders, depression, anxiety, etc.). They also understand the need to work in a collaborative way with survivors, as well as their families and friends, and integrate other human services agencies in a manner that empowers survivors. Some of the well-known trauma specific interventions include the Sanctuary Model, Essence of Being Real, Seeking Safety, Risking Connection, Addition and Trauma Recovery Integration Model (ATRIUM), and the Trauma Recovery and Empowerment Model (TREM).[38]

Peer support, as a therapeutic model, has recently proven to be an innovative, successful, and cost-effective approach in response to disaster trauma. It is based on the simple principle that those who have previously experienced a traumatic event and have used mental health services in their recovery are well equipped to help others face the same challenges. In fact, it's been shown that the shift from a passive victim to a proactive survivor offering leadership and support plays a valuable role in the peer-provider's own relief from trauma. In addition, peer-counselors help

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reduce the burden on the often undersized, overwhelmed professional staff. These peer-based programs emphasize outreach, focus on people's strengths, avoid mental health labels, occur in local settings, offer social support, and are more culturally sensitive because they are delivered by people who are themselves community members. Notable examples of successful peer-support programs include Oklahoma City following the Murrah Building bombing, New York City after 9/11, and Louisiana in the wake of hurricanes Katrina and Rita.[39] Many states are still in the early stages of developing a network of peer-support services in preparation for disasters, and unfortunately, no peer response model currently exists for those trauma victims in the criminal justice area.

Resilience development is another exciting, proactive innovation for the prevention as well as treatment of trauma. Dennis Charney, M.D., Ph.D., dean of research and professor of psychiatry at Mt. Sinai School of Medicine, believes that through focused training and cognitive behavioral therapy, people can be inoculated against stress. "You can learn to recognize your own character strengths and engage them to deal with difficult and stressful situations," he notes. Charney and Yale psychiatry professor Steven Southwick, M.D., identified personality traits associated with resilience in 250 American POWs held captive for up to eight years in the Vietnam War, who were subjected to torture and solitary confinement. Then in two other studies, they interviewed women who had suffered severe trauma from sexual and physical abuse, and a group of people who displayed courage and resilience in the face of serious medical problems. All three groups shared the same characteristics of resilience: optimism, cognitive flexibility, altruism, strong or heroic role models, adeptness at facing fears, physical fitness, a supportive social network, active coping skills, a sense of humor, and a personal moral compass or shatterproof set of beliefs. Fostering those characteristics will help people deal with adversity when it occurs and recover faster from a traumatic event.[40]

Trauma-Informed Services — Solutions for the Growing Public Health Crisis

Recent public disasters, such as 9/11 and Hurricane Katrina, have provided a new sense of urgency for the long-standing need for trauma education and awareness-building among all organizations, institutions, and agencies that come into contact with survivors of violent events.

When a program moves toward becoming trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic knowledge of how trauma impacts the life of the individual seeking help. Trauma-informed systems are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional approaches may actually aggravate or intensify, making this new generation of programs more supportive and less likely to re-traumatize the victim.

This is necessary to promote the health and wellbeing of survivors and their families, and to set the stage for health and mental health professionals, organizations providing services to trauma survivors, law enforcement and criminal justice officials, emergency responders, and others to effectively and seamlessly integrate trauma understanding into their existing programs and procedures.

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And there is no time to lose in developing trauma-informed solutions for the growing population of violence and disaster victims. In a Sept. 29, 2006, letter to President Bush, the U.S. House of Representatives Bipartisan Caucus on Addiction, Treatment, and Recovery stated:

"It has become more clear than ever psychological trauma is a primary — but often ignored or overlooked — factor of health (both physical and mental) with which survivors of violent crime, abuse, disaster, terrorism and war must contend, and this presents a public health crisis in the United States that needs to be addressed immediately."

Witness Justice agrees, and continues to advocate not only for education and awareness on the issue, but also for:

- Legislators to consider how psychological trauma may play a role in pending or future legislation, including policy that addresses disaster preparedness and response, national defense and our armed forces, plus initiatives on crime (domestic violence, sexual assault, stalking, child abuse/neglect), mental health, education, homelessness, and more

- Inclusion of programs, services, and funding in legislation that addresses trauma and provides short-term, intermediate, and long-term support through the healing process

- Development and implementation of prevention measures, such as peer-support service networks and resilience training education

- More support for efforts that address psychological trauma through new models with proven track records of success, such as peer-support

In addition, Witness Justice recently launched a new advocacy program, Survivors Taking Action, that is the first of its kind in the nation. This initiative brings together interest groups for crime victimization, child abuse, veterans' issues, disaster preparedness, homelessness, substance abuse, mental health, and more to tackle the "common denominator" of trauma. The goal is to reach all those who attempt to live under the cloud cast by violence, whether natural or man-made, and provide the light of both hope, healing, and support for them, their families, and for the health and wellbeing of America.

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A. Kathryn Power, M.Ed

Family Safety: A Significant Concern for Returning Veterans and Their Families
Capitol Hill, Washington, DC, Cannon Caucus Room (CHOB 345)
October 24, 2008

Remarks submitted by **A. Kathryn Power, M.Ed.**, Director, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

I grew up as a member of a military family. My father was a Navy Engineer. We lived in shipyards all across the west coast and the east coast for all of my upbringing. I'm a member of a military family and I went to five different elementary schools and four different high schools. So the issue of living in a military family is very important to me and I understand the risk and protective factors that go along with being with a family member, and also the resiliency issues for family members and what you have to really be aware of and think about. The second thing was that I married a Marine which my Navy dad never forgave me for. And, in marrying a Marine, we began to live the Marine life. He was an Infantry Officer so I'm a spouse of a military person as well. We were on active duty for several years and then he became a reserve officer and stayed in the Reserves for almost 25 years. And the third piece is that I, myself, am a military officer. I'm a Captain in the Navy Reserve so I have the experience of that professional opportunity as well as working with other members of the military across several years. So, for me, this is a very personal issue from that experience.

Winston Churchill once said that courage is what it takes to stand up and speak. Courage is also what it takes to sit down and listen. Before we can fully understand trauma, before we have the words we need to discuss it, and before we can offer appropriate treatment, we must be willing to listen to the lives of those who, for too, long have suffered in silence. I had the privilege to listen to trauma survivors when I began my work over 30 years ago. First as a rape crisis counselor and a domestic violence counselor, and then as a victim-services advocate. It was the most meaningful, transformative work of my life. I learned that given time and support, individuals have an enormous potential to recover - to recover from even the most unspeakable acts of violence against their body, against their mind, and their soul.

The survivors that I worked with inspired me to work tirelessly to help open the nation's eyes to the impacts of trauma, whether it is trauma induced by criminals, by disasters, by terrorism, or by wars and the need to promote emotional health and recovery for every man, woman, and child who has been affected by traumatic events.

Trauma is increasingly seen as an almost universal experience of public mental health and human service recipients. Addressing trauma is increasingly recognized as essential for recovery.

Over the past 15 years, SAMHSA has recognized the need to address trauma as a **fundamental obligation** for effective public health and substance abuse service delivery. We have both elevated the visibility of this critical public health issue and have provided helpful tools for States and communities to promote recovery and healing for trauma survivors.

With our partners in the private sector, such as Witness Justice, and in the public at DOD and DVA we must recognize the **prevalence of trauma**, acknowledge its **impact**, and provide the **evidence-based services** that address trauma in a context that is trauma-informed and recovery-oriented. We know that

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trauma is universal, highly disabling, and largely ignored.

According to a recent study by the Rand Corporation, about **one-third** of the 1.64 million service members who have deployed in support of Operation Enduring Freedom or Operation Iraqi Freedom have major depression, posttraumatic stress disorder, or traumatic brain injury, and about 5 percent report symptoms of all three.

A one-time traumatic event can lead to PTSD, but so can ongoing stress—harsh climates, austere living conditions, constant danger, and repeated deployments put our servicemen and women at risk.

Past experiences also increase risk. Individuals who have previously been traumatized run a high risk of being re-traumatized (during wartime), and some will develop PTSD as a result.

Most of the men and women who serve in our armed forces and the families they leave behind are incredibly resilient. Most of our servicemen have strong mental health that enables them to deal successfully with combat-related stressors and trauma. Indeed, writing about the experiences of family members, psychologist Michelle Sherman notes that while the adverse effects of trauma receive the greatest attention, many survivors of trauma experience positive changes termed Post Traumatic Growth. They become more aware of inner strength and courage. They build empathy for others. They grow spiritually and they appreciate the opportunity for a fresh start.

Sherman notes that mental health professionals can gently challenge their clients to explore the positive outcomes that may emerge when working through painful experiences. But as mental health professionals, we must also be aware that left untreated, particularly in service members who are vulnerable, trauma can impair future health, or productivity, family, and social relationships. Individuals whose mental health problems go unaddressed are at risk for substance abuse, homelessness, and suicide. We need to pay attention.

Paralleling the civilian sector, I think this is most important, paralleling the civilian sector only about half of the service men and women who need mental health resources actually seek them. It is very similar to what goes on in the civilian sector.

Last year alone, 121 active duty soldiers took their own lives, the highest number on record since the Army began tracking suicides in 1980. Attempted suicides are up, too, numbering 2,100 in 2007—six times the rate in 2002. This is one of the reasons that SAMHSA added a feature to the National Suicide Prevention Lifeline so callers can identify themselves as veterans and be connected to VA professionals. Thus far, more than 55,000 calls have been received, connecting over 22,000 veterans with direct support.

The common responses to trauma also may affect family relationships with partners and children. Three out of five service members have a spouse, a child, or both. Trauma survivors often experience considerable social anxiety, which causes them to withdraw from everyday outings and family events. Frequently, they deal with significant anger, which can alienate them from their families, who experience their loved one as unpredictable, hostile, and frightening. Finally, many survivors become emotionally numb to avoid facing the pain associated with the trauma they experienced, which may cut them off from positive feelings and family support, as well.

We can help our returning soldiers and their families make this transition because **we know what to do to help them recover from the invisible wounds of war**. Relative to just ten years ago, we now have a wide range of models designed to help service providers meet the needs of individuals that have been

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traumatized by war, natural or manmade disasters, or interpersonal violence and abuse.

Many of these effective and promising models are compiled in the recently released report from the National Center for Trauma-Informed Care, and Helga is a member of that board, called *Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services*, which was prepared in conjunction with the National Association of State Mental Health Program Directors. To be effective, any model for treating individuals affected by trauma must begin with the understanding that **trauma is not a disease**. Trauma is a **public health issue** that affects the quality of lives of individuals, of their families, and of our Nation as a whole.

A public health model focused on recovery from trauma must be characterized both by trauma-specific diagnostic and treatment **services** and by a "trauma-informed" **environment** capable of sustaining these services.

We learned from SAMSHA's Women, Co-occurring Disorders, and Violence Study, which was the first large-scale evaluation of trauma interventions, that **integrated** treatment—for example, group and individual therapy that addressed trauma, mental health, and substance use conditions together—was the key element associated with better outcomes.

Clinical psychologist Roger Fallot, Director of Research and Evaluation at Community Connections in Washington, DC, has written extensively about this topic. Trauma-informed systems, he tells us these things: incorporate knowledge about trauma—including its prevalence and impact—in all aspects of service delivery; are hospitable and engaging for survivors; minimize revictimization; and facilitate recovery.

SAMHSA is not alone in our efforts to address trauma in the lives of our servicemen and women. DOD is launching an estimated $25 million project to discover the best treatments for combat-related PTSD. Called the STRONG STAR Multidisciplinary Research Consortium, this project will include eight randomized clinical trials of several treatment conditions, with active duty and veteran participants.

DVA, as well, recognizes both the problems of trauma among our Nation's veterans and its obligation to help. Military sexual trauma counselors at VA facilities meet with female veterans in private areas so they can safely hear a woman's feelings of fear, anxiety, shame, anger, and embarrassment and can connect her to the resources she needs to heal.

In addition, we can point to the wonderful work of the more than 200 community-based Vet Centers located in all 50 States, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands. The Vet Centers are staffed by small multidisciplinary teams of dedicated providers, many of whom are combat veterans themselves.

We must welcome our servicemen and women home with gratitude, respect, and the full support of the mental health community behind them. We must understand the prevalence of trauma, recognize its impact, and be prepared to offer evidence-based practices that help people recover not only their emotional and physical health, but also their hopes and dreams. I really welcome the opportunity today to have further dialogue.

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Helga Luest (West), briefing host

Family Safety: A Significant Concern for Returning Veterans and Their Families
Capitol Hill, Washington, DC, Cannon Caucus Room (CHOB 345)
October 24, 2008

Remarks submitted by **Helga Luest (West)**, President and CEO, Witness Justice

Good morning and welcome to our briefing on family safety as a significant concern for returning veterans and their families.

I would like to thank our four collaborating bipartisan caucuses:

- Addiction Treatment and Recovery Caucus
- Mental Health Caucus
- Veteran's Mental Health Caucus and
- Victim's Rights Caucus

I would also like to thank our Congressional supporters:

- Rep. Filner (D-CA), Chairman of the House Veterans' Affairs Committee
- Rep. Michaud (D-ME), Chairman of the House Veterans' Affairs Subcommittee on Health
- As well as Rep. Brown (D-FL) and Rep. Hare (D-IL)

and the dozens of organizations and interest groups that have signed on to recognize and support this important issue facing veterans of the current conflicts.

The significant support around this briefing and your attendance here speaks to the reason why Witness Justice together with the Veterans' Initiative Center and Research Institute decided to host this briefing. Very seldom do we see interest groups including veteran service organizations; trauma, mental health and substance abuse service providers; and domestic violence and crime victim groups coming together to focus on a single issue. While our overarching goal of this briefing is to prevent family violence, we also hope that the discussion here today will help to facilitate a national response in the form of meaningful programs and services. All of our briefing collaborators, supporters and panelists recognize that need and are doing their own part to address it and respond proactively.

What we see and hear from veterans is that combat stress creates conditions like strong startle responses and trauma triggers that can be not only divisive with family members after return, but can lead to violent responses. High levels of adrenaline, the "barking of orders", and long and repeat separations for service abroad has lead to breakdowns in communication, disconnection, and even domestic violence. It's time that we recognize that veterans are affected by their experiences – the impact has a ripple effect spanning the entire family. Some of what we see with families from the outside looking in has much more to do with response to the conditions of war, rather than intentional actions.

When alcohol is used for some relief to the memories of war;
When a soldier can no longer enjoy his children tackling and tickling him because he's not able to be completely alert to his surroundings and is too anxious to enjoy it,
When the tapping on a veteran's shoulder results in being pinned to the wall...

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These experiences are precisely what we need to respond to. And while everyone is responsible for their own actions, if we can take a step back and work on prevention through family education and support, then we can also avoid the punitive responses that can be destructive and traumatizing in their own right

In getting to some of those possible preventive solutions, it is my pleasure to thank our panelists for being here to share their knowledge with you.

While brief biographies are included in your briefing packets, I would ask each of the panelists to share a few words about their backgrounds. Each of them brings unique personal and professional experiences to this very important issue.

At this time I would ask that if you have not already done so, please silence your cell phone. I would also like to note that there will be time after our panelists share their remarks for you to ask questions.

It is now my pleasure to introduce Dr. Thomas Berger.

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Thomas J. Berger, Ph.D

Family Safety: A Significant Concern for Returning Veterans and Their Families
Capitol Hill, Washington, DC, Cannon Caucus Room (CHOB 345)
October 24, 2008

Remarks submitted by **Thomas J. Berger, Ph.D.**, Chair, PTSD & Substance Abuse Committee, Vietnam Veterans of America

First, as you can see from my bio, I am a combat Vietnam Veteran having served as a Navy Corp man with elements of the third Marine Division, 1966-1968, at different times because of my injuries. I then moved from there to deal with my own mental illness, if you will, PTSD. I completely submerged myself in academia. I'm a recovering academic, as a matter of fact. My last position was Director of the center that dealt with domestic violence and high risk, sexual behaviors. So I have an interest in the subject that we are talking about. For the last decade I have been serving as the Chair for the National PTSD and Substance Abuse Committee for Vietnam Veterans of America. And just recently, two months ago, I accepted a full time position with VVA here in Washington. Our offices are over in Silver Spring and I moved here. I still haven't unpacked but I can find my way around the city pretty well on the Metro. Just one other comment as a recovering academic, I have way too many books that I've been hauling around.

So, with that background, on behalf of Vietnam Veterans of America I'm proud to be here today and I'd like to thank Witness Justice and the Veteran's Initiative Center and Research Institute for providing me with the opportunity to participate in today's briefing on veterans, combat stress, and the family. I should like to say right at the beginning, if any of the things that I say bother you, feel free to get up and walk out and get a drink of water. For those of you who are still addicted, have a smoke downstairs. But I'm going to be pretty frank about some things and, wherever possible, I will use my own experiences as self-disclosure to illustrate some points.

"We'll always have Paris." That's what Humphrey Bogart said as he parted from Ingrid Bergman in Casa Blanca. It's a great movie line and it says a lot about the amazing human gift called memory. Like Bogey, you can keep your favorite places and people with you simply by pulling up your happy memories with them, even if they are miles away or long gone. Without flipping open a scrapbook or putting on a CD you can conjure up your newborn's first smile, first few words. The ecstasy or agony of prom night or even the aroma of mom's baked cookies.

But memories have a dark side also. They can make you feel devastated, furious or humiliated. Did that make you think of your prom night again? Even decades after something bad happened, bad memories seem to stick more than happy ones. And that's especially true for the type of memories like our combat veterans have. While many of us are well aware of the prevalence of combat stress amongst our Vietnam veterans and our returning OIF/OEF veterans, it's my sincere hope that you'll leave today's briefing with a better understanding of the impact of combat stress and the reintegration for our returning troops - how this effects families and how it can potentially lead to family violence.

First, however, a very brief history of combat stress or what we now know today as post traumatic stress disorder - or PTSD. It's a very old malady. Dr. Jonathan Shea, whom I'm proud to say is a colleague and a friend, traces PTSD back, or the first written accounts of PTSD back to Homer's Iliad. It's a very old malady, as I said, and as such, has been called a variety of names. In the 1670's, Swiss military doctors

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described the symptoms as nostalgia. During the Napoleonic wars, during the 19th century, battlefield surgeons began calling it exhaustion. And by the time of the American Civil War, it had become known as Soldier's Heart and the Effort Symptom. I don't know how many of you know this bit of trivia but the reason we have veteran's homes in this country is because after the Civil War, and there were thousands of veterans from both sides roaming the country. So we set up these institutions for them because the people didn't know what was going on with them.

"Shell shock" became the term commonly used in World War I, and this was succeeded by "combat fatigue" and "battle fatigue" in World War II. By the time the war in Vietnam was winding down in the early 1970s, the term "Post-Vietnam Syndrome" was being used to describe veterans' traumatic stress reactions during and after their military service in Southeast Asia. Finally, in 1980, the term "Post-traumatic Stress Disorder" appeared in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM III) and is still used today.

Now, PTSD has a lot in common with a normal stress reaction, the big difference is that it's a much more powerful response, and it doesn't go away. PTSD also looks a lot like acute stress disorder – in fact, acute stress disorder becomes PTSD, diagnostically speaking, if symptoms last more than a month, generally speaking.

Every medical disorder has its own signature, a pattern of symptoms that allows physicians to make a diagnosis and plan a treatment approach. In the case of PTSD, doctors look for three main types of symptoms: 1) *re-experiencing the traumatic event or events*, which includes intrusive, distressing recollections of the past event, flashbacks, nightmares, exaggerated emotional and sometimes physical reactions to triggers that remind the person of the event(s); 2) *avoidance or emotional numbing*, which includes avoidance of activities, places, thoughts, feelings, or conversations related to the trauma, and restricted emotions; and 3) *increased arousal* as indicated by difficulty sleeping, irritability or anger outbursts, difficulty concentrating, hyper vigilance, and an exaggerated startle response.

Normally you can easily brush aside an unpleasant thought. If you have PTSD, however, thoughts and emotions force their way into your mind, leaving you completely at their mercy.

The intrusive thoughts that occur in PTSD almost always cause a strong surge of emotion – anger, fear, humiliation, and helplessness – because the stress response is a total mobilization of the body's physical resources. Powerful neurochemicals flood our brain and body, including epinephrine, Nora epinephrine, serotonin, dopamine, and endogenous opiates and benzodiazepines. Sugars are also mobilized from liver and muscle, the respiratory rate is increased, as is heart rate and blood pressure, and the immune system is activated.

When you're asleep, these intrusive thoughts show up as nightmares. During the daytime, they pull you away from present time, sometimes making you behave in ways that don't make sense to the people around you. The best-known type of these daytime intrusions – although not everyone with PTSD experiences it – is a flashback.

A *flashback* is a memory from your trauma that intrudes into the here-and-now, making you feel like you're right back in the past. Flashbacks typically contain random bits and pieces of information – a sound, odor, the color of a bystander's umbrella – rather than a full-fledged memory. That's one reason it's hard to make sense of these blasts from the past or gain control over them without help from a therapist.

Flashbacks usually involve sights and sounds as when a veteran sees and hears the sounds of a long-ago battle, but as I said, they can also include smells, tastes, or sensations of touch. Sometimes a flashback

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just won't go away.

Not all intrusive thoughts, however, involve sensory flashbacks. Often, people with PTSD have other negative thoughts, such as "Other people are out to get me", or Nothing goes right for me" that stems from their trauma.

If you have PTSD, other people around you may mistakenly believe that a flashback or other intrusive thought is "all in your head". What they don't understand is that in reality, your whole body, not just your mind, gets in the game. That's because you're not just thinking about the past, you're actually reliving it.

After a trauma, you desperately want your terrible feelings to go away -- but when PTSD strikes, unpleasant emotions just don't pack their bags and leave. In fact, they grow even stronger over time, causing you intense distress. In order to cope, your mind tries to block or avoid these bad feelings with the intention of protecting you from the hurt. These mind games lead you to change your behavior in different ways. For example, you may avoid activities associated with the trauma – if your trauma occurred in a moving convoy in Iraq, when you return home, you may drive faster without regard for other vehicles or directions. Or you may block out key parts of the trauma - this blocking is called *psychogenic amnesia*, or you may avoid movies or TV shows for fear of seeing scenes that remind you of your trauma, or you may find it hard to fall asleep because you worry that nightmares will dredge up the fears that you're trying to suppress -- and of course, when you're awake, all you want to do is sleep as a means of escape from the daytime thoughts that plague you, a real *Catch 22*.

A related problem that occurs with PTSD is *emotional anesthesia*, a different trick your mind uses to help you avoid pain. It works to some degree, but it also makes feeling the emotions you *want* to feel more difficult. For example, people who viewed themselves as outgoing, fun, warm, and loving before a trauma often say that they now have trouble feeling an emotional attachment to others or reacting in a normal way to life events. It hurts relationships, you may find sexual relations and intimacy unpleasant or simply boring, and it steals the joy in your life – you may lose interest in hobbies and recreational activities that you formerly enjoyed. And emotional anesthesia can also make it harder for you to conjure up the emotions or enthusiasm you need to envision your future. The fancy term for this is called "foreshortening", which means that you have difficulty planning ahead and picturing where you'll be in the future, or you lose interest in your personal health – perhaps developing nutritional and substance abuse issues.

The last hallmark of PTSD that I want to mention today is *hyper arousal*, or when the nervous system stays on red alert all the time, and they can't let their guard down. This situation causes a range of problems that affect their relationships with other people and their general overall well-being such as chronic irritability, difficulty sleeping, other physical reactions triggered by a fight-or-flight reaction whenever a PTSD trigger occurs, and quickness to anger – what I'll call the ride on the adrenaline train..

Anger is one of the most common problems that troops encounter after deployment to the battlefield. This emotion, which stems from the high level of arousal and aggression needed for survival during war, can make re-establishing connections with family and friends a difficult challenge because military training often teaches the use of feelings and emotions for the most rudimentary of purposes, namely differentiation between safe and dangerous situations. Skills required for distinguishing emotional nuances and exploring emotions within interpersonal relationships are *not* taught by the military. The military's mission requires training our service members to go into dangerous situations, effectively assess the level of danger within the situation, and neutralize that danger using whatever force is necessary, regardless of how personnel feel about the mission.

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Combat missions are inherently aggressive and that aggression is reinforced each time a service member is placed in harm's way. Combat veterans have been taught to use aggressive tactics to maneuver safely through issues and problems, and when you add the component of learning how to disconnect from emotions, combat survival skills are nearly useless in creating an emotionally fulfilling relationship in civilian life.

So there are lots of reasons a combat veteran feels angry. First, anger is usually easy to tap into (and therefore accessible at a moments' notice) and is often used to mask underlying feelings that are much more difficult to deal with such as sadness, depression, or guilt. Post-deployment anger can also stem from discouragement or frustration the veteran felt during deployment and even during reintegration.

"Following the rules" is critical while you're in war, and you may become angry if those around you aren't following the rules or doing what they're supposed to be doing at home. This can even start during deployment because while in battle, problems become amplified. This means any fault you find in your comrades or superiors before or during deployment become more obvious during critical situations; just at the moments when you believe the person needs to perform better or at a higher level. Thus, you come to believe that others are not performing their jobs the way they should.

This same anger carries over upon transition, manifesting itself with family and friends or others in the community. For example, you get angry over minor traffic situations or getting cut out of line at the movies...

And because you feel like others aren't doing what they're supposed to be doing, you may try to take over and wind up being over-controlling, and that has serious consequences in personal relationships and with children in particular. Anger can also be easily displaced onto the wrong person or into the wrong situation.

Anger can also be related to issues of trust and betrayal. When service members return from war, they often realize that they're exasperated with the way life works, with the government and military systems, furious about being dragged into a war when war was unexpected in their life, or angry with their "higher power." Anger can be a response to being victimized and can also be directed toward a perpetrator of violence such as an enemy combatant or perpetrator of military sexual violence.

Lastly, anger and irritability can be associated with the fear or loss of control felt at times during deployment. In times of extreme stress, terror, or life threatening situations, such fear may be expressed as fight, flight, or freeze responses. Anger can motivate you, protect your feelings of self-esteem, or make you feel in control. You may feel angry from discouragement or frustration over leaving a job unfinished (such as leaving when the war is not finished) or even at the injustices of the world over which you have little or no control.

In conclusion, our complex brains and powerful memories distinguish us as one of the most intelligent of animals on the planet, and yet this very intelligence that leaves us vulnerable to the intrusive effects of trauma such as flashbacks, body memories, post-traumatic nightmares, and behavioral re-enactments. Exposure to trauma alters people's memories in a number of ways, producing extremes of remembering too much and recalling too little. In my opinion, barriers exist to recognizing the impact of trauma – the reality of traumatic amnesia in individual trauma survivors has repeatedly left our society with a cultural amnesia, especially when the trauma has occurred within marginalized groups such as veterans. In other words, there's a reluctance of both the survivors to dredge up the memories of the trauma and reluctance on the part of the larger audience to listen to the stories. As a result, it's been easy for both survivors and the public to lose the thread of the cause and effect relationships inherent in trauma. It is time to look seriously at how the impact of combat trauma can play in the role of responses - responses which can

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place the family in a situation that is not safe and one that is often seen as domestic violence.

Thank you, and afterwards I'll be glad to answer any questions you might have.

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Understanding and Responding to People in the Criminal Justice System Who Live with Self-Inflicted Violence
By Ruta Mazelis

Introduction

Every day, every hour, inmates in jails, prisons, and juvenile detention centers are bleeding, burning, and bruising themselves. These actions, known as Self-Inflicted Violence (SIV), are often considered to be the behaviors of the highly disturbed or pathologically manipulative, yet they are actually the most effective coping mechanisms many people have to manage their lives in the moment. When understood, the cuts, bruises, and blisters of SIV can guide us to better understand incarcerated individuals. They also provide us with ideas to stimulate healing and change not only for those individuals, but for our criminal justice system as well.

SIV is the intentional injuring of one's body as a means of coping with severe emotional and/or psychic stressors. It is used most commonly to manage the aftereffects of earlier trauma, especially experiences of childhood physical, sexual, and emotional abuse or severe neglect. Because the majority of persons who are incarcerated in correctional or psychiatric facilities have histories of trauma, staff in these facilities—both clinical staff and line staff—will work with people who self-injure and should have a clear understanding of:

- what self-injury is,
- who does it,
- why people do it, and
- what staff can/should do about it.

What is self-inflicted violence?

Clinically, SIV has been referred to by many terms, including "self-mutilation," "delicate skin cutting," and "parasuicidality." While commonly used, all of these labels misrepresent the behavior and meanings of SIV. Mutilation is not a goal of someone who self-injures, and some forms of SIV leave no scars. While cutting is one of the most prevalent methods of SIV, other common forms of self-inflicted violence used are punching, hitting, burning, bruising, head-banging, picking, or scalding the body. Each of these serves its own purpose and these different methods are not often interchangeable.

Many myths abound regarding SIV. One of the most prevalent is that the behavior is a failed, minimal suicide attempt, known as "parasuicidality." In fact, the opposite is actually true. SIV is often used to manage the strong emotions that lead one to consider dying, and it often serves to avert suicide attempts. Practices that seek to eliminate SIV (including physical and chemical restraints, seclusion, constant observation, and intervention) actually increase the risk of successful suicide by removing an effective coping strategy that acts as an alternative to ending one's life.

Who self-injures?

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Currently, attention to SIV by the media and the mental health field has focused on youth, particularly adolescent girls. While use of SIV often begins in childhood or adolescence, it is not uncommon among men and women of all ages. Therefore, while SIV is an important issue in the juvenile justice system, it is equally important that it be understood in the adult system as well. Other assumptions regarding people who live with SIV are that they are white and of middle or higher socioeconomic class. This is inaccurate. SIV is utilized by men and women of all classes, races, and cultures. The common denominator amongst people who live with SIV is a history of some form of trauma. Research shows that the vast majority of incarcerated people have known histories of childhood trauma, especially childhood abuse. For example, a recent study of men incarcerated in a county jail reported that 59% of them acknowledged some form of sexual abuse occurring before the age of 13.[1] A history of abuse, as well as other forms of trauma, is especially likely for people in the criminal justice system who struggle with mental health and/or substance abuse problems. Rates of prior trauma are as high or higher for individuals in the criminal justice system as for individuals in the mental health system.[2]

Childhood trauma often has profound repercussions in later life and can greatly impact a person's physical, emotional, and spiritual being. As reported by NYCASA, a 1999 study of female inmates at Bedford Hills Correctional Facility in New York found that over 80% had a history of childhood physical and sexual abuse, and more than 90% had experienced battering or sexual assault during their lifetime.[3] In a study of inmates on death row, 100% had histories of family violence and more than 87% were victims of severe physical and/or sexual abuse and met criteria for Post Traumatic Stress Disorder.[4]

A history of abuse does not excuse criminal behavior, but it may help explain it. For example, the use of alcohol and other substances is an effective method of "self-medicating," commonly used by traumatized people to "numb-out" or escape from intrusive thoughts and emotional pain. The use of illegal substances, and the behaviors necessary to access such drugs, often results in criminal behavior and incarceration. Similarly, most of the people (male and female) who work in the sex trade are victims of childhood sexual abuse. People who learn as children that sex is the most effective currency for maintaining relationships and feeling valued (not to mention making money) find as adults that sex work still meets these needs. The vast majority of incarcerated women have been arrested on charges of solicitation, drug offenses, or both.

Childhood trauma can take many forms, including experiences of:

- early loss and separation, especially of a parent /caregiver or sibling due to
    - illness
    - death
    - divorce/separation
    - drug and/or alcohol abuse
    - incarceration
    - neglect
- poverty and deprivation

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- severe illness, hospitalization, surgery
- war
- racism
- childhood abuses, including
    - sexual assault, including incest
    - physical assault
    - emotional abuse
    - witnessing domestic violence, and
    - neglect (emotional and/or physical)

These same traumatic events or conditions during childhood are the antecedents of SIV.

> *. . . the age at which their abuse and/or neglect had occurred played an important role in both the severity of their self-destructive behavior and the form it took: The earlier the abuse, the more self-directed the aggression. Abuse during early childhood and latency was strongly correlated with suicide attempts, self-mutilation, and other self-injurious behaviors. . . .Histories of sexual abuse, in particular, predicted continued suicide attempts, self-mutilation, and other self-destructive acts. Severity of neglect scores predicted continued suicide attempts, self-mutilation, and other self-destructive behaviors. During this period, the subjects with the most severe separation and neglect histories were the most self-destructive.*
>
> —Bessel A. van der Kolk, M.D.[5]

Acts of SIV often lead to psychiatric interventions. By far, the most common psychiatric label given to those who self-injure, especially women, is Borderline Personality Disorder. This diagnosis, while now acknowledged to be strongly correlated with childhood trauma, often elicits intensely judgmental and punitive treatment from clinical staff, both in psychiatric hospitals and in corrections facilities. While the most common accurate diagnoses given to childhood trauma survivors are Post Traumatic Stress Disorder and any of the Dissociative Disorders (and the recognition that anxiety, depression, extreme mood swings and hearing voices are not uncommon amongst trauma survivors), these are not usually applied to people who live with self-injury. Also, recent research has identified that people with psychiatric diagnoses not previously considered to be related to childhood trauma, such as schizophrenia and obsessive-compulsive disorder, do have a very high prevalence of childhood trauma and that the trauma might be related to the development of those disorders.[6]

> *All too often, the result of psychiatric diagnosis is to stigmatize certain people as dishonest, unlikable, and, worst of all, hopeless. Nowhere are these iatrogenic (harm caused by treatment) effects of diagnosis more pernicious than in the criminal justice system, and no diagnosis hurts more than that of a personality disorder. . . people who are so described*

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are treated as if their disruptive and self-destructive acts are simply evidence of moral weakness, dishonor, and perhaps evil.

—Joel Dvoskin, Ph.D., A.B.P.P.[7]

Why do people deliberately cut, punch, or burn themselves?

Just as the substance use and sex work (described above) serve a purpose and solve a problem for survivors of childhood trauma, so too does SIV (and most other trauma-related behaviors) serve a functional purpose for those who do it. Typically, SIV is driven by the underlying need for self-regulation and serves as a means of grounding, a way of managing highly dissociative states that impinge and impair functioning. It helps the person manage intense, seemingly overwhelming feelings, memories, and experiences. It is best understood as an act of self-defense, defending oneself from being consumed by the overwhelming distress of despair, numbness, or the re-experiencing of abuse. When asked how SIV helps, those who live with it say it helps them to:

- feel real, get a sense of their physical boundaries
- diminish intense emotions such as despair, terror, grief, self-hate, rage, shame, or helplessness
- facilitate dissociation, to disconnect from their sense of self when overwhelmed
- diminish dissociation, when the sense of disconnection is unwanted; SIV serves as "grounding"
- symbolize internal pain through an external expression
- remember without consciously knowing; re-enacting of previous abuse as an attempt to gain mastery
- communicate what cannot be said verbally
- express anger at someone else by directing it at their own body; i.e. punching themselves to avoid violence towards another
- stop or diminish flashbacks of abuse
- communicate between personalities in those with Dissociative Identity Disorder (formerly known as Multiple Personality Disorder)
- symbolize spiritual beliefs

Many people who self-injure feel no physical pain at the time of the acts of SIV. While some clinicians believe that this is a result of certain naturally produced brain chemicals (endogenous opioids known as endorphins), this theory is flawed. The wounds of SIV are often minimal. Many require little or no medical attention. They are no different from many minor wounds that are the results of accidents, and these do not cause any sort of chemically induced relief. The absence of pain from self-injury is much more likely related to the depth of the psychological disconnection (or dissociation) the self-injuring person is experiencing at the time. Also, as SIV is often used as a release for profound emotional pain, persons who self-injure report that the emotional pain is so overwhelming it makes the less intense physical pain from the self-injury irrelevant. Many people who cut themselves do so as an act of expression and release of deep and

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very difficult emotions. As a poet once wrote: "I hurt so much, I bleed."[8] People who have survived traumatic childhoods often struggle with dissociation, which is the sense of having one's thoughts, feelings, and identity separate from one's body. Dissociation is often described as a sense of "extreme spaciness." While an effective form of self-preservation, dissociation leads to feelings of disconnection and/or unreality and thus interferes with learning new ways of being in, and interacting with, the world. For some people it may be a preferable state of being when overwhelmed; at other times dissociation is unwanted or frightening. SIV is often used as a tool to manage dissociation, either to increase it or to decrease it. As a result, SIV serves as an "all-purpose tool" for many institutionalized or incarcerated people.

Persons with histories of severe abuse who experience emotional numbness often turn to SIV to "feel something." This is particularly poignant for those who are kept in isolation most of the time. Inmates in highly restrictive environments who have no hope for change in their situations not only tend to self-injure, but often do so with escalating severity as their helplessness and hopelessness increase. For these people the SIV serves as a way of feeling "something" in the midst of continued intolerable emotional and experiential numbness.

> *Many of the most violent men in prisons mutilate themselves at least as viciously as they mutilate their victims (that is to say, very viciously. . . . The things these men do to themselves are the most common, "everyday" events in the world of maximum-security prisons. . . . At the least violent of the self-mutilative spectrum, these men cut their wrists or forearms or other areas of their bodies. . . . On the other hand, I have also known prison inmates who have cut off their own penis and testicles, others who have torn out their own toenails, and others who have blinded themselves. When these various forms of self-mutilation no longer bring feeling, many of these men come to realize that the only way to kill the pain in their souls is to kill the whole body. For these men, their living death is an intolerable, zombie-like existence.*
>
> —James Gilligan, M.D.[9]

Abuse survivors, especially those who disconnect from themselves and others through dissociation, often struggle with a fluid sense of personal boundaries. Because their personal physical and emotional integrity have been repeatedly violated they may literally not know where they end and "other" begins. Sometimes the sight of a cut and the presence of one's own blood help a person literally understand his/her own physical boundary. It is a way of experiencing that "what is bleeding is me, it is where I begin."

Abuse survivors' struggle with identifying and exercising personal boundaries is especially difficult when they are housed in facilities that are unsafe or overcrowded, or when they are kept in isolation (isolation of someone who self-injures is a very common institutional reaction to SIV). The need to manage strong feelings (or absence of feeling anything) in these settings contributes to the use of SIV. This is especially true in the face

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of ongoing sexual and physical violence and intimidation while incarcerated, when the inmates' options are so very limited.

Violence in correctional facilities, especially sexual assault, is remarkably common. Research in seven Midwestern prison facilities showed that over 20% of male inmates experienced pressured, coerced, or forced sexual contact, both by other inmates and by staff.[10] Women in correctional facilities also face threats and acts of violence and sexual abuse. For many the experience of sexual abuse and objectification is a continuation of their childhood and adolescent lives. "Women prisoners report experiencing routine sexual harassment once incarcerated. In addition, many women in prisons and jails across the U.S. report they are victims of sexual abuse by staff. Reported incidents include male guards touching women's breasts and genitals when conducting searches, watching prisoners while they shower and dress, and raping prisoners."[11]

What can staff do to stop people from injuring themselves?

Typically, interventions for self-injury focus on the immediate prevention or stopping of acts of SIV. While this seems logical, it generally results in an escalation of SIV rather than diminishing it. The reason for this is simple: coercion, even if intended to "prevent harm to self" is inherently retraumatizing. It reenacts or mimics previous trauma, with its resultant loss of control, helplessness, fear, outrage, and overwhelmed coping.

> *I have been in prison for the last five years. Three years ago I tried to kill myself. I cut my throat. It was serious. They put me in solitary confinement for 14 months. I didn't talk to anyone. I had a really hard time in there. I got extremely depressed.*
>
> *I just cut myself an hour ago. Now I do it in the shower. I don't tell the prison shrink that I do this. It's too risky. I cut my thighs, stomach, or breasts so I can hide it. I bandage myself with toilet paper and scotch tape. I will be released in two months. Until then I pray I don't get strip-searched for anything.*
>
> *I don't want anyone to "help me" ever again.*
>
> —d.t.[12]

"Doing nothing" actually leads to better outcomes than coercive measures, especially those that involve restraint, seclusion/isolation, and/or forced medication (chemical restraint). Unfortunately many psychiatric and criminal justice practices and policies promote revictimization. However, as awareness of the impact of trauma on mental (and physical) health increases, more clinicians, judges, and wardens are reconsidering the use of interventions that ultimately cause more harm than good. While interventions that directly address trauma and its impacts are very useful, what might be even more significant for healing is the creation of a trauma-informed environment. Such an environment promotes collaboration between staff and inmate to identify what is both

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helpful and hurtful when struggling with the urge to self-injure. People who have survived trauma have experienced frightening helplessness and need as much control over their lives as possible. This includes making decisions about SIV. All staff can be taught skills to promote collaboration, insight, and communication even while focused on the maintenance of security and safety.

> *Many who self-harm have limited ability to modulate or tolerate emotional responses to the world, and often do not have a very concrete sense of self. I have often found that although it may be the anxiety that surfaces first and can trigger the self-harm, that as individuals learn to sit with that anxiety for longer and longer periods of time (delaying the self-harm) these people often discover another emotion that is below the anxiety, be it sadness, fear, anger, abandonment, etc. I have also seen where memories are beginning to surface and the self-harm can push that back down. What I have seen as very powerful is beginning to see their self-harm as a language, as saying "I am overwhelmed" or "I am scared" or "this feels too familiar," in combination with learning that they can at first delay the act for a few moments (which then allows them to try a few more moments, and so on and so on), and the behaviors slowly begin to lessen. As they begin to experience some intense emotions and then see that these emotions can lessen by experiencing them, they begin to lessen the behaviors. My work the last 7–9 years with incarcerated females has really opened my eyes to these behaviors. We see some of the most extreme: massive cutting with objects inserted into cuts, both eyes blackened, head banging to the point of a laceration. These women have some of the most severe abuse histories and are some of the most unattached. Many have histories of torture by families with many generations of extremely sick individuals.*
>
> —Dr. Maggie Zinman, Ph.D.[13]

Systemic Change

To reduce SIV and to promote recovery from other sequelae of trauma, violence between inmates or between staff and inmates must ultimately be addressed. Healing can rarely occur when physical and/or emotional safety is threatened. Correctional facilities in which this is a problem must strive to create, implement, and enforce policies to end the ongoing violence, rape, molestation, or intimidation within the institutional setting. This pertains to actions between inmates as well as between corrections staff and inmates. As this current violence decreases, so will the need for SIV to cope with the repercussions of unsafe environments. The most successful approach to decreasing violence, intimidation, and misunderstanding is to provide staff and inmates with information about the prevalence and repercussions of severe childhood trauma, to facilitate the creation of trauma-informed environments, and to promote the development of trauma-informed practices and policies. For example, when corrections officers receive trauma training they often learn to perceive inmate behavior from a different, less personal and inciting

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- Speaking with someone who is able to listen compassionately and not overreact to the idea of SIV; this may be a mental health professional or a peer
- Meditating or using progressive muscle relaxation and grounding techniques to facilitate calm and manage dissociation
- Writing, drawing, or using music and other creative pursuits, which are often helpful in facilitating expression of feelings that cannot be verbalized, and
- Learning about the impacts of trauma and healing, as such information can contextualize SIV for that person. Many trauma survivors, especially those who experienced abuse in early childhood, are unaware of the profound and ongoing impact that the trauma has on their adult lives.

People living with SIV can benefit from the following health, mental health, and support programs that can be conducted effectively in corrections settings. In addition to specific skills, these programs provide a sense of connection and meaningful activities. What is most important is providing a space, place, and opportunity for the learning of self-respect, boundaries, communication, and emotional expression.

- Education regarding
  - self-injury, especially as it relates to a history of trauma
  - harm-reduction principles
  - strategies to create alternative behaviors
- Group therapy and support groups to
  - identify and address the sequelae of trauma
  - explore the meanings of SIV
  - develop and practice alternative choices for managing the triggers that lead to SIV
  - practice mutually supportive, healthy relationships amongst peers. Inmates with trauma histories report that peer support is the greatest single factor in changing self-perceptions and the need to self-harm.
- Purposeful, community betterment, self-improvement, and support programs such as
  - mentoring
  - gardening
  - animal training
  - job training
  - parenting

I am a 40 year-old woman recovering from SIV. Since coming here (to prison) with a life sentence in 1997 I've grown beyond the need to self-injure, though the impulse still arises in highly stressful or painful circumstances. The healing I've found was self-motivated, not due to being treated for the disorder while property of the Department of Corrections. Their method of dealing with inmates who self-harm is not much different than some outside ones. Inmates who hurt themselves are punished for it by being stripped and confined for up to 3 weeks in a small bare cell. Of course this is done under the guise of protecting that inmate from

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themselves. . . . I found strength by forming my own support group consisting of people who were doing positive things for themselves. Some of those had self-harmed in the past and found other ways to deal with life. As I grew I began reaching out to people who were actively harming themselves, passing on what I had learned. I also took steps to begin healing from my past trauma, sexual abuse issues. I believe my healing there, the self-forgiveness I found, were the biggest achievements in no longer having the need to harm myself.

Darlene D.[15]

Helping an inmate look at the strengths that he or she has within is more productive than focusing on what are often considered to be pathological or manipulative acts. Acts of SIV often trigger intense feelings (such as disgust or anger) in those who work with people who self-harm. It may be easier to not "take it personally" if staff can reframe their thinking about "manipulative" behavior in terms of an inmate's attempt to *indirectly* communicate his/her story. For the person living with SIV, the self-injury is an act of self-preservation and self-help. It is not useful to punish a person who is attempting to manage the pain of profound emotional and spiritual wounding. Remembering the following may make it easier to be patient with a self-injuring inmate:

- Acts of SIV are helpful as well as harmful; people with histories of trauma, often severe, turn to SIV as a way of managing what feels unmanageable any other way.
- The wounds of self-injury are seldom life-threatening, SIV is often used to avert suicide in people who are considering suicide. Mandating the elimination of SIV increases the likelihood of suicide.
- Behavior change takes time.

Trauma-Informed Correctional Systems

Education about the consequences of childhood trauma is crucial for staff and inmates alike. Training provides staff with the most effective approaches for intervening with persons who self-injure, as well as for all inmates who live with other sequelae of trauma, while increasing the safety of everyone concerned. These trauma-informed interventions equip officers and other staff to "provide a respectful human encounter, to facilitate medical treatment if it is needed, to help begin or advance the process of understanding self-injury as an adaptation or reaction."[16] As a criminal justice facility becomes trauma-informed, incidents of violence towards self, staff, and other inmates will decrease. This provides a safer environment for staff and inmates alike, and reduces recidivism in the long run. For people who have lived lives in which violence is the norm, it is crucial to provide opportunities for understanding of their history and instilling hope for personal change. With such support, even inmates with life sentences, and those on death row, have transformed themselves.

I use my cutting as a way to hide my anguish, sadness, and guilt. If I use violence against myself I can typically hide all the negative feelings,

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appearing quite happy and content to those who don't know me. This decreases the questions and the prying. . . . The most help I have received has been provided by those with no psychological training, the other people who are housed here with me. The ones I have allowed close enough to get to know the real me. . . . When people aren't afraid of me or the fact that I may cut this helps me to feel "normal," which helps the desire decrease. Being in prison is in no way helpful to the sickness that thrives on hatred, loneliness and guilt. . . . What it all comes down to is yes, I am a felon, a murderer, a cutter. . . . But I am a sister, an aunt, a daughter, a granddaughter, friend, and lover. I am . . . a young woman who has survived herself.

—Stephanie Sara Timothy[17]

Change needs to occur on multiple levels, from policy development to individual interventions. Stopping retraumatization is crucial. As of 2002, fourteen states had no law prohibiting sexual relations between inmates and correctional staff.[18] Education of corrections staff regarding the prevalence of trauma histories in the people they work with is also critical. Staff can learn how these histories impact the lives of the inmates that they work with and can facilitate environments that permit greater personal dignity and respect. As wardens increasingly become aware of the benefits of trauma-informed facilities, specific staff educational programs are being developed. Mental health care providers who are experienced in the dynamics of abuse and the process of recovery are developing trauma care strategies that address inmate needs. Peer-driven activities that promote harm reduction and healing from SIV and trauma are inarguably meaningful. Progress in these areas is not only possible but has already begun. Judges, wardens, corrections staff, mental health professionals, and former inmates are leading the shift toward a trauma-informed criminal justice system. Guides now exist to facilitate the launch of peer support groups for trauma survivors. The greatest hope for profound change will come in the collaboration between all stakeholders in the criminal justice system, including former prisoners and providers who have lived with SIV.

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STATEMENT OF

JUSTICE KATHRYN E. ZENOFF
PRESIDING JUSTICE
ILLINOIS APPELLATE COURT, SECOND DISTRICT

BEFORE THE

UNITED STATES SENATE
COMMITTEE ON THE JUDICIARY
SUBCOMMITTEE ON HUMAN RIGHTS AND THE LAW

HEARING ENTITLED

"HUMAN RIGHTS AT HOME:
MENTAL ILLNESS IN U.S. PRISONS AND JAILS"

SEPTEMBER 15, 2009

Chairman Durbin, Ranking Member Coburn, and distinguished members of the Senate Judiciary Subcommittee on Human Rights and the Law, thank you for the opportunity to testify before you today at this important hearing on persons with mental illnesses in our jails and prisons. My name is Kathryn Zenoff, and I am the Presiding Justice of the Illinois Appellate Court, Second District. The Second District is comprised of the thirteen northernmost counties in Illinois, from Lake Michigan on the east to the Mississippi River on the west. I also serve as the National Co-chair of the Judges' Criminal Justice/Mental Health Leadership Initiative (JLI).

Prior to my assignment to the Appellate Court in Illinois, I served as a trial judge and Chief Judge of the Seventeenth Circuit, which consists of Winnebago and Boone counties. Winnebago County is the second largest county outside of metro Chicago, covering 513 square miles and including the city of Rockford. The 2000 U.S. Census indicates a population of 278,418 people. Recent local statistics indicate there were 22,808 bookings in the Winnebago County jail in 2008. During my tenure as Chief Judge, I had the privilege of organizing and facilitating a community-wide task force in Rockford, Illinois, to examine the problem of persons with serious mental illnesses cycling in and out of our Winnebago County jail. One of the accomplishments of the task force was the development and implementation of a mental health court (Therapeutic Intervention Program), which we opened in Winnebago County in February 2005. While I was Chief Judge of the Seventeenth Circuit, I served as the presiding judge of that problem solving court for over two years. I hope that my experience and my perspective can assist the Subcommittee.

OVERVIEW OF THE PROBLEM[1]

In the last fifty years, persons with serious mental illnesses have gone from being institutionalized in psychiatric hospitals to being institutionalized in our jails and prisons. The phenomenon has been called the "criminalization of the mentally ill" and has had adverse consequences both for our communities and for those persons with mental illnesses. When psychiatric hospitals closed in the 1960s and the community-based mental health providers never received funding–or at least adequate funding–to support the move from institutional to community-based treatment, our jails and prisons saw a significant increase in persons with mental illnesses cycling in and out of their doors. According to Bureau of Justice statistics, 7 to 16% of those incarcerated were diagnosed with a serious mental illness, as compared with a much lower percentage of those persons with mental illnesses in the general population.[2] The impact was significant. There was no, or woefully inadequate, treatment for those with mental illnesses. The criminal justice system saw an increase in arrests and the number of cases that needed to be handled, straining an already overburdened system. Costs rose for counties and states as police made repeated arrests, and tax dollars went to pay for additional court functions and staff.[3]

Recent booking statistics and data are even more alarming. According to Bureau of Justice statistics, during the twelve months ending in mid-2007, there were thirteen million admissions to local jails in the United States. The numbers of adult male and adult female inmates had increased 24% and 42%, respectively, since mid-2000. Over 2.2 million were acutely mentally ill bookings, with 75 to 80% having a co-occurring substance abuse disorder.[4] A recent study of

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the prevalence of serious mental illness among jail inmates in five communities in 2002-2003 and 2005-2006 reported prevalence rates of current serious mental illness as 14.5% for incarcerated men and 31% for women![5] While a narrow study, it confirms that the number of inmates with serious mental illnesses in our jails is still substantial, and the report recommends continued study and explication of the contributing factors and discussion of the appropriate responses.

THE RESPONSE

As communities across the country began to recognize the problem, the question became what were the solutions and whose job was it to implement them? While it certainly was possible for the responsibility to be placed on the legislative or executive branches, as they control our tax dollars and run our prisons and jails, that is not what happened. Instead, non-traditional collaborations were forged among stakeholders, such as mental health providers, law enforcement and corrections personnel, members of the legal profession and judiciary, and representatives of state and local governments and agencies. Innovative initiatives, such as mental health courts,[6] pre-trial diversion programs, and special crisis response training programs for law enforcement, were started. At the forefront of these collaborations were judges who stepped forward to assume key leadership roles.

Winnebago County's Therapeutic Intervention Program

I think that as judges we are in a unique position to assist in addressing the problem. We have the ability to use our authority and visibility in the community to convene stakeholders and to urge them to develop new collaborations and partnerships. In fact, that is the role I played in my own community. In June 2003, the Seventeenth Circuit Court and local mental health professionals felt that the time for talk had ended and a call to action was needed. A snapshot of the Winnebago County jail demonstrated that 14% of the inmates had serious mental illnesses, such as schizophrenia, bipolar disorder, and depression. Moreover, the additional costs of psychotropic medication alone boosted the daily cost of housing those inmates with mental illnesses way above the $50 to $60 per day for other inmates. The jail was terribly overcrowded.

On behalf of the Circuit, I convened a seventy-person/agency Community Mental Health Task Force (Task Force), which met regularly for eighteen months. We documented the scope of the problem and studied what steps and models other communities had adopted. The result was that in February 2005, the Therapeutic Intervention Program Court (TIP) opened in Winnebago County. TIP accepted referrals of persons charged with both misdemeanors and non-violent felonies who had been diagnosed with serious mental illnesses.[7] Participation was voluntary. A multi-disciplinary team of legal and mental health professionals was assembled to work with the defendants in the court. The Task Force also drafted protocols that were signed by the judiciary, the state's attorney, public defender, law enforcement, corrections, and court services, all coordinating their responses to persons with mental illness. The city police and sheriff's deputies began crisis intervention training to enable them to more efficiently respond to emergency situations in the community so that they could avoid arrests where appropriate and

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divert persons with mental illness to treatment. A Community Mental Health Coordinating Council was formed to succeed and build on the accomplishments of the Task Force.

TIP has been referred to as an "invention"; it was something new to our community and uniquely adapted to the needs of Winnebago County. Certainly, it represents an innovative collaboration and partnership of a wide range of stakeholders committed to a common goal and to leaving their individual and agency agendas behind. The common mission of this problem solving court was and is to enhance and protect public safety, while also restoring the liberty and community functioning of defendants with severe mental illnesses through comprehensive and therapeutic judicial intervention.

TIP has been operating for over four years with a team working together to provide defendants with case management, mental health and probation services, and linkages to housing and other entitlements. We had weekly staffings to discuss each defendant's compliance with a structured set of goals. Each defendant appeared in court on a weekly basis for a review of his or her progress. Shortly after beginning operations, it became evident that almost 50% of TIP's participants had a co-occurring substance abuse disorder, which required intensive treatment. I convened a local summit in March 2006, inviting community leaders to inform a solution. Approximately sixty representatives attended. The spirit of collaboration and cooperation that had permeated the Task Force motivated two exceptional agency directors, Mr. Frank Ware of the Janet Wattles Center, our community mental health center, and Mr. Phil Eaton of the Rosecrance Health Network, a well-known substance abuse treatment facility, to find a way to overcome obstacles, such as financial reimbursement, to create an integrated dual-diagnosis day treatment group for the defendants in TIP, one of only a few such dual-diagnosis programs in the entire state. Yet another local mental health agency, Stepping Stones, came forward to provide living space for appropriate TIP clients in its supervised mental health residential treatment facility.

I am pleased that further enhancement of the TIP program was possible when a two-year federal enhancement grant was awarded in 2007, allowing the addition of a trauma therapist, a dual-disorder specialist, and a family advocate specialist to the ten-person team. The program has continued to develop and expand to sixty-eight current participants under the expert guidance and leadership of my successor, Chief Judge Janet Holmgren.

Recent statistics show that among the graduates of TIP, few re-arrests have occurred and fewer hospitalizations have been required.[8] Also remarkable in this entire process was the willingness of the Winnebago County Board Chairman, Mr. Scott Christiansen, and the County Board members not only to become informed, but also to become truly educated about the problem and the proposed TIP program and to be willing to assist with some key funding through appropriations from a county supplemental sales tax revenue source.

The impact of TIP on our community and on the lives of the participants has been significant. At graduation, one defendant wrote:

> "My life has undergone a shift from the constant unwellness of most of the previous decade to a life worth living. This change occurred slowly, and in many different ways.

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> The three main keys to my success, that truly got the ball rolling towards wellness, are the backbone of the court structure (TIP), my support system, and both mental and behavioral tools used to stay above my illness. The constant responsibility to appear before the judge, and meet with various (mental health case managers) were the essential first step...."

Another commented: "The whole TIP team has watched, helped and guided me through my recovery.... I would be deathly afraid to know where I would be or what sort of person I would've become if it wasn't for this program. Because of this program I feel like I finally have my life back."

While there have been a few ongoing studies examining various aspects of court operations of several of the now-over-175 mental health courts around the country, we do not yet have all of the results. It is imperative that as we continue to look at the problem and decide what programs and solutions are most successful, we define success. Of course, success can be measured in different ways. One way is to consider whether the quality of life of persons with mental illnesses has been improved in the sense that the court defendants/participants and graduates have taken increased responsibility for their own treatment and recovery. A second is whether the revolving-door cycle has decreased, resulting in fewer visits to our jails and hospitals and in lower recidivism rates, which, in turn, results in increased public safety. Under either of these methods, the statistics kept by TIP demonstrate that TIP certainly has been successful. Still, questions remain unanswered by researchers examining mental health courts: Will improved mental health outcomes in individuals consistently and broadly result in long-term improved public safety? Is special emphasis also needed on criminogenic factors to achieve the goal of long-term improved mental health and public safety?

Part of TIP's success and the difference it and other mental health courts around the country have made, in my view, has to do with the synergy of the presiding judge and the team, in addition to the interaction of the team and the judge with the defendants. While I have been privileged to be on the bench since 1995 and to have handled many different assignments, I found my role as presiding judge in this specialized problem solving court to be especially challenging and rewarding. Unlike judging in a regular criminal call, a judge in a mental health court must form a rapport or relationship with the defendants themselves by using the knowledge of their mental illnesses and their criminal background to inspire confidence and trust and to set realistic, but firm, expectations. The presiding judge in a mental health court must also use and balance incentives (such as being called earlier in the order of cases on status days, or fewer court appearances being scheduled) and sanctions (such as sitting through an additional court call on another day, writing an essay, or even minimal jail time) to hold defendants accountable. Judges must also recognize that many defendants in the court, though, do not just have a serious mental illness, but also a co-occurring substance abuse disorder, which complicates treatment and recovery.

National Judges' Criminal Justice and Mental Health Leadership Initiative

I believe that judges need to serve as catalysts for change and transformation not only in our communities, but also at the state and national level if there is to be continued change and

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improvement in the response to persons with mental illness who become involved in the criminal justice system. To that end, the National GAINS Technical Assistance and Policy Analysis (TAPA) Center[9] recognized this need several years ago and in 2004, together with the Council of State Governments,[10] with support from the Bureau of Justice Assistance (BJA) and U.S. Department of Justice, Division of Mental Health/Substance Abuse and Mental Health Services Administration (SAMHSA), assisted in the formation of the national Judges' Criminal Justice and Mental Health Leadership Initiative (JLI). The resources and activities of JLI are open to any judge in the country. Its mission is to support and enhance the efforts of judges who have taken leadership roles on these difficult and complicated issues in their communities and to promote leadership among those who are considering how to become involved in forming mental health courts or creating other diversion programs to improve community responses to justice-involved persons with mental illnesses. The JLI, through its Advisory Board, the Council of State Governments Justice Center, and the GAINS Center, has worked tirelessly to complete several projects, including publication of a *Judges' Guide to Mental Health Jargon* in 2007, and the *Judges' Guide to Mental Health Diversion Programs* (forthcoming this fall). A quarterly electronic newsletter, with updates from the field, is distributed to over three hundred fifty judges nationwide.[11]

The valuable work of JLI was recognized and encouraged by the United States Conference of Chief Justices in its adoption of "Resolution 11" on January 18, 2006. In that resolution, the Conference recognized that "mental illness is a far-reaching problem with enormous impact on the judicial system; and ... in examining the best practices for improving community responses to offenders with mental illness, the common element was effective leadership." The Conference then referred to its previously adopted "Resolution 22," which endorsed problem-solving courts and their value in the court system. Resolution 11 concluded by encouraging each Chief Justice to take a leadership role to address "the impact of mental illness on the court system through a collaborative effort involving stakeholders from all three branches of government," and by expressing its unequivocal support of JLI.

At the end of 2006, funding for JLI's Chief Justice Initiative program was secured. This unique project has provided policy guidance and technical assistance through the Council of State Governments and the GAINS TAPA Center to eleven states whose Chief Justices are spearheading the formation of statewide task forces to make system-wide improvements to the states' criminal justice systems for persons with mental illnesses.[12] Policy forums were held in Atlanta in 2007 and in Philadelphia in 2009. Unfortunately, although strides have been made by these states, ongoing technical support will be greatly limited in the future, as private funding for this project will expire at the end of 2009.

While JLI has made significant inroads, it is now at a key juncture in continuing its mission, as funding is no longer available from BJA and SAMHSA for staff support provided by the Council of State Governments and the GAINS Center for JLI's activities. Our leadership is currently faced with the daunting task of either determining how to address JLI's mission without that support or finding alternative sources of funding in this difficult economic climate.

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Illinois Initiatives

Although Illinois did not participate in JLI's Chief Justice project, it certainly has been in the forefront of other important initiatives. Several years ago, the Illinois Conference of Chief Judges formed a Specialty Courts Committee, which I chaired. We authored a comprehensive report on mental health courts and drug courts in 2006.[13] The Illinois General Assembly, in 2008, passed one of the first statutes in the country authorizing the establishment of mental health courts, the Mental Health Court Treatment Act.[14] In 2004, the General Assembly passed a bill allowing county boards to adopt resolutions imposing fees on defendants in certain circumstances to help finance mental health courts.[15] To date, there are ten mental health courts operating in nine jurisdictions in Illinois, with several more in the planning stages.

Remarkable and unprecedented interdisciplinary and interagency collaborations have taken place to address the challenges we face. These challenges have been especially daunting with 22,000 individuals in the jail population in 2005 and 42,000 currently in our prisons.

Members of the judiciary in Illinois, with support from Director Cynthia Cobbs of the Administrative Office of the Illinois Courts, have collaborated at the invitation of the Illinois Department of Human Services, Division of Mental Health, to map available resources and identify the gaps in services for persons with mental illnesses and substance abuse issues involved in the criminal justice system. Dr. Lorrie Rickman Jones, Director of the Department of Human Services, Division of Mental Health, and Dr. Anderson Freeman, Deputy Director for Forensic Services of the Division of Mental Health, have been remarkable leaders. They convened an advisory board and began planning meetings in early 2008, pursuant to a Transformation Transfer Initiative grant from SAMHSA through the National Association of Mental Health Program Directors. Policy Research Associates, Inc. (PRA) of Delmar, New York, was hired to provide technical assistance to facilitate the mapping project and to inform the transformation efforts. Representatives from the five regions in the state met in each region to identify gaps in services and needed enhancements, using a visual and conceptual model termed the "sequential intercept model."[16] A final detailed report was prepared by PRA, with specific cross-disciplinary recommendations.[17] I look forward to assisting Dr. Jones and Dr. Freeman with convening a statewide committee this fall to examine these recommendations and to develop a statewide strategic plan on how best to implement them. The process also engendered interest and collaboration for the submission of a grant application last April to BJA for the establishment of a Center of Excellence in Illinois to develop the infrastructure to support mental health and justice collaborations and enhancements in the future.

Another Illinois innovation is the "Data Link" project, funded in part by the Illinois Criminal Justice Information Authority and federal dollars. This project allows electronic sharing of records, pursuant to state statute,[18] by the Illinois Department of Human Services, Division of Mental Health, with the Department of Corrections and local jails for the purpose of continuity of care in admission, treatment, re-entry planning, and discharge of persons with mental illnesses. There are now eight participating counties. The project reports positive results in an overall reduction in hospital events and hospital days.

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The Division of Mental Health is also collaborating with the Illinois judiciary and the Council of State Governments on yet another separate project to develop a uniform database for all mental health courts in Illinois.

Two statewide educational conferences with nationally known experts in attendance were held in 2008 and 2009: "Skills and Strategies for Mental Health Courts in Illinois" and "Lessons Learned: Innovative Approaches to Mental Health Courts and Related Services; Generating Hope in Times of Scarce Resources." Each of the conferences, held in Du Page County, drew over four hundred participants from numerous disciplines, including mental health, law enforcement, and the judiciary. Consumers and family members were also in attendance. Our statewide mandatory education conference for judges will include a presentation on mental health courts and veterans courts[19] for the first time in 2010.

Lastly, in June of this year, professionals and consumers interested in promoting statewide collaboration and organization formed the Mental Health Court Association of Illinois. Its mission is "to create a statewide association of professionals, consumers, families, advocates and public officials who support the development and sustainability of Mental Health Courts and criminal justice diversion programs for persons with mental illness in Illinois." The first meeting of the Board of Directors will take place this month. No other state has formed such an association. We hope that it will further coordination of efforts and sharing of expertise here in Illinois.

WAYS TO MOVE FORWARD

Despite these significant steps and collaborations in Illinois and elsewhere in the country, the number of persons with serious mental illness in our jails and prisons has nevertheless increased. In part, this attests to the complexity of the problem, including the stigma attached to mental illness. Our jails and prisons have become the "safety nets" of our unfunded/underfunded system of community health care. How do we find workable solutions? How do we move forward? One key to finding effective and lasting solutions is at last appropriating sufficient resources for our communities to continue the collaborative work that was begun when the problem was first identified. We must now be able to identify which are the most promising programs and evidence-based practices, i.e., practices that integrate the best research evidence with clinical expertise, so as to improve upon our responses to persons with mental illnesses who are involved or at risk of becoming involved with the justice system. As we move forward, we must not lose sight of our goals to reverse the criminalization of mental illness, improve public safety, reduce recidivism, minimize acute care spending, and assist those with mental illnesses in living a life of recovery in our communities.

Where should our focus be? Respectfully, I suggest that the areas that especially need study, action, and resources involve continuity of care, i.e., filling "gaps" and creating additional linkages in the systems involved with persons who have serious mental illnesses. Following is a discussion of my recommendations.

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1. Continued/Increased Funding for Mental Health Courts and Diversion Programs

While Congress has authorized the creation of a number of programs in the last several years that have helped fund court related initiatives (Justice and Mental Health Collaboration Program (JMHCP); SAMHSA's Targeted Capacity Expansion (TCE) Program), federal funding must continue and even be increased for mental health courts. While long-term benefits still have not been fully assessed, the short-term effectiveness has been documented. These court programs provide the necessary formal structure for integrated treatment services for defendants released from our jails. Consideration should also be given to expanding funding for even earlier diversion options (See Sequential Intercept Model, Intercepts 1 and 2). Thought should be given to promoting statewide internal coordination efforts to minimize internal competition among various courts and jurisdictions for these limited federal funds. Perhaps grant dollars could be directed to the administrative offices of the state supreme courts or to the supreme courts in conjunction with the state departments of mental health to foster the best use of the resources and appropriate prioritization.

I also think we should make funding available specifically for initiatives directed toward addressing the mental health needs of our veterans returning from Iraq and Afghanistan. Many of them are suffering from depression, post-traumatic stress syndrome, and substance addictions. We need to act now to prevent them from entering the criminal justice system and our jails and to help those who have been arrested be wrapped into the services of our mental health courts or accepted into the few specialized veterans courts that have been created.[20] One important step taken by the U.S. Department of Veterans Affairs is the creation of Veterans' Justice Outreach Specialists as part of the V.A. Justice Outreach Program. These specialists are to be attached to each Veterans Administration Medical Center and are to be responsible for direct outreach, assessment, and case management for justice involved veterans. Discussions have been ongoing with JLI regarding providing guidance and technical assistance for this program. In addition, and as a result of the May 2009 conference at Columbia University, the National Center on Addiction and Substance Abuse is forming a national commission to make recommendations regarding the problems of returning veterans.

2. Improved Screening and Mental Health Services in Our Jails and Prisons

We must also re-examine the adequacy of mental health screening and services in our correctional settings. While some jurisdictions do have special mental health screening tools used at the booking stage in their jails and specialized mental health units within their jails, many jurisdictions do not. They house prisoners with serious mental illnesses with other inmates. Because those inmates with mental illnesses often exhibit the symptoms of their illnesses and may threaten staff and other inmates or act out, they may be sent to solitary confinement and/or have any accumulated "good time" taken away, which only exacerbates their symptoms and increases the time they must spend incarcerated.

In Winnebago County, Illinois, our jail uses a special screening tool with questions designed to flag a potential mental illness and need for further screening. There are also designated pods for men and women diagnosed with mental illnesses. Two special jail assessors who are licensed

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professional counselors assess inmates with signs of mental illness and evaluate them with regard to the need for treatment and/or eligibility for the TIP court program. They also coordinate treatment plans for those inmates being released. An average of over 3,200 inmates are seen each year. The University of Illinois, School of Medicine at Rockford, also contracts for and provides psychiatric consultation, staff, and necessary medications within the jail. Winnebago County bears a heavy cost burden for this arrangement. These measures, while costly, are necessary--and they may prove cost effective in the long run. By careful screening, and by providing necessary medication and treatment, inmates with mental illnesses may be identified as appropriate for earlier release into community programs and/or into mental health courts. Their jail stays may be less volatile. Staff training is an important component and is as essential in our jails as crisis intervention training is for our police on the street in their interactions with persons who have mental illnesses. Transitional case management may be facilitated by programs such as Illinois's Data Link. Jurisdictions that have not explored these issues should be encouraged to come together to find ways to make these changes. Certainly, any federal resources that could be brought to bear would be encouraging.

3. Improved Release Planning

While the goal is diversion from jail to community mental health treatment, for appropriate defendants, diversion is not always an option. Whether jail stays are short or lengthy, mental health treatment in jail and/or prison and transition planning for release of inmates back into our communities is essential.

There are several obstacles that hinder effective release planning: (a) record sharing problems; (b) the Medicaid termination/suspension dilemma; and (c) best practices that are out of line with reimbursement structures. With respect to the problems of record sharing, I am informed that in Illinois, for example, an inmate who requests that jail records be sent to a particular community mental health agency with which he or she will have contact must pay, before his or her release, a charge for the sending of those records. Needless to say, this cost discourages the requests from being made. Then, when the released inmate shows up at the community mental health center, if no records have been sent, the agency must start anew with evaluations, diagnoses, etc. or wait before providing treatment until the records arrive. This gap poses significant risks for the released inmate and the community, as without continued treatment and medications, or even with delays, the risk of re-offending grows. Perhaps additional federal dollars can be found for projects to help address this problem.

Despite the enormous costs of health care in our jails and prisons, my understanding is that federal law prohibits states from receiving federal reimbursement under Medicaid for care or services provided to inmates by these institutions. Often, this is referred to as the "inmate exception" to the Social Security Act. Perhaps consideration can be given to permitting states to receive federal matching funds that could offset these expenses borne exclusively by the states and our counties that tend to impede the delivery of constitutionally required health care for inmates.[21]

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In many states, including Illinois, when an eligible individual receiving medical benefits under Medicaid is incarcerated, the benefits are automatically terminated. Applications cannot even be submitted while an inmate is still in jail, even if the person is otherwise eligible. For those inmates with mental illnesses and/or substance addictions this is especially problematic, as service agencies may not be able to provide needed care, treatment, and medications without a Medicaid card in hand when the inmate is released. This gap in treatment certainly can lead to difficult re-entry into the community and greater risk of re-offending and re-entering the revolving door back into jail. Ironically, federal law does not require states to automatically terminate the benefits of an otherwise eligible prisoner upon incarceration. Federal officials might consider assisting states in implementing suspension procedures together with expedited re-application mechanisms for ensuring that these persons receive continuous care upon their release from custody. The American Bar Association's Criminal Justice Section made this recommendation in its 2007 Report to the ABA House of Delegates, as well as the recommendation that the "inmate exception" be repealed. The recommendations are worthy of serious consideration.

While SAMHSA has developed best practices for an integrated recovery model for persons with mental illnesses that includes supported housing, vocational training and supported employment, as well as psychiatric services and medications, it is my understanding that the services unrelated to health are not reimbursable or are subject to fragmented reimbursement at best. A complete examination of this anomaly would be in order. Further consideration could be given to supporting states that would open their Medicaid service plans to include billable service definitions that do include these supports, as well as trauma informed care and case management/linkage services for jail diversion planning.

4. Funding for JLI Technical Support

Effective leadership in our communities is one of the ways that we can improve upon what we have already accomplished. JLI is now in its fifth year and has helped communities across the nation make great strides in jail diversion efforts for persons with mental illnesses. Those accomplishments have already been detailed and discussed in this Statement. I believe that JLI's activities are essential components of the solution to what we all acknowledge is a complex problem. I strongly urge federal dollars be reallocated to the Council of State Governments and the GAINS TAPA Center to provide us with this key staff support to allow us to continue these vital contributions.

5. Funding for Centers of Excellence

Continued federal funding, or even increased funding, for the creation of Centers of Excellence, discussed earlier in this Statement, on a statewide or regional basis can also facilitate the necessary research, study, and dissemination of best practices and cross-disciplinary training for professionals. They can also lead the way in involving consumers and the National Alliance for Mental Illness (NAMI) in the process of finding solutions.

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6. The Health Care Debate

Getting others to think about mental illness as a disease is one step that can reduce the stigma and can encourage people to get treatment for their illnesses before they come in contact with the justice system. Now that the national health care debate is engaged, it may be a good time to discuss access to treatment and broader coverage for mental illnesses and substance addictions even for those outside our jails and prisons.

CONCLUSION

The task of this Subcommittee is as daunting as the problem is complex, and I acknowledge that the resources may be limited. I am pleased to see that the Subcommittee nevertheless has undertaken these hearings, as the problem affects us all as professionals and as citizens concerned about public safety and the status of those with mental illnesses in our jails, prisons, and communities. In reflecting on my role as a judge and the work I have been privileged to do in the area of mental health and the criminal law, I am reminded of the sage words of retired Illinois Chief Justice Mary Ann McMorrow to a group of new judges:

> "As judges, we look beyond the legal formalities of a particular dispute - to remain aware of the human dilemma that underlies almost every case brought before us, and, always within the bounds of our authority, try to resolve the problems presented to us in a manner that satisfies both the legal and the human aspects of the case. Let us not forget that the law is first and foremost about human beings and their problems."

I sincerely hope that I can continue to play a meaningful role in this very human problem.

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NOTES

1. Portions of this testimony originally appeared in Kathryn E. Zenoff, *Foreword: Confronting the Challenges of Persons Who Are Mentally Ill: A Judge's Perspective*, 29 N. ILL. U. L. REV. 477 (2009).

2. Press Release, Bureau of Justice Statistics, More Than a Quarter Million Prison and Jail Inmates are Identified as Mentally Ill (July 11, 1999), *available at* http://www.ojp.usdoj.gov/bjs/pub/press/mhtip.pr.

3. Bureau of Justice Statistics, Direct Expenditure by Level of Government, 1982-2006, http://www.ojp.usdoj.gov/bjs/glance/expgov.htm http://www.ojp.usdoj.gov/bjs/glance/expgov.htm(last visited Sept. 8, 2009).

4. WILLIAM J. SABOL & TODD D. MINTON, U.S. DEP'T OF JUSTICE, JAIL INMATES AT MIDYEAR 2007 (2008), *available at* http://www.ojp.usdoj.gov/bjs/pub/pdf/jim07.pdf.

5. Henry J. Steadman et al., *Prevalence of Serious Mental Illness Among Jail Inmates*, 60 PSYCHIATRIC SERVICES 761 (2009).

6. A mental health court is a structured judicial intervention process for treatment of eligible defendants that brings together mental health professionals, local social service programs, and intensive judicial monitoring. It substitutes a problem solving model for traditional case processing.

7. Serious mental illnesses include a broad range of psychological disorders that are severe and persistent and involve impairment of functioning, such as schizophrenia, bipolar disorder, and depression. *See* AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, Axis I (4th Ed. 1994).

8. For example, TIP statistics from January 1, 2005, to July 31, 2009, show that of the current participants, 59 had over 12,000 jail days before being accepted into the program, for a cost of over $738,000 (at $60 per day). After being accepted, they had 761 days for a cost of $45,670. Hospitalizations for TIP defendants who graduated from the program between January 1, 2005, and December 31, 2008, were 3,614 days before entering the program and only 15 days after leaving the program.

9. The GAINS TAPA Center has operated since 1995 as a policy and technical assistance center for systems integration and the development of comprehensive plans for service delivery among state and local behavioral health and criminal justice systems. It is funded through the Center for Mental Health Services of SAMHSA as part of the CMHS Transformation Center.

10. The Council of State Governments is a national nonprofit organization serving policymakers at the local, state, and federal levels of all branches of government. Its Justice Center coordinates the Criminal Justice/Mental Health Consensus Project and provides technical

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assistance to grantees of the Justice and Mental Health Collaboration Program, an initiative of the Bureau of Justice Assistance of the Office of Justice Programs.

11. Judges' Criminal Justice/Mental Health Leadership Initiative, http://gainscenter.samhsa.gov/listserv/judges/jli_8_25_09.html (last visited Sept. 9, 2009).

12. A competitive application process resulted in the following states being selected: California, Florida, Georgia, Missouri, Nevada, Texas, Vermont, Wisconsin, Delaware, Idaho, and New Hampshire.

13. SPECIALTY COURTS: A REPORT TO THE ILLINOIS CONFERENCE OF CHIEF JUDGES (2006).

14. Mental Health Court Treatment Act, 740 ILL. COMP. STAT. 168/1 to 168/35 (Supp. 2007).

15. *See* 55 ILL. COMP. STAT. 5/5-1101(d-5) (2008).

16. The sequential intercept model was developed by Patty Griffin, Ph.D., and Mark Munetz, M.D. (2006). See Mark R. Munetz & Patricia A. Griffin, *Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness*, 57 PSYCHIATRIC SERVICES 544 (2006) (describing the sequential intercept model as a framework for "considering the interface between the criminal justice and mental health systems as they address concerns about criminalization of people with mental illness" and explaining that the model "envisions a series of points of interception at which an intervention can be made to prevent individuals from entering or penetrating deeper into the criminal justice system"). It was used by Policy Research Associates, Inc. as a tool for discussion of diversion possibilities in Illinois at the various stages or "intercepts" in the criminal justice system: (1) law enforcement/emergency services; (2) initial detention/initial court hearings; (3) jails/courts; (4) re-entry; and (5) community corrections/community support.

17. POLICY RESEARCH ASSOCIATES, TRANSFORMING SYSTEMS AND SERVICES FOR JUSTICE-INVOLVED PERSONS WITH MENTAL ILLNESS: FINAL REPORT (2008).

18. *See* 740 ILL. COMP. STAT. 110/9.2 (2008).

19. Two veterans courts are operating in Illinois, one in New York, and only a handful of others in other states. These specialty courts are designed as diversion programs and accept United States veterans who have been charged with misdemeanor and/or non-violent criminal offenses. The goal is to provide comprehensive services to these veterans to assist them in staying out of jail and prisons and in leading productive lives.

20. *See supra* note 19.

21. AM. BAR ASS'N CRIMINAL JUSTICE SECTION, REPORT TO THE HOUSE OF DELEGATES (August 2007).

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