Mental Health Association
of Rhode Island

Community and Stakeholder Perceptions of the Rhode Island Criminal Justice System's Interactions with Persons with Mental Illness

A System Wide Stakeholder Study
Conducted in Collaboration

with

Roger Williams University

Judith Platania, PhD
Ann M. Varna Garis, PhD
Michael C. Cerullo, Jr, MS, LMHC
Principal Investigators

185 Dexter Street, #16, Pawtucket RI 02860 • 401.726.2285 • fax 401.726.2404 • mhari@mhari.org

This report is dedicated to the memory of

Scotti DiDonato

Former President of the Mental Health Association of Rhode Island

Without her tireless commitment and persistence in advocating for the rights and needs of persons with mental illness who become involved with the criminal justice system, this survey would not have taken place.

Scotti DiDonato is shown here discussing the survey with John Prince of Direct Action for Rights and Equality's Behind the Walls Project. This meeting took place at Roger Williams University in late December 2013 shortly before her passing.

From left to right: Ann Varna Garis, PhD.; Ryan Kelly; Judith Platania, PhD; Michael Cerullo, Jr., MS, LMHC; Scotti DiDonato and John Prince

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ABSTRACT

This survey, sponsored by the Mental Health Association of Rhode Island (MHARI) in collaboration with Roger Williams University, was conducted as part of a collaborative statewide effort to improve mental health services in the Rhode Island Criminal Justice System (RICJS).

Public and professional perceptions of the adequacy of mental health related services, practices, and training within the RICJS were explored. One hundred and forty one respondents, including RICJS professionals, mental health and health professionals, interested members of the public, and current and past prisoners and their families all consistently and overwhelmingly reported perceptions that interactions of an individual with mental illness' involvement with the RICJS, are less than adequate. This is true across all phases of involvement. Negative responses ranged from 86.1% to 66.6%. Diversion to treatment was perceived as most in need of attention, with an 84.4% negative response rating. The area next most concerning to respondents was training, with an 81% negative response rating.

PREFACE

Since 1916, the MHARI through its education, prevention and direct service programs has been advocating to promote the well being of persons with mental illness (MI). Much of our work has focused on the needs of adults whose conditions are characterized as *seriously mentally ill.* (SMI)

In the early 1960's, after more than twenty years of advocacy by the Mental Health Association, the deinstitutionalization movement took hold and over the ensuing years, nearly all persons with MI left the state funded institutions to return home, to nursing homes or other community based residences. At the same time, community mental health centers (CMHC) were established to provide the treatment services these individuals needed in order to flourish in these much less restrictive environments. Unfortunately, throughout the country as well as here in Rhode Island, the funding for these centers that was initially subsidized, primarily by Federal Comprehensive Community Mental Health Grants, as well as the State of Rhode Island, ended. In reality, the originally projected community based capacity, both nationally and here in Rhode Island was never fully funded. By some estimates just one third to one half of the required capacity was put in place.

Among the most significant unforeseen consequences of deinstitutionalization was the steady increase in the number of untreated individuals with mental illness who became involved with the Rhode Island Criminal Justice System (RICJS). In fact, the number of available state hospital psychiatric beds in Rhode Island has declined from a high of about 3500 in the early 1960's, to approximately 139 today. Over the same period, as noted by Department of Corrections (DOC) Director A. T. Wall in a *Providence Journal* interview with Mark Patinkin, the number of incarcerated Rhode Islanders has risen from 483 in 1962 to 3200 in 2012.

In 2007, under the leadership of MHARI board president Scotti DiDonato, the MHARI Corrections Committee was formed and chaired by Joseph Bevilaqua, PhD, a former Director of what is now known as the Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH). By 2009, the corrections committee began to formulate a white paper documenting the treatment and service needs of individuals with MI who are involved with the RICJS; current levels of adequacy, effectiveness and access to these services; and recommendations for future initiatives to meet them. In the fall of 2011 the white paper was presented to the Directors of DOC and BHDDH with whom the committee had been collaboratively advocating for more than a year.

As a result of that meeting, it was clear that more information regarding the perspectives of various stakeholders involved in all phases and sectors of the RICJS was needed to continue successful collaborative advocacy. In December 2011, the Corrections Committee established a Task Group to develop and conduct this community wide stakeholder survey to collect and document their perceptions of the **effectiveness** and **adequacy** of, and the **access** to services for individuals with mental illness involved with the RICJS.

LITERATURE REVIEW

The National Situation

The ever-increasing problem whereby individuals with Serious Mental Illness (SMI) are housed in correctional institutions without appropriate support has been repeatedly well documented over the past 15 to 20 years. It is now a generally acknowledged reality that jails and prisons have become America's largest mental institutions. The primary contributing factor leading to the current situation was the well-intentioned Community Mental Health Act of 1963.

However, due to the lack of follow through at both federal and state levels, the essential community based treatment resources needed to provide ongoing mental health (MH) services for deinstitutionalized individuals with SMI were never fully funded. By some estimates, just one-third to one-half of the necessary funding to establish and maintain CMHC's) was ever allocated. Sadly, over the past 40 years, even the funds that were provided have been steadily eroded by budget driven cuts.

In addition, the changes in the certification laws that accompanied de-institutionalization have made it more difficult or impossible to hospitalize a person with SMI or to mandate their adherence to treatment and medication recommendations. These changes are also contributing to the steady rise in incarceration and recidivism rates.

The problems caused by this *de facto* process of criminalizing persons with MI, has been devastating for them, for their families and for the community as a whole. Additionally, steady increases in poverty, homelessness, and unemployment rates; along with a lack of adequate health insurance, are further exacerbating these problems in the general population as well as those directly impacted by SMI. Finally, the cumulative impact of these problems has overwhelmed and devastated Criminal Justice Systems (CJS) and state budgets.

Brandt (2012), in her review of the literature on the treatment of individuals with SMI in the criminal justice system, notes the dramatic population shifts from state psychiatric hospitals to prisons resulting from this criminalization process. She reports that the number of hospitalized persons with SMI decreased from 550,000 in the 1950's to 70,000 in 2012, while the prison population that was 178,000 in the 1950's, has grown to 5.6 million. She further observes that the percentage of individuals with SMI in prisons increased from .7% in 1880 to 21% in 2005.

One of the reasons Brandt lists for the increased numbers of individuals with SMI being arrested is "mercy bookings" in which police arrest them as a way of protecting them from victimization situations. Victimization is, indeed, an important issue for persons with SMI. Frank & McGuire, (2011) report that these individuals are 8 times more likely to be robbed, 15 times more likely to be assaulted, and 23 times more likely to be raped.

Brandt (2012) also expressed concerns regarding minorities with SMI in prison populations. She cites 2005 Bureau of Justice statistics, which address the fact that different ethnic groups are less likely to acknowledge symptomatology. Additionally, she reports incidence rates for substance abuse among individuals with SMI in inmate populations ranging from 25-59% and, that an NIMH survey finds

minorities are less likely to receive MH treatment. She believes this is due to less trust and belief in MH treatment on the part of minorities and cultural differences in the experience of mental illness.

In 2002 The Sentencing Project (a national, non- profit organization engaged in research and advocacy on criminal justice issues) produced a comprehensive report, "Mentally Ill Offenders in the Criminal Justice System: An Analysis and Prescription"

In order to address the ever-increasing problem of the "criminalization" of those with mental illness, the report suggested:

- Expanded and improved community services and integration of services for those with co-occurring disorders.
- Police training in dealing with persons with MI and specialized police units (CIT-Crisis Intervention Teams, which could take individuals to "no refusal" 24 hr. crisis/triage centers).
- Increased diversion from the CJS for those with mental illness. Post booking/pre-trial diversion programs should also be developed.
- Training for defense lawyers and judges on MH issues so as to better represent and adjudicate.
- An expansion of MH services and increased access to those services within the confines of the prison, including suicide assessment, screening, crisis management, referrals, in jail counseling, discharge planning and community follow-up.
- Pre-release planning in the areas of ensuring provision of necessary medical, counseling, housing, and employment services for persons with SMI.

The availability of more community MH services, and supportive housing for individuals with SMI, the report suggested, would go a long way toward reducing their contact with the CJS. In the interim, much should be done to improve the way in which the CJS deals with persons with SMI.

Torrey et al, (2010) of the Treatment Advocacy Center produced a comprehensive report of the 21st Century state of affairs in which persons with SMI have been systematically relocated from this nation's MH institutions to the nation's correctional institutions. Sadly, this has effectively reversed the gains won by the 19th century reform movement of Dorothea Dix. Dix's movement sought more enlightened, humane treatment for individuals with mentally illness by removing them from jails and prisons and placing them in hospitals where they could receive treatment instead of isolation and punishment.

In his study, Torrey (2010) examined the current likelihood of someone with SMI being found in a jail or prison, rather than in a psychiatric hospital. Data on the inmate populations in correctional settings was obtained from the Bureau of Justice Statistical Report, "Prison and Jail Inmates at Midyear 2005". Data on the number of inpatient beds in public and private MH hospitals; in psychiatric units of general hospitals; and forensic beds in jails and prisons was obtained from a 2004 SAMSHA survey. Using data from a 2009 study by Steadman, Torrey found that 16.5 percent of jail and prison inmates in 5 jails in New York and Maryland had SMI. Thus, for his study, Torrey utilized 16 percent as a conservative estimate of the percentage of inmates with SMI in state jails and prisons across the US.

Reviewing data from all 50 states, Torrey found that in 2004-2005 the odds were 3.2 to 1 that individuals with SMI would be found in jails or prison, rather than in hospitals. Even in North Dakota, the state most likely to send a person with SMI to a hospital, that individual had an equal chance of being in a prison or in a hospital. In Nevada, individuals with SMI were 9.8 times more likely to be in jail or prison than a psychiatric hospital. While there is a correlation between states spending the most MH

dollars/per capita and those more likely to hospitalize individuals with SMI this relationship is not consistent across the country.

Torrey (2010) notes that additional problems incurred by sending individuals with SMI to prison include: a more expensive daily rate per inmate with SMI including all forms of medical services; inmates with SMI are incarcerated for longer periods due to difficulties in following rules; inmates with SMI are more likely to be "frequent flyers" and likely to return to prison more often because of untreated and unresolved MH issues and/or a lack of aftercare; inmates with SMI who are more likely to be management problems, which, in turn, increased staff requirements; higher suicide rates; and, inmates with SMI who are victims of higher rates of inmate abuse and the subsequent cost of resulting litigation.

Torrey's (2010) most compelling suggestions for improving the situation include:

- MH courts which have the authority to require medication as a condition for living in the community in cases of multiple hospitalizations when combined with arrest or violent behavior.
- Unannounced surveys of the number of individuals with SMI in jails and prisons. Those states with the fewest prisoners with SMI would receive Federal block grants.
- Requiring state Departments of MH to pay the DOC for treatment costs of all inmates with SMI.

Phan (2014), in reviewing the current state of mental illness and the CJS reports that in most instances, "MH treatment, housing and rehabilitative resources are inadequate and that mentally ill persons are often discharged into communities ill equipped to meet their needs …". Assertive case management programs are mentioned as one way in which the needs of some persons with SMI might be met.

The Bazelon Center for MH Law, on April 29, 2014, submitted testimony to the US Senate Judiciary Subcommittee on the Constitution, Civil Rights and Human Rights. The hearing, also known as Ethan's hearing, was held in honor of Ethan Saylor, a 26-year-old man from Virginia, with Down's syndrome who was shot and killed by 3 law enforcement personnel who had a physical confrontation with him in a movie theater in 2013. Bazelon's statement, "Law Enforcement Responses to Disabled Americans: Promising Approaches for Protecting Public Safety" clarifies the current nationwide crisis involving persons with mental illness in the CJS and cites the following Sept 2006, Bureau of Justice statistics:

- Persons with mental illness are 4.5 times more likely to be arrested than those in the general population.
- Throughout the US, the percentage of incarcerated individuals with mental health conditions in the criminal justice population ranges from 15 percent to 56 percent of state prison inmates throughout the US.

The Bazelon Center (2014) statement asserts that MH systems throughout the US have failed to provide needed services for persons with SMI resulting in wide reaching, serious consequences of that failure including:

- Many preventable deaths due to encounters with law enforcement.
- Lengthy and repeated incarcerations with poor outcomes at very high cost to taxpayers and which do not and cannot address the treatment issues.
- Stigmatization of this already stigmatized population, impacting, for the rest of their lives, their ability to get jobs, have access to housing, or lead normal, productive lives.

The interventions Bazelon proposed to address the crisis were as follows:

- Assertive Community Treatment (ACT): An intensive, coordinated, comprehensive services intervention available 24/7 to assist with housing, employment, and clinical MH recovery needs.
- Mobile Crisis Teams (MCT): A team of psychiatric nurses, social workers and paraprofessionals providing 24/7 emergency services to de-escalate crisis situations.
- Supportive Housing (SH): Provides apartments in which individuals also have access to case management, employment supports, substance abuse services, etc.
- Crisis Intervention Teams (CIT): Training for police and first responders to effectively identify and respond to dangerous situations involving individuals with mental illness.

In one study (Borum, 1998), MCT's were found to be effective in avoiding hospitalization 55 percent of the time vs. police intervention, which avoided institutionalization 28 percent of the time. The study also noted, that the MCT was 23 percent less costly than police involvement.

Pathways to Housing, a program in Philadelphia, providing supportive housing to formerly homeless individuals with SMI, reduced incarcerations by 50 percent; hospitalizations by 71 percent; and psychiatric crises by 71 percent. (Culhane, 2002)

CIT training has been shown to increase the likelihood that an individual will be directed to treatment rather than incarceration. It also decreases the likelihood for physical injury in an encounter with law enforcement. (Frank & McGuire, 2010)

In other testimony presented on April 29, 2014, US Bureau of Justice Assistance Director, Denise O'Donnell, expressed concern about the misunderstandings and mistreatment which the developmentally disabled and mentally ill face on a regular basis. "It is important to recognize an often misleading perception in society that individuals with mental illness are violent; a person with a severe mental illness who has no history of substance abuse or violence has the same likelihood of being violent as any member of the general public."

Director O'Donnell enumerated a number of federal programs created to help address the informational and support needs of those in each state and community trying to correct the situation, including the Justice Assistance Grant Program (JAG) "to improve criminal justice responses to individuals with mental illness". On almost a daily basis, there are reports from various communities and states regarding the inappropriate, untenable, financially unsustainable impact of the criminalization of individuals with SMI.

On February 19, 2014, the Gazette.Net of the Maryland Community News reported that 28 percent (2,222) of the Montgomery County correctional facilities' population needed MH screenings. Of those screened, 926 were taken to the jail's 34 bed crisis intervention housing unit which is reserved for individuals with the most severe SMI. Scott Davis, Montgomery County Police CIT coordinator, reported that 20 percent of the police calls in 2013 were mental illness related.

McFarland et al, (1989) surveyed 260 family members of persons with SMI regarding the situations most often leading to an arrest. Respondents reported substance abuse and non-compliance with psychiatric medications as the most significant predictors of arrest. Family members also reported that a psychiatric crisis and failed hospital commitment often had immediately preceded the arrest.

The Wall Street Journal (6/6/14) reported that Colorado's governor John Hickenlooper had just signed legislation ensuring that inmates with mental illness will no longer be held in solitary confinement. The Federal Bureau of Prisons is currently conducting a study of its use of segregated detention, a report expected by the end of the year.

Swanson et al (2013) in "Costs of Criminal Justice Involvement Among Persons with Serious Mental Illness in Connecticut" reports that over a two year period, a CJS involved group of individuals diagnosed with Schizophrenia and Bipolar Disorder incurred costs of care twice that of individuals with SMI who were not involved with the CJS ($48,980 vs. $24,728).

National Public Radio (August 20, 2014) reported that San Antonio has developed a coordinated community approach to the problem of prisons becoming the *de facto* psychiatric facility of the community. The idea for their reformed program evolved from the notion that "For people with mental illness, treatment works, and jail does not". The director of the San Antonio community MH system reviewed all the money that community agencies including courts, police, jails and hospitals were individually spending on the care of the mentally ill. He developed a program in which these agencies combined their funding and agreed to work together at a single site. Named, The Restoration Center, it was intentionally located across the street from San Antonio's homeless shelter. The resulting coordinated, timely and preventative services reportedly saved the city $10 million per year and are successfully addressing the MH needs of the community.

The Situation in Rhode Island

In 2009, NAMI, The National Alliance on Mental Illness gave the USA an overall grade of "D" for its delivery of MH services. They listed innovations and challenges for each state. The *innovation* NAMI reported for Rhode Island was the establishment of the "Dial 211" information system that helps any caller find MH services among a wide range of other resources. The *challenge* identified for Rhode Island was long waits in emergency rooms faced by uninsured individuals when in crisis.

Ucik (2013) investigated the current "treatment conditions at the Rhode Island Department of Corrections". For this qualitative study she conducted interviews with five "directly affected individuals" involving incarceration and MI, two local researchers; and two prison medical staff.

Ucik reports that MH services at the ACI include: 12 full time social workers, 4 psychologists and 6 part time psychiatrists. Therapists are viewed positively, but "appointment times are notably short, and meetings rare, so they have little impact on MH conditions". Reportedly it may take weeks or months for requests to meet with clinical staff to be realized. Ucik further reports that inmates have to wait two weeks or longer for clearance to receive previously prescribed medications. Stigma and placement in isolation as a form of treatment result in serious under-reporting of psychiatric symptoms.

Prison medical staff, as well as inmates, report that the focus of treatment is "damage control and emergency care to prevent suicide, self-harm, harm to others and manageability." Prison medical staff view ACI MH services as adequate, but acknowledge that they could benefit from an increase in MH staffing.

Prisoners at the ACI demonstrating serious symptoms of MI, including self- harm or behavioral issues, are sent to the Observation and Stabilization Unit (OSU) or into Segregation. The OSU is a 10-bed unit. Upon entering, inmates are stripped and handcuffed. All meals are served cold and without utensils. "Segregation serves as an unofficial stabilization and disciplinary unit for those with MH issues." Individuals are sent to segregation for acting out, or for slow response time. Inmates with MI are alone in their cells 23 hours of each day. Informants report cold temperatures and bright lighting all night.

The resultant sleep disruption, diet issues, lack of socialization, and lack of exercise undoubtedly would worsen anyone's mental health, let alone someone with serious and persistent mental illness."

In characterizing the dehumanization experienced by each former prisoner, Ucik reports, "Prisoners felt like they were being treated like animals, and had to constantly fight for their survival." Ucik summarizes her impressions of the ACI's MH system as follows: "It is abundantly clear that the system is not built for maintenance or even appropriate care, but rather damage control." Her recommendations echo those of Torrey, et al (2010) and others. Ucik also indicates that there is a CRITICAL need for basic data regarding the currently incarcerated population with SMI at their facility.

Of particular significance is her recommendation to quantitatively examine the effect of incarceration, and segregation on MH. A related recommendation is for the ACI to discontinue their dependence on the OSU as the *de facto* psychiatric unit for the prison by performing more meaningful assessment screenings. Such assessments could lead to diversion to more appropriate treatment-oriented placements.

In 2010 and 2011, the RIDOC was awarded grants through the Justice and Mental Health Collaboration Program specifically to address the issues of co-occurring disorders and for reduced prosecution of misdemeanor offenses, i.e. diversion.

In 2011,the MHARI White Paper, Brain Based Illnesses in the Criminal Justice Population: Providing Mental Health Care for Incarcerated Individuals was presented to the Directors of DOC and BHDDH. It explored and addressed the current situation in RI; existing mental health and forensic commitment law; alternative approaches to facilitating inmate transfer to the forensic mental health unit; and system wide changes.

The White paper identified two strategies to address the situation. First, that DOC and BHDDH enforce existing law more consistently. Second, divert individuals with mental illness away from incarceration and involvement with the RICJS. Specifically, with respect to diversion, the following interventions were recommended:

- Police training.
- Involvement of emergency services.
- Court based mental health clinical evaluations.
- Dedicated probation and parole staff with caseloads specializing in mental health issues.
- Dedicated case management provided by mental health professionals and located in the prison.
- Enhanced co-operation of the DOC and BHDDH on issues of return to the community at the end of a sentence.

It is significant to note that the current Rhode Island Mental Health Advocate, Megan Clingham, Esq. reports that court based clinical mental health evaluations are now conducted at or through the Kent County and Providence County District Courts. With further respect to the White Paper's Recommendations she reports there is now just one Probation/Parole Officer dedicated to persons with MI. Ms. Clingham also indicates that the DOC has convened a work group that "is currently studying ways to amend policies and decrease use of segregation for SPMI inmates". (personal communication, January 5, 2015)
As a result of that meeting, it was agreed that more information from all stakeholders within the RICJS, BHDDH and the community involved with MI was required regarding what issues need to be addressed; what procedures need to be changed; and what aspects of coordination need to be enhanced.

The present study regarding public and professional perceptions of the current state of the RICJS interactions of individuals with MI is MHARI's next step in our efforts to find some answers and to identify the best direction forward.

METHODOLOGY

From fall 2011 through August 2013, the Task Group with input and feedback from the Corrections Committee and several committee members who were also members of Direct Action for Rights and Equality (DARE) developed a draft questionnaire. Advice and feedback was also sought and received from:

- A local police chief and former state trooper
- A former Rhode Island District Court judge
- A defense attorney
- A former Rhode Island Attorney General
- A former Rhode Island Mental Health Advocate
- The director of a court diversion program
- The former clinical director of a correctional half way house in Connecticut
- A clinical psychology professor and researcher in the field of criminal justice
- A retired Deputy Commissioner of Massachusetts Mental Health Services
- A retired Deputy Director of the Rhode Island Department of Health
- A retired DOC Clinical Psychologist
- Several individuals formerly involved with the RICJS

After developing the basic survey instrument and in order to ensure a confidential, anonymous data collection process; and to provide for unbiased, objective and academically rigorous data analysis, the Task Group reached out to Roger Williams University (RWU) and its Community Partnership Center. In December 2012 Professor Judith Platania, PhD, a psychologist interested in the interaction of psychology and the law, agreed to partner with the Task Group in this effort.

Dr. Platania and RWU Graduate Student Ryan Kelly have consulted on the final design, potential respondents, the content, conduct and analysis of the survey and its results.

This study sought information on seven Critical Factors affecting individuals with MI involved with the RICJS and the services necessary to address their needs effectively and adequately. These Critical Factors include: Training; Assessment; Collaboration/Communication; Diversion to Treatment; Case Management; Treatment; and Continuity of Care.

The survey questions explored stakeholder perceptions of these critical factors at four different phases of an individual's potential interaction with the Rhode Island criminal justice system: prior to arrest (4 questions); after arrest (9 questions); while incarcerated (16 questions); and while in the community (6 questions). Stakeholders self-selected into one of six respondent classes: (a) individuals who have been involved with the RICJS or a family member; (b) persons interested in individuals with MI who come to the attention of the RICJS; (c) behavioral health or governmental policy officials; (d) community based service providers; (e) judge, defense attorney, prosecutor or court officials; and (f) police, probation, parole or correctional officers.

Each question was rated on a 5 point Likert-Scale (Poor; Fair; Adequate; Very Good; or Excellent) or, respondents were able to indicate Does Not Apply/Don't Know. At the end of each group of questions, respondents were invited to offer open-ended comments or observations related to the questions posed

in that phase. (See Appendix E for a listing of the 35 Questions and Appendix F for selected open-ended comments.)

Additionally, at the end of the survey, there were two sets of narrative questions: one set for professionals in the community and the other for laypersons in the community. A content analysis of responses to these questions is underway at this time.

Surveys in both downloadable paper and pencil forms and in a web-based format were circulated through e-mail, postal mail and personal contact. Individuals across all potential respondent classes were invited to participate. Recipients of e-mail invitations were encouraged to share their invitations with other potentially interested individuals in the various respondent classes.

From April 15, 2013 through August 1, 2014, surveys were collected via the RWU website. Additionally, during that period, members of the Task Group administered the survey directly to individuals who had been or were at that time involved with the RICJS as well as their family members at the DARE offices in Providence. Also, in collaboration with the DOC and members of the DARE Behind the Walls project, more than 120 paper and pencil versions of the survey were mailed to DARE members incarcerated at the Adult Correctional Institution (ACI).

RESPONDENT CHARACTERISTICS

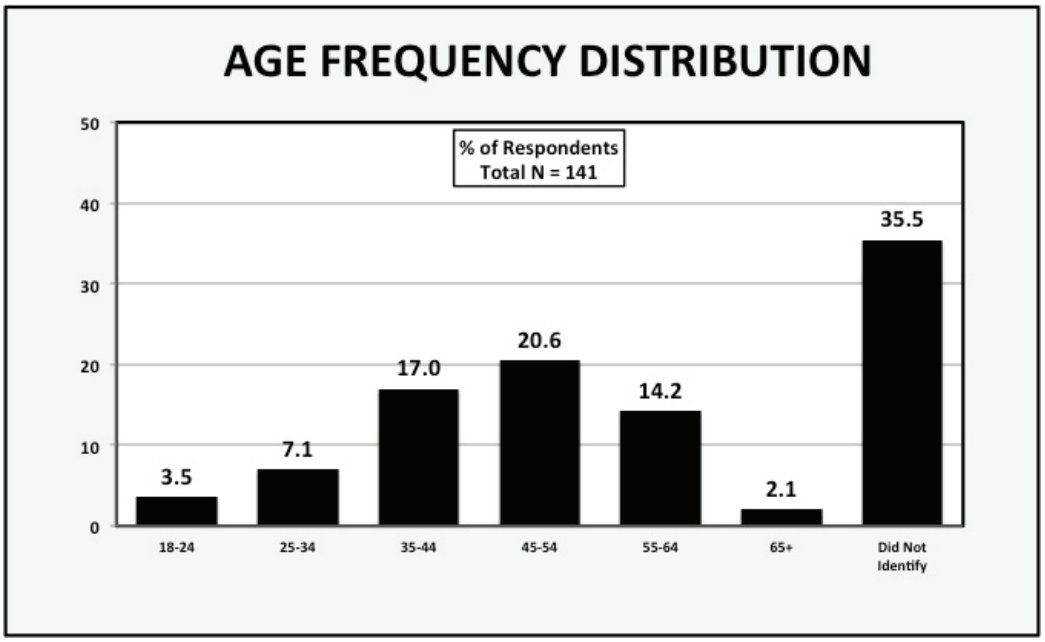
The overall N for surveys completed was 141. Since respondents were asked to rate only the items with which they had personal knowledge or experience N's vary from question to question.

With respect to gender, 36.2% of the respondents did not identify themselves as either male or female. Of those that did, 57.8% were male and 42.2% were female. It should be noted that despite repeated efforts that included postal mail facilitated by DOC and personal contact from representatives of DARE's Behind the Walls project, no responses from incarcerated females were received. Therefore, while several women respondents reported having had previous involvement with the RICJS, the absence of information from currently incarcerated females is an area warranting further efforts, perhaps through face-to-face administrations of the instrument by one of the principal investigators. As noted in Appendix A, Dr. Varna Garis has experience conducting research as well as supervising psychology interns within the ACI women's unit.

In contrast to currently incarcerated females, 32 responses or approximately 27% of those surveys mailed into the ACI were received from incarcerated males. This represents 22.7% of the 141 respondents.

Of those respondents reporting their age, 51.2% were between the ages of 35 and 64, presenting a normal distribution.

Chart 1



The most recently available figures in DOC's "Report on the Rhode Island Correctional Population, FY1976 – FY2011" indicate ethnic and racial composition of 55% Caucasian, 24% Black or African-American and 19.0% Hispanic.

By comparison, the Rhode Island census reports an ethnic and racial population distribution of 86% Caucasian, 7.5% Black or African-American and 13.6% Hispanic.

As Chart 2 below indicates, the racial and ethnic composition of those respondents who self-identified was 73.6% Caucasian, 5.5% % were African-American and 12.1% were Hispanic.

The participation rates of Black or African-American and Hispanic Rhode Islanders in this survey as compared with their proportionate representation in the general population is similar to a remarkable degree. Therefore, it would be reasonable to observe that the results of this study are apparently unbiased with respect to race or ethnicity.

Chart 2

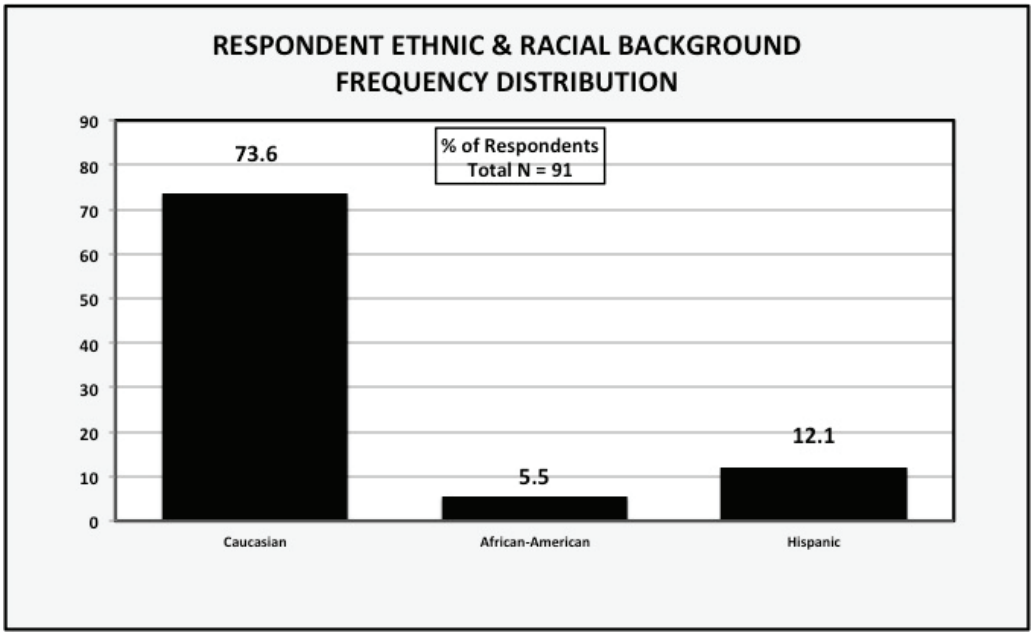


Chart 3 below shows the frequency distribution of surveys received from each Respondent Class.

Chart 3

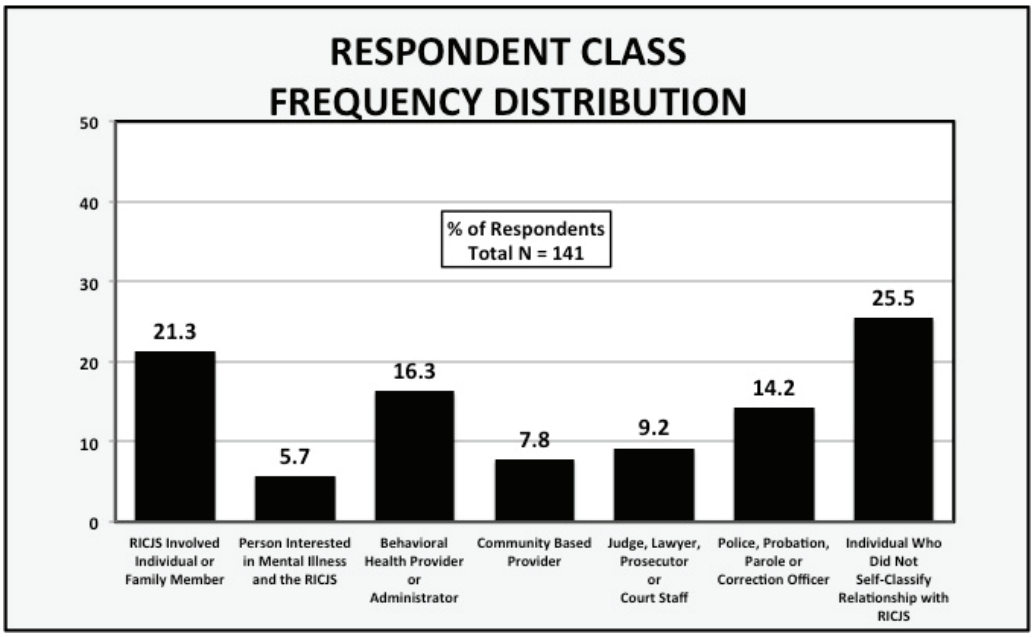
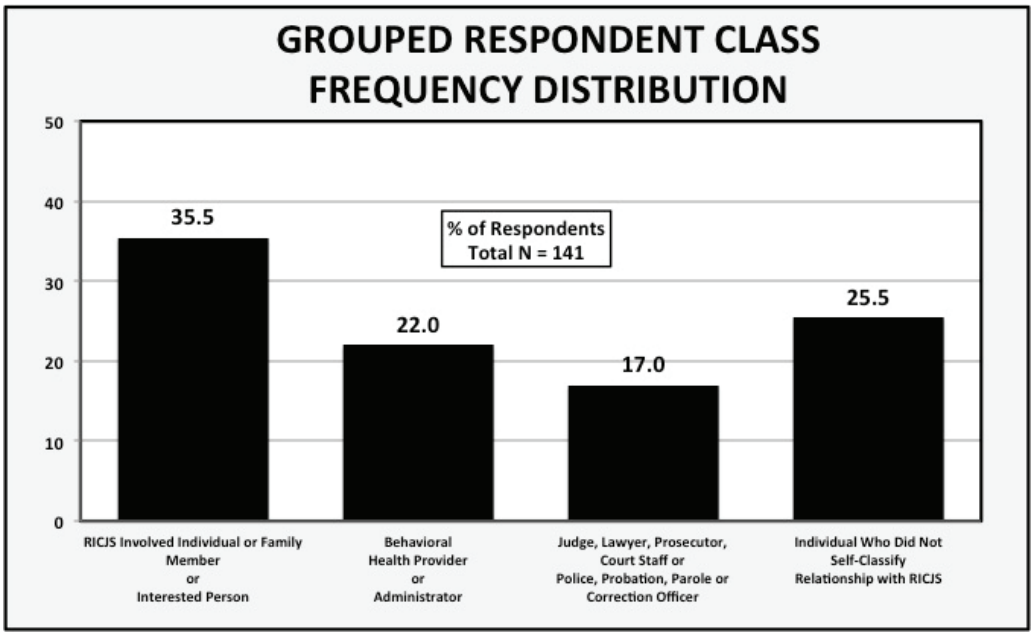


Chart 4 below represents frequency distributions for 3 categories of respondents grouped as follows:

- A RICJS Involved Individual, Family Member or Interested Person (35.5%).
- A Behavioral Health Official or Community Based Provider (22%).
- Judge, Lawyer, Prosecutor, Court Staff or Police, Probation, Parole or Corrections Officer (17%).

Individuals who did not self-classify as to their relationship with the RICJS were assigned to a fourth group.

Chart 4



OVERVIEW of RESULTS

Respondents from all categories, including RICJS professionals, report perceptions, across all phases of involvement, that interactions with persons with MI are currently perceived as less than adequate.

As Chart 5 below indicates, RICJS professionals' average ratings for all questions across all phases were 66.6% Poor-Fair or a margin of 2 to 1 compared to those rating it as Adequate to Excellent. Behavioral health professionals and administrators rated the system 75.3% Poor-Fair, a 3 to 1 margin. RICJS involved individuals, family members or interested persons' perceptions of the RICJS regarding its response to individuals with chronic or acute mental illness are reflected in ratings for all questions across all phases of 86.1% or a margin of 6 to 1.

The consistency of these perceptions from all respondent groups is compelling.

Chart 5

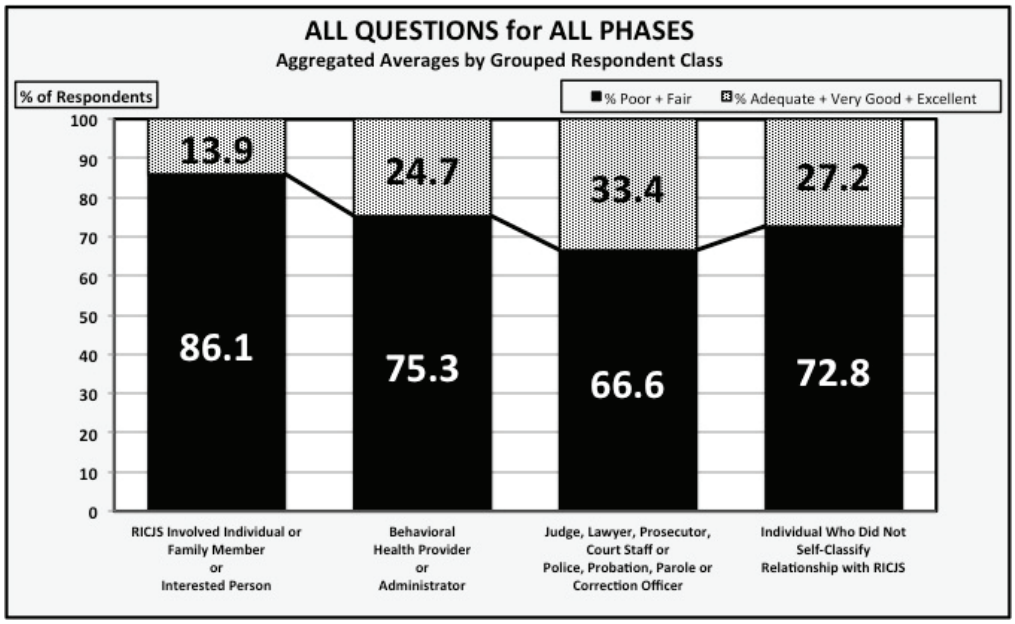
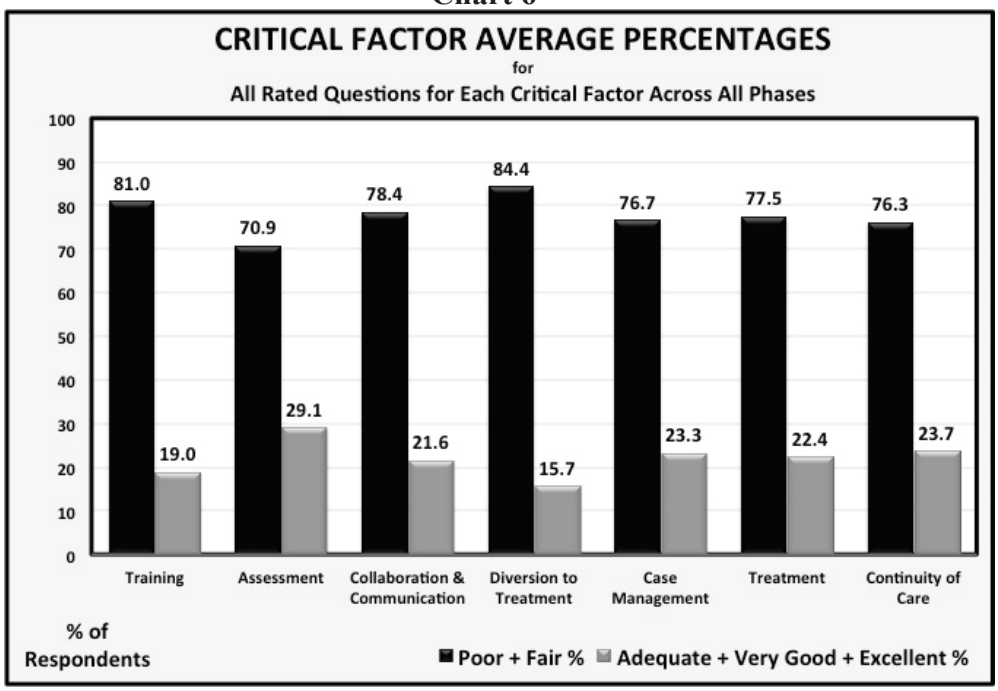


Chart 6 below looks at community and professional perceptions of each of the critical factors explored in the survey. All areas are perceived as markedly less than adequate.

Diversion to Treatment was perceived as most in need of attention, with an 84.4% negative response rating. The area next most concerning to respondents was Training with an 81% negative response rate.

Despite being perceived least negatively at 70.9%, respondent ratings of Assessment were nonetheless seen as low by a margin of nearly 3 to 1.

Chart 6



ANALYSIS by CRITICAL FACTOR

Data for each Critical Factor follows in modules made up of charts with aggregated responses by grouped respondent classes. A table containing the survey questions related to each factor and the total N and frequency distributions for Grouped Respondent Classes follows the charts. Questions related to more than one Critical Factor have been included in each relevant module.

Training Critical Factor

Chart 7

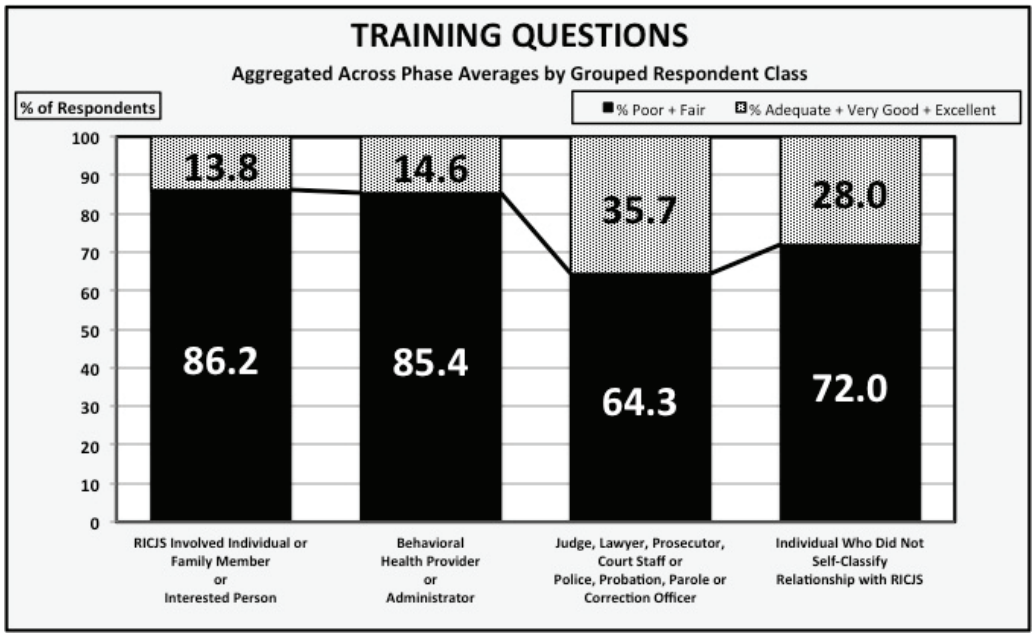


Chart 7 above shows that RICJS professionals across all phases of involvement rate Training at 64.3% Poor to Fair, which is fairly consistent with their ratings for many critical factors. However, behavioral health professionals and RICJS involved individuals report 85% Poor to Fair, perceptions which are markedly less adequate ratings than those held by RICJS professionals.

Chart 8 below indicates Probation and Parole Officers are perceived as somewhat more well trained (32.8% Adequate to Excellent) when compared to Police (15.7%), Sheriff's (15.9%) and Correctional Officers (13.2%).

Most concerning are the very strong perceptions (a margin of 6 to 1) that police, sheriffs and corrections officers are not well trained in recognizing and responding to acute signs and symptoms of MI.

Safety for both RICJS professionals and persons with MI are a very real concern if these perceptions are accurate reflections of the adequacy of training.

Chart 8

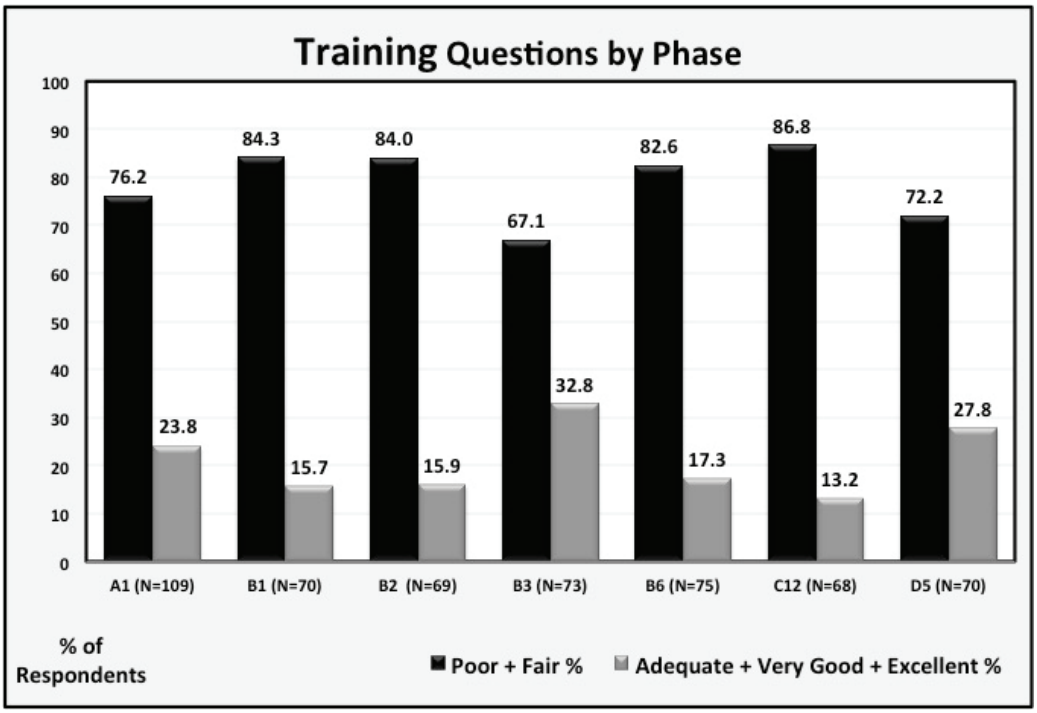


Table 1: TRAINING QUESTIONS	Total N	Group 1* N	Group 2* N	Group 3* N	Group 4* N
BEFORE ARREST QUESTION					
AI Police are trained to recognize and respond to individuals with MI.	108	37	21	18	32
AFTER ARREST QUESTIONS					
BI Sheriffs are trained to recognize and respond to acute signs and symptoms of MI.	70	29	12	8	21
B2 Court Personnel are trained to recognize and respond to acute signs and symptoms of MI.	72	29	12	13	18
B3 Probation Officers are trained to recognize and respond to acute signs and symptoms of MI.	68	25	11	10	22
B6 Corrections Officers at the Intake Center are trained to recognize and respond to acute signs and symptoms of MI.	74	31	17	10	16
WHILE INCARCERATED QUESTIONS					
C12 Corrections Officers are trained to recognize and respond to acute signs and symptoms of MI.	67	33	13	9	12
IN THE COMMUNITY QUESTION					
D5 Probation, parole and community confinement staff are trained to recognize and respond to individuals with MI.	53	22	11	7	13

*Group 1 = RICJS Involved Individual or Family Member or Interested Person
*Group 2 = Behavioral Health Official or Community Based Provider
*Group 3 = Judge, Lawyer, Prosecutor, Court Staff or Police, Probation, Parole or Corrections Officer
*Group 4 = Individual Who Did Not Self-Classify Relationship with RICJS

Assessment Critical Factor

Chart 9

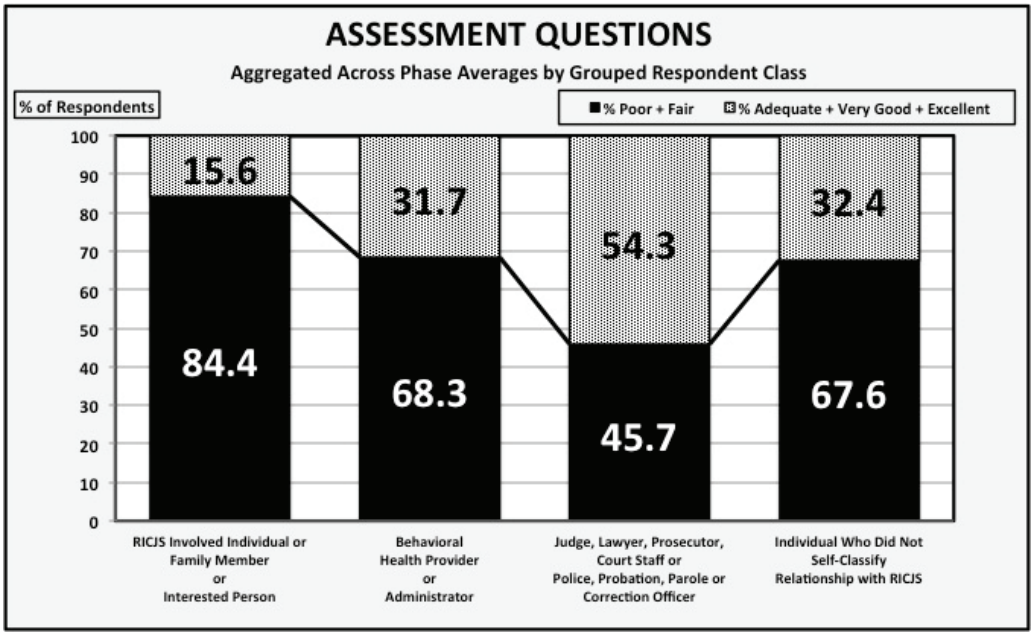


Chart 9 above indicates considerable variability among the 3 respondent groups' perceptions as to Assessment of the mental health status of RICJS involved individuals. The highest level of concern (84.4% Poor-Fair) was registered by RICJS involved persons, family members and interested individuals; followed by behavioral health professionals (68.3%); and RICJS professionals (45.7%).

Chart 10 below indicates that Assessment receives generally negative ratings in all phases of involvement subsequent to arrest.

Chart 10

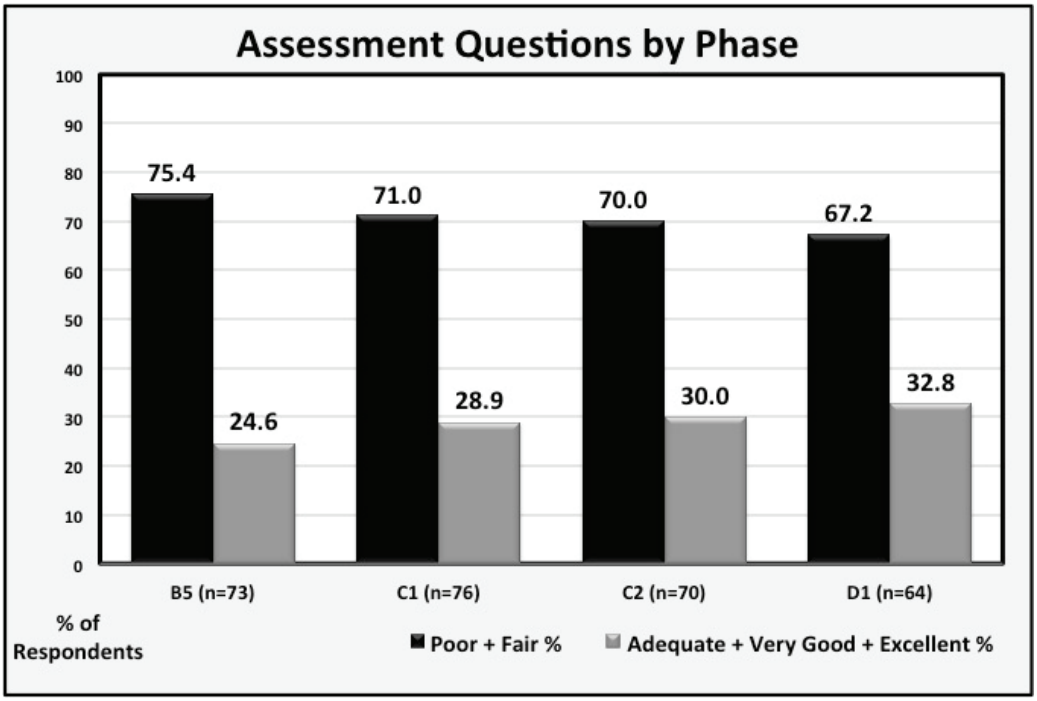
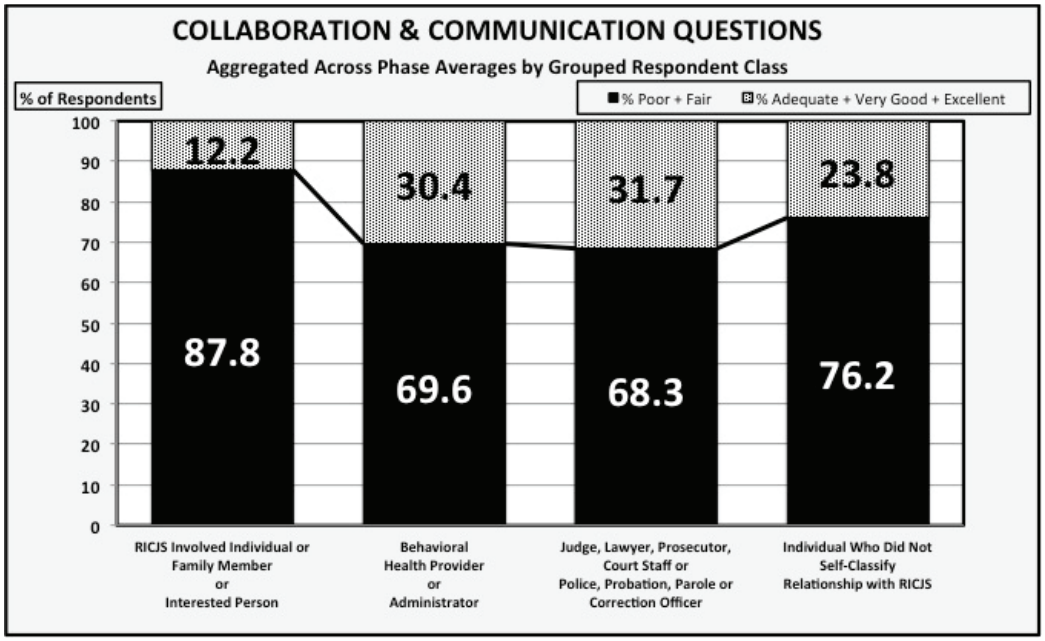


Table 2: ASSESSMENT QUESTIONS	Total N	Group 1* N	Group 2* N	Group 3* N	Group 4* N
AFTER ARREST QUESTION					
B5 DOC uses evidence-based assessments and interventions for detained individuals with SPMI.	72	31	15	9	17
WHILE INCARCERATED QUESTIONS					
C1 DOC identifies individuals with serious MI upon sentencing to ACI.	75	34	14	11	16
C2 DOC uses evidence based assessments to evaluate the current clinical status of Incarcerated individuals with SPMI.	69	30	14	9	16
IN THE COMMUNITY QUESTION					
D1 Probation and Parole Officers facilitate assessment of the current clinical status individuals with SPMI.	63	24	14	9	16

*Group 1 = RICJS Involved Individual or Family Member or Interested Person
*Group 2 = Behavioral Health Official or Community Based Provider
*Group 3 = Judge, Lawyer, Prosecutor, Court Staff or Police, Probation, Parole or Corrections Officer
*Group 4 = Individual Who Did Not Self-Classify Relationship with RICJS

Collaboration & Communication Critical Factor

Chart 11



Charts 11 above and 12 below rate perceptions of the level and adequacy of collaboration & communication among agencies, providers or departments in the form of notifications as the status with the RICJS, the treatment history or the current condition of an individual with SPMI.

RICJS involved persons; family members; and interested individuals report the most negative perceptions regarding collaboration and communication (87.8% poor-fair). Both behavioral health and RICJS professionals rated collaboration and communication at somewhat lower levels of dissatisfaction (69.6% and 68.3% respectively).

This critical factor is perceived as problematic across all phases: before arrest, after arrest, while incarcerated, and in the community.

Chart 12

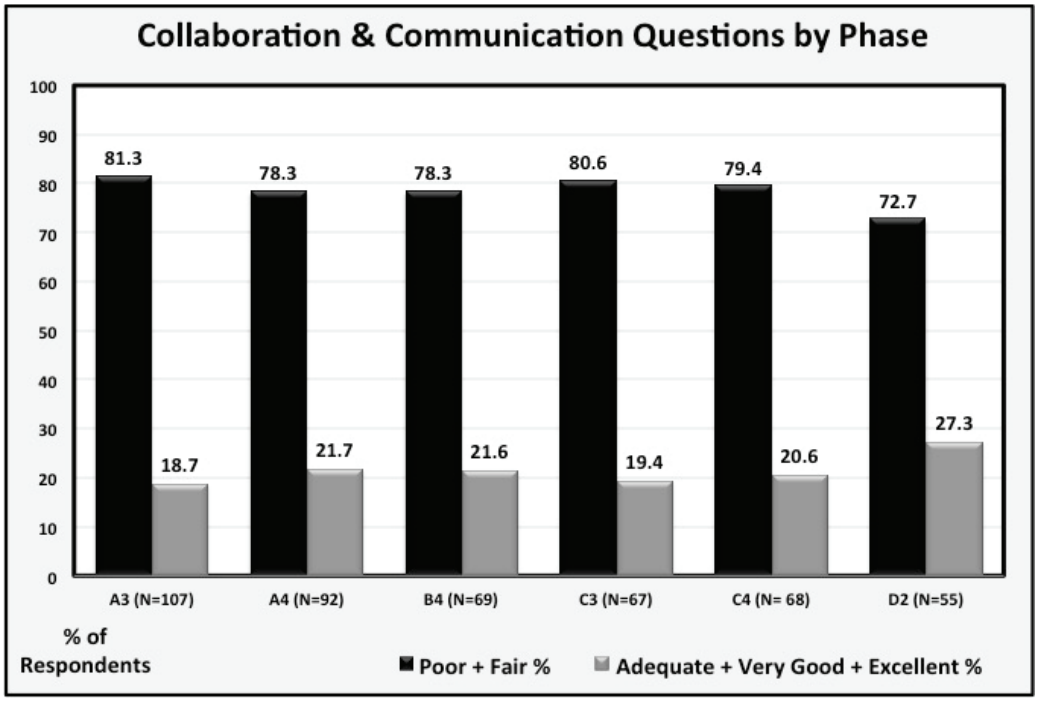
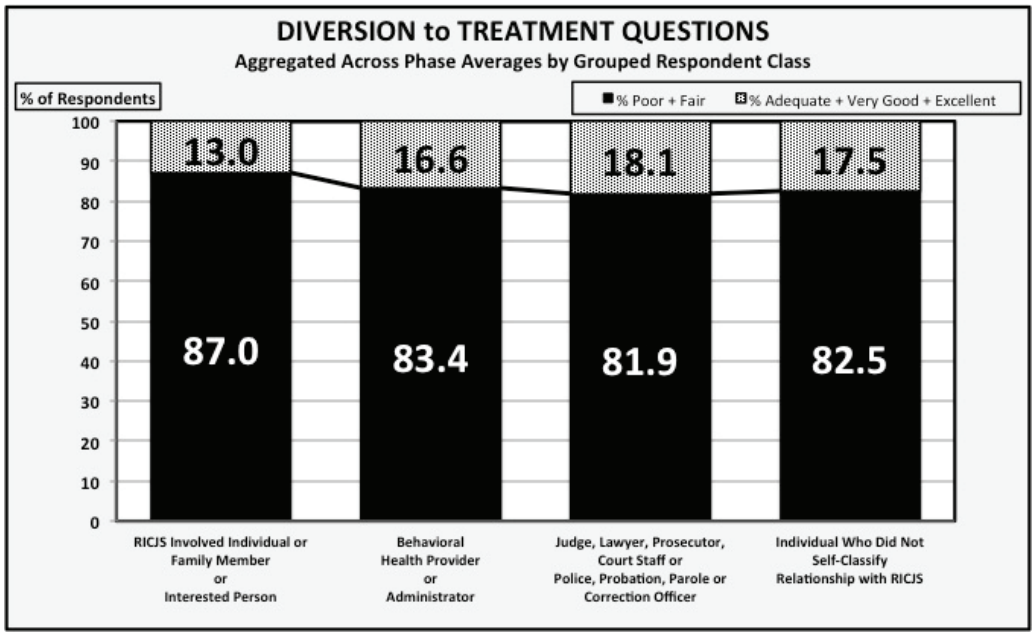


Table 3: COLLABORATION-COMMUNICATION QUESTIONS	Total N	Group 1* N	Group 2* N	Group 3* N	Group 4* N
BEFORE ARREST QUESTIONS					
A3 Police and providers collaborate to ensure access to treatment.	106	36	22	17	31
A4 Police notify providers when their patient has been arrested.	93	32	18	17	26
AFTER ARREST QUESTION					
B4 DOC notifies providers when an individual with SMI is detained at Intake center.	68	30	13	9	16
WHILE INCARCERATED QUESTIONS					
C3 DOC notifies current providers when an individual with SMI enters the ACI.	66	31	12	9	14
C4 DOC notifies providers when an individual with SMI is discharged from ACI.	66	32	11	8	15
IN THE COMMUNITY QUESTION					
D2 Current providers are notified when an individual with serious MI is serving a sentence in the community.	54	22	11	8	13

*Group 1 = RICJS Involved Individual or Family Member or Interested Person
*Group 2 = Behavioral Health Official or Community Based Provider
*Group 3 = Judge, Lawyer, Prosecutor, Court Staff or Police, Probation, Parole or Corrections Officer
*Group 4 = Individual Who Did Not Self-Classify Relationship with RICJS

Diversion to Treatment Critical Factor

Chart 14



Charts 14 above and 15 below describe responses to questions involving Diversion to Treatment for individuals with MI in the form of alternatives to arrest, prosecution or incarceration. Diversion options include referral to inpatient or outpatient treatment; abusive substance residential rehab programs; specialized courts (e.g., Drug or Veterans); and/or specialized housing.

All response groups perceive the use and availability of diversion in an especially negative light with Poor to Fair ratings of 81.9% by RICJS professionals; 83.4% by behavioral health providers and 87% by RICJS involved persons; family members and interested individuals.

It is significant to note that of the entire 35 survey questions, the two that received the highest number of responses A2 (N=107) and A3 (N=106) involved police having diversion options prior to arrest. The two items (B7 & C13) related to diversion to housing for individuals with SMI were rated 85.7% and 90.0% Poor to Fair, respectively.

Chart 15

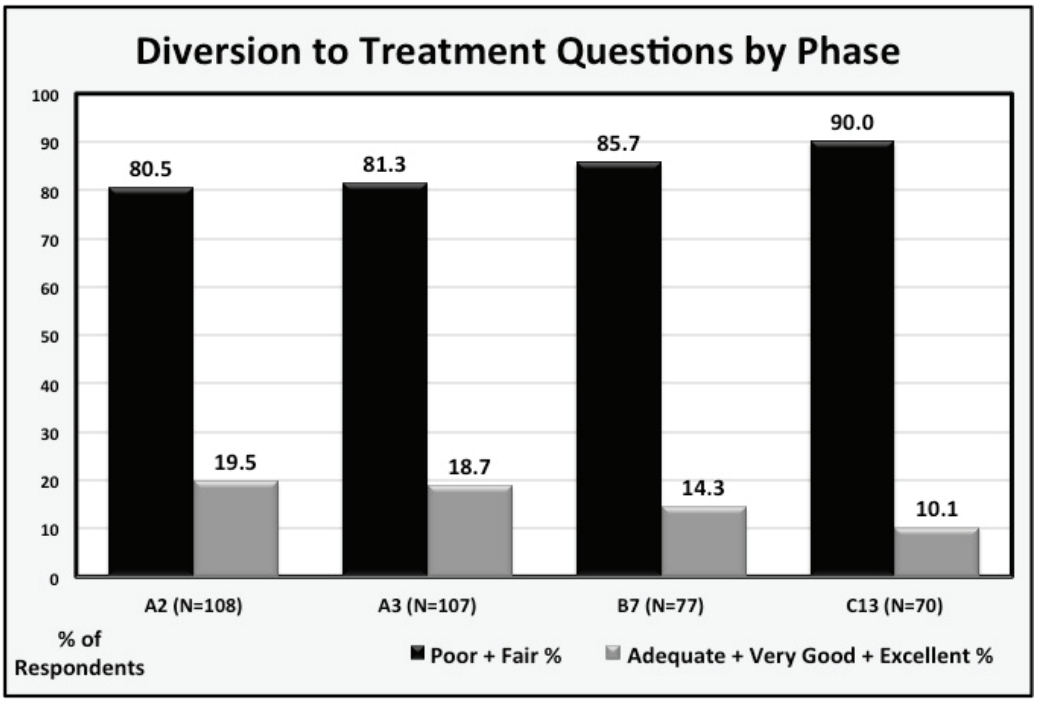
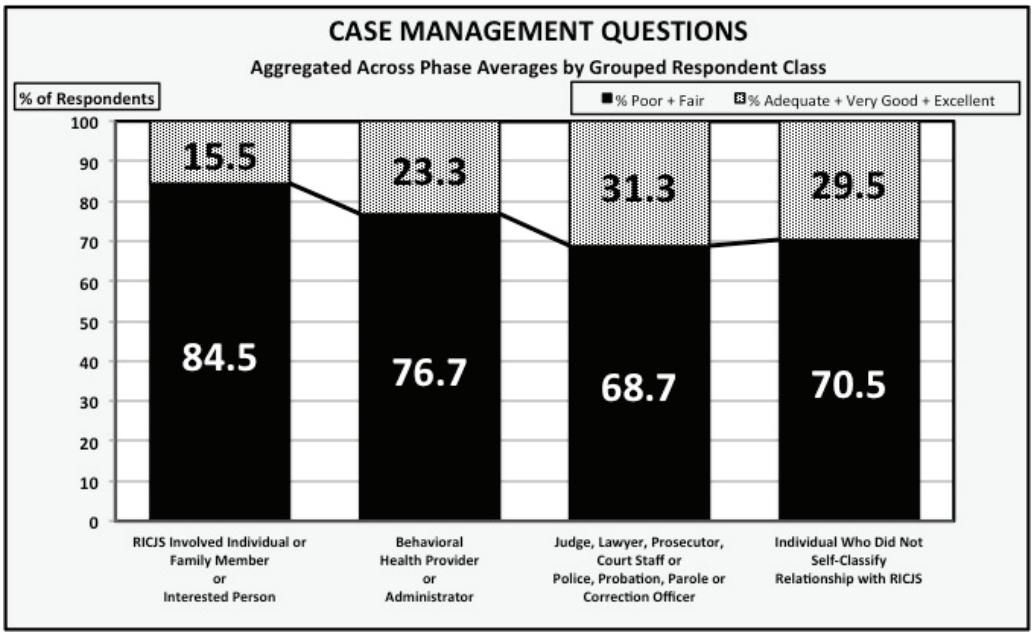


Table 4: DIVERSION to TREATMENT QUESTIONS	Total N	Group 1* N	Group 2* N	Group 3* N	Group 4* N
BEFORE ARREST QUESTIONS					
A2 Police are given alternatives to arrest for MI.	107	36	21	18	32
A3 Police and providers collaborate to ensure access to treatment.	106	36	22	17	31
AFTER ARREST QUESTION					
B7 At discharge from Intake DOC provides halfway houses or housing for individuals with SPMI.	76	29	19	11	17
WHILE INCARCERATED QUESTION					
C13 At discharge from Incarceration DOC provides halfway houses or housing for individuals with SPMI.	67	33	13	9	12

*Group 1 = RICJS Involved Individual or Family Member or Interested Person
*Group 2 = Behavioral Health Official or Community Based Provider
*Group 3 = Judge, Lawyer, Prosecutor, Court Staff or Police, Probation, Parole or Corrections Officer
*Group 4 = Individual Who Did Not Self-Classify Relationship with RICJS

Case Management Critical Factor

Chart 16



Charts 16 above and 17 below describe respondent perceptions of Case Management activity in the before arrest; while incarcerated and in the community phases of RICJS involvement. This critical factor differs from Collaboration & Communication in that it requires consistent involvement over a period of time on behalf of individuals with SMI in order to ensure that a resource, service or placement has been received or taken place.

As was the case with collaboration & communication, RICJS involved persons; family members and interested individuals rated case management considerably more negatively (84.5% Poor to Fair) than either behavioral health providers (76.7%) or RICJS professionals (68.7%).

Interestingly, Chart 17 indicates relatively positive levels of perception (42.0% Adequate to Excellent) related to question D6 regarding referrals to substance abuse treatment and recovery services by probation and parole officers. However, by comparison, items C15 and C16 involving case management to ensure continued access to medication and to resumption of Medicaid coverage were rated as Adequate to Excellent by just 15.7% and 16.2% of respondents respectively.

Chart 17

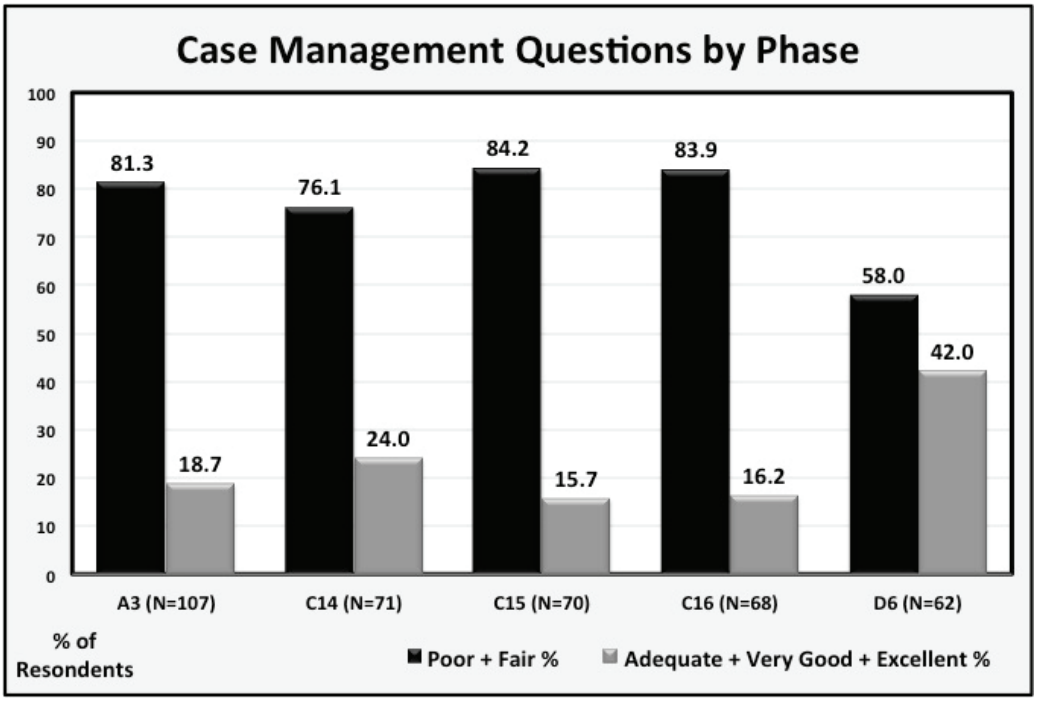
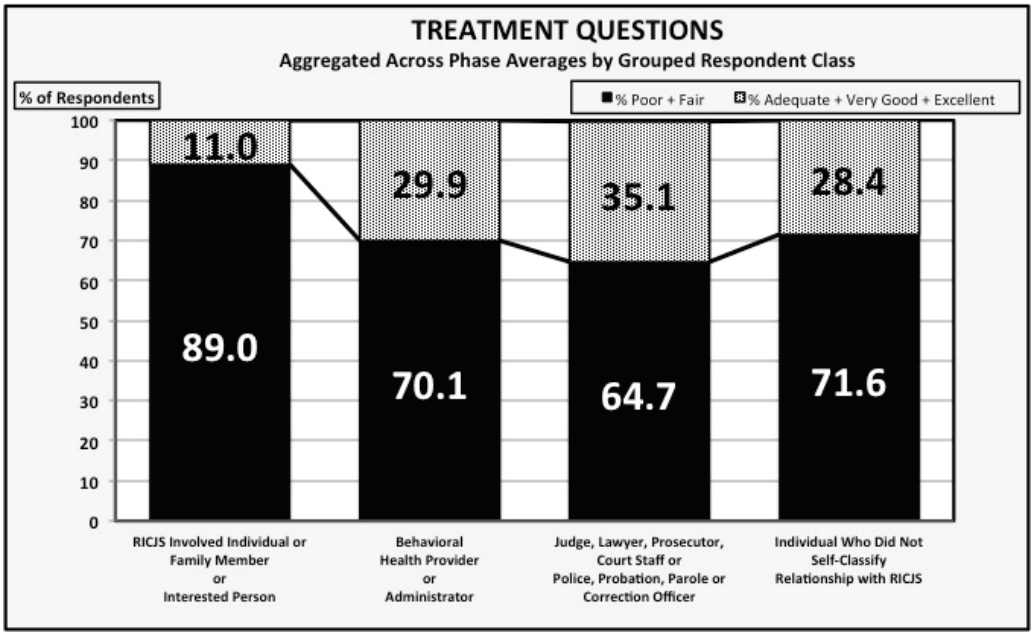


Table 5: CASE MANAGMENT QUESTIONS	Total N	Group 1* N	Group 2* N	Group 3* N	Group 4* N
BEFORE ARREST QUESTION					
A3 Police and providers collaborate to ensure access to treatment.	106	36	22	17	31
WHILE INCARCERATED QUESTIONS					
C14 At discharge DOC arranges for treatment and recovery services for individuals with SMI who also struggle with abusive substances.	70	30	16	10	14
C15 At discharge DOC ensures continuity of care including medication for individuals with SMI through appropriate referrals.	69	28	16	10	15
C16 At discharge DOC provides case management for individuals with SMI including resumption of insurance benefits.	67	29	14	10	14
IN THE COMMUNITY QUESTION					
D6 Probation and Parole Officers make referrals as appropriate for Substance Abuse treatment and recovery services for individuals with SMI.	61	25	14	9	13

*Group 1 = RICJS Involved Individual or Family Member or Interested Person
*Group 2 = Behavioral Health Official or Community Based Provider
*Group 3 = Judge, Lawyer, Prosecutor, Court Staff or Police, Probation, Parole or Corrections Officer
*Group 4 = Individual Who Did Not Self-Classify Relationship with RICJS

Treatment Critical Factor

Chart 18



Charts 18 above and 19 below represent respondent perceptions of the adequacy, availability and appropriateness of actual Treatment interventions for an individual with a chronic or acute MI condition during either the after arrest or while incarcerated phases of involvement.

With respect to Treatment RICJS involved persons; family members and interested individuals rated this critical factor considerably more negatively (89.0% Poor to Fair) than either behavioral health providers (70.1%) or RICJS professionals (64.7%). Nonetheless, it is significant to note that, even between the latter two respondent groups, perceptions were markedly more negative than positive.

As Chart 19 indicates, each of the 9 items exploring the Treatment critical factor received strongly negative ratings by margins of three or four to one.

It is important to note that 5 of these 9 questions involved interventions related to the management of serious issues of suicidality or acute manifestations of MI.

Chart 19

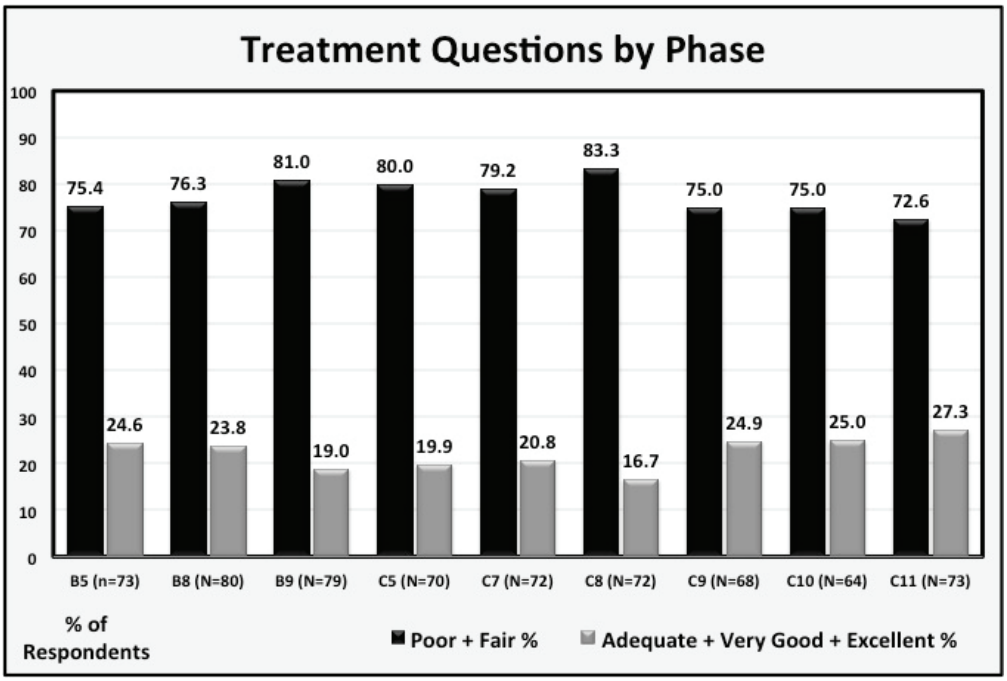


Table 6: TREATMENT QUESTIONS	Total N	Group 1* N	Group 2* N	Group 3* N	Group 4* N
AFTER ARREST QUESTIONS					
B5 DOC uses evidence-based assessments and interventions for detained individuals with SPMI.	72	31	15	9	17
B8 DOC ensures MH professionals monitor detained Individuals at acute risk for suicide in dignified settings.	79	32	16	11	20
B9 DOC provides timely, well-monitored, clinically appropriate treatment for Incarcerated individuals with underlying MI conditions that become acute.	78	33	18	9	18
WHILE INCARCERATED QUESTIONS					
C5 DOC develops and implements individualized treatment plans for incarcerated individuals with SPMI.	69	31	12	9	17
C7 DOC provides timely, well-monitored treatment when Incarcerated individuals with SMI experience acute signs of MI.	72	33	13	11	15
C8 DOC provides timely, well-monitored, clinically appropriate treatment for Incarcerated individuals with underlying MI conditions that become acute.	72	34	13	9	16
C9 While incarcerated, the effectiveness and side effects of psychotropic medications are monitored.	67	32	12	8	15
C10 Throughout incarceration, DOC uses evidence based treatments and interventions for individuals with SPMI.	64	32	12	8	12
C11 DOC ensures MH professionals monitor Incarcerated Individuals at acute risk for suicide in dignified settings.	72	34	14	8	16

*Group 1 = RICJS Involved Individual or Family Member or Interested Person
*Group 2 = Behavioral Health Official or Community Based Provider
*Group 3 = Judge, Lawyer, Prosecutor, Court Staff or Police, Probation, Parole or Corrections Officer
*Group 4 = Individual Who Did Not Self-Classify Relationship with RICJS

Continuity of Care Critical Factor

Chart 20

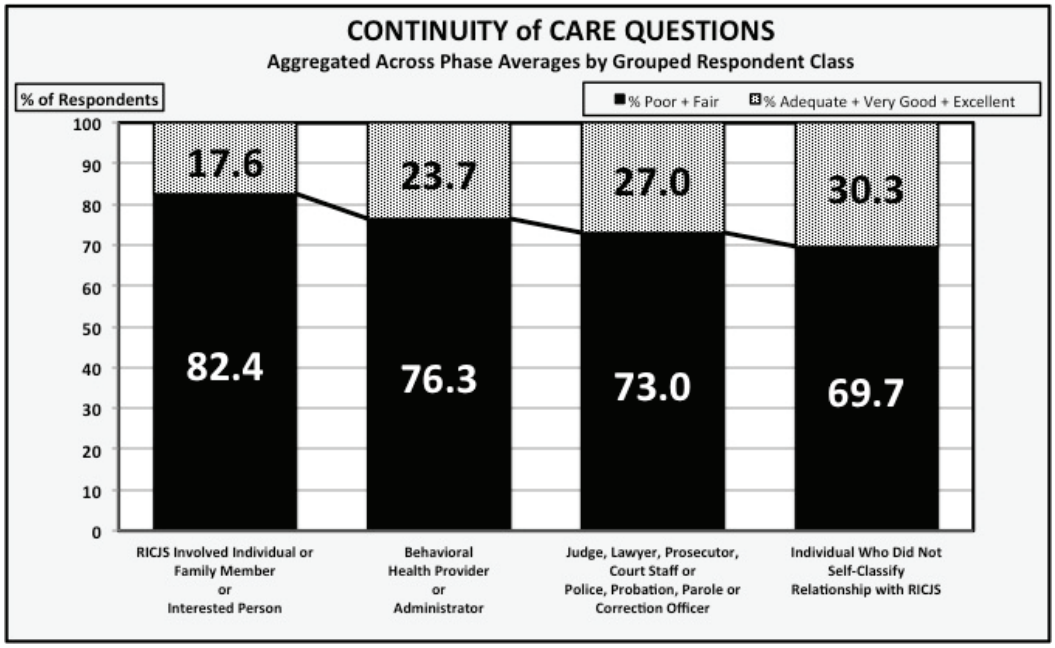


Chart 20 above shows similarly rated perceptions of Continuity of Care across all three grouped respondent classes ranging from 73.0 % to 82% Poor to Fair. This factor involves ensuring that the medications on which a RICJS involved individual with MI is stabilized on is available to her or him and that it can continue to be

accessed and prescribed upon moving from one phase of the system to another. This is also a concern regarding other forms successful interventions and clinical services including those related to abusive substance treatment and recovery maintenance.

As Chart 21 below indicates, the items involving housing (C13, 90.0%) and (C15, Medication, 84.2%) received the most negative (Poor to Fair) ratings, while perception of abusive substance treatment interventions (D6, 58.0%) was less negative.

Chart 21

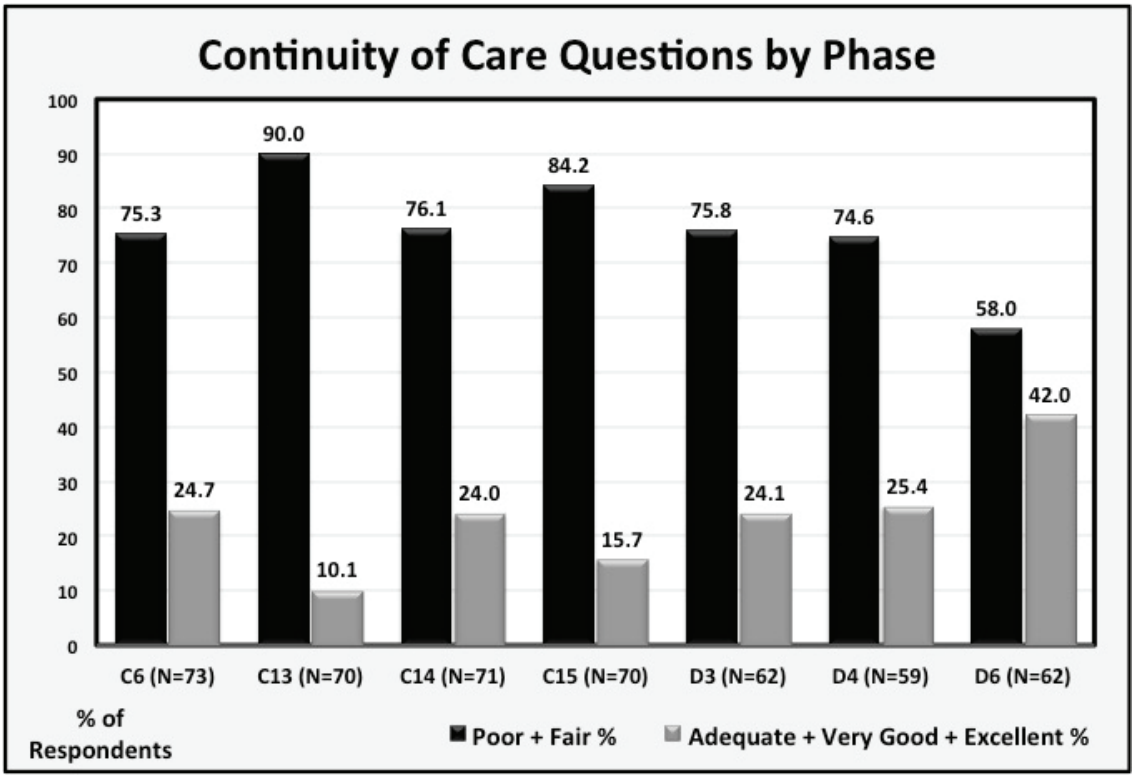


Table 7: CONTINUITY of CARE QUESTIONS	Total N	Group 1* N	Group 2* N	Group 3* N	Group 4* N
WHILE INCARCERATED QUESTIONS					
C6 DOC maintains pre-incarceration medication regimes as clinically indicated.	75	34	15	10	16
C13 At discharge from Incarceration DOC provides halfway houses or housing for individuals with SPMI.	69	31	14	9	15
C14 At discharge DOC arranges for treatment and recovery services for individuals with SMI who also struggle with abusive substances.	70	30	16	10	14
C15 At discharge DOC ensures continuity of care including medication for individuals with SMI through appropriate referrals.	69	28	16	10	15
IN THE COMMUNITY QUESTION					
D3 Probation and Parole Officers facilitate continuity of care for individuals with SPMI.	61	25	12	8	16
D4 Probation and Parole Officers facilitate development and implementation of Individualized treatment plans for individuals with SPMI.	58	23	13	6	16
D6 Probation and Parole Officers make referrals as appropriate for Substance Abuse treatment and recovery services for individuals with SPMI.	61	25	14	9	13

*Group 1 = RICJS Involved Individual or Family Member or Interested Person
*Group 2 = Behavioral Health Official or Community Based Provider
*Group 3 = Judge, Lawyer, Prosecutor, Court Staff or Police, Probation, Parole or Corrections Officer
*Group 4 = Individual Who Did Not Self-Classify Relationship with RICJS

CONCLUSIONS

This survey has demonstrated that perceptions regarding the effectiveness and adequacy of, and access to the services, programs and resources necessary to respond to mental illness within the RICJS are overwhelmingly negative. This is true across all respondent classes whether RICJS involved individuals, community based providers or RICJS professionals. This is also true across all four phases of involvement with the RICJS inclusive of Before Arrest; After Arrest; While Incarcerated or, while In the Community.

The responses to each of the 35 questions analyzed in this report were rated negatively (Poor to Fair). The study found that 34 of these questions were rated negatively by margins ranging from 2 to 1 to 6 to 1. The one item that was rated less negatively at 58% Poor to Fair related to abusive substances treatment while in the community.

Results also demonstrate that each Critical Factor: Training; Assessment; Collaboration & Communication; Diversion to Treatment; Case Management; Treatment; and Continuity of Care was perceived negatively by all grouped respondent classes except one. This exception was with respect to assessment, in that RICJS professionals' rating was 54.3% adequate to excellent versus 45.7% poor to fair.

The consistency of these perceptions across all phases of involvement; all respondent groups; and all critical factors makes it clear that further collaborative exploration involving all stakeholders will be necessary.

Clearly, an inclusive, open and highly focused effort to address these perceptions is necessary if Rhode Island is to move forward meaningfully and effectively in its efforts to confront the growing and widely acknowledged, albeit unintended practice of criminalizing mental illness.

As has been asserted by others, including some RICJS professionals, there is a clear lack of relevant and current data about mental illness in the RICJS. This concern regarding the need for consistently available data is perhaps no more clearly evident than in the fact there is no mention of SMI or MI in the DOC's publication, Report on the Rhode Island Correctional Population FY 1976-FY 2011,

Data gathering and tracking procedure, resources, systems and the funding to maintain them are necessary if all of our efforts to end the criminalization of mental illness is to succeed.

QUESTIONS for FURTHER EXPLORATION

Regarding Data

MHARI proposes to partner with all stakeholder agencies, institutions and individuals in this effort. To this end, we would suggest that representatives of each branch and department of government; behavioral provider agencies; and individuals living with MI who are or have been involved in the RICJS come together. The initial goals of this group would be to:

- Inventory existing databases and relevant analyses as well as data gathering and tracking resources.
- Establish a research agenda to fill any gaps in available data.
- Develop a plan and budget to fill identified data gaps.

and to:

- Collaboratively advocate for consistently allocated funds to support ongoing data gathering, tracking and analysis.

Implicit in this groups' work would be for each participating entity to bring the answer to the following question to the initial meeting:

How many annual employed or contracted staff hours are dedicated to or available for ongoing data gathering and analysis regarding MI in the RICJS population?

Finally, it is our hope that, as part of the group's effort to achieve the above goals, an immediate, collaborative and coordinated effort to answer the questions listed below will serve to clarify, challenge or validate the perceptions expressed by the 141 respondents to this survey.

Regarding Assessment and Treatment

What mental health assessment instrument is administered upon entry to RIDOC?
Is it a risk assessment or a diagnostic assessment or both?

Who administers it?

How many risk and diagnostic assessments are conducted annually?

What is the percentage of individuals with SMI in the RIDOC population?

What is the percentage breakdown of SMI diagnoses?

What percentage of those with SMI are being treated with psychotropic medication?
What percentage of the total population with any form of MI are being treated with psychotropic medication?

Are all psychotropic medications administered by a psychiatrist or by a MH professional under the supervision of a psychiatrist?

How many individual psychotherapy and/or MH counseling sessions are provided annually to inmates?

What is the average length of time for each session?
What percentage (unduplicated) of the overall ACI population participates in individual sessions?

How many mental health or abusive substances group therapy sessions are provided annually?

What percentage (unduplicated) of the overall population participates in these groups?
What differences in available treatment interventions or services exist between the female and male units at the ACI?

If differences exist, which of these interventions or services are gender-specific?

How many completed suicides have occurred at the ACI during the past 5 years?

Of these, how many have occurred in the

- Intake Unit?
- Minimum Security Unit?
- Medium Security Unit?
- Maximum Security Unit?
- Women's Unit?

How many completed suicides have occurred at the BHDDH Forensic Unit during the past 5 years?

Regarding Diversion to Treatment

Annually, how many individuals dealing with MI and/or abusive substances are diverted for assessment and/or treatment as an alternative to arrest, adjudication or incarceration by the following programs, departments and agencies?

- Pretrial services
- Court Diversion Programs
- Drug Court
- Veterans' Court

- Attorney General
- The Traffic Tribunal
- Probation or Parole

How many individuals who have been diverted for assessment or treatment fail to meet requirements or expectations and are subsequently adjudicated to incarceration.

Regarding Training

How many hours of specific training regarding MI are the following RICJS professionals required to undergo prior to beginning their respective roles and responsibilities?

- Municipal Police
- State Police
- Sheriffs
- Corrections Officers
- Court Staff
- Probation Officers
- Parole Officers
- Home Confinement Staff

Are these training programs nationally accredited or recognized as evidence based with respect to positive outcomes?

Regarding Continuity of Care

How frequently do BHDDH and DOC meet to deal with issues and concerns regarding the population of individuals with SMI incarcerated at either the ACI or the BHDDH forensic unit?

What is the procedure through which an inmate with SMI is transferred from the ACI to the BHDDH forensic unit?

How many staff hours (directly employed or contracted) are dedicated to addressing the specific needs of individuals with SMI in the RICJS?

Annually, how many individuals with SMI adjudicated to incarceration are discharged within one year?

Of these individuals, what percentage is discharged with active health insurance?

Annually, how many individuals with SMI are discharged after having served more than one year?

Of these individuals, what percentage is discharged with active health insurance?

APPENDIX A

PRINCIPAL INVESTIGATORS'S BACKGROUNDS

Judith Platania earned a Ph.D. in Applied Psychology from Florida International University in 1995 with a specialization in legal psychology. She is a Professor of Psychology at Roger Williams University in Bristol, Rhode Island. Her research centers on the interaction of psychology and law within the context of the capital trial. Her published work is most often the result of collaborative efforts of colleagues and students. Her teaching responsibilities include courses in undergraduate and graduate research methods and statistics.

Ann M. Varna Garis, Ph.D. (1977) obtained her M.S. and Ph.D. at the University of Rhode Island with training assistantships at the Rhode Island Institute of Mental Health and the Rhode Island Training School. After a pre-doctoral internship in family systems at Philadelphia Child Guidance Clinic, in 1973, she began work on the Children's' team at the Newport County Mental Health Center. After graduation, she did private practice (for 25 years) with adults and families, and began teaching the Family therapy practica for the University of Rhode Island's doctoral psychology program. In 1994 she became the Director of the Psychological Consultation Center at URI. In that position she developed and supervised doctoral candidate training sites at the ACI Intake Center, Eleanor Slater Hospital and the Wyatt Federal Detention Center. Dr. Varna Garis was a principal investigator for an NIJ research grant "Collaborative Development of Individual Discharge Planning for Incarcerated Women", 1/1/97-12/31/99 conducted at the Women's unit of the ACI. She is also a co- author of "Through the Bullet-Proof Glass: Conducting Research in Prison Settings" in (2007) Journal of Trauma and Dissociation, 8(2), 123-139.

Michael C. Cerullo, Jr., MS, LMHC, a former marketing executive, is a licensed psychotherapist in private practice. He has extensive experience treating males involved in the juvenile and adult corrections system.

He graduated LaSalle Academy in 1960 and attended Brown University. Since earning a Masters Degree in Human Development, Counseling and Family Studies at URI in 1990, he has managed a homeless shelter; worked in direct care and clinical case management roles at The Key Program; and provided home-based treatment services in the Greater Woonsocket area as a CIS Clinician. Mike has conducted or supervised more than 350 diagnostic assessments and parent-child evaluations for Rhode Island Family Court. Mike also conducts continuing education and training workshops on engaging and treating male adolescents and adults at the Rhode Island Child Welfare Institute and Rhode Island College Graduate School of Social Work.

Mike has served on the Governor's Task Force on Juvenile Justice Reform (1997); the Rhode Island Training School Transition Planning Team (2007-09); the Rhode Island Children's Policy Coalition (1992-2012); the Rhode Island System of Care Task Force (2001-03); the Washington County Coalition for Children (since 2002) and the Exeter Town Council (2002-04).

APPENDIX B QUESTIONS BY PHASE
BEFORE ARREST
Police are trained to recognize and respond to individuals with MI.
Police are given alternatives to arrest for MI.
Police and providers collaborate to ensure access to treatment.
Police notify providers when their patient has been arrested.
AFTER ARREST
Sheriffs are trained to recognize and respond to acute signs and symptoms of MI.
Probation Officers are trained to recognize and respond to acute signs and symptoms of MI.
Court Personnel are trained to recognize and respond to acute signs and symptoms of MI.
DOC notifies providers when an individual with SPMI is detained at Intake center.
DOC uses evidence based assessments and interventions for detained individuals with SPMI.
Corrections Officers at the Intake Center are trained to recognize and respond to acute signs and symptoms of MI.
At discharge from Intake DOC provides halfway houses or housing for individuals with SPMI.
DOC ensures Detained Individuals at acute risk for suicide are monitored in dignified settings by MH professionals.
At the Intake Center the effectiveness and side effects of psychotropic medications are monitored.
WHILE INCARCERATED
DOC identifies individuals with serious MI upon sentencing to ACI.
DOC uses evidence based assessments to evaluate the current clinical status of Incarcerated individuals with SPMI.
DOC notifies current providers when an individual with SPMI enters the ACI.
DOC notifies providers when an individual with SPMI is discharged from ACI.
DOC develops and implements individualized treatment plans for incarcerated individuals with SPMI.
DOC maintains pre-incarceration medication regimes as clinically indicated.
DOC provides timely, well monitored treatment when Incarcerated individuals with SPMI experience acute signs of MI.
DOC provides timely, well monitored, clinically appropriate treatment for Incarcerated individuals with underlying MI conditions that become acute.
While incarcerated, the effectiveness and side effects of psychotropic medications are monitored.
Throughout incarceration, DOC uses evidence based treatments and interventions for individuals with SPMI.
DOC ensures Incarcerated Individuals at acute risk for suicide are monitored in dignified settings by MH professionals.
Corrections Officers are trained to recognize and respond to acute signs and symptoms of MI.
At discharge from Incarceration DOC provides halfway houses or housing for individuals with SPMI.
At discharge DOC arranges for treatment and recovery services for individuals with SPMI who also struggle with abusive substances.
At discharge DOC ensures continuity of care including medication for individuals with SPMI through appropriate referrals.
At discharge DOC provides case management for individuals with SPMI including resumption of insurance benefits.
IN THE COMMUNITY
Probation and Parole Officers facilitate assessment of the current clinical status individuals with SPMI.
Current providers are notified when an individual with serious MI is serving a sentence in the community.
Probation and Parole Officers facilitate continuity of care for individuals with SPMI.
Probation and Parole Officers facilitate development and implementation of Individualized treatment plans for individuals with SPMI.
Probation, parole and community confinement staff are trained to recognize and respond to individuals with MI.
Probation and Parole Officers make referrals as appropriate for Substance Abuse treatment and recovery services for individuals with SPMI.

APPENDIX C
SELECTED OPEN ENDED COMMENTS by RESPONSE GROUP by PHASE

Prior To Arrest:

RICJS Involved Individual or Family Member or Interested Person

- Was never asked about MI when I was arrested
- Police treat people like criminals, they do not consider MI
- Police are not concerned when arresting MI offenders
- Mental illness is one of the leading causes to incarceration. It is also one of the leading causes of police violence against a person… . Several high profile killings of mentally ill RI'ers did little to create systemic reform. This reinforces the notion that all (individuals with MI) are dangerous and uncontrollable… .
- I get the sense from police officers that they do not want to be tasked with the job of caring for someone's physical or mental health. Many of them don't see that as a part of their job duties.

Behavioral Health Official or Community Based Provider

- Having just recently been in a situation where police needed to respond to an incident with an individual (with MI), I can say first hand that the police were not properly trained and aware of best practice for dealing with an individual (with MI),.

Judge, Lawyer, Prosecutor, Court Staff or Police, Probation, Parole or Corrections Officer

- In my experience some police departments are much better trained to deal with individuals (with MI), than others. Also, although police often initiate psych evaluations for persons who appear to be in need of one, very often the person who is referred for an evaluation is ALSO charged with a crime. It is then left to the defense attorney to deal with the culpability issue in defending the person, and not all prosecutors and/or judges are versed enough in this area to dismiss charges and accept treatment as an alternative...
- The response by the police departments is generally abysmal and, service providers, when the individual is indigent and uninsured, aren't much better. They shoot them up with meds and release folks to the street when they calm down.
- Police agencies seem to be utilized more and more as the "first responder" for persons having mental health issues. I have concern with the circumstances and situations police personnel are being tasked with (without) training. The police are handling more situations that may be more appropriately handled by a mental health provider or service.
- The Providence Police dept. has been very proactive in responding to the needs of the Mentally Ill though liaisons at the Providence Center and Family Services.

After Arrest:

RICJS Involved Individual or Family Member or Interested Person

- If you are suicidal, they put you in a cold room w/ no mat, pillow, or blankets
- Been off meds for 3 months
- Inmates are given meds and not monitored
- DOC has mistreated (individuals with) MI for years.
- Intake fails to recognize (individuals with) MI (its) unprofessional

Behavioral Health Official or Community Based Provider

- My program works with many individuals who have been incarcerated and have (MI) and do not have housing. It is very difficult to find appropriate housing that will take someone with a record and (MI). It is my understanding that not all discharged from the ACI with MI challenges get support from discharge planners upon release with housing. It might be just a list of shelters (that) may or may not take them.

Judge, Lawyer, Prosecutor, Court Staff or Police, Probation, Parole or Corrections Officer

- … putting (inmates) in ISO is not suicide prevention
- It has been our agency practice that persons taken into custody with mental health concerns are first referred or directed to a mental health provider to deal with their mental health. The criminal charges if any, become (to a point) secondary to their mental well-being.
- Many mentally ill clients frequently end up in segregation.

While Incarcerated

RICJS Involved Individual or Family Member or Interested Person

- I have (been discharged from) prison 6-8 time w/ no help
- DOC fails in ongoing med care upon release

Behavioral Health Official or Community Based Provider

- Discharge referrals are not enough for most individuals. Coordination of care needs to take place for the successful transition of inmates with behavioral health challenges upon discharge. Housing continues to be scarce especially for those with dual diagnosis.
- No follow up with inmate

Judge, Lawyer, Prosecutor, Court Staff or Police, Probation, Parole or Corrections Officer

- A lot of individuals (with MI) are in and out of intake center and receive very little services or planning.
- A State wide data base should be established which would provide information pertaining to individual's (MI) condition as well any potential suicide risks previously displayed during contact with any mental health or law enforcement agency. An individual's past mental health condition would allow for the classification of individuals … . This type of database is currently in use in other New England states.

In the Community

RICJS Involved Individual or Family Member or Interested Person

- Once you are released you are on your own
- People are left to their own devices upon release. Let us not fool ourselves regarding a class over a few weeks, and a handout with phone numbers. People can't even get a free bus pass. Probation sees them once per month for 15 minutes. This is not any sort of effective monitoring. People generally just want to move the paperwork along.

Behavioral Health Official or Community Based Provider

- Part of the challenge is the inadequacy of existing mental health resources for offenders who struggle with major MI. Waiting lists at the ACI and in community based programs are long.

Judge, Lawyer, Prosecutor, Court Staff or Police, Probation, Parole or Corrections Officer

- … the process of discharge of (adults with SPMI) is very slow when they are slotted for (a) mental health group home … they may languish at the state hospital … when there is actually a bed in community group homes, which are far less expensive … . Meanwhile a person, who has been interviewed, accepted and looking forward to transitioning to community will sit helplessly waiting … .
- Many probation officers have clinical training and are great at working with and referring their clients to appropriate services in the community. I know there are specialty caseloads in the probation department, including a mental health probation officer who sees clients at the Providence Center and other places in the community.

APPENDIX D
GLOSSARY of TERMS and ABBREVIATIONS

ACI	Adult Corrections Institution
ACT	Assertive Community Treatment
BHDDH	Department of Behavioral Health, Developmental Disabilities & Hospitals
CIT	Crisis Intervention Teams
CMHC	Community Mental Health Center
DHS	Department of Human Services
DOC	Department of Corrections
DOH	Department of Health
EOHHS	Executive Office of Health and Human Services
EOS	Enhanced Outpatient Services
MCT	Mobile Crisis Teams
MHARI	Mental Health Association of Rhode Island
MH	Mental Health
MI	Mental Illness
OSU	Observation & Stabilization Unit
RWU	Roger Williams University
SMI	Serious Mental Illness
SH	Supportive Housing

APPENDIX E
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