Written Testimony

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"Physical and Mental Health Care and Related Issues"

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by

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It is a privilege to provide this testimony to the Commission on Safety and Abuse in America's Prisons. I am hopeful that testimony provided and information generated as a result of commission hearings and discussions will yield positive contributions to justice practitioners.

I'd be remiss, albeit, if I did not convey my apprehension about the mission of this initiative. When the "Abuse" commission was announced, many persons who serve as corrections administrators across this nation let out a collective sigh as if to say, "not again." If it were not for the intervention of respected members of the Commission, such as Gary Maynard and Tim Ryan, you may have very well experienced an "anti-abuse commission" response. It will depend on the final product that the Commission will publish in less than a year whether or not advocates and practitioners will come closer together or move further apart on the topic of safety and abuse in America's correctional facilities.

My corrections career has spanned 32 years. I have served in various administrative positions to include warden, state director of training, and strategic planning coordinator. Also, prior to being appointed director of the Ohio Department of Rehabilitation and Correction in 1991, I served as a deputy director of prisons.

In addition to my work in Ohio, I have served in numerous national and international capacities. A few of these roles include being a past president of both the American Correctional Association and the Association of State Correctional Administrators. I am also the chairperson of the National Institute of Corrections Advisory Board, the vice-chair for North America of the International Corrections and Prisons Association, and the president and executive director of the International Association of Reentry.

I am pleased I have been asked to specifically address issues relating to offenders with a mental illness. For over ten years I have made this subject one that deserves the highest priority. Before I provide you with more details about my agency's mental health history and initiatives, I want to list some key projects that I have been involved with regarding this topic:

- Last month I provided testimony on mental health transformation to the Governor's Health Care Reform Panel in Louisiana.
- Last year I provided a keynote address and conducted two workshops to mental health professionals in Rhode Island.
- I provided Congressional testimony on the Mentally Ill Offenders Treatment and Crime Reduction Act.
- Ohio's correctional system was the subject of a PBS *Frontline* documentary entitled "The New Asylums."
- I have authored three journal articles published in *The Correctional Psychologist, The National Psychologist,* and *Correctional Mental Health Report*.
- I serve on several Ohio state-wide committees on mental health concerns: the Advisory Council on the Mentally Ill and the Courts and the Ohio Transformation Working Group.
- In September I will host and moderate a hearing sponsored by the National Institute of Corrections on mental health collaborations.
- In November I will moderate a plenary session on the mentally ill offender at the annual training institute of the Association of State Correctional Administrators.

I provide the aforementioned details to give you insight into my commitment of helping to oversee the reformation of dealing with felony-convicted persons who have been diagnosed with a mental illness. These persons include prison inmates as well as formerly incarcerated individuals. It is a misnomer that when a convicted person is determined to be mentally ill that this is his or her sole plight. Indeed, they will generally have multiple problems, both social and medical. Many persons with a mental illness have co-occurring disorders. Mental illness can be complicated with certain offender groups such as sex offenders. I am also concerned with the high number of persons who have been assessed as having retardation or a developmental disability.

Moreover, there are obviously varying degrees of mental illness. According to the Bureau of Justice Statistics, sixteen percent of all incarcerated persons have a diagnosed mental illness.

About half of the persons sentenced to correctional facilities are diagnosed as having a "serious mental illness." Given the fact that there are nearly 2.2 million persons in prisons and jails, you may understand how detention facilities have, in fact, become the "new asylums." "Deinstitutionalization" has been a major movement for community mental health providers for a number of years. I believe we are now experiencing a "transinstitutionalization" of persons with a mental illness. That is, many persons who may have been civilly committed to a mental hospital twenty years ago have now found their ways to prisons and jails. What this means for corrections administrators is that we not only are responsible for *de facto* mental health systems, but we have become *de facto* mental health directors.

As you might imagine, the daily challenges that confront a correctional agency are wide-ranging and formidable. The Ohio Department of Rehabilitation and Correction, the nation's sixth largest state corrections system, is no exception. In addition to operating 32 prisons, the agency is responsible for parole supervision state-wide and some form of probation supervision in 52 of Ohio's 88 counties. Obviously, one of the monumental challenges facing Ohio is our health care delivery system for 44,000 prisoners.

Two major events took place which gave rise to our agency's renaissance in prison mental health care. First, in 1993, Ohio experienced a prison riot at the Southern Ohio Correctional Facility in Lucasville. Nine inmates and one employee were killed. This event put the department under the public microscope. No single facet of our operations was left unexplored, including mental health services. Second, in 1993 the *Dunn v. Voinovich* lawsuit was filed in federal court in Cincinnati, claiming that care for prisoners with serious mental illness was constitutionally inadequate. This litigation was settled and resulted in a five-year consent decree, which was terminated in 2000. There was never an admission of deliberate indifference.

In addition to what I have noted above, why is it important to have a good correctional mental health treatment program? Beyond all the legal and practical reasons one might express, above all, it's the right thing to do! However, treatment for inmates with mental illness is more than

just "the right thing to do," it is a constitutional requirement and enforceable in federal court. Let me share with the Commission some of the overarching reasons why operating a comprehensive and sound correctional mental health service delivery system is critical:

- Nearly seven percent of Ohio's inmates are diagnosed as "seriously mentally ill." A host of other inmates with a less serious mental illness co-exist as normally as possible in the prisoner population. Good management and effective clinical care are required to resolve this prodigious problem.
- For both security and health reasons, we need to know whether offenders are demonstrating purposeful negative behavior as opposed to those who are "acting out" because of their mental illness. Mental health professionals working closely with security professionals assist in this task.
- Whether the prisoner has an acute psychiatric illness or a personality disorder, correctional staff should be concerned with preventing further deterioration. Suicide and suicide attempts are stark examples of the consequences of unknown or unattended deterioration. Accordingly, prevention and amelioration of mental health related problems, from an administrative and clinical perspective, are a conscious, ongoing mission.
- Unfortunately, prisoners with a "weakness," either physical or mental, are at a disadvantage and are sometimes preyed upon by "stronger" inmates. There is, of course, a constitutional duty to protect vulnerable inmates, and the mentally ill and developmentally disabled often fall into this category.
- Knowing inmates' physical and mental limitations allows staff to appropriately house, classify, assign jobs, and treat prisoners. Good mental health, then, includes screening and evaluations, which provide this crucial information.

As is the case with 97 percent of all prisoners, transition to the community is inevitable. For community health and safety reasons, operating a holistic mental health service delivery program for offenders is paramount.

Briefly, the organizational structure for mental health services in Ohio is as follows. Overseeing

our mental health delivery system is the Bureau of Mental Health Services. We operate a psychiatric hospital: the Oakwood Correctional Facility. In addition to Oakwood, our 32 prisons are divided into nine separate "clusters," or catchment areas. Each cluster has a designated Residential Treatment Unit (RTU) or easy access to one. Assignment to one of the nine RTUs is for appropriate care and never a disciplinary action.

RTUs provide care and supervision for inmates who require special housing on a graduated basis; that is, as mental disability improves or stabilizes, generally via psychopharmacology and cognitive and behavioral therapies, more privileges and movement are permitted. For instance, in the least restrictive RTU environment, inmates with a mental illness may be afforded the same privileges as those in general population such as eating, working, and participating in recreation with the other general population inmates.

Treatment plans are developed for all prisoners on the mental health caseload, which includes all inmates housed in a RTU. The basic mission of the RTU is to reintegrate the offender back into the general population. Similarly, Oakwood's mission is to stabilize the inmate and return him or her back to his or her RTU or parent prison.

Thus, the structure of mental health services in the Ohio Department of Rehabilitation and Correction resembles a triangle, with Oakwood at the top, treating the most seriously mentally ill who need hospital care; the RTUs as intermediate or chronic care facilities; and the broad-based outpatient population, who receive treatment, yet are able to function in the prison community.

The recruitment, training, and deployment of trained personnel are ongoing challenges. Enhanced care means an enhanced staff, thus recruitment is now a perpetual process. Overall, mental health staff has increased dramatically. Department mental health staff salaries are now commensurate with those of other local and state mental health agencies. Nevertheless, in order to maintain adequate staffing tables, diligence in recruitment must be maintained.

Staff training is a time-consuming necessity. New employees must complete a five-week pre-service training program: three weeks at the Corrections Training Academy and two weeks of on-the-job training (corrections officers complete a seven-week program.) Annual in-service training also is required. For many mental health clinical and administrative staff, working in corrections is a new career choice. Clinical staff must adapt to the correctional environment, regardless of a staff member's credentials. Specialized mental health training is provided for all correctional staff including custody, medical, clerical, and mental health assigned to work in segregation, medical, and mental health areas. This is a two-day program designed to increase knowledge about mental illness, support appropriate attitudes and behaviors, and better integrate security and mental health concerns. There is ongoing evaluation of this training, and preliminary results are quite positive.

Partnering with the appropriate organizations augments our ability to provide state-of-the-art services to offenders with mental disabilities. For example, an ongoing relationship with the state mental health agency has proven very beneficial. Working closely with community mental health agencies and boards has additionally provided assurances of quality mental health care for offenders, especially those who are being supervised in the community.

Maximizing communication between our central office staff and prison/community corrections personnel is viewed as one of the keys to good health care services. Regularly scheduled meetings for field staff allow concerns to be addressed and issues resolved. Personnel at these meetings typically represent a combination of clinical workers and administrators. Hence, good management of mental health care is directly correlated to good clinical services and vice versa.

If correctional agencies are to have a positive impact on minimizing the problems associated with the reintegration of mentally ill offenders to the community, the process must be well coordinated. Most prisoners who are released back into a community only receive about two weeks of medication to sustain them. Thus, in the spirit of reentry, referrals regarding the continuity of mental health services must be a part of discharge planning. Most persons with a

mental illness are able to work, but when you combine the stigmas of being a formerly incarcerated person and a person with a mental illness, work possibilities diminish significantly. Nevertheless, this special needs group can achieve successful community reintegration.

It is now appropriate to briefly discuss the impact of the so-called "super-max" prisons on persons with a mental illness. There are typically two issues associated with the mentally ill and this housing assignment. First, it is asserted that persons who are mentally ill should not be assigned to a super-max prison. And second, inmates who are assigned to a super-max may develop a mental illness. I agree that it is a good idea to avoid placing persons with an active mental illness in a super-max prison. I don't agree that inmates should not be assigned to one because a mental illness might develop or cause decompensation to occur with inmates whose mental illness is in remission. Albeit, continuous monitoring of unusual behavior by prisoners assigned to a super-max institution should be an ongoing security and clinical responsibility.

It is my contention that involving the courts in clinical and supervision planning for persons with a mental illness is a critical element. Judges have influence. In Ohio, a Supreme Court justice plays a pivotal role. It is important that all stakeholders have input, but prevention and diversion are critical components that can be best facilitated with juridical involvement. Thus, in an attempt to ensure a holistic approach to mental health case management for offenders, looking beyond traditional methodologies may be warranted.

From my perspective, it is clear that comprehensive mental health care for offenders yields positive results: offenders are better able to cope with the prison environment; releasees stand a better chance of not recidivating; staff feel safer as they perform their duties in calmer environments; and, fewer citizens are victimized, thereby improving public safety.

Conclusion

I must first say that the aforementioned model is that of the Ohio Department of Rehabilitation

and Correction. I am in no way suggesting that this should be the prototype for any other correctional jurisdiction. What may work in Ohio may not be appropriate for other states. Although any correctional administrator will admit that continuous improvement is an ongoing part of our mission, there is little evidence of intentional abuse inflicted upon persons with a mental illness in prisons and jails in this nation. Yes, there are isolated and unacceptable incidents that occur. But these incidents are no way reflective of the normal correctional protocols of how persons with a mental illness are managed.

Again, I am appreciative of the opportunity to provide this testimony.