154860

REPORT OF THE STATE/LOCAL CRIMINAL JUSTICE/MENTAL HEALTH TASK FORCE

THE HONORABLE
PARRIS N. GLENDENING
GOVERNOR

JANUARY, 1995

TABLE OF CONTENTS

For additional copies or information, contact:

Governor's Office of Justice Administration
301 West Preston Street, 15th Floor
Baltimore, MD 21201
(410) 225-1834 ☎ (410) 333-5924 fax

EXECUTIVE SUMMARY

The Report of the State/Local Criminal Justice/Mental Heath Task Force addresses the many issues regarding the custody and care of offenders with serious mental illnesses. The Report is submitted to chronicle the deliberations and accomplishments of the involved criminal justice and treatment agencies and to organize into one document the knowledge gained regarding this population.

In January 1991, the Maryland Correctional Administrators Association (MCAA) requested the Governor's Office of Justice Assistance, now the Governor's Office of Justice Administration (GOJA), to assume leadership in the work of the Task Force. MCAA generated this request as it was apparent that there was a lack of comprehensive and integrated treatment for offenders with serious mental illnesses. These individuals utilize a multitude of services from a wide variety of agencies resulting in an inability for any singular agency to adequately supply all the treatment and management needs of this population.

The summary of Maryland Jail Statistics for the month of July 1994, compiled by the Department of Public Safety and Correctional Services, indicates an average daily population of approximately 10,000 offenders held in local county detention centers and the Baltimore City Detention Center. Utilizing the 1992 Maryland and national data regarding inmates with mental illnesses, the Task Force estimates that there may be a population of 600-700 inmates in local correctional facilities who require mental health intervention.

A consortium of agencies has examined these issues. Based on thier work, the Task Force has recommended a collaborative approach utilizing the strengths and capabilities of criminal justice and treatment entities to develop a systemic treatment program for offenders with serious mental illnesses. (A full roster of participants is listed in Appendix B.) As an outgrowth of this process, the Mental Hygiene Administration (MHA) has made the commitment to assist in the treatment of this population through the development of the Jail Mental Health Program, which is fully discussed in Section V (pages 21-27) in the body of this Report.

Based on its deliberations, the Task Force has made recommendations to improve the service delivery system in the areas of enhanced mental health services, cross-training,

local networking and planning, improved inter-agency coordination at State and local levels, and areas for further review.

The Task Force study resulted in numerous findings which are detailed in Section IV (pages 7-21). They can be summarized as follows:

- Increased resources for the identification, management and treatment of the offender with serious mental illnesses during confinement, both at the state and local level; and

- Increased aftercare resources for those individuals released back into the community to promote mental health and impact on relapse to mental illnesses and criminal activity.

The complete list of Task Force recommendations are found in Section VII (page 28). Summary highlights of the Task Force findings are:

1. Treatment and management of offenders with serious mental illnesses should be an ongoing priority, allowing for the continued development and expansion of the Jail Mental Health Program statewide.

2. Executives from the appropriate involved State agencies and private organizations should enter into a shared service agreement enabling development of a systemic treatment program for offenders with serious mental illnesses.

3. Innovative fiscal mechanisms for serving this population (such as grants and support from private individuals and businesses) and coordination of funds from a variety of different federal, State and local agencies (e.g., corrections, mental health, substance abuse, developmental disabilities, etc.) should be explored and utilized.

4. The Task Force has developed numerous recommendations for the establishment, maintenance, and enhancement for communication and enhancement of networking between agencies.

I. INTRODUCTION

In January 1991, the Governor's Office of Justice Assistance, now the Governor's Office of Justice Administration (GOJA), assumed the leadership role in examining the many issues regarding the custody and care of offenders with serious mental illnesses. The Report is submitted to chronicle the deliberations and accomplishments of the Task Force and to advise the Governor, the Department of Public Safety and Correctional Services, the Department of Health and Mental Hygiene, the Maryland Police and Correctional Training Commissions, and the Maryland Correctional Administrators Association on current issues attendant to the management and treatment of offenders with serious mental illnesses.

II. PROBLEM STATEMENT

MCAA reports that over the past decade there has been a continuing influx of offenders with serious mental illnesses into local correctional facilities. Many speculate this increase may be attributed to de-institutionalization of persons with mental illnesses attendant to the downsizing of state psychiatric hospitals, the lack of mental health treatment resources in the community for the population, an overall increase in the number of individuals with mental illnesses and the fiscal crisis existing at the inception of the task force. Whatever the cause, there has been a lack of comprehensive and integrated treatment for offenders with serious mental illnesses. This problem will worsen as the population of persons with mental illnesses in the local detention centers, state correctional facilities, and under parole or probation supervision continues to increase.

III. THE NATIONAL PERSPECTIVE

In June 1990, a report entitled "Effectively Addressing The Mental Health Needs Of Jail Detainees: Breaking Through The Barriers" was issued by the National Coalition for the Mentally Ill in the Criminal Justice System. Funded by the National Institute of Corrections (NIC), the report provides an important nationwide perspective in the review of key issues related to the custody and care of offenders with serious mental illnesses.

The NIC report is based on four (4) major assumptions:

- mentally ill persons in jail (detention) are a community problem
- the jail (detention center) is part of the community
- mentally ill misdemeanants whose illegal behavior usually is survival behavior should be diverted into appropriate mental health treatment services
- mentally ill felons have a right to essential mental health evaluation and treatment services as well as linkage to community services.

In the Introduction to the NIC report, Henry J. Steadman, Ph.D., cites some compelling statistics regarding the status of local jails and detention centers:

> "From 1978 to 1988, the number of persons on a given day in a jail in the United States increased 117% from 158,394 to 343,569 (BJS, 1990). These numbers meant that in 1988 there were 9.7 million jail discharges (BJS, 1990). Based on Teplin's (Undated) survey of 542 randomly selected pre-arraignment inmates in the Cook County jail (Chicago), 7% of the inmates were severely mentally ill. Nationally, this would mean that there were 679,000 admissions to U.S. jails in 1988 who are severely mentally ill and as many as 672,000 persons released to the community who were severely mentally ill upon admission."

In the NIC report, Steadman also cites a 1988 report of the National Association of Counties (NACo) entitled "Exemplary County Mental Health Programs" which illustrates the natural tension between correctional administrators and mental health service providers regarding the offender with serious mental illnesses:

> "People with mental illnesses comprise approximately ten percent of the population of local jails. While some of these people must be incarcerated due to the nature of their crimes, a large portion of them are in the criminal justice system because it is the only resource in many communities available to this population (Adams, 1988)."

Steadman added that while this is true, the problem is often "more one of poor coordination of existing resources rather than the total lack of resources." The NACo report also addresses the issue:

> "Jail is inappropriate treatment for people with mental illnesses who commit misdemeanors or no crime at all. Such individuals need to be diverted from jail to a continuum of services which include crisis intervention, outreach, residential, vocational training, family support, case management and other community support services. Further, individuals with mental illnesses whose crimes warrant their incarceration need access to appropriate mental health services. These services should be provided either through linkages with the community mental health system, and/or the development of programs to deliver mental health services in the jail setting (Adams, 1988)."

The NIC report delineates six (6) major themes which are important in the Maryland review of these issues:

- both diversion and in-jail mental health services are desperately needed;
- inadequate resources are a problem, but often a greater issue is poor use of existing resources and the lack of integration of mental health and criminal justice programs;
- mentally disordered offenders require a full array of services, but the priorities vary by the point at which they are in the criminal justice system;
- community safety and individual rights to treatment are both able to be addressed when the two (2) systems are properly coordinated and funded;
- good mental health treatment does not conflict with security concerns; and
- the jail and the mental health problems of its detainees must be seen as a community problem.

In 1989, Steadman, McCarty and Morrissey conducted a national survey of 42 jail mental health programs to determine whether certain methods for delivery of mental health services to jail detainees are better than others. The conclusion was that while there is "no one best way to provide those services," there are some principles which are characteristic of all of the better programs; i.e., the jail and the mental health needs of inmates are seen as a community problem; in addressing the mental health needs of its detained population, the jail cannot be viewed as an isolated institution responsible for solving its own problems; and programs must operate as a part of a continuum of services.

In the NIC report chapter regarding "Jail-Based Mental Health Services," Joel Dvoskin, Ph.D., notes that there is "incontrovertible evidence of the existence of significant numbers of severely mentally ill citizens among jail populations." Citing the chronic overcrowded status of America's jails and prisons, Dvoskin asserts that diversion programs are clearly necessary; but he then adds that even if such programs are implemented and realize significant successes, "jails and lockups will continue to house a large number of seriously mentally ill individuals while they are either serving sentences for serious offenses or awaiting trial."

According to the NIC report, the reasons for the ongoing problem of the management of offenders with serious mental illnesses which faces local detention administrators include:

- the inmate is being held for a current offense that is severe and unrelated to their mental illnesses;

- the stress of the jail environment can bring about a psychiatric crisis in someone who was mentally intact in the community;

- with the dramatic rise in illegal drug use, and the documented relationship between such drug use and criminal behavior, jails are facing large increases in the numbers of newly admitted inmates who are "toxically psychotic upon arrest."

A second set of problems relates to the liability related to psychiatric crises and the presence of offenders with serious mental illnesses in local detention centers.

Strategies must also address the fact that public opinion usually turns negative at news of jail suicide. The NIC report also provides other important research findings:

- among jailed misdemeanants there is significant discrimination against psychotic inmates in accessing various types of pretrial release (Axelson, 1987);

- psychotic inmates are four (4) times more likely than non-psychotic inmates to be incarcerated for less serious charges such as disorderly conduct and threats (Valdiserri et al, 1986);

- the prevalence rates of schizophrenia and major affective disorders among jail inmates are two to three times higher than those of the general population, even after adjusting for the demographic differences between the two populations (Teplin, 1990);

- estimates of mental disability among jail inmates exceed those for prison populations (Teplin and Schwartz, 1989); and

- prevalence of severe or significant psychiatric disability among sentenced felons is at least 15% (Steadman, 1987).

IV. TASK FORCE FINDINGS

A. OVERVIEW

Acting upon MCAA's request, GOJA formed an inter-disciplinary Task Force to investigate the scope of the problem in Maryland and to make specific recommendations regarding possible changes in law, policy, procedure or regulation to implement a more efficient and effective service delivery system to this population. Over the past four (4) years, nearly forty (40) people representing over twenty (20) agencies have been involved in this effort. Some of the agencies represented included the Governor's Office of Justice Administration, the Mental Hygiene Administration, the Division of Parole and Probation, the Maryland Police and Correctional Training Commissions, the Division of Correction, the Office of the Public Defender, the Maryland Correctional Administrators Association, several detention centers, several

community mental health centers, the State's Attorney's Association, and the Administrative Office of the Courts.

Beginning in March of 1991, twenty-five (25) meetings of the full Task Force were convened, along with numerous subcommittee meetings, to respond to the request from MCAA and to develop a systemic mental health program for offenders confined to correctional facilities as well as those supervised in the community. The Task Force began by reviewing documents of three (3) previous Maryland task forces and committees that had studied the problems of offenders with mental illnesses:

- the Report to the Governor by the Subcommittee on Mentally Ill Offenders-Maryland Criminal Justice Coordinating Council (November, 1984);

- The Problem of the Mentally Ill Confined In Jail by Kent W. Mason for the Maryland Correctional Administrators Association (1985); and

- the Report of the Task Force on Mentally Ill Offenders, chaired by Judge Alan Wilner (1986).

The significant conclusions of these Maryland studies are summarized below:

1. There is a significant number of offenders who suffer from some form or degree of mental illnesses or mental retardation and that, both from a humane and self-protection point of view, society has an obligation to address the problem and attempt to find some solutions;

2. Historically, there has been controversy over which offender(s) within the criminal justice system in Maryland should be provided with mental health treatment and which agency(s) are responsible for ensuring that these treatment needs are met;

3. There has been a clear increase in the number of persons with mental illnesses in detention centers, prisons, and on parole and probation;

4. Community services for offenders with serious mental illnesses in the State of Maryland are woefully inadequate; and

5. A major problem in addressing the issue of offenders with serious mental illnesses has been ineffective coordination between the various agencies that provide services for this population.

Recommendations made in these reports fall into seven (7) major categories:

1. DEFINITION: the subgroup of individuals comprising the population of offenders with serious mental illnesses needs to be clearly and definitively delineated;

2. NEEDS ASSESSMENT: accurate figures need to be obtained on the number of persons with mental illnesses in Maryland's correctional facilities;

3. CENTRAL COORDINATION: an interdisciplinary advisory group of state and local policy makers and service providers needs to be formed;

4. SEPARATION: the purpose and methodology for classifying and separating the offenders with serious mental illnesses from the general offender population needs to be explored;

5. TRAINING: training across all involved disciplines needs to occur regarding how to identify and manage offenders with serious mental illnesses and to increase awareness of alternative programs and treatment resources for offenders with serious mental illnesses, as well as training regarding legal and custody/supervision issues;

6. DIVERSION: presentence programs must be developed to assist the courts in providing a variety of options for offenders with serious mental illnesses to avoid inappropriate incarceration; and

7. COMMUNITY RE-ENTRY PROGRAMS: programs to assist offenders with serious mental illnesses upon return to the community which will

enhance public safety and provide for continuity of care for offenders with serious mental illnesses must be developed.

Certain fundamental principles worth denoting from the "Wilner Report" include:

- At times inmates with serious mental illnesses act inappropriately while incarcerated due to the conditions in many correctional facilities which exacerbate their illnesses;

- The population of offenders with serious mental illnesses is neither static nor monolithic. No one program will work universally. Therefore, adaptability in programs and individualized services is crucial to adequate service delivery;

- Nearly all offenders are eventually released back into the community; and

- Virtually all the studies report that a substantial number of offenders suffer from more than one handicapping condition. These conditions must be fully diagnosed and addressed in a coherent and coordinated fashion.

The Wilner Report went on to state that "... failure to recognize these principles would be unrealistic. Failure to design programs with them in mind will prove self-defeating."

In the years since these studies, a considerable number of programs have been developed and implemented which, directly or indirectly, have improved services for offenders with mental illnesses. The Community Forensic Evaluation Program at Clifton T. Perkins Hospital Center offers pretrial and presentence psychiatric evaluations for the courts. The Division of Correction has adopted standards of care for offenders with mental illnesses and has centralized mental health treatment in specialized programming at the Correctional Mental Health Center - Jessup located at the Patuxent Institution. Community Re-Entry Programs were initiated in several of the major jurisdictions in Maryland; but are limited in scope and currently operational in only three (3) counties. Improved services are available in some

jurisdictions through mobile treatment teams. Women needing maximum security psychiatric inpatient care are now admitted to Clifton T. Perkins Hospital Center instead of being only admitted to the regional Mental Health Administration (MHA) hospitals. As important as these programs have been, the Task Force concluded that a significant need for more coordinated services persists and that many offenders with serious mental illnesses still do not have access to adequate treatment.

Public mental health services at the local level are primarily focused on persons who fall within the MHA's priority population definition. MHA funding mandates that 70% of the persons served by adult mental health programs in local mental health clinics be individuals eighteen (18) years of age or older, who have a serious mental illnesses, who lack sufficient financial resources to obtain required treatment, and who meet certain criteria. Diagnostic categories included in the MHA priority population include:

1. Primary Diagnosis - Major mental illness as defined by:

    a. Schizophrenic disorders (DSM-IV 295.00-295.99); or

    b. Major affective disorders (DSM-IV 296.00-296.99); or

    c. Organic mental disorders (DSM-IV 290.00-290.99, 293.00-294.99 and 310.00-310.99); or

    d. Other psychotic disorders (DSM-IV 297.00-297.99, 298.9) or

    e. Borderline and schizotypal personality disorders (DSM-IV 301.83, 301.20-301.22) with the exclusion of an abnormality that is manifested only by repeated criminal or otherwise antisocial conduct.

See Appendix A for the complete definition of priority population.

B. LOCAL CORRECTIONAL FACILITIES

In November 1992, the Task Force completed a survey of Maryland's local detention centers to identify those individuals with mental health problems. In completing this survey, the Task Force adopted MHA's current definition of serious mental illnesses. Nineteen (19) facilities responded to the survey and reported an average of 5.7% of the detained population having some form of severe mental illness. This number is below the national average of 7.2% reported by the joint report, Criminalizing the Seriously Mentally Ill (1992), by the National Alliance for the Mentally Ill and the Public Citizen's Health Research Group. The Task Force believes that Maryland's survey results fall below the national average as the persons completing the survey tool were not trained mental health professionals. Other disorders such as substance abuse, mental retardation/developmental disabilities are included in the DSM-IV but were not addressed in this survey.

The summary of Maryland Jail Statistics for the month of July 1994, compiled by the Department of Public Safety and Correctional Services, indicates an average daily population of approximately 10,000 offenders held in local county detention centers and the Baltimore City Detention Center. Utilizing the 1992 Maryland and national data regarding inmates with mental illnesses, the Task Force estimates that there may be a population of 600-700 inmates in local correctional facilities who require mental health intervention.

Correctional health standards mandate appropriate care and treatment of offenders with mental illnesses. As a result, Code of Maryland Regulations (COMAR) 12.14.03.04R requires the managing official shall have "...a written policy and procedure governing the identification, housing, treatment, supervision, and referral of mentally ill and retarded inmates according to established guidelines to include due process guarantees."

The MCAA Task Force recognized the difficulty for local detention centers to meet this standard and proposed that a specialized program be developed to help serve this population. Several pilot programs were developed to respond to the needs of the local detention centers. These pilot projects are described in Section V (pages 21-27) of this document.

From these surveys and discussions with mental health and correctional staff, the Task Force made the following determinations:

1. A significant population of offenders with serious mental illnesses exists in correctional facilities and on parole/probation in Maryland;

2. Some offenders with serious mental illnesses can neither understand nor follow detention center rules and procedures and may thereby disrupt correctional activities, operations and programs;

3. Inmates with serious mental illnesses are at risk for abuse or victimization. Such abuse or victimization may range from verbal torment to inappropriate treatment to physical attacks and rape;

4. Increased resources are required for the identification, management and treatment of the offender with serious mental illnesses during confinement, both at the state and local level;

5. Offenders with serious mental illnesses are more likely to gesture, attempt and/or commit suicide than other offenders;

6. The traumatic experience of incarceration often exacerbates the psychiatric conditions of an offender resulting in further deterioration;

7. Offenders with serious mental illnesses often cannot appropriately or adequately communicate their urgent medical/psychiatric needs to correctional staff, leading to extended periods without proper medications and treatment, further exacerbating their condition;

8. Offenders with serious mental illnesses are often given low priority for services and very few treatment/rehabilitation options exist for them;

9. In many correctional facilities, no one is charged with the responsibility of monitoring offenders with serious mental illnesses, frequently resulting in their service needs remaining unaddressed by the system;

10. In some regional State-run psychiatric hospitals, there are no secure areas to treat offenders with serious mental illnesses. This has raised security related concerns within the criminal justice system;

11. Criminal justice staff have insufficient training in identifying and managing offenders with serious mental illnesses;

12. Mental health staff have insufficient training in the legal and custody issues facing the criminal justice system in managing offenders with serious mental illnesses;

13. Offenders with serious mental illnesses may be inappropriately channeled into the correctional facilities due to a lack of awareness of alternative mental health resources and difficulty in accessing those services which are available;

14. Current practices impede information flow between agencies resulting in difficulty in providing comprehensive services;

15. There is a lack of coordination of case management across State and local boundaries and between the criminal justice and mental health systems;

16. There is often a lack of individual health insurance to pay for necessary community mental health treatment services;

17. There has been a general lack of perspective and commitment to view the management and treatment of offenders with serious mental illnesses as a major problem for the entire community, crossing State and local government boundaries, which must be addressed collaboratively by criminal justice and treatment systems;

18. The limited priority population, as currently defined by MHA, precludes availability of community mental health services for a large numbers of offenders with other mental illnesses. In addition, these offenders are not considered a high priority for most other community-based services;

19. The national trend toward deinstitutionalization of the individuals with mental illnesses has not, for the most part, been accompanied by an equivalent reallocation of resources to the community;

20. There are primary issues vital to public safety and effective community supervision of offenders with serious mental illnesses: identification of the offender with mental illnesses and diversion at the earliest stage in the criminal justice process; access to psychiatric and psychological treatment and medication when appropriate; case management services are needed to access resources such as medical coverage, financial assistance, housing, in-patient hospital services, and to monitor continued resource utilization on a local health department's out-patient basis;

21. The standard for determining the need for psychiatric hospitalization is whether or not the individual is a danger to self or others by reason of a mental disorder. Individuals whose behavioral disorders are manifest only through criminal or antisocial conduct are considered to belong to the criminal justice system;

22. Prison and jail overcrowding has increased the burden on diversionary programs. The Division of Parole and Probation is a major component of criminal justice diversion. The development of strategies and initiatives to divert the offender with mental illnesses from incarceration must include an examination of resources available for parole and probation referral in the community setting. It has been demonstrated that persons can be successfully treated in out-patient programs where such resources are available. This is a critical factor in the process of avoiding reinstitutionalization in either a hospital or correctional setting.

C. DIVISION OF PAROLE AND PROBATION

A Congressional Breakfast and Briefing for Members of the United States Congress on "Mental Illnesses in America's Prisons" was held in Washington, D.C. on May 26, 1994. This event brought together key national leaders and organizations, as well as members of the National Coalition for the Mentally Ill in the Criminal Justice System, and was attended by a representative of the Governor's Office of Justice

Administration. Timothy Matthews, Executive Director for the American Probation and Parole Association, addressed the briefing and noted that while significant accomplishments have been achieved regarding the individuals with mental illnesses within the juvenile justice system, state prison systems, and local detention facilities, the community supervision and aftercare role of parole and probation agencies are frequently overlooked and must be included in the necessary systemic approach for the custody and care of offenders with mental illnesses. Mr. Matthews made the following key observations from the national perspective:

- in 1992, there were 3.2 million offenders under parole and probation supervision, with an average caseload of 125 offenders

- if only 3 to 5 percent of this 3.2 million suffers from being mentally disordered, there are over 100,000 offenders in need of mental health services while under the community supervision of parole and probation

- offenders under parole and probation supervision nationally receive only 14% of mental health dollars resulting in the struggle to provide the most basic services

Since its inception, the Maryland Task Force has included representatives of the Division of Parole and Probation (DPP). The Division has conducted internal reviews of the population identified by virtue of a court or Parole Commission mandate as needing mental health services. Additionally, DPP has worked in cooperation with the Mental Hygiene Administration (MHA) to survey intensive supervision caseloads in specific subdivisions in order to determine the extent of the offender population under probation or parole community supervision which require mental health services.

DPP staff involved with the Task Force have reviewed previous reports and documents to chronicle the history of recommendations for services to this population with mental illnesses in the community.

On November 17, 1992, the Division of Parole and Probation, in conjunction with the Mental Hygiene Administration, conducted a one-day census in two (2) pilot sites (Cecil and Charles County) to identify individuals on intensive case loads who have

serious mental illnesses. Eighteen (18) individuals where identified in Cecil County and seventeen (17) in Charles County. These numbers reflect only individuals who are considered within the confines of the MHA priority population.

As of May 1, 1994, DPP data show that there are 2,706 offenders under community supervision with court ordered "special conditions" for mental health services. Of these, 788 are cases under the Division's intensive category of supervision, which is indicative of the highest level of community risk and offender need according to the DPP classification system. A review of these May, 1994 data for the four (4) initial Jail Mental Health Program pilot counties is summarized in the following table:

COUNTY	# CASES W/MENTAL HEALTH SPECIAL CONDITIONS	# INTENSIVE CASES W/MENTAL HEALTH SPECIAL CONDITIONS
CECIL	66	28
CHARLES	93	13
FREDERICK	97	49
WICOMICO	68	15
TOTALS	324	105

MHA has expanded the Jail Mental Health Program to four (4) additional subdivisions in Fiscal Year 1995. DPP data of May 1994 for these sites are indicated in the following table:

COUNTY	# CASES W/MENTAL HEALTH SPECIAL CONDITIONS	# INTENSIVE CASES W/MENTAL HEALTH SPECIAL CONDITIONS
BALTIMORE CITY	504	158
CALVERT	43	15
HARFORD	150	38
ST. MARY'S	38	7
TOTALS	735	218

Through participation in the Task Force and planning for the implementation of the pilot projects, DPP staff have provided the following findings and recommendations:

- The national trend toward deinstitutionalization of the individuals with mental illnesses has not, for the most part, been accompanied by an equivalent reallocation of resources to the community.

- There are primary issues vital to public safety and effective community supervision of offenders with serious mental illnesses:

  Identification of the offender with mental illnesses and diversion at the earliest stage in the criminal justice process. The staff of the Division of Parole and Probation need access to training resources in the areas of identification and assessment of individuals with mental illnesses, medication issues, civil commitment procedures, and availability of community resources.

  Access to psychiatric and psychological treatment and medication when appropriate. Many of these individuals supervised by the Division of Parole and Probation, mandated by the courts or the Parole Commission, who would benefit from treatment do not meet the eligibility standards for MHA funded services. In addition, the private sector has <u>not</u> developed an adequate supply of services for this population. Many of these individuals do not have resources to pay for services even if they did exist.

  Case management services are needed to access resources such as medical coverage, financial assistance, housing, in-patient hospital services, and to monitor continued resource utilization on a local health department's out-patient basis.

- The standard for determining the need for psychiatric hospitalization is whether or not the offender is a danger to self or others by reason of a mental disorder. Individuals whose behavioral disorders are manifest only through criminal or antisocial conduct are considered to belong to the criminal justice system.

- Prison and jail overcrowding has increased the burden on diversionary programs. The Division of Parole and Probation is a major component of criminal justice diversion. The development of strategies and initiatives to divert the offender with mental illnesses from incarceration must include an examination of resources available for parole and probation referral in the community setting. It has been demonstrated that persons can be successfully treated in out-patient programs where such resources are available. This is a critical factor in the process of avoiding reinstitutionalization in either a hospital or correctional setting.

D. DIVISION OF CORRECTION

Subsequent to the aforementioned Wilner Task Force on the offender with mental illnesses, the Division of Correction (DOC) conducted a prevalence survey in 1986 which revealed that 35% of DOC's population exhibited significant mental illnesses. That article, published in the Journal of Prison Health, limited the definition of mental illnesses to those Axis I diagnoses exclusive of personality disorder and substance abuse. The summary of that article indicated a substantial increase in the number of offenders committed to the state correctional system with serious mental illnesses.

Johnson v. Levin (1978) was a consent decree DOC entered to provide mental health inpatient services for inmates suffering from mental illness(es) who were at that time housed in segregation because of their inability to adjust appropriately to the general population. The Division of Correction established an acute and chronic care mental health system for inmates with psychiatric illnesses confined within State facilities. Four (4) regional mental health units were developed for Baltimore, Jessup, Hagerstown, and the Eastern Shore.

In 1991, in the face of severe cost containment, DOC, for efficiency and economy, consolidated those four (4) regional mental health units into a 190 bed acute, intermediate and chronic care facility within the confines of the Patuxent Institution in Jessup, Maryland. Psychiatric stabilization units exist in each of the regions to stabilize individuals in acute distress for return to general population, or for maintenance prior to transfer to the Correctional Mental Health Center - Jessup at Patuxent.

Increasingly, DOC has experienced a steady, significant increase in the number of offenders with serious mental illnesses confined to the state correctional system. Case review and anecdotal evidence suggest that many of the offenders with serious mental illnesses are repeated failures, both within the Department of Health and Mental Hygiene treatment system and at readjustment to the community after their release from confinement. As detailed elsewhere in this report, the Division of Correction experiences a revolving door phenomena similar to local detention facilities.

The significant cost containment measures forced upon the state has contributed to a sacrifice of support service positions, i.e., psychiatrists, psychologists, social workers, in the service of maintaining traditional custody staff to provide control and security for our institutions. This severe reduction of positions for support staff has negatively impacted on the ability of DOC to manage the offender with serious mental illnesses during confinement.

The Division of Correction, through its consolidation of mental health treatment at Patuxent, has developed a system to identify and manage, through a chronic care model, those offenders with serious mental illnesses who need active, ongoing treatment while confined, and aftercare for those offenders with serious mental illnesses who can adjust to confinement in general population. The Division of Correction maintains the ability to provide transition and referral for aftercare services in the community upon release.

Given the serious reductions in the community mental health budgets within the localities to which these inmates return, many released inmates cannot be maintained in the level of treatment necessary to reduce symptoms of mental illnesses and recurrence of criminal behavior. The Division of Correction believes as elsewhere stated in this report, that a significant need exists for more coordinated services for offenders with serious mental illnesses upon release.

The relationship between the state correctional system and local detention facilities has significantly improved over the course of the past five (5) years, largely through the Maryland Correctional Administrators Association (MCAA). The Division of Correction actively participates in addressing concerns that interface in the transition from local to State correctional facilities in the area of developing uniform policies, guidelines, and procedures for mental health treatment, as well as general health issues. The work of the Governor's Office of Justice Administration has played a significant role in facilitating that relationship and the Division of Correction is committed to maintaining an active dialogue through that organization.

The Division of Correction concurs with the Task Force on two (2) major areas of concern for this population:

1. Increased resources for the identification, management and treatment of the offender with serious mental illnesses during confinement, both at the state and local level; and

2. Increased aftercare resources for those individuals released back into the community to promote mental health and impact on relapse to mental illnesses and criminal activity.

V. THE JAIL MENTAL HEALTH PROGRAM

The Mental Hygiene Administration (MHA) has designed a program to meet the basic needs of offenders with serious mental illnesses; and to assist local detention centers

in meeting services as mandated by COMAR. MHA provided seed funding and administrative staff to create the "Jail Mental Health Program," which was piloted in two (2) jurisdictions in Fiscal Year 1993.

In an effort to better serve criminal justice involved clients, MHA expanded the priority population for the Jail Mental Health Program. MHA does not require that consumers in this program meet the priority population requirements regarding chronicity of illness or level of functional impairment. This allows individuals first experiencing symptoms of mental illnesses to receive services. Additionally, MHA has given these individuals equal access to MHA funded services and housing as those persons being discharged from MHA inpatient facilities. These changes have been made available to individuals in local detention centers or who are under the supervision of the Division of Parole and Probation who are at risk of reinstitutionalization (re-incarceration or psychiatric hospitalization).

Two (2) key factors were identified early in the process of program development:

1. Offenders with serious mental illnesses need to be identified as early in the criminal justice process as possible, with appropriate intervention being offered upon identification; and

2. Programs need to be coordinated locally so they may be tailored to meet specific needs of each jurisdiction.

The program was organized by representatives from the Governor's Office of Justice Administration, the Mental Hygiene Administration, detention center representatives from the Maryland Correctional Administrators Association, Maryland Police and Correctional Training Commissions, mental health clinics, the Division of Parole and Probation, mental health housing providers, law enforcement agencies, the Alcohol and Drug Abuse Administration, Core Service Agencies and the Alliance for the Mentally Ill. An advisory board to the Director of the Jail Mental Health Program (MHA administrative staff) has been selected to represent these agencies and serve in

a consulting capacity for the program at the statewide level. MHA staff provide guidance and technical assistance to the local jurisdictions.

Advisory boards of local representatives of these agencies have been established in each jurisdiction piloting the program. This group is initially responsible for conducting a needs assessment regarding offenders with mental illnesses in their community. They also assist the local lead agency in program implementation and problem resolution. Issues which are more systemic in nature or cannot be resolved at the local level are referred to the Director of the Jail Mental Health Program.

The Jail Mental Health Program was piloted in Cecil and Charles Counties in Fiscal Year 1993. In Fiscal Year 1994 it was expanded to include Frederick and Wicomico Counties. By creatively combining additional funding from local detention centers, Core Service Agencies and McKinney/PATH funds, the Jail Mental Health Program is being expanded to include Calvert, Harford and St. Mary's Counties and portions of Baltimore City for Fiscal Year 1995. Several jurisdictions (Allegany, Anne Arundel, Carroll, Dorchester, Washington, and Worcester Counties) are exploring program development independent of current funding expansion. Efforts are underway to incorporate existing community re-entry programs (Baltimore City, and Prince George's and Montgomery Counties) into the Jail Mental Health Program. MHA staff and the advisory board are providing technical assistance in this process.

Programs in each jurisdiction are expected to include the following basic components:

1. development of a mechanism for early identification of offenders with serious mental illnesses;

2. assistance in diversion of inappropriately incarcerated offenders with serious mental illnesses;

3. provision of enhanced mental health services in the local detention centers;

4. enhanced aftercare coordination with intensive case management in the community, upon release;

5. tracking of offenders with serious mental illnesses for increased communication and coordination of services by providers;

6. program evaluation and monitoring of resource utilization;

7. development of community based residential resources; and

8. memoranda of agreements between all participating agencies, outlining services to be provided by each agency.

The major goal of the program is to reduce reinstitutionalization in either correctional facilities or state psychiatric hospitals. The primary means of achieving this goal is through intensive coordination of services. These services are individually tailored to meet the specific needs of each individual served by the program.

MHA administrative staff is working closely with a subcommittee of the Task Force to identify cross-training needs for all those involved in providing services. Mental health treatment providers will be trained in criminal justice issues and corrections; law enforcement and criminal justice staff will be trained regarding mental health issues. Specific training for correctional staff regarding appropriate classification and housing of offenders with serious mental illnesses while detained will be included in this cross-training. This subcommittee is also examining curricula of training academies to determine if generic training in mental health issues may be enhanced.

MHA administrative staff is developing a clearinghouse of information regarding services for offenders with serious mental illnesses to offer assistance and guidance to local jurisdictions. This clearinghouse will provide information regarding grants and alternative funding sources as well as information regarding service provision and model programs.

As a result of the search for alternative funding and resources, the Jail Mental Health Program has been able to obtain, or assist local jurisdictions in obtaining three (3) National Institute of Corrections technical assistance grants. Frederick County received a NIC technical assistance grant focusing on development of a special management unit within the detention center and mental health training for correctional and police officers. Wicomico County received a similar grant focusing on developing a cross-training curriculum for all involved staff. The MHA administrative staff received a grant focusing on programmatic evaluation tools and outcome measurements. Additionally, representatives from the original four (4) pilot programs and the Director of the Jail Mental Health Program have been awarded opportunities to attend NIC-sponsored workshops on interagency collaboration between mental health and criminal justice agencies.

The Jail Mental Health Program faces numerous challenges as it attempts to provide these services. Because of the interagency nature of the problem, no one funding source is adequate to meet the overall needs of this population. Therefore the program is attempting to combine a multitude of funding sources: federal, State, local, as well as private foundations and grants. The parameters and requirements of each funding source are unique and must be specifically fulfilled while still attempting to provide comprehensive services. This requires much juggling of budgets and efforts at ensuring that all the requirements of each funding source are met. It also requires much work at incorporating these services into a multitude of varying bureaucracies and characteristics of different systems.

Development of needed support for this program is hampered by negative stereotypes associated with mental illnesses. Nevertheless, it is a segment of our society which desperately needs services and will continue to impact extensively on a number of systems until these needs are addressed in an organized and coherent manner.

The program is working to enlist the support of a large number of organizations and agencies. Overall, good working relationships among the agencies have been established; however, some gaps remain in service delivery. Additional support

agencies should be enlisted to assist in providing a comprehensive array of community-based services.

An additional challenge faced by the program is the lack of adequate and affordable housing for this population. The measure of adequacy of housing must include the level of stability, structure and supervision required by each individual. Most of the individuals served through this program only receive Supplemental Security Income benefits through the Social Security Administration, which is woefully inadequate to meet basic housing costs. The program has been able to obtain equal access to MHA funded housing for locally incarcerated individuals as for those being discharged from a state psychiatric hospital. However, this establishes a competition for available housing which hampers service providers in both systems.

As previously stated, many of the individuals served through the Jail Mental Health Program have coexisting conditions, which increases the complexity of need and the difficulty in obtaining adequate services. Most individuals being served have a concurrent substance abuse disorder, which must be treated to achieve any degree of stability for that individual in the community. Other coexisting problems may include, homelessness, HIV/AIDS, unemployment, mental retardation or developmental disabilities, physical disabilities (e.g., hearing, sight, mobility impaired, etc.) or language/communication barriers. These issues must be addressed while also providing an adequate response to any existing criminal behavior.

Meaningful daytime activities are crucial for achieving stability for this population. Many of these individuals do not fit into the community rehabilitation program model which has been so widely implemented in Maryland. A continuum of activities including low-demand therapeutic activities, volunteer work, sheltered employment, and gainful employment needs to be developed for these individuals.

Most police departments, sheriffs' offices and detention centers do not currently have adequate facilities for screening arrestees for the presence of alcohol or drugs at the time of arrest or staff who are able to make a differential diagnosis between someone

who is intoxicated and someone suffering from a severe psychiatric disorder. Detention centers are not adequately prepared for the medical management of intoxicated arrestees or those who are withdrawing from these substances. With the prevalence of substance abuse in the general public, these issues must be addressed to effectively serve the needs of offenders with mental illnesses.

The program will continue to attempt to resolve these challenges through the same type of interagency collaboration and creativity as has characterized its beginning stages. While the challenges are numerous and complex, they are not overwhelming.

VI. SUMMARY

- The programs should reflect local uniqueness; however, basic services should include - identification, diversion, enhanced treatment in detention, coordinated aftercare, and housing.

- It is important that the mental health needs of offenders, including parolees and probationers, be seen as a community problem. No one agency or provider can adequately meet their needs.

- A continuum of community services are needed to enhance public safety and continuity of care. Coordination of existing resources and linkages need to be the focus of program development.

- MHA succeeded in initiating the Jail Mental Health Program, and encouraging the community of providers to work together to resolve the needs of the offender with serious mental illnesses in their community.

- There is a public safety benefit to good treatment.

VII. RECOMMENDATIONS

1. Treatment and management of offenders with serious mental illnesses should be an ongoing priority, allowing for the continued development and expansion of the Jail Mental Health Program statewide.

2. Executives from the appropriate involved State agencies and private organizations should enter into a shared service agreement enabling development of a systemic treatment program for offenders with serious mental illnesses.

3. Innovative fiscal mechanisms for serving this population (such as grants and support from private individuals and businesses) and coordination of funds from a variety of different federal, State and local agencies (e.g., corrections, mental health, substance abuse, developmental disabilities, etc.) should be explored and utilized.

4. Confidentiality laws should be structured to allow criminal justice and treatment information to be shared among appropriate agencies to ensure appropriate treatment of the individual.

5. State officials should encourage academic institutions to develop curricula for professional training in working with offenders with mental illnesses in criminal justice settings.

6. Personnel systems should be modified to offer inducements to recruit and retain professionals skilled in the treatment of the forensic population.

7. Families should be assisted in understanding the civil commitment process, appropriate police roles and practices, services available to local detention centers, and how to access these services.

8. The Maryland Police and Correctional Training Commissions, in concert with MHA and other appropriate agencies, should develop curricula for appropriate cross training.

9. The Division of Parole and Probation should work collaboratively with MHA, to address the treatment needs of those individuals who are not included in the MHA priority population (a definition of MHA current priority population is Appendix A).

10. MHA should develop the resources to provide law enforcement access to 24 hour referral, evaluation, and diversion services in each jurisdiction as alternatives to arrest and incarceration.

11. MHA should develop the resources to provide treatment alternatives for the housing and on-going care of persons with mental illnesses who would otherwise be inappropriately incarcerated.

12. The MHA Jail Mental Health Program Advisory Board should continue to assist in responding to the needs of the Jail Mental Health Program.

13. Local Jail Mental Health advisory boards with multi-agency representation should take responsibility to enhance interagency communication and networking to meet the needs of the offenders with serious mental illnesses at different points throughout the system.

14. The current system of monitoring aftercare compliance for those individuals who are on parole, parole, or conditional release status needs to be augmented to ensure the compliance with treatment as ordered by the court. Core service agencies should take some responsibility in conjunction with appropriate State agencies who are invested with oversight responsibilities.

15 A formal system should be developed to monitor compliance with aftercare

treatment for individuals not on parole, probation, or conditional release status. Core service agencies should be responsible for responding to individuals identified by the criminal justice system to enhance compliance with treatment.

16. Treatment issues for offenders with serious mental illnesses incarcerated in the Division of Correction and supervised by the Division of Parole and Probation were reviewed in the report; however, these issues need to be more fully examined.

Appendix A

The Priority Population

The priority population definition that follows is revised from the previous definition to reflect our success in preventing long-term hospitalization for a number of individuals with psychiatric disabilities through alternative community based services and to include persons first experiencing symptoms of serious mental illness.

DEFINITION OF PRIORITY POPULATION
ADULTS AGED 18-64

MHA identifies the adult priority population as those individuals 18-64 years of age , who are seriously mentally ill, who lack sufficient financial resources to obtain required treatment, and who meet the criteria in the following categories:

1. Primary Diagnosis - Major mental illness as defined by:
   a. Schizophrenic disorders (DSM-IV 295.00-295.99); or
   b. Major affective disorders (DSM-IV 296.00-296.99); or
   c. Organic mental disorders (DSM-IV 290.00-290.99, 293.00-294.99 and 310.00-310.99); or
   d. Other psychotic disorders (DSM-IV 297.00-297.99, 298.9) or
   e. Borderline and schizotypal personality disorders (DSM-IV-R301.83, 301.20-301.22) with the exclusion of an abnormality that is manifested only by repeated criminal or otherwise antisocial conduct,

AND

2. Impaired Role Functioning Resulting from Mental Illness:
   In addition to meeting the above categories, clients must meet at least three of the following five criteria on a continuing or intermittent basis for at least two years.
   a. Is unemployed, employed in a sheltered setting, or has markedly limited skills and a poor work history.
   b. Exhibits inappropriate social behavior which results in a demand for intervention by the mental health system.
   c. Is unable, due to cognitive disorganization, to procure financial assistance to enable him/her to remain outside of the hospital.
   d. Shows severe inability to establish or maintain a personal social support system.
   e. Requires help in basic living skills.

Note: Adults who would have met impaired role functioning criteria during the reference years without the benefit of treatment or other support services are considered to be members of this priority population for adults aged 18-64.

3. Priority for Services

When resources are limited, consumers who meet criteria 1 and 2 have the following psychiatric history will have priority for services.

a. Single psychiatric hospitalization of six months or more in duration during the past ten years; or who have been

b. Psychiatrically hospitalized more than once during the past two years.

Appendix B

ACKNOWLEDGMENTS

During the period 1991-1994, the following individuals were involved in the Task Force:

Frank Bauer, Division of Parole and Probation
Richard Blackwell, Mental Hygiene Administration
Stephen Bocian, Governor's Office of Justice Administration
Beth Feenstra, Division of Parole and Probation
Dr. Sanford Fishbein, Community Outreach and Treatment Services
Larry Fitch, Mental Hygiene Administration
Joan Gillece, Mental Hygiene Administration
Hilary Hammerman, Governor's Office of Justice Administration
Donald Hopkins, Maryland Police and Correctional Training Commissions
Katherine Jones, Division of Parole and Probation
Dr. Jeremy Kapnek, Division of Correction
W. Roland Knapp, Division of Parole and Probation
George Lipman, Office of the Public Defender
Marilyn Mathias, Prologue, Inc.
Sally Marker, Governor's Office of Justice Administration
Casey McDevitt, Charles County Detention Center
Stephen McLain, Baltimore County Detention Center
Dr. Harry Murphy, Maryland House of Correction
Nancy Nowak, Governor's Office of Justice Administration
Theresa Satterfield, Maryland Police and Correctional Training Commissions
Debra Schnier, Mental Hygiene Administration
Kathy Seifert, Peninsula Regional Center
Dr. Stuart Silver, Mental Hygiene Administration
Patricia Sollock, Montgomery County Detention Center
Dr. Anthony Swetz, Division of Correction
Richard Warren, Division of Correction
Eldon Watts, Mental Hygiene Administration
Dr. Lee Weatherly, Hamilton House
John William Welch, Jr., Maryland Correctional Administrators Association
Dr. Richard G. Wirtz, Department of Corrections for Queen Anne's County
Beverly Wise, Clifton T. Perkins Hospital Center