Testimony of

Dr. Reginald Wilkinson

July 30, 2003

S. 1194

"Mentally Ill Offender Treatment and
Crime Reduction Act of 2003"

United States Senate Judiciary Committee

testimony by

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INTRODUCTION

Good afternoon. Thank you Senator DeWine, Chairman Hatch, and Ranking Member Leahy for inviting me to testify regarding S. 1194, the "Mentally Ill Offender Treatment and Crime Reduction Act of 2003."

My name is Dr. Reginald A. Wilkinson, and I am the Director of the Department of Rehabilitation and Correction (ODRC) for the State of Ohio. ODRC comprises more than 30 prisons, and, on any given day, our agency supervises 45,000 inmates housed in our correctional institutions. We, moreover, supervise another 30,000 persons on parole and probation.

Today, I represent not only the great state of Ohio, but also the Association of State Correctional Administrators (ASCA). ASCA is the national organization that represents persons who serve in my position in each of the 50 states and several other jurisdictions. I am the current president of ASCA.

I'd also like to provide testimony on behalf of the Council of State Governments (CSG). CSG is a non-profit organization that serves the interest of governmental bodies in the United States. They recently undertook a major initiative dealing with the mentally ill offender. Their work culminated in the publishing of the landmark report: Criminal Justice / Mental Health Consensus Project. This bipartisan initiative (of which I was part) brought together 100 leading law enforcement officials and mental health experts. This Senate committee, at a hearing chaired by Senator Leahy, reviewed the report recommendations one year ago.

I'd first like to give you a brief history of how ODRC has dealt with problems associated with the mentally ill inmate. In 1993, following a prison riot at the Southern Ohio Correctional Facility

where one correctional officer and 9 inmates were killed, a federal lawsuit was filed (Dunn v. Voinovich) challenging the constitutionality of ODRC's mental health delivery system in Ohio prisons. While our agency believed we met the constitutional minima to provide mental health services, the system needed repair. Therefore, rather than spending millions of tax dollars defending our previous methods we agreed to a five-year consent decree in 1995 and decided to concentrate on, with the oversight of the federal court, improving our mental health services for the mentally ill prisoner.

Throughout the life of this lawsuit (the case was terminated per the settlement in 2000), all parties, including plaintiff's counsel, the court monitor, the state's attorneys, correctional administrators, and health care professionals, agreed to manage points of contention privately. Consequently, I am personally proud of the mental health delivery system that currently exists in Ohio. I consider the current system to be a national benchmark as it relates to prison mental health care.

On behalf of all directors of state departments of correction and hundreds of thousands of correctional employees across the country, representing prisons, jails, juvenile facilities, and community corrections operations, I want to tell you this: Senator DeWine's introduction of S. 1194, together with the bipartisan support Senator Leahy and various members of the Committee have provided, has been the single most important and positive legislative development for corrections and mental health workers to occur in Congress in recent memory.

It is gratifying to see a group of leaders in the Senate rally, as they have under Senator DeWine's leadership, around a bill that practitioners and policymakers alike agree will save lives, increase public safety, and reduce state and local government spending. My testimony will review the extraordinary toll that the overrepresentation of people with mental illness in the criminal justice system is exacting on the lives of people with mental illness, public safety, and state and county budgets. My testimony will also explain how the legislation can be an unprecedented resource to state and local governments grappling with this complex problem.

I. SAVE LIVES

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

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

Sadly, suicide is the leading cause of death in jails. The suicide rate in Ohio county jails is about 77 per 100,000 people--7 times greater than the rate in the general population. These rates are not unique to Ohio; correctional systems in other states share similar rates.

By improving procedures to screen inmates for mental illness, and training staff to identify signs of suicide risk, S. 1194 will help corrections administrators fulfill part of their core mission: ensuring safe and humane conditions for staff and inmates alike.

II. INCREASE PUBLIC SAFETY

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

Unless we provide these offenders with the services and treatment they need while they are incarcerated, we are virtually guaranteeing that they will commit new crimes when they return to the community. Nevertheless, few corrections systems are able to prepare inmates adequately for their release. For example, a study of individuals with serious mental illness leaving Washington State prisons showed that only 3 out of 10 received mental health services in the three months subsequent to their release. Planning for the transition of inmates with mental illness back into the community is even more difficult in the jail context, where stays are shorter, and release dates less certain.

Not surprisingly, studies show that rates of recidivism for people with mental illness should concern all elected officials. One study showed that 72 percent of inmates with mental illness leaving the Lucas County Jail, in northwest Ohio, were re-arrested within 36 months. In the same Washington State study mentioned above, 77 percent of the individuals had some post-release arrest, violation, or offense.

Community safety corresponds in part to the degree to which jail and prison systems develop and implement effective transition plans for inmates with mental illness. In this regard, S. 1194 will be of enormous value. It will promote effective reentry planning for people with mental illness through efforts such as encouraging mental health providers to come into corrections facilities and connect with the offender prior to his release, and ensuring inmates have an adequate supply of medications upon their release. Typically, two weeks of psychotropic medications are provided to the offender. Without planned follow up services, this is hardly adequate for released offenders.

Correctional administrators, furthermore, support efforts by local law enforcement to help manage this dilemma. Many persons with a mental illness are arrested and sent to jail for minor infractions. A great number of these can be better served, as well as our communities, by employing crisis intervention methodologies rather than the standard justice techniques. This suggests that more and better training of police officers and the establishment of crisis centers is critical.

III. REDUCE SPENDING

In nearly every state--and, again, Ohio is no exception--we're discovering that corrections is no longer "recession proof." Funds to build, and more significantly, staff and operate prisons and jails are diminishing. State legislatures and governors are ordering us to find ways to cut costs, and the only way we can realize savings of the scale they are mandating is to curb the rate of growth of our corrections systems.

We know that people with mental illness stay incarcerated much longer than the average inmate. A case in point, the Pennsylvania Department of Corrections reports that inmates with serious mental illness are three times as likely as other inmates to serve their maximum sentence. One of the central reasons for this discrepancy, according to department officials, is that the lack of adequate community services makes it difficult for the parole board to develop an effective community treatment and supervision plan. The irony of this is that, when these inmates do "max out," they reenter the community with no supervision, and, usually, without effective connections

to much needed services.
The lack of community-based services and supports for parolees with mental illness means that we parole inmates with mental illness far less frequently than general population inmates. Not only does that mean that they will be released without any community supervision, it also means that we spend much more money to keep them incarcerated. In this context, it is crucial to remember that it is significantly more expensive to incarcerate individuals with mental illness than other inmates. Pennsylvania estimates that an average prison inmate costs $80 per day to incarcerate, while the added costs of mental health services, medications, and additional correctional staff means that it costs approximately $140 per day to incarcerate an inmate with mental illness.
The sooner we get people with mental illness who don't represent a threat to public safety out of the corrections system, and the more we can ensure people with mental illness released from prison do not violate their conditions of parole, the more likely we are to realize the savings that state officials are ordering us to find.
S. 1194 provides us with the tools needed to achieve these goals, facilitating the design and implementation of risk assessment instruments, encouraging the enrollment of ex-offenders with mental illness (of those who are eligible) in federal benefit programs, and promoting aspects of programs that prove effective in reducing recidivism.

IV. BUILDING ON OHIO'S SUCCESSES
We have recognized in Ohio that we cannot fix this problem by simply building better mental health hospitals in prison; corrections facilities are typically the largest mental health providers in many communities, and we don't want to become an even stronger magnet for sick people who haven't gained access to the community mental health system.
We also recognize that when people with mental illness are released from prison or jail their success depends largely on the extent to which they are effectively linked to community mental health services.
Dr. Mike Hogan, the Ohio Director of the Department of Mental Health, and I, along with our staffs, have worked hard to establish joint ventures that reflect this commitment to collaboration between corrections and mental health.
However, the road to success is hampered by a number of barriers that are faced by correctional jurisdictions, on both the state and local levels, that this proposed legislation addresses.
S. 1194 recognizes that no program or policy designed to improve the response to offenders with mental illness can be successful without such inter-agency collaboration. Accordingly, it will be an extraordinary stimulus for collaboration in those counties and states where policymakers and practitioners have yet to work together in a meaningful way. And, in states like Ohio, it will help us translate fledgling initiatives into strong, sustainable partnerships that have a credible evidence base.
For these reasons, we in the corrections community and in state government generally believe S. 1194 is a bill that should be passed immediately, and as an Ohioan, I am especially proud of the leading role my senior Senator and Congressman have taken on this issue.

DR. REGINALD A. WILKINSON

Dr. Reginald A. Wilkinson has been employed by the State of Ohio, Department of Rehabilitation and Correction (DRC) since 1973. He has served in a variety of positions including superintendent of the Corrections Training Academy, warden of the Dayton Correctional Institution, and deputy director of prisons--south region. Former Governor George Voinovich (now U.S. Senator) and Former Lt. Governor Mike DeWine (now U.S. Senator) appointed Wilkinson DRC director in February 1991. Current Ohio Governor Bob Taft reappointed him director in January 1999.

Director Wilkinson's academic background includes a B.A. degree in political science and a M.A. degree in higher education administration, both from The Ohio State University. He was also awarded a doctor of education degree (Ed.D.) from the University of Cincinnati.

Wilkinson is President of the Association of State Correctional Administrators. He is also a Past President of the nation's oldest and largest corrections organization, the American Correctional Association. Wilkinson is furthermore Vice Chair for North America of the International Corrections and Prisons Association.

Dr. Wilkinson has authored numerous articles on a variety of correctional topics. He also has chapters published in the following books: Best Practices: Excellence in Corrections; Correctional Best Practices: Directors' Perspectives (editor); Ohio Crime, Ohio Justice; and Prison and Jail Administration: Practice and Theory.

Director Wilkinson has received numerous awards from a variety of organizations. A few of the associations he has received honors from include the National Governors' Association, the American Correctional Association, the Association of State Correctional Administrators, the International Community Corrections Association, and the National Association of Blacks in Criminal Justice.

The Ohio Department of Rehabilitation and Correction is acknowledged nationally and internationally for its many innovative correctional programs and services in categories such as substance abuse, victims services, correctional health care, correctional education, security management, restorative justice, offender reentry, and much more. DRC is recognized as being one of only several correctional agencies in the nation that is fully accredited by the American Correctional Association.