U.S. Senate Judiciary
Subcommittee on Human Rights and the Law
Incarceration and Persons with Mental Illness
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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.

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.

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.