

ATTACHMENT 1:

Hidden Cost of Homelessness – Lincoln, NE

## Hidden Cost of Homelessness – Lincoln, NE

The cost to the community of individuals not accessing mainstream services and housing.

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### Introduction:

Research conducted in 2002 by Culhane, Metraux, Hadley indicated a marked reduction (59.8 percent) in emergency shelter use, hospitalizations, length of stay per hospitalization, and time incarcerated when individuals were housed in supportive housing versus living on the streets. Over the past five years, communities nationwide have implemented successful supportive housing projects. The success of Nebraska's housing rental assistance for individuals with serious and persistence mental illness is one example of the viability of this housing approach. Supportive housing for individuals and families who are homeless represents a cost-effective alternative to emergency shelter and services.

### Lincoln Continuum of Care Research:

Over the past year, members of Lincoln's Continuum of Care: Long-Term & Discharge Planning Committee researched the cost of the top utilizers of emergency services in Lincoln, NE. The purpose was to determine the top utilizers, who were homeless, of emergency services in Lincoln. Committee representatives from Bryan Hospital, the jail, the ambulance service and Cornhusker Detox provided unduplicated data. Personal identification was coded so names were not revealed. The top 27 utilizers had continuous or repeated episodes of street homelessness in Lincoln. Data was collected for the one-year period from September of 2005 - 2006.

Individual data is shown for the top 13 users of emergency services in Lincoln. Additionally, a dollar amount was determined for the next 14 individuals. The data is shown in the table below.

<b>Cost of Services – Sept. 2005-2006</b>	
<b>Client #</b>	<b>Cost of Services Used</b>
1	\$77,105.00
2	\$67,958.00
3	\$57,616.00
4	\$45,404.00
5	\$45,032.00
6	\$43,299.00
7	\$42,045.00
8	\$40,128.00
9	\$38,024.00
10	\$34,472.00
11	\$32,863.00
12	\$27,768.00
13	\$22,238.00
<b>Sub-Total</b>	<b>\$573,952.00</b>
Next 14 individuals	\$126,521.00
<b>Grand Total (27 individuals)</b>	<b>\$700,473.00</b>

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The cost to the community of individuals not accessing mainstream services and housing.

**Sources:**

1. Detox costs were provided by Cornhusker Place and are actual costs incurred by top utilizers for the time period September 2005 - 2006.
2. Assistant Fire Chief Furseak estimated ambulance costs at \$200.00 per ride. This was an average; some rides may be less and others may be more.
3. Jail costs are based on \$200.00 per booking and daily care of \$70.00 per day. The costs provided are actual costs of the top utilizers for the September 2005 – 2006 time period.
4. Hospital costs were provided by Bryan/LGH and are actual costs incurred by top utilizers for the September 2005 – 2006 time period.

Note: Costs do not include other medical costs, such as drug and/or alcohol abuse treatment, mental health services, or any prescriptions; services from agencies and organizations that serve persons who are homeless; any contact with the Crisis Center.

**Housing & Food Costs for Household of One:**

<b>Housing &amp; Food Costs – Lincoln, NE Household of One</b>			
<b>Housing</b>	<b>Description</b>	<b>Monthly Expense</b>	<b>Annual Cost</b>
HUD 2008 Fair Market Rent (includes utilities, but not telephone)	Efficiency Apartment	\$450.00*	\$5,400.00
Food Stamp Allowance – (Household of one)	(\$40.50 per week)	\$162.00	\$1,944.00
<b>TOTALS</b>		<b>\$612.00</b>	<b>\$7,344.00</b>

Note: For an individual to afford a Fair Market Rent (FMR) of \$450.00 and maintain housing costs at 30 percent of income, s/he should earn \$8.65 per hour at 40 hours per week. This would be a gross annual income of \$18,000.00. For the purpose of this example, other household costs, such as clothing, are not estimated.

FMR is established annually by the Department of Housing and Urban Development. FMR varies in each of Nebraska's 93 counties. The FMR used in this example is HUD's 2008 rate.

**Cost Comparison of Living on the Streets to Living in an Apartment:**

	<b>Living on the Street</b>	<b>Living in an Efficiency Apartment</b>	<b>Potential Savings as a Result of Housing</b>	<b>% Saved</b>
<b>Monthly Cost</b>	\$2,162.00	\$612.00	\$1,550.00	71.3
<b>Annual Cost</b>	\$25,943.00*	\$7,344.00	\$18,599.00	71.7

\*Total cost of 27 individuals (\$700,473.00) divided by 27 = \$25,943.00

<b>Comparison of Costs: Street Living versus Efficiency Apartment</b>				
<b>Location</b>	<b>Number of Individuals</b>	<b>Annual Cost per Person</b>	<b>Annual Cost for 27 Individuals</b>	<b>% Saved</b>
Living on the Streets	27	\$25,943.00	\$700,461.00	71.7
Living in an Efficiency	27	\$7,344.00	\$198,288.00	
<b>Annual Cost Savings</b>			<b>\$502,173.00</b>	

ATTACHMENT 2:

Chapter 269: SB262 Final Version

CHAPTER 269

SB 262 – FINAL VERSION

03/09/06 1199s

19Apr2006... 1705h

05/24/06... 2375eba

2006 SESSION

06-2700

08/09

SENATE BILL **262**

AN ACT establishing the position of an administrator of women offenders and family services within the department of corrections and establishing an interagency coordinating council on women offenders.

SPONSORS: Sen. Larsen, Dist 15; Sen. D'Allesandro, Dist 20; Sen. Hassan, Dist 23; Sen. Fuller Clark, Dist 24; Sen. Roberge, Dist 9; Rep. Price, Hills 26; Rep. Dowling, Rock 5; Rep. Houde-Quimby, Sull 1; Rep. E. Blanchard, Merr 10; Rep. Wall, Straf 7

COMMITTEE: Judiciary

AMENDED ANALYSIS

This bill establishes an administrator of women offenders and family services and an interagency coordinating council on women offenders.

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Explanation: Matter added to current law appears in ***bold italics***.

Matter removed from current law appears [~~in brackets and struck through.~~]

Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

03/09/06 1199s

19Apr2006... 1705h

05/24/06... 2375eba

06-2700

08/09

STATE OF NEW HAMPSHIRE

*In the Year of Our Lord Two Thousand Six*

AN ACT establishing the position of an administrator of women offenders and family services within the department of corrections and establishing an interagency coordinating council on women offenders.

*Be it Enacted by the Senate and House of Representatives in General Court convened:*

269:1 New Sections; Administrator of Women Offenders and Family Services; Council Established. Amend RSA 21-H by inserting after section 14-a the following new sections:

21-H:14-b Administrator of Women Offenders and Family Services.

I. There is hereby created the position of administrator of women offenders and family services within the department of corrections. The administrator shall be responsible for programming and services for women offenders in the state adult correctional system including probation, parole, and state correctional facilities. The administrator of women offenders and family services shall be a classified position.

II. The administrator may:

(a) Establish goals and objectives for state correctional systems within the framework of the department's philosophy, including planning, organizing, implementing, directing, and monitoring state gender-responsive programs and services, as well as developing policies, procedures, and standards for the provision of such programs and services. The administrator shall participate in the development, implementation, and review of all policies, directives, and standards that involve supervision of women offenders. The administrator shall also coordinate continuum and continuation of gender-responsive services to women offenders moving from one setting to another, and re-entering their communities.

(b) Write standards for, execute, and monitor all non-clinical contracts with service providers who work exclusively with women offenders. The administrator shall review and provide feedback on an ongoing basis on all clinical contracts and services for women offenders regarding consistency with contract language and gender-responsive principles.

(c) Establish and coordinate partnerships, and maintain working relationships within the department of health and human services, with other government agencies, with communities, and with community-based organizations, volunteers, advocacy groups, the academic community, and other external stakeholders.

(d) Provide supervision and technical assistance to the women's facility warden and field managers regarding issues related to women offenders and gender-responsive programs, services, and practices. The administrator shall provide input into the evaluations of other facility wardens, field managers, and personnel relative to their roles in the supervision and provision of services for women offenders.

(e) Provide input regarding necessary data collection and evaluation to measure effective programming and supervision of women offenders. The administrator shall consult with and provide input with other directors regarding appropriate levels of staffing in both the field and institutions responsible for the management of women offenders. The administrator shall also confer with and make recommendations to the commissioner regarding women offender supervision and services, oversee the planning, development, and implementation of training guidelines for staff working with women offenders, and recommend changes in duties assigned to casework and security staff who work with women offenders.

(f) Act as a resource in cases of staff sexual misconduct involving women offenders and provide input into personnel actions for addressing misconduct involving staff who work with women offenders and misconduct involving women offenders.

III. The administrator shall:

(a) Prepare budget recommendations regarding women offenders' program services consistent with the departmental budget cycle. The administrator shall also engage in budget formation, grant applications, and resource allocation activities related to women offenders as assigned.

(b) Act as liaison to the interagency coordinating council for women offenders and the department of corrections.

21-H:14-c Interagency Coordinating Council for Women Offenders.

I. There is established an interagency coordinating council for women offenders.

II.(a) The members of the council shall be as follows:

- (1) One member of the governor's office, appointed by the governor.
- (2) One member of the senate, appointed by the president of the senate.
- (3) One member of the house of representatives, who shall be knowledgeable about county corrections, appointed by the speaker of the house of representatives.
- (4) The executive councilor representing district 5/Goffstown.
- (5) The commissioner of corrections.
- (6) The warden of the state prison for women.
- (7) The commissioner of health and human services, or designee.
- (8) The director of division of children, youth, and families, or designee.
- (9) The attorney general, or designee.
- (10) The chief justice of the superior court, or designee.
- (11) The chief justice of the supreme court, or designee.
- (12) The commissioner of the department of education, or designee with knowledge of Title IX, Carl Perkins Grants, and other federal funding sources.
- (13) One member from the Hillsborough county government, appointed by the New Hampshire Association of Counties.
- (14) One former inmate of the state prison for women who is no longer under correctional supervision, appointed by the governor.
- (15) A representative from the New Hampshire commission on the status of women, appointed by the governor.
- (16) A representative from the New Hampshire Coalition Against Domestic and Sexual Violence, appointed by the governor.
- (17) A representative from New Hampshire Task Force on Women and Addiction, appointed by the governor.
- (18) A representative from the Citizens Advisory Committee of the New Hampshire State Prison for Women, appointed by the governor.
- (19) A community member with knowledge of correctional practices with particular expertise with female offenders, appointed by the governor.

(b) Legislative members of the council shall receive mileage at the legislative rate when attending to the duties of the council.

III. The duties of the council shall be as follows:

- (a) Identify opportunities for interagency cooperation in the effective management of female offenders.
- (b) Develop memoranda of understanding outlining "in-kind" services or cooperation to provide services to incarcerated women and their children.

(c) Develop cross-training opportunities to foster understanding of system responses to the shared population across agencies of incarcerated women and their children.

(d) Develop gender-specific treatment for co-occurring conditions and a continuity of treatment from incarceration to community.

(e) Coordinate interagency case management and re-entry planning.

(f) Assess the impact of incarceration on family relations during and after incarceration.

(g) Apply for and administer federal and private sector grants for the furtherance of the

duties of the council and the development of gender-responsive, trauma-informed management of female offenders and their children.

IV. The council shall meet at least monthly during its first year, then at least quarterly thereafter. The members of the council shall elect a chairperson from among the members. The first meeting of the council shall be held within 45 days of the effective date of this section. The first meeting of the council shall be called by the senate member. The council shall convene at the call of the chairperson when deemed necessary by the chairperson.

V. The term of each member appointed under paragraph III who has a term of office shall be coterminous with his or her term in office. The terms of the remaining members shall be for 3 years. Vacancies shall be filled for the remainder of the term in the same manner and from the same group as the original appointment.

VI. The council shall report its findings and any recommendations for proposed legislation to the president of the senate, the speaker of the house of representatives, the senate clerk, the house clerk, the governor, and the state library annually on or before November 1.

269:2 New Classified Position; Funding. The position of administrator of women offenders and family services established under RSA 21-H:14-b, as inserted by section 1 of this act, shall be a classified position at labor grade 33. Funding for this position shall not affect the general fund appropriations reduction required in 2005, 176: 11. The funding for the administrator of women offenders and family services position shall be from the department of corrections' fiscal year 2007 operating budget.

269:3 Effective Date. This act shall take effect July 1, 2006.

Approved: June 9, 2006

Effective: July 1, 2006



ATTACHMENT 3:

NPR – Veterans Court – Buffalo, NY

## **NPR VETERANS COURT – BUFFALO, NEW YORK. APRIL 29, 2008**

### **Court Aims to Help Vets with Legal Troubles**

By Libby Lewis

As the wars in Iraq and Afghanistan put renewed focus on the issue of veterans' mental health, a judge in Buffalo, N.Y., has created a special court to assist veterans who wind up in the criminal justice system.

Gary Pettengill wanted to make a career out of the military, but the Army made him take a medical discharge in 2006 after he injured his back in Iraq. At the time, Pettengill was 23 and married, with a third child on the way.

To cope with what he says were empty days and nightmares caused by post-traumatic stress disorder, Pettengill says he started smoking marijuana. Then he began selling it to pay his bills. In February, he was arrested during a drug sweep and accused of being in possession of two pounds of marijuana.

Pettengill found himself facing serious time and the possibility of losing his children to the child welfare system. His family was evicted from their apartment.

Then he was referred to Judge Robert Russell's "veterans court."

### **Searching for Stability**

On a recent Tuesday, Pettengill was one of about 20 veterans sitting quietly in the courtroom waiting to be called before Judge Russell. Along one wall is a line of volunteers — mostly veterans but a few active duty officers — who are waiting to be assigned as mentors.

Pettengill, sporting a buzz cut and wearing a clean plaid shirt so big it looked like he might disappear in it, was called before the judge. Russell greeted him and then asked for an update on his life.

"My family and I moved into a new home ... it's pretty nice. Different neighborhood. More room for the kids to play inside," Pettengill told the judge.

Since Pettengill was arrested, the veterans court — working in conjunction with the Veterans Affairs Department — has helped him get drug counseling as well as part-time work, cash and help in finding a new apartment. He also has been assigned one of the volunteer veteran mentors.

## **Treatment and Help**

Russell and his staff started a docket for veterans in January when they realized increasing numbers of them were showing up in court. They counted 300 veterans who came into the local courts last year.

"The reality is, we knew we had to do something now ... because soon we're going to have 400,000 coming home," says Hank Pirowski, who heads Judge Russell's staff. He says a lot of the veterans they've seen got into trouble because they were dealing with the aftermath of combat.

"It starts out simply from a prescription abuse, to illicit substances, to some type of crime activity to support that [drug] activity, to being arrested, to going to jail," says Pirowski.

The court, he says, is Buffalo's way of trying to do right by veterans while also trying to prevent incidents of suicide or violence.

Hank Pirowski says he and Russell have thought a lot about the stories of Iraq veterans who came home and then killed themselves — or other people.

"If we would have reached that person sooner, would they have gotten to this point and to that charge?" Pirowski asks? "That's a good question. There's a chance we could have."

## **Down and Out**

Pettengill says he was headed for suicide before he wound up in Judge Russell's court. "I was having nightmares and I couldn't sleep," he says. "I wanted to do anything to rest. Anything."

Pettengill says he turned to drugs to fill a void that opened up when he left the Army. He hopes the court will help him stay on track.

"I have three beautiful children who need their father, and they don't need a suicide hanging over their heads for the rest of their lives either," he says.

Other veterans, such as Darryl Harper, say they're grateful for Judge Russell and his new court.

Harper learned Arabic from a babysitter while growing up in Buffalo. Air Force intelligence put him on the front lines in Lebanon after a Marine barracks was bombed in Beirut in 1983. He says he's dealt with manic depression for years.

Last year, it got the best of Harper and he turned on the oven in his house to kill himself. He survived, but he was charged with attempted arson. Now he's on probation, and Russell has ordered him to stay on his medication and see a counselor.

Harper's son was killed a few months ago during a robbery, and Russell's staff has kept a very close eye on him.

And Harper is glad for that attention and direction.

"This is how I look at it: He's my general, who has ordered me to do these things," Harper says.

ATTACHMENT 4:

Veterans and the Justice System

## Veterans and the justice system

By **KELLYN BROWN**, Chronicle Staff Writer, Bozeman Daily Chronicle

5/30/08

He was coined "The Last Marine" after all 11 men in his squad were killed six months ago by a roadside bomb in Iraq.

He was the lone survivor, and the national media ran with the story.

"My photo was on the front of every paper," Marine Lance Cpl. Travis Williams, of Helena, said in a recent interview. "But when I got home, no one had a clue. No one pays attention to (the war) anymore."

Williams soon felt forgotten and, more or less, like he was owed something. He had served his country. He had witnessed constant carnage in Iraq's most hostile province, Anbar.

His transition back to civilian life made him volatile. He would drive drunk, pick fights and get kicked out of bars. He was angry. Dozens of other combat-weary veterans feel the same way. Many, like Williams, suffer from post-traumatic stress disorder. Others simply hit a breaking point when they realize the life and personal relationships at home had changed. And some end up breaking the law.

This raises the issue of whether veterans -- especially those returning from the current war -- should be given special consideration if they end up in the justice system.

In Montana, more than 20 percent of the current prison population is veterans. Of the 600 people on probation or parole in this county, 45 are veterans. The vast majority are from past wars, primarily Vietnam.

Carroll Jenkins is hoping history doesn't repeat itself.

The president and founding member of the Montana Veterans Foundation said "mental illness, such as PTSD, needs to be seen as an opportunity to help, instead of an opportunity for incarceration."

Nationwide, 30 percent of U.S. troops surveyed developed a stress-related mental illness three to four months after returning home from the Iraq war, according to the Army's surgeon general.

And despite a robust economy and the highest employment levels in six years, according to the U.S. Senate Committee on Veterans' Affairs more than 15

percent of young veterans don't have jobs.

Jenkins sees the results of these numbers every day as a psychotherapist in private practice in Helena. Returning soldiers come to his office -- some are involved in a crime, homeless or simply angry.

"One guy came home to nothing," Jenkins said. "His wife had sold the farm, the house, the snowmobiles and left him a note. He got drunk, got into a fight and got arrested."

Jenkins has been working with Michael Donahoe, president of the Montana Association of Criminal Defense Lawyers, to better prepare attorneys who may counsel returning veterans.

Donahoe called it a preemptive measure, and said "if the war continues, we're going to see these folks, it's just a matter of when."

He said whether an offender is a returning veteran has to be considered by defense attorneys with regard to preparation, litigation techniques and bargaining.

Many soldiers need counseling, not a jail cell, he said.

"We owe these men and women something above and beyond ordinary people," Donahoe said.

Pre-sentence investigation reports compiled by probation and parole officers already include psychological and veteran information. Those reports are used during sentencings in Montana courts.

Gallatin County Attorney Marty Lambert said mental health issues in general are taken into account when working out plea bargains with defense lawyers. But he added that veterans' cases definitely deserve close scrutiny.

"All you can hope is that God grants you the wisdom to know the folks who deserve a break and the folks who don't," Lambert said.

Some veterans who witnessed heavy combat in Iraq just want the public to have a general understanding of returning soldiers. And most of them are law-abiding citizens.

Anthony Embesi, of Conner, lost an eye and half of his nose when a roadside bomb struck his convoy on July 4, 2004, near Falluja.

The 33-year-old petty officer with the Navy, who also suffers from PTSD, acknowledged that he has mood swings and can be short-tempered.

"I don't think people have any idea what's going through your head," Embesi said.

He said another soldier from his unit was arrested following a bar fight in Missoula. One police officer, a fellow veteran, wanted to work with him. But he was still eventually taken to jail.

Embesi and Williams have found some solace through counseling.

Williams is now studying geography at the University of Montana. Despite some rough nights, he avoided the law and is moving forward with his life.

He still, however, thinks that combat soldiers should be cut some slack as they adjust to civilian life.

"By no means should they be excused of a crime," Williams said. "But there should be an alternative to just throwing them in jail.

"Throwing them in jail is the worst thing you can do to them. You're just boxing up a problem that will come out later."

The Montana Association of Criminal Defense Lawyers will address the issue of counseling veterans at the group's annual conference in Chico on March 16 and 17. Carroll and Darlene McBee, national service officer with the military order of the purple heart with both be keynote speakers.



ATTACHMENT 5:  
CIT Tracking Form



# CIT TRACKING FORM

<b>Last Four Numbers of Subject's SSN:</b>	<b>Date of Birth (or age):</b>	
<b>Race:</b>	<b>Sex:</b>	<b>Time &amp; Date of Incident:</b>
<b>Agency Case #:</b>	<input type="checkbox"/> <b>Call Dispatched</b>	<input type="checkbox"/> <b>Self-Initiated</b>

<b>Nature of Incident (check all that apply):</b> <input type="checkbox"/> Disorderly/disruptive behavior <input type="checkbox"/> Neglect or self-care <input type="checkbox"/> Public intoxication <input type="checkbox"/> Nuisance (loitering, panhandling, trespassing) <input type="checkbox"/> Theft/other property crime <input type="checkbox"/> Drug-related offenses <input type="checkbox"/> Suicide threat or attempt <input type="checkbox"/> Threats or violence to others <input type="checkbox"/> Other (specify): <input type="checkbox"/> No Information	<b>Threats/Violence/Weapons</b> Did subject use/brandish a weapon? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know Type of weapon (check all that apply): <input type="checkbox"/> Knife <input type="checkbox"/> Gun <input type="checkbox"/> Other (specify):  Did subject threaten violence toward another person? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know If so, to whom? (Partner, Law Enforcement, Stranger, etc.)  Did subject engage in violent behavior toward another person? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know If so, to whom? (Partner, Law Enforcement, Stranger, etc.)  Did subject injure or attempt to injure self? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Prior Contacts (check all that apply):</b> Know person (from prior police contacts): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know Repeat Call (within 24 hours) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know  <b>Drug/Alcohol Involvement</b> Evidence of drug/alcohol intoxication <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know If YES – <input type="checkbox"/> Alcohol <input type="checkbox"/> Other Drug (Specify): <input type="checkbox"/> Don't Know  <b>Medication Compliance:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know  Specify if known:
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<b>Behaviors Evident at Time of Incident (check all that apply):</b> <input type="checkbox"/> Disorientation/confusion <input type="checkbox"/> Delusions (specify if known): <input type="checkbox"/> Hallucinations (specify if known): <input type="checkbox"/> Disorganized speech (freq. derailment, incoherence) <input type="checkbox"/> Manic (elevated/expansive mood, inflated self-esteem, pressured speech, flight of ideas, distractible) <input type="checkbox"/> Depressed (sadness, loss of interest in activities, loss of energy, feelings of worthlessness) <input type="checkbox"/> Unusually scared or frightened <input type="checkbox"/> Belligerent or uncooperative (angry or hostile) <input type="checkbox"/> No information	<b>Incident Injuries</b> Where there any injuries during incident? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know  If so, to whom? (Partner, Law Enforcement, Stranger, etc.)
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<b>Disposition (check all that apply):</b> <input type="checkbox"/> No action/resolved on scene <input type="checkbox"/> On-scene crisis intervention <input type="checkbox"/> Police notified case manager or NRVCS/ACCESS <input type="checkbox"/> Outpatient/case management referral <input type="checkbox"/> Transported to Carillion NRVMC (Bridge) <input type="checkbox"/> ECO <input type="checkbox"/> Arrested If YES, most serious charges: _____  Mental health treatment referral: <input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Other (specify):	Prior to CIT, would you have taken this individual to jail? <input type="checkbox"/> Yes <input type="checkbox"/> No  What would the charges have been? _____ _____  Printed Officer Name: _____ Badge/ID#: _____ Agency: _____ Date: _____
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Comments (use the back if necessary):

\*\*\*This form should only be completed by a trained CIT officer\*\*\*  
 DO NOT include any individually identifying information about the subject

ATTACHMENT 6:

Brief Jail Mental Health Screen

# BRIEF JAIL MENTAL HEALTH SCREEN

## Section 1

<b>Name:</b> _____ <small style="display: flex; justify-content: space-between; width: 100%;"> <span>First</span> <span>MI</span> <span>Last</span> </small>	<b>Detainee #:</b> _____	<b>Date:</b> ___/___/____	<b>Time:</b> _____ AM _____ PM
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## Section 2

Questions	No	Yes	General Comments
1. Do you <i>currently</i> believe that someone can control your mind by putting thoughts into your head or taking thoughts out of your head?			
2. Do you <i>currently</i> feel that other people know your thoughts and can read your mind?			
3. Have you <i>currently</i> lost or gained as much as two pounds a week for several weeks without even trying?			
4. Have you or your family or friends noticed that you are <i>currently</i> much more active than you usually are?			
5. Do you <i>currently</i> feel like you have to talk or move more slowly than you usually do?			
6. Have there <i>currently</i> been a few weeks when you felt like you were useless or sinful?			
7. Are you <i>currently</i> taking any medication prescribed for you by a physician for any emotional or mental health problems?			
8. Have you <u>ever</u> been in a hospital for emotional or mental health problems?			

## Section 3 (Optional)

<b>Officer's Comments/Impressions (check <i>all</i> that apply):</b>		
<input type="checkbox"/> Language barrier	<input type="checkbox"/> Under the influence of drugs/alcohol	<input type="checkbox"/> Non-cooperative
<input type="checkbox"/> Difficulty understanding questions	<input type="checkbox"/> Other, specify: _____	

### Referral Instructions: This detainee should be referred for further mental health evaluation if he/she answered:

- YES to item 7; OR
- YES to item 8; OR
- YES to at least 2 of items 1 through 6; OR
- If you feel it is necessary for any other reason

Not Referred

Referred on \_\_\_/\_\_\_/\_\_\_\_\_ to \_\_\_\_\_

Person completing screen \_\_\_\_\_

INSTRUCTIONS ON REVERSE

## INSTRUCTIONS FOR COMPLETING THE BRIEF JAIL MENTAL HEALTH SCREEN

### GENERAL INFORMATION:

This Brief Jail Mental Health Screen (BJMHS) was developed by Policy Research Associates, Inc., with a grant from the National Institute of Justice. The BJMHS is an efficient mental health screen that will aid in the early identification of severe mental illnesses and other acute psychiatric problems during the intake process.

This screen should be administered by Correctional Officers during the jail's intake/booking process.

### INSTRUCTIONS FOR SECTION 1:

NAME: Enter detainees name — first, middle initial, and last  
DETAINEE#: Enter detainee number.  
DATE: Enter today's month, day, and year.  
TIME: Enter the current time and circle AM or PM.

### INSTRUCTIONS FOR SECTION 2:

#### ITEMS 1-6:

Place a check mark in the appropriate column (for "NO" or "YES" response).

If the detainee REFUSES to answer the question or says that he/she DOES NOT KNOW the answer to the question, do not check "NO" or "YES." Instead, in the General Comments section, indicate REFUSED or DON'T KNOW and include information explaining why the detainee did not answer the question.

#### ITEMS 7-8:

ITEM 7: This refers to any *prescribed* medication for any emotional or mental health problems.

ITEM 8: Include any stay of one night or longer. Do NOT include contact with an Emergency Room if it did not lead to an admission to the hospital

If the detainee REFUSES to answer the question or says that he/she DOES NOT KNOW the answer to the question, do not check "NO" or "YES." Instead, in the General Comments section, indicate REFUSED or DON'T KNOW and include information explaining why the detainee did not answer the question.

#### General Comments Column:

As indicated above, if the detainee REFUSES to answer the question or says that he/she DOES NOT KNOW the answer to the question, do not check "NO" or "YES." Instead, in the General Comments section, indicate REFUSED or DON'T KNOW and include information explaining why the detainee did not answer the question.

All "YES" responses require a note in the General Comments section to document:

- (1) Information about the detainee that the officer feels relevant and important
- (2) Information specifically requested in question

If at any point during administration of the BJMHS the detainee experiences distress, he/she should follow the jails procedure for referral services.

### INSTRUCTIONS FOR SECTION 3:

OFFICER'S COMMENTS: Check any one or more of the four problems listed if applicable to this screening. If any other problem(s) occurred, please check OTHER, and note what it was.

### REFERRAL INSTRUCTIONS:

Any detainee answering YES to Item 7 or YES to Item 8 or YES to at least two of Items 1-6 should be referred for further mental health evaluation. If there is any other information or reason why the officer feels it is necessary for the detainee to have a mental health evaluation, the detainee should be referred. Please indicate whether or not the detainee was referred.

**ATTACHMENT 7:**

**Reducing Risk and Responding to Mental Health  
Needs: Kentucky's New System of Care**

# *Reducing* Risk and Responding to Mental Health Needs: *Kentucky's* **New** System of Care

By Connie Milligan and  
Ray Sabbatine

Imagine a simple solution to some of America's detention centers' most complex problems, a solution that involves a system of care that would reduce suicide and expand mental health services, and would not increase cost to the jails. That was the task and the accomplishment of the Kentucky Jail Mental Health Crisis Network. After the first year of implementation, the data appear to show that this new network of services, fully funded by legislative action through an increase in court cost, is reducing suicides and increasing service connections.

Why was this needed? In 2002, the *Louisville Courier Journal* did an investigative report on 17 suicides and two deaths in restraints that had occurred in Kentucky jails in the previous 30 months.<sup>1</sup> The articles highlighted the disconnect between proper risk assessment and the appropriate delivery of services. It was clear that detention center personnel were being asked to provide services to a population they little understood without the training and skills to manage them, while mental health professionals were not adequately involved.

Kentucky legislators took notice of the problem, and during the 2002 legislative session, four hours of mental health training was mandated for all detention center personnel. The authors, who were involved in the development and the delivery of that training, heard from the jailers that, although the training was helpful, it was not a substitute for

actual services. In 2003, the authors began to develop a consultation service — the Telephonic Triage program — and piloted it in five jails. It was clear from the outcomes of the pilot program that the jails needed a more comprehensive service delivery system. Because of limited local and state resources for new jail services, legislative funding was sought for the program in 2004. With the passage of the legislation and more than a year of implementation across the state, Kentucky has a new program that takes a different approach to solving a problem that plagues detention centers across the nation.

The solution, implemented by legislative action in 2004, is a new statewide program that involves a four-step process to clearly define protocols for integrating mental health services into the state detention centers.<sup>2</sup> It includes the use of two standardized detention center risk-screening instruments; a telephonic triage to assess the level of mental health risk; recommended management protocols defined for each risk level; and follow-up services provided by the regional community mental health boards.

The goals of this program are to identify suicide and/or acute mental health symptoms, reduce self-harm and suicide in jails, provide a secondary level of assessment by a licensed mental health professional, and to increase possible diversion and treatment.

## Rationale for Kentucky's Solution

In Kentucky, most of the 86 jails are in rural areas, are governed by local fiscal courts, and have difficulty accessing and affording services. In many areas, the use of criminal charges and jail time has become the most frequent solution for difficult social problems that would be better served by extensive professional involvement. This includes behavioral problems related to mental illness, suicidal behavior, domestic violence and substance abuse. Alternatives such as court diversion programs and extensive treatment programs are unavailable in rural areas. Although some of the larger detention centers have contracts for mental health services, most small to medium-size jails are dependent upon limited medical staff for risk assessment. Thus, the day-to-day management decisions and response to these complex behavioral problems are left to officers. Staff discretion in caring for and responding to people with mental illness and/or who are suicidal can pose tremendous risk. It becomes clear that the more those decisions are taken out of the hands of staff who are not trained or considered mental health experts, the better.

According to the National Institute of Corrections, objective jail classification “is considered one of the most important management tools for jail administrators and criminal justice system planners.” It helps ensure consistency in assessing and responding to the risk and needs of individuals by offering clear protocols and a consistent nonsubjective model for decision-making. It helps ensure safe housing, management and response to the highest risk people. A classification system used in Lexington Fayette County Detention Center resulted in the detention center experiencing a dramatic reduction in suicides, from 10 in a 13-year period to none in the 12 years after classification was implemented. Kentucky's program has been developed based on the lessons learned from this experience.

The protocols for the program are built on the basic tenants of a good classification system and integrate most of the key components that Lindsay Hayes, project director of the National Center of Institutions and Alternatives, has promoted for the reduction of suicide in jails.<sup>3</sup> It includes standardized screening instruments, telephonic triage, jail-management protocols and mental health follow up.

## Standardized Screening Instruments

The success of this program is dependent on the detention center's use of reliable and standardized screening instruments. The two questionnaires developed for this program have no more than 20 yes-or-no questions that reduce the booking/screening officer's role in making judgment calls. The yes answers have prompts on who to notify if risk is present.

The first instrument is given to the arresting officer. It has been noted in Kentucky, and is certainly true across the country, that numerous deaths have occurred because critical information was not provided by the arresting officer. Three questions related to behavioral indicators of suicide, mental illness or negative reactions to the charge are immediate prompts for a call to the Telephonic Triage Line (described below).

The second instrument is given to the arrestee by the booking/screening officer. Again, the questions are limited to those that simply identify risk and need. The five questions that are flags for a call to the Triage Line include a serious mental health problem that needs attention; a history of psychiatric hospitalization in the past year; history of a suicide attempt; current suicidal thinking; and a severe reaction to the charge that may result in self-harming behavior. Additional yes answers to the questions related to substance abuse, mental retardation and acquired brain injury are also reviewed during the Telephonic Triage.

During the training, detention center personnel are instructed to supplement the intake and booking questionnaires with additional processes to identify risk at any time during incarceration. This includes an alert file on people with previous high-risk status, officer observation of mental health or suicide risk, individual requests for services, and an automatic reassessment of risk when the legal status changes for the worse. Therefore, this program recommends that six different methods of identifying risk and need be used by detention center personnel.

## Telephonic Triage Line

The toll-free Telephonic Triage Line offers 24-hour response by a licensed mental health professional who uses a research-based mental health and suicide risk-assessment instrument. This instrument was developed with consultation from a technical resource provider from NIC. A positive answer to any of the mental health and suicide flags on the screening instrument (or from other methods of identification) prompts an immediate call to the 24-hour toll-free Triage Line.

The intent of the triage is to identify a level of risk related to current and potential symptoms of suicide and mental illness. The risk level corresponds to clear protocols for



detention center management and follow-up services. Because the service is offered telephonically, it is not intended to be a psychosocial or diagnostic assessment. The triage is a guided interview with the detention center officer and also includes direct conversation with the individual in question. It included questions in the following categories: risk related to the charge, risk related to substance abuse withdrawal or overdose, risk related to suicide and risk related to symptoms of mental illness in four diagnostic categories. Additional factors also are considered and include history of hospitalization and treatment, substance abuse, post-traumatic stress disorder, victimization, mental retardation/developmental disabilities and acquired brain injury. Each one of the data variables is defined in a data dictionary so that the mental health professionals and the detention center personnel can be consistent in their interpretation of terms.

The Telephonic Triage information is scaled at three points in the triage process: the risk related to the charge, the risk related to suicide (including current substance use risk), and a final risk level that integrates suicide and the mental illness variables. The final level of risk is tightly defined with protocols to guide the clinicians' determination and is labeled critical, high, moderate or low. The risk assignment also includes recommendations for additional follow-up services that include a face-to-face follow-up visit by a local mental health professional, civil commitment to a psychiatric facility or referral for a competency evaluation. The triage clinician e-mails or faxes the completed triage assessment to the detention center and the follow-up clinician, and makes calls as needed for follow up.

## Jail Management Protocols

The Telephonic Triage summary risk level is tied to suggested detention center risk-management protocols. These protocols represent the best practice standards in the industry and integrate typical detention center standards and classification program recommendations. For each clinical risk level, the detention center is guided on housing, level of supervision, property, clothing and food. Again, it ties the mental health risk back to appropriate, safe and humane detention center management.

The clinical risk levels' management techniques encourage the detention centers to implement new best practice protocols. For instance, the critical risk level is reserved for when an individual is actively trying to take his or her life. Four-point restraints are no longer acceptable because of the high safety risks they pose. At the high-risk level, safe or single-cell housing is used along with frequent and staggered supervision (instead of the standard 20-minute observation in most detention center protocols). This type of supervision ensures that someone on a suicide watch does not find opportunity for an attempt. Suicide smocks are recommended instead of paper jumpsuits. The only property allowed is a suicide blanket. Finger foods are recommended. At the moderate risk level, the individual can be in general housing but will receive individualized observation to determine if he or she develops symptoms that need further assessment. The low-risk level indicates that the individual can be housed in general population.

## Follow-Up Mental Health Consultation

The final innovation of this program is the funding for the regional community mental health center boards to provide 24-hour coverage for detention center emergency follow-up response. The result is now a tight system of response that has trained clinicians on 24-hour call to respond to detention center emergencies as identified during the Telephonic Triage.

Mental health follow-up is defined as a consultation service to those individuals with acute risk for suicide or mental illness. It is a mandatory response for people assessed at the critical level of risk and required for those with acute symptoms at a high level of risk. To ensure consistency in response across the state, time frames are established for each level of risk. Critical level of risk requires a three-hour response time; high level, a 12-hour response time; and moderate level, a next business day, or as needed response time.

Clinicians conduct an assessment to determine if the triage risk assessment and the corresponding risk-management protocols should be maintained, reduced or increased. In addition, the clinician determines if other services are needed, makes consultation recommendations and initiates the legal process for diversion to hospitals, or in some circumstances, for conditional release, dependent on outpatient follow up. Most important, the clinician becomes an important ally to the people with mental illness and a consultant for risk management to the detention center staff. Staff in both agencies are now being cross trained.

## Program Results

In the first year of implementation, there was 88 percent participation among Kentucky detention centers, with more still requesting training and entry into the program. The data are showing some interesting results.

Of the 5,500 triages completed in the first year, it is estimated that they represent 7 percent of the bookings. This is consistent with data from national clinical studies that suggested 6 percent to 16 percent of individuals in city or county detention centers have mental illness.<sup>4</sup>

The data provide an interesting profile of the people with suicidal and mental illness risk factors who are incarcerated in Kentucky jails:

- A high percentage of people (64 percent) have relatively minor misdemeanor charges;
- The relatively low number of people who are at risk related to their charge (12 percent) actually pose some of the highest risk for self-harm;
- Suicidal risk represents a great concern to the jails. It is present in 65 percent of the people triaged, with high- to critical-risk protocols needed in 35 percent of the cases;
- The high rate of previous psychiatric hospitalization (30 percent during the past year and 16 percent in the past six months) confirms what is known anecdotally: Many of these people are falling through the cracks of an unsuccessful cycle of hospitalization, failed outpatient treatment follow up, and arrest on relatively minor misdemeanor charges;

- The rate of concurrent substance use problems is 38 percent lower than expected;
- Seventy-seven percent have mental health symptoms, a greater rate than in the general population; and
- High risk is not being over-identified: A low number of people are at the critical level of risk (0.5 percent) and 32 percent are at high risk.

According to Kentucky Justice Cabinet officials, the jail self-report of in-custody suicides indicates that the suicide rate in Kentucky jails has been significantly reduced since the inception of the program. The 17 deaths by suicide that were reported from 2000 to 2002 have been reduced to one from 2003 to 2005 in jails participating in the state Jail Mental Health Crisis Network. The program appears to be accomplishing one of its significant goals.

Observations from clinical staff include recognition that this is important work, and the previous barriers between jails and mental health agencies have been reduced by a new spirit of collaboration and cross-training. Problem-solving continues. Issues being discussed include how to increase pre-arrest and post-arrest diversion through collaboration with pretrial release officers and the courts, and increasing in-facility treatment options. The clear cycle of recidivism suggests new treatment options must be considered.

The new Kentucky Jail Mental Health Crisis Network is bringing mental health services to the detention centers, increasing the cross-training in both professions and reducing the rate of suicide in Kentucky jails. The detention

centers now have statewide best practice protocols that reduce their risk and provide better options for people with mental illness or suicide risk. The triage process, follow up and tight protocols reduce the staffing outlay for managing risk and provide good consultation. It is a program that has clear potential for future development.

## ENDNOTES

<sup>1</sup> Adams, J. 2002. Locked in suffering: KY jails and the mentally ill, a four-part series. *Louisville Courier-Journal*, Feb. 24-March 3.

<sup>2</sup> Kentucky Revised Statutes. 2004. HB 157 SCS(2), create a new section of KRS chapter 21, KRS 441 and KRS 23A and 24A.

<sup>3</sup> Hayes, L. 2003. Jail suicide and liability and policy assessment and development services. National Center on Institutes and Alternatives. Available at [www.ncianet.org/cjisl.cfm](http://www.ncianet.org/cjisl.cfm).

Crawford, M. 2005. Attitude, communication can prevent suicide. Nov-Dec 2005, *CorrectionalNews.com*.

<sup>4</sup> Lamb, R. and L. Weinberger. 1998. Persons with severe mental illness in jails and prisons, a review. *Psychiatric Services*, 49 (April):483-492.

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**ATTACHMENT 8:**

**The EXIT Program: Engaging Diverted Individuals  
Through Voluntary Services**



# The EXIT Program: Engaging Diverted Individuals Through Voluntary Services

Gerald Foley<sup>1</sup> and Elisa Ruppel<sup>2</sup>

The CMHS National GAINS Center

May, 2008

Among justice-involved people with serious mental illness and co-occurring substance use disorders, those who repeatedly commit misdemeanors are perhaps the most difficult to effectively divert into services from the criminal justice system. Despite extensive criminal histories, with today's overcrowded jails they face relatively little jail time. Offered a choice between a few days in jail or 12 to 24 months of court supervision, they often serve the jail sentence on recommendation of defense counsel.

In 2002, the New York City Mayor's Office partnered with the Center for Alternative Sentencing and Employment Services to develop a strategy for engaging this population in services. This partnership led to the development of EXIT, a jail diversion program for justice-involved people with mental illness who are processed through Manhattan's Criminal Court.

At arraignment, a forensic clinical coordinator screened referred individuals for serious mental illness and program eligibility standards: nonviolent misdemeanor instant offense, at least three prior misdemeanor convictions, and a possible 5 to 30 day jail sentence on the current charge.

Rather than divert people into a lengthy period of court supervision, EXIT emphasized voluntary access to services through a required three-hour Mandated Treatment Assessment Session (MTAS), which was conducted by staff at the program's office immediately following sentence. The goals of the MTAS were to: 1) assess and address the participant's immediate needs, including food, shelter, and clothing; 2) outline short- and medium-term goals the participant could pursue through nonmandated case management services; 3) explain the potential benefits of program engagement; and — if the individual accepted services — 4) establish mutually agreed-upon expectations,

including means for maintaining contact, level and frequency of contact, and service goals.

After completing the MTAS, an individual could elect to participate in nonmandated case management services to address identified needs. The program coordinated services among various providers, and maintained as-needed contact with participants to ensure sufficient community supports necessary for stability and the reduction of risk for rearrest. Core program elements were drawn from identified best practices, focusing heavily on strengths-based engagement combined with intensive case management. EXIT established a strong commitment to consumer involvement at all stages of program planning, implementation, evaluation, and promotion. A peer specialist was employed to serve as an escort to appointments and to provide other supportive services to participants and staff, including case consultation, as a full member of the treatment team.

EXIT's high engagement–low coercion model provided a path from the court to community-based treatment with minimal judicial oversight and no probation or parole monitoring. Beyond reporting completion of the MTAS, the program was not obligated to provide status updates on participants to the court.

## Participant Characteristics

As shown in Table 1 (below), bipolar, schizophrenia spectrum, and depressive disorders were about equally distributed among defendants who entered the program with a diagnosis. There were 31 of 173 (18 percent) individuals who could not specify a diagnosis, but were admitted to the program based on signs of mental illness apparent to clinical staff during screening.

1 EXIT Project Director, New York City Mayor's Office of the Criminal Justice Coordinator, New York, New York

2 Research Associate, Center for Alternative Sentencing and Employment Services, New York, New York

Mental Health Diagnosis	Number	Percent
Schizophrenia/Schizoaffective Disorder	38	22
Bipolar Disorder	37	21
Depressive Disorder	36	21
Anxiety	2	1
Two or More Diagnoses	29	17
Diagnosis Unavailable	31	18
Intake Arrest Charge		
Property Crime	57	33
Possession of Controlled Substances	47	27
Theft of Services	12	7
Trespassing	12	7
Disorderly Conduct	12	7
Forgery Crimes	8	5
Criminal Tampering/Criminal Mischief	6	3
Criminal Possession of a Weapon	5	3
Other/Unknown	14	8
Gender		
Male	150	87
Female	20	12
Other	3	1
Race/ Ethnicity		
Non-Hispanic African American	108	63
Hispanic	35	20
Non-Hispanic Caucasian	28	16
Other	2	1
Age Range		
18-29 years	32	18
30-39 years	51	29
40-49 years	66	39
50-59 years	23	13
60+ years	1	1

**Table 1. Demographics of EXIT Participants (n=173)**

EXIT participants were a needs-intensive group. In addition to serious mental illness, 87 percent reported current substance use and approximately half were homeless.

The largest number of participants (57) entered the program due to arrest for a property-related offense, followed by possession of a controlled substance (47).

Although screenings comprised only 11 percent women, women were admitted to the program at a rate comparable to their male counterparts (43 percent, compared to 41 percent of all men screened). The average age of participants at intake was 39 years.

## Results

### Criminal Justice Buy-In

The EXIT program experienced increased levels of criminal justice buy-in over the life of the program as evidenced by the high utilization rate among judges. All but 23 of the 196 defendants found eligible were released to the program. This is significant given the initial reticence on the part of some judges to release defendants to the program due to concerns that the three-hour MTAS did not constitute a sufficiently stringent sanction. Moreover, judges expressed concern that the program's voluntary case management model would neither allow for judicial oversight nor provide a compelling reason for participants to remain engaged with services.

*EXIT's high engagement-low coercion model provided a path from the court to community-based treatment with minimal judicial oversight and no probation or parole monitoring.*

Moreover, judges expressed concern that the program's voluntary case management model would neither allow for judicial oversight nor provide a compelling reason for participants to remain engaged with services.

### Consumer Engagement

Ninety-seven percent of defendants court ordered to complete the MTAS fulfilled their obligation to the court. Of the 168 defendants who completed the MTAS, 120 (71 percent) had subsequent nonmandated in-person contact with program staff. Two-month retention was at 54 percent, with 21 percent remaining engaged with the program for a minimum of six months. For those who remained engaged for a minimum of eight months, program contacts averaged approximately three per month.

### Recidivism

A snapshot of 90 EXIT participants was selected for the purpose of analyzing conviction patterns. Participants with felony convictions in the 12 months before or after the MTAS were excluded, since it was

## Discussion

expected that far fewer days at liberty would decrease their likelihood of reconviction on misdemeanor charges. EXIT participants with open cases were also excluded from the analysis. Nine individuals were excluded, leaving a cohort of 81.

Across the cohort, there was an 18 percent reduction in the aggregate number of convictions in the year following program engagement compared to the year before, representing a decrease from 261 convictions to 214 convictions in the 12-month pre- versus post-MTAS periods [ $t(80) = 2.09, p = .039$ ].

To determine whether participation in post-MTAS case management services had any effect on recidivism, the 81 participants were divided into three subgroups:

- Group 1 - Those who did not engage in any post-diversion case management sessions
- Group 2 - Those who engaged in between one and nine case management sessions
- Group 3 - Those who engaged in 10 or more sessions

Groups were defined based on an analysis of case management engagement patterns across the entire sample pool. Of the 81-member cohort, 24 subjects (29.6 percent) had no contact, 25 (30.9 percent) had between one and nine contacts, and 32 (39.5 percent) had at least 10 post-MTAS case management contacts.

While all groups experienced a reduction in the aggregate number of convictions in the post- versus pre-MTAS period, the cohort with 10 or more post-MTAS case management contacts (Group 3) experienced the largest decline (24 percent, compared to 18 percent and 11 percent for Groups 2 and 1, respectively). Further analysis revealed that in the post-MTAS year this same Group 3 cohort comprised the highest number and percentage of individuals with no convictions (11, or 34 percent of cohort, representing 52.4 percent of the 21 subjects across all groups with zero convictions in the post-MTAS year).

Based on the EXIT program data, the chronic patterns of both re-conviction and transient service engagement long associated with people with serious mental illness who repeatedly commit misdemeanors can be interrupted through nonmandated engagement in services. It also suggests that the program services provided by EXIT were viable and responsive to individual needs, as evidenced by the number of participants who remained engaged in program services for periods up to and exceeding six months, and as confirmed through consumer feedback.

The presumption that mandated engagement would have yielded lengthier program tenure rates is tempered by several considerations. First, the aggregate and cohort conviction rate decline suggest that retention drop off is not necessarily indicative of undesirable outcome. Drop off could have reflected more positive alternatives such as reduced reliance on EXIT resulting from the fulfillment of immediate service needs or successful transition to permanent

providers. Also compelling is the possibility that retention rates may have been increased with enhanced staffing as opposed to imposition of mandate. For example, during the program's second year, when it was fully staffed, the minimum six-month retention rate of 35 percent approximated the three-month rate averaged over the life of the program (36%).

EXIT demonstrates that people with mental illness who repeatedly commit misdemeanor offenses can engage voluntarily and remain engaged in services beyond any court mandate, with significantly reduced recidivism as an outcome. ■

... there was an 18 percent reduction in the aggregate number of convictions in the year following program engagement compared to the year before ...

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Recommended citation: Foley, G., & Ruppel, E. (2008). *The EXIT program: Engaging diverted individuals through voluntary services*. Delmar, NY: CMHS National GAINS Center.

ATTACHMENT 9:

“20 in 20” – Innovation Number 17

## "20 in 20" -- Innovation Number 17

### **Researching Risk, Ending Homelessness: A replicable strategy targets the most vulnerable and disabled people living on the streets**

- The Vulnerability Index is a research and data driven tool that is consumer centric, housing focused, and replicable, demonstrating results in ending homelessness for the most vulnerable and disabled people living long term on the streets.

#### **What is the Innovation and How Does It Work?**

##### **Using research data that identifies the most vulnerable and disabled people living on the streets, a replicable street-based strategy targets individuals for housing interventions.**

*Problem:* Translate available research on health conditions that disproportionately lead to death for people living long term on the streets to a tool that can identify and target those most at risk for priority intervention and move them from homelessness to housing, thus closing the gap between knowledge and practice and demonstrating positive results on the streets and in the lives of those experiencing chronic homelessness.

*Solution:* The Vulnerability Index employed by Common Ground's Street to Home engagement initiative converts more than a decade of research and results to a format that surveys, captures, and measures "medical vulnerability" and creates a numbered registry of individuals for housing priority based on mortality risk and length of homelessness.

A fundamental dilemma for preventive strategies is identifying specific indicators before the fact to profile those for whom a given intervention can be subsequently documented to prevent the possible alternative outcome. Identifying the factors, the population, and the solution with specificity aids in targeting scarce resources to the greatest demonstrated effect.

The Vulnerability Index as developed by Street to Home is applied as a street-level survey, intended to change strategies addressing street homelessness and reduce deaths. Based on research by Dr. James O'Connell of Boston Healthcare for the Homeless, Street to Home categorized as "high risk" those individuals who have been homeless for at least six months with one or more of the following characteristics: more than three hospitalizations or emergency room visits in a year; more than three emergency room visits in the previous three months; aged 60 or older with cirrhosis of the liver, end-stage renal disease, history of frostbite, immersion/trench foot, or hypothermia, HIV+/AIDS, or tri-morbidity of co-occurring psychiatric, substance abuse, and chronic medical conditions.

Street to Home then conducts a three-night survey in the early morning hours using the index in a specified geographic area, canvassing to identify and interview people routinely sleeping on the streets, and generating a registry based on their responses to the list of characteristics named above. The registry results in a prioritized housing list which acts as an action plan for the Street to Home team.



## Who Benefits from the Innovation?

**Individuals living long term on the streets** with disabilities and other serious health conditions benefit from a goal of solving - not servicing - their homelessness, by being engaged with a housing solution to end their homelessness, rather than by having their homelessness serviced on the street.

**The community benefits** by the highlighting of serious health issues among a vulnerable population that are now the focus of results-oriented intervention and the antidote of housing to end homelessness, rather than a continuation of random ricocheting of an expensive population through emergency and acute public systems of care and treatment.

**Public systems of care and treatment** benefit by reducing the costly impact of frequent users through the antidote of housing that ends homelessness, and housing and service agencies benefit by a data-driven plan to organize resources, supports, and housing for vulnerable individuals.

**Communities not currently engaged in targeted strategies** to end chronic homelessness can observe a results-oriented trajectory that provides an identifiable starting point for engagement and intervention that is both compassionate and cost effective for the community.

## What Results are being Achieved and Reported?

Common Ground's Street to Home initiative has reported the following results from employing the Vulnerability Index in sites around the country where it is working currently. The Street to Home strategy is also at work in Canada and Australia.

In New York's Times Square, the Street to Home partnership of Common Ground Community and the Times Square Alliance reduced homelessness in a 20-block area by 87% over two years. In Brooklyn and Queens, over 300 individuals sleeping on the streets have been surveyed. The City of New York has adopted Street to Home as the citywide strategy to reduce street homelessness.

Los Angeles County, Santa Monica, and New Orleans have all used a version of the survey to promote rapid response and housing results. Los Angeles County has placed 27 of the 50 most vulnerable persons on Skid Row directly into housing, with an average time from initial contact to housing placement of less than 14 days.

Santa Monica has moved 10 of the 110 most vulnerable persons into housing, and the City Council has pledged support for all 110.

UNITY of Greater New Orleans used the survey results to secure emergency housing funds initially for the 41 people identified as most at risk, and subsequently for a total of more than 50 of 150 individuals surveyed.

## Who is the Innovator?

**Dr. James O'Connell**, President of Boston Health Care for the Homeless, has been researching risk factors for death among people who are chronically homeless

for over a decade. With his research colleagues, he has examined the profile of those homeless individuals who were more likely to die than their counterparts in the general population, and what factors other than their homelessness were associated with their high risk of death.

In 1999, Dr. O'Connell presented to a Massachusetts Housing and Shelter Alliance - U.S. Department of Health and Human Services conference on discharge planning the findings from his Massachusetts Department of Public Health funded morbidity review of the records and recent treatment contacts of 13 people who were homeless who had died on downtown Boston streets in a matter of months. In 2006, Dr. O'Connell acted as expert faculty for a meeting of jurisdictional leaders convened jointly by the U.S. Interagency Council on Homelessness, Common Ground, and the Rockefeller Foundation to examine city data practices in tracking deaths of people who are homeless.

The **Street to Home initiative** of New York City's Common Ground, under the leadership of founder and President Rosanne Haggerty and Innovations Director Becky Kanis, incorporates strategic targeting of individuals and intensive followup modeled on the successful approach used in the United Kingdom's Rough Sleepers Initiative. The Rough Sleepers Initiative achieved a 75% reduction in street homelessness across England and prompted deeper investment in homelessness from Parliament.

Street to Home replaced the random "first come, first served" approach with a targeted, strategic process: identify and prioritize the most vulnerable individuals on the street, assess and negotiate housing options with them, then house those individuals quickly and support their tenancies with services. Those are three key elements of Street to Home's initiative with the Times Square Alliance. The strategy has reduced homelessness in the area by 87% over two years. A simple tracking tool enables workers to differentiate between those who are consistently in the targeted area - "anchors" - and those who are transients. The role of "anchor" individuals in street homelessness was identified in the Rough Sleepers Initiative, with subsequent targeting of those individuals yielding greater success - a tipping point - in engaging and moving individuals in the surrounding area.

### **[Where Can I Learn More About the Innovation?](#)**

Read the research of [Dr. James O'Connell](#) and his colleagues on street deaths.

Read more about [Boston Health Care for the Homeless'](#) research on chronic homelessness and frequent users of care.

Contact Dr. O'Connell at BHCHP:  
729 Massachusetts Avenue  
Boston MA 02118  
Phone: 857-654-1000

Read more about Common Ground's [Street to Home Initiative](#).

Contact Innovations Director Becky Kanis at Common Ground:  
Phone: 212-389-9300  
E-mail: [info@commonground.org](mailto:info@commonground.org)

ATTACHMENT 10:

“20 in 20” – Innovation Number 14

## **"20 in 20"-- Innovation Number 14**

### **St. Paul Police Department partners for housing solutions to chronic homelessness**

- A police-homeless outreach partnership in St Paul/Ramsey County creates tenancies for men and women experiencing chronic homelessness who have been living on downtown streets, in encampments, and in abandoned buildings.
- Pilot funding came from the Minnesota Department of Public Safety, in collaboration with Ending Long-Term Homelessness Advisory Council and the Minnesota Department of Human Services Office of Economic Opportunity, which has extended its investment through 2009.

#### **What is the Innovation and How Does It Work?**

#### **Police officers working the St. Paul "downtown beat" and responding to encampments and abandoned buildings are creating housing opportunities for men and women experiencing long term homelessness, using 30 state rental vouchers for the Police-Homeless Outreach Program (P-HOP).**

P-HOP began in 2005 as one of three pilot homeless outreach projects funded by the Minnesota Department of Public Safety (DPS). South Metro Homeless Services, a non-profit in St. Paul/Ramsey County applied to DPS at the request of the St. Paul Police Department. With the new grant, South Metro added an outreach worker to its ACCESS team and co- located the worker in a police sub-station to work directly with police officers to improve outcomes from repeated police encounters with individuals who are homeless. Outreach worker Bret Byfield is working with "Downtown Beat" officer Sgt. Paul Paulos and Code Enforcement Officer Dean Koehnen to promote cross training, secure treatment and housing opportunities for individuals who are experiencing long term homelessness, and enhance police and community dialogue through a "police-provider forum" and monthly breakfast meetings between police officers and other members of the criminal justice system.

Recognizing that many of the persons they routinely encountered have poor rental histories, criminal records, and/or substance abuse histories that exclude them from housing opportunities, one P-HOP focus has been on developing relationships with landlords to facilitate housing access. The team has demonstrated resilience in dealing with the loss of housing units as landlord circumstances change. One loss involved 23 individuals living in shared housing in three buildings that had been accessed through one participating landlord. Alternate housing was located within 30 days using a variety of community resources nurtured through the P-HOP program and included 8 persons who were able to be housed through the P-HOP rental voucher initiative.

The rental voucher initiative was a successful application to the Minnesota Housing Finance Agency "Long Term Homeless Rental Assistance Program" by South Metro Human Resources, which had secured 30 vouchers for a unique collaboration in which the vouchers would be administered by South Metro but would only be available for persons experiencing long term homelessness and referred by police officers through the P-HOP program. To date, 20 such individuals have been

identified and referred by the officers and have received vouchers. One man in his 60s had a cancer diagnosis, was without income for housing and medicine, and had been living in an encampment for two years. Since the voucher resources from the MHFA come "without services attached," case management is provided by four staff from South Metro Human Services' PATH program in collaboration with P-HOP coordinator Byfield.

### Who Benefits from the Innovation?

**Men and women experiencing long term homelessness** and living on St. Paul's downtown streets, in encampments, and abandoned buildings are being assisted off the streets into permanent housing and connected to community services.

"New pathways of trust and communication" have been opened between the **police and persons living on the downtown streets** and in encampments. St. Paul/Ramsey County 10-Year Plan "Heading Home Ramsey" Coordinator Carol Zierman describes the commitment of the police officers to helping persons off the streets into housing through the P-HOP effort as having a "transforming" impact for many individuals who previously viewed the police only as "adversaries."

The **St. Paul community** is benefiting from reduced costs in detoxification and re-arrests and increased stability for persons who had been homeless long term and living with disabilities.

### What Results are being Achieved and Reported?

20 men and women living long term on the streets, or in encampments and abandoned buildings have been housed using the MHFA rental vouchers. All but one remain currently housed.

Ramsey County Detox Director Peter Bieri reports a notable decline in the number of repeat visits to detox from the P-HOP effort: " Detox used to be 50% of the same chronics - now it is down to about 15% chronic return. It saves money and it saves people."

A November 2007 Report to the Minnesota Legislature on the Homeless Pilot Project Grants reported that the P-HOP program has been approved for a second two-year grant of \$98,000 to continue the program till 2009. During the initial 2-year funding, the three pilot projects - which included People Incorporated in Hennepin County and Churches United Ministry in St. Louis County - collectively served 354 persons experiencing homelessness, including more than 80% identified as long term homeless. Of the 218 actively receiving services at the end of the funding period, 65 percent had obtained stable housing. Additional services offered by the programs included access to benefits, medical care, substance abuse and mental health treatment, and case management. Other report findings:

- Data collected from the Bureau of Criminal Apprehension (BCA) illustrates a decrease in arrests for program participants. Prior to entering the program, 87 percent of program participants had been arrested at least once as compared to 33 percent who have been arrested one or more times since entering the program.

- Detoxification center admissions data showed that 70 percent of program participants had one or more admissions to detox previously versus 45 percent with one or more admissions during the program.

### **Who is the Innovator?**

At the request of the St. Paul Police Department, South Metro Human Services, a non-profit organization in St. Paul, applied for and received \$82,000 to create a Police-Homeless Outreach Program (P-HOP) as one of three Homeless Pilot Projects funded by the Minnesota Department of Public Safety in 2005. The purpose of these 2-year pilot project grants was to "reduce the use of public safety and correctional resources in response to the community of homeless; promote stronger communities through street and shelter outreach; connect people experiencing homelessness with housing and services; and develop cooperative, collaborative relationships with local police departments."

The state funds, including a \$5000 match from the City of St. Paul, allowed South Metro Human Services to hire an additional outreach worker for their ACCESS team to develop an active, ongoing collaboration with the St. Paul Police Department to respond more effectively to issues arising from encounters between the police and persons experiencing homelessness. Outreach worker Bret Byfield acts as the overall coordinator for the P-HOP effort and works closely with Sgt. Paul Paulos of the "downtown beat" and Code Enforcement Officer Dean Koehnen on encampment and abandoned buildings issues. Officer Koehnen was recognized by the U.S. Interagency Council on Homelessness in 2007 with a "Home for Every American" award for innovation for his work.

In addition to their direct outreach and engagement work, the P-HOP team are founding members of a Police-Provider Forum which meets regularly to air issues. St. Paul Police Chief John Harrington and Listening House Director Rosemarie Rumsey received the Minnesota Housing Finance Agency 2006 "Leadership to End Long Term Homelessness" award.

The P-HOP team also meets regularly with other members of the criminal justice community, including the Ramsey County Mental Health Court.

### **Where Can I Learn More About the Innovation?**

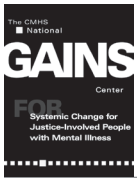
**To learn more about P-HOP**, contact P-HOP Coordinator Bret Byfield at South Metro Human Services:  
400 Sibley Street, Suite 500  
St. Paul, MN 55101  
Phone: 651-291-1979

**To learn more about Heading Home Ramsey**, contact the City and County 10-Year Plan Coordinator, Carol Zierman:  
Phone: 651-266-8004

**To learn more about the state funded Homeless Pilot Project Grants**, read the [Report to the Minnesota Legislature](#).

## ATTACHMENT 11:

Sensitizing Providers to the Effects of Incarceration  
on Treatment and Risk Management (SPECTRM)



# Sensitizing Providers to the Effects of Incarceration on Treatment and Risk Management (SPECTRM)

Expanding the Mental Health Workforce Response to Justice-Involved Persons with Mental Illness

The CMHS National GAINS Center for Systemic Change for Justice-Involved People with Mental Illness

February, 2007

People with serious psychiatric disorders experience high rates of incarceration. Through their experiences in the uniquely demanding and dangerous environment of jail and prison, many develop a repertoire of adaptations that set them apart from persons who have not been incarcerated. Although these behaviors help the person adapt and survive during incarceration, they seriously conflict with the expectations of most therapeutic environments and interfere with community adjustment and personal recovery after release.

Simultaneously, mental health providers are frequently unaware of these patterns and misread signs of difficult adjustment as resistance, lack of motivation for treatment, evidence of character pathology, or active symptoms of mental illness. Sensitizing Providers to the Effects of Correctional Incarceration on Treatment and Risk Management (SPECTRM) targets provider training with a defined modality of rehabilitation to expand the willingness and ability of clinicians to help individuals with mental health issues reach their recovery goals.

## History of SPECTRM

Despite recent increased attention to the prevalence of persons with mental illness in the criminal justice system, little attention has been paid to the cultural impact of incarceration when these individuals are released from incarceration and enter civil inpatient or community-based treatment settings. Rotter and colleagues found that when individuals were directly transferred upon release from prison to a civil hospital inpatient unit, they experienced difficulties adjusting to their surroundings and displayed more disruptive behaviors and serious incidents.

In 1996, Rotter and colleagues obtained an Occupational Safety and Health Administration (OSHA) grant as part of a workforce development initiative with the hypothesis that increased staff awareness of the incarceration experience and specialized treatment of patients with incarceration histories may benefit from the therapeutic atmosphere, which is likely to improve safety on a psychiatric inpatient ward.

To develop some empirical underpinnings for this program, initially a series of focus groups was developed with inpatient, outpatient, and corrections-based mental

health providers to identify behaviors that they believed distinguished the population of offenders struggling with mental health issues. Concurrently, the authors videotaped patient interviews that were structured to draw out offenders' experiences in jail and prison and their reactions to their current clinical environment.

Further, a behavioral observation scale was developed that staff could use to rate an individual patient's attitudes and behaviors. Its elements were drawn from six behavioral categories: (1) intimidation, (2) snitching, (3) stonewalling, (4) using coercion and jail language, (5) conning, and (6) clinical scamming. The scale was administered to 30 inpatients with a history of incarceration and to 15 inpatients without such a history. Categories more prevalent among patients with incarceration histories included intimidation, stonewalling, and snitching.

Individuals adapt to the culture of incarceration by adopting the inmate code. While adaptive in a correctional setting, these beliefs and behaviors may obstruct engagement in treatment and residential programs. The table (over) illustrates the transference of inmate code to the therapeutic setting, where these behaviors become maladaptive. In the clinical sense, staff may misinterpret these behaviors as resistance to treatment and/or as acute symptoms of mental illness (e.g., depression-related passivity or guardedness secondary to paranoia).

In 2002, Project Renewal in New York City, introduced SPECTRM provider training and the Re-Entry After Prison/Jail (RAP) program in two shelters (one men's and one women's shelter) for single adults who were homeless and had serious mental illness. The duration of the program was four months, and participants were surveyed before and after the program. Ten men began the RAP program, and seven completed; fifteen women began the program and eight completed. Throughout the training program, it was discovered that both men and women developed a greater sense of trust in staff and peers, despite the fact that they described the environment of the shelter as similar to jail or prison. Men who completed the RAP program found that discussing the experience of incarceration with those who shared the same experience was relieving, and that they experienced reduced concerns about vulnerability, especially in regard to the effects of medication.



<b>Inmate Code</b>	<b>Behaviors in a Therapeutic Setting</b>
<i>Adaptations dictated by inmate code and environmental factors</i>	<i>The same behaviors are interpreted by staff as resistance in the therapeutic setting</i>
Do your own time	Lack of treatment involvement
Don't be a snitch/rat	Don't talk to staff
Don't trust anyone	Don't engage with staff or other patients
Respect	Violent or threatening behaviors
Strength and Weakness	Medication refusal, Violent or threatening behaviors
Fear and Vigilance	Medication refusal, Violence as a response to threat
Freedom Limited	I did my time, Hospital or Prison
Extortion, Gambling, Drug Trafficking and Use	Treating the hospital or residence program as an extension of prison; e.g., trading cigarettes and commissary
Transiency	Lack of treatment involvement; does not engage with staff or other clients
Lack of Privacy	No eye contact; strict demands regarding personal space

(Rotter, Larkin, Schare, Massaro, & Steinbacher, 1998).

### Features

The provider training component of SPECTRM reviews potential behaviors that are considered adaptive in jail and prison and uses a cultural competence approach to address them. Through teaching treatment providers about the incarceration experience and showing them how behaviors adapted therein are traditionally misinterpreted in community treatment settings, staff are better able to understand their clients and engage them in treatment more effectively and efficiently.

The Re-Entry After Prison/Jail (RAP) Program is designed to assist providers in working with people with serious mental illness who have histories of correctional incarceration. The purpose of this program is to help participants make a successful transition from correctional settings to therapeutic settings and the community. It provides participants with the skills necessary to better engage in therapeutic services and to help avoid further hospitalization and/or incarceration.

Based on a cultural competence model, the program is based in cognitive behavioral theory and utilizes psycho-educational and reframing techniques. It helps participants to relinquish behaviors learned or reinforced in the cultures of jail and prison that interfere with successful readjustment and to replace them with skills that will help them better achieve their own personal goals.

### Conclusion

Cultural competence requires that agencies be able to identify and understand the help seeking needs of the population they serve and deliver services tailored to their unique needs. Meeting the needs of individuals with mental illness who have histories of incarceration is challenging, and compounded by providers' unwillingness to treat this poorly understood and estranged clinical population. SPECTRM is an approach to increase the mental health workforce capacity to provide quality clinical work in therapeutic settings and add a best

practice dimension to cultural competence by recognizing the need for a special clinical emphasis on adaptations to incarceration. Simultaneously, individuals with incarceration histories and now receiving services in civil and community treatment settings may be better able to take advantage of community rehabilitation.

To learn more about the SPECTRM training, contact Dr. Merrill Rotter (Bronx Psychiatric Center, Bronx, NY / Albert Einstein College of Medicine, Yeshiva University, Bronx, NY 10461) at [Brdomrr@omh.state.ny.us](mailto:Brdomrr@omh.state.ny.us). ■

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## ATTACHMENT 12:

### Integration of Telemedicine Practice into Correctional Medicine: An Evolving Standard

# Journal of Correctional Health Care

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## **Integration of Telemedicine Practice Into Correctional Medicine: An Evolving Standard**

Charles R. Doarn, Debbie Justis, Muhammad S. Chaudhri and Ronald C. Merrell  
*JOURNAL OF CORRECTIONAL HEALTH CARE* 2005; 11; 253  
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## Integration of Telemedicine Practice Into Correctional Medicine: An Evolving Standard

Charles R. Doarn, MBA  
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Ronald C. Merrell, MD, FACS

*Abstract:* The application of telemedicine in corrections has grown rapidly. A comprehensive literature review was conducted to develop a status report on the value that telemedicine has added to health care delivery in the prison setting. When most state and federal correctional telemedicine projects started, operation costs were high and applications were limited. However, with technologies increasingly affordable, access to specialized consultations for prisoners expanded greatly. Further, many legal barriers to service have been resolved. The number of health complaints that result in trips outside of a secure facility has dropped significantly. Each avoided trip saves hundreds of dollars in transport and security expenses, which has been the best indicator of success. Published material supports the value of telemedicine as a highly effective tool in health care delivery without compromise to patient safety or confidentiality. In fact, telemedicine can increase quality of care due to interaction between specialist and caregiver, as well as greater access to specialty care.

### Introduction

The Eighth Amendment to the U.S. Constitution mandates access to health care for inmates. Lack of access to appropriate medical care was deemed “cruel and unusual punishment” by the

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Supreme Court in its decision in *Estelle v. Gamble* (1976). Since then, many prison systems have been placed under court supervision to provide appropriate care. Many factors weigh on the ability to provide such care, including greater numbers of inmates due to longer sentences and increasing age of the general population.

Telemedicine serves and supports health care with telecommunications. Correctional health care is a well-developed and highly specialized endeavor providing a strong motive for the use of telemedicine to overcome challenges of distance, physical separation, and isolation.

Before telemedicine technology became available in prison systems, most care was rendered by physicians outside the prisons, necessitating travel to a less secure facility. Telemedicine has been shown to reduce the cost of health care to prisons by reducing expensive travel to appointments for services such as specialty consultations and disease management. Telemedicine also reduces security threats from prisoners being transported outside of the secure correctional environment.

A literature review was conducted to understand how correctional telemedicine has evolved and to what extent it has become integrated into health care practice in America's federal and state prison systems. This review provides a framework for addressing the following issues:

1. Explanation of correctional telemedicine, including establishing the need for telemedicine in corrections
2. Benefits of correctional telemedicine, including initial satisfaction survey results
3. Limitations/barriers of correctional telemedicine
4. Financial analysis
5. Examples of programs, including specialty health care

### **Correctional Telemedicine Defined**

Telemedicine is a tool that supports a health care delivery system. It combines computer, video, information systems, and telecommunications technology to provide health care to patients at distant sites (Burdick, Mahmud, & Jenkins, 1996). The term "correctional

telemedicine” can be defined as the application of this technology to assess, diagnose, or treat a patient’s medical condition in any correctional setting. The goals of correctional telemedicine are to maintain the continuity and quality of care at community standards, enhance public safety, and contain health care costs.

Applications of telemedicine in prison systems began in 1974 when the University of Miami connected physicians with prisoners at three area facilities using a microwave link. The introduction of telemedicine into prison health care was short-lived due to the high cost of equipment. Telemedicine initiatives in correctional facilities essentially ended in the late 1970s, only to reappear in the 1990s with advanced technology, including improved cameras, software, and compression-decompression (CODEC) technology. Telemedicine in prisons now enjoys the growth seen in telemedicine overall (Linkous, 2002).

Real-time video enables medical practitioners and inmates to view and interact with each other simultaneously. Store-and-forward telemedicine involves obtaining medical information (for example, photographs or other data sets) for viewing at a later time by the practitioner. Both forms of telemedicine are useful in prison settings.

### The Need for Telemedicine in Prisons

Providing quality health care to inmates at the required community standards has proven to be challenging. Financial, time, and distance constraints often hinder prisoners’ access to appropriate specialists. Also, health care costs are increasing in prisons. Given such circumstances, telemedicine can provide immediate access to low-cost, high-quality health care.

Telemedicine has appealed to government payers for many reasons, including better management within the prison complex; reduction in total cost of consultations (including transportation personnel, support equipment, potential escape, etc.); potential reduction in the number of patient complaints (once inmates realize that a trip off-site is no longer automatic); and provision of health care equal to the community standard of care.

### **Benefits of Telemedicine in Prisons**

Telemedicine offers many benefits in prison settings. Cost analysis demonstrates the cost-effectiveness of this method of health care delivery (see Summary of Financial Analysis below). The fundamental financial benefit comes from avoidance of transport and security risk (Aoki et al., 2004). Telemedicine also can improve clinical care and patient satisfaction, and it reduces security concerns and safety risks to patients and society.

Increased access to specialty care is a primary benefit. Telemedicine has been applied to many specialties, including infectious diseases such as HIV and hepatitis C (Sterling et al., 2004), emergency medicine, and psychiatry. Importantly, it can provide access to a specialist in emergency situations where an immediate diagnosis can profoundly affect the patient's outcome (Burdick et al., 1996; Ellis, Mayrose, Jehle, Moscatti, & Pierluisi, 2001).

Further, many prisons are in rural locations. The nearest tertiary care facility can be many miles away, increasing cost and risk in transporting ill inmates. Some states report successful partnerships with academic health centers for telemedicine services (Kendig, 2004; Raimer & Stobo, 2004). To illustrate, the Texas Department of Criminal Justice contracted with the University of Texas Medical Branch at Galveston, which provides medical services, including telemedicine, to prisoners in the Huntsville facility 80 miles away.

In Virginia, where the Virginia Commonwealth University (VCU) Medical Center has received contracts for telemedicine since 1995, VCU provides specialty consultation in most disciplines as well as disease management for HIV and hepatitis C. The technology has been especially useful in dermatology, ophthalmology, and psychiatry (Barry, Henderson, Kanagasingam, & Constable, 2001; Hammack, 2003; Leonard, 2004).

For physicians, a major benefit is the ability for the consulting specialist and the prison-based primary care provider to discuss the consultation in real time. By enabling these physicians to talk to each other while the patient is being examined, the quality of care can actually improve (Brunicardi, 1998). In Virginia, HIV practi-

tioners noticed a higher rate of compliance with medication treatment plans after implementing telemedicine. They associated this improvement with the ability to communicate directly with the caregivers in the prison (Wong et al., n.d.).

Primary care providers also benefit from increased opportunities to learn from specialists (Zollo, Kienzle, Loeffelholz, & Sebille, 1999). Further, telemedicine “provides a way to reduce the isolation of physicians who practice full time in a prison setting” (Zincone, Doty, and Balch, 1997). It also gives residents and medical students more opportunities to participate in inmate care from their training environments (Phillips et al., 1996; Raimier & Stobo, 2004).

Medical malpractice cases constitute the largest group—about 11%—of legal claims, according to prison officials (Mekhjian, Turner, Gailiun, & McCain, 1999), and telemedicine can help here, as well. Zincone et al. (1997) state two reasons why telemedicine tends to decrease litigation: “[I]f a prisoner has access to a range of specialists at a medical school, it is less likely that the care received will either be or be perceived to be inferior,” and the consultations are recorded, which decreases subjectivity when defending lawsuits.

Satisfaction surveys conducted with patients and caregivers show positive reactions to telemedicine. Table 1 summarizes results from three surveys reported in the literature. In the Texas prison system, patients were comfortable and positive about their telemedicine experiences (Brecht, Gray, Peterson, & Youngblood, 1996). Ohio had similar results (Mekhjian et al., 1999).

In the Virginia system, all physicians receive telemedicine training and are assimilated to the special circumstances of telemedicine encounters. The basic elements of human confidence, comfort, and respect remain unaltered.

As for societal benefits of correctional telemedicine, Zincone et al. (1997) describe these as “expected values of cost of apprehension of an escaped prisoner, the expected value of legal fees saved by avoiding lawsuits, and the expected value of lives saved” by preventing prison escapes. These values can be high, as seen in the case of a federal correctional officer who was ambushed and killed during an escape while the patient was going from the prison to a medical appointment (Burdick et al., 1996).



Location	Survey results
Ohio (Mekhjian et al., 1999)	Patients satisfied with information exchange and level of comfort
Iowa (Zollo et al., 1999)	Hub and distant site personnel satisfied with overall adequacy of telemedicine to meet patient population needs
Texas (Brecht, Gray, Peterson, & Youngblood, 1996)	95% of telemedicine consults avoided a trip to Galveston. Inmate satisfaction results were overwhelmingly positive; practitioners were satisfied with their ability to make a diagnosis in 72% of their visits

Reduced public exposure to communicable disease is another benefit of telemedicine. For instance, inmates have a much higher rate of hepatitis C than the general population. By decreasing inmates' exposure to the public, prisons reduce the risk of this disease spreading. A report from one institution highlights the benefits from a hepatitis C program (Kendig, 2004).

Although not as easily quantified, other benefits of telemedicine include eliminating the embarrassment of inmates who may be shackled and avoiding the discomfort of noninmate patients.

### **Limitations/Barriers of Prison Telemedicine**

The top three barriers to prison telemedicine for East Carolina University (ECU) are "physician acceptance at the prison, nursing acceptance at the prison, and physician acceptance at the medical school" (Kesler & Balch, 1995).

The State of Ohio's program lists the most important barriers as (a) the technical aspect of telemedicine and the joint decisions between prison staff and health care staff regarding equipment and management; (b) the potential barrier from within the organization if top personnel do not support the program; (c) the hidden costs of

training and misunderstanding that each site needs an administrator and technical support; (d) a conceptual barrier, with distrust of technology among corrections staff as well as medical professionals; and (e) a communications barrier, including the technical jargon associated with the equipment (Wilkinson & Gailiun, 1998).

Financial factors are another barrier to telemedicine. Much of the funding for telemedicine projects in federal and state institutions was initially provided through federal grants (National Commission on Correctional Health Care [NCCHC], 1997). The availability of federal funds has fluctuated over time, however, so many telemedicine projects operational today receive funding through a number of sponsorship programs.

While analysis shows that telemedicine is cost-effective, initial investment in the equipment can be expensive, especially if a telecommunications network needs to be built. Many states face budget constraints and must scrutinize each investment for its potential financial return on investment (ROI). Although telemedicine systems have become more affordable, they require larger volumes of cases and may take months or even years to achieve an ROI.

In order for revenue to exceed cost, telemedicine programs must have sufficient numbers of consultations. In some models patients are transported from smaller units to a hub site in the prison for telemedicine care. If specialists are too few in number at the hub site, the target number of consultations may not be reached.

Certain limitations are inherent in any prison medical care. In the hub model, transportation of prisoners within the facility can present security risks and other problems.

## **Legal Issues**

### **Patient Confidentiality**

In the final rule of the Health Insurance Portability and Accountability Act legislation, inmate health information was included as protected health information and therefore is subject to the privacy rule regulations. According to Bednar (2003), however, protected health information may be released to a correctional insti-

tution, without an authorization, for several possible reasons, including the provision of health care to the inmate. The rule also permits inmates to view their records unless such information sharing would jeopardize safety. The denial of such access must be documented.

### Patient Consent, Documentation, and Licensure Issues

Patients must consent to a telemedicine consultation before it is initiated, similar to a traditional consultation. If pictures are to be taken or video recorded, the consent should state this, along with how photographs will be used. All of this should be considered a part of the medical record, according to an American Health Information Management Association practice brief cited in the NCCHC position statement on telemedicine (NCCHC, 1997).

Practicing medicine across state lines has been a limitation for several entities. The status of medical licensing for doctors involved in telemedicine varies greatly (Siwicki, 1999). A common solution is to mandate that physicians obtain a license in each state where consultations will originate. A few states have adopted a revised medical license that can be used to provide care via telemedicine across state lines. The 2001 Telemedicine Report to Congress has a synopsis of licensure models and proposed solutions to the licensure issues faced by many telemedicine programs (U.S. Department of Health, 2001).

### Summary of Financial Analysis

Table 2 summarizes financial reports for selected telemedicine programs. The telemedicine consult cost is compared to cost for similar consultation at the referral center. Since the definitions of the cost/benefit analysis differed for each program, the items included are listed in Table 3.

These analyses demonstrate that telemedicine offers a cost savings. The major difference is due to security and transportation. However, there are other savings. For instance, the telemedicine consultant can order radiology or laboratory testing in the prison facility, where overhead costs are considerably less than those of a medical center. Furthermore, improved disease management should

System	Year data published	Telemedicine cost	Total cost of outpatient care
Texas (Kesler & Balch, 1995)	1996	\$40-\$70/visit	\$180-\$200
Federal (Harris, 1999)	1999	\$71	\$173
Virginia (cardio) (McCue et al., 2000)	1998	\$132	n/a
Arizona (Powering, 2001)	1996	\$140	\$415
Ohio (Brunnicardi, 1998)	1999	\$255	\$263.51/visit
Virginia (HIV) (McCue et al., 1997)	1997	\$256/visit	\$497/visit

reduce hospital admission rates. At the VCU Medical Center, the Department of Corrections pays a facility fee for telemedicine and thus the contracted physician fee.

### **Program Examples**

The U.S. Department of Justice conducted a demonstration study on telemedicine in federal correctional facilities in the late 1990s and found that, "When telemedicine became available in January 1997, it rapidly evolved to become the dominant form of specialty consultation, and the combination of telemedicine and some remaining conventional consultations provided about as many encounters as had been delivered by conventional medicine alone in 1996" (*Telemedicine*, 1999).

As programs mature, services generally expand to include consult specialties. In federal prisons today, telemedicine consultations have completely replaced conventional consultations in some specialties. Four specialties—psychiatry, dermatology, orthopedics, and cardiology—accounted for 84% of all teleconsultations.

According to the Department of Justice, more than 10% of the U.S. prison population is mentally ill. This presents challenges when prisons must arrange for visits from mental health clinicians

**Table 3**  
**Cost Factors for Selected Correctional Telemedicine Programs**

Location	Provider	Telemedicine costs	Traditional costs	Notes
North Carolina (Doty, Zincone, & Balch, 1996)	East Carolina University (ECU)	Included: site costs, equipment, maintenance contracts, engineering staff, office overhead, phone line lease charges (from ECU)	Included: security, transportation, private physician fees, costs of escape, possible litigation	Assumed outcomes of care were similar
Iowa (Zollo et al., 1999)		Included	Included: transportation, security Excluded: Medicare costs	Formula: circuit charges + eqpt + (per-minute chg x minutes x no. consults) + personnel + facilities/ space = total annual cost
Ohio (Brunicardi, 1998)		Included: equipment, corrections officer time, telemedicine coordinator time, physician and RN charges and ancillary costs	Included: transportation, chase vehicle, physician, nursing	
Virginia ( <i>Telemedicine</i> , 1999)	Virginia Commonwealth University / University of Virginia	Included: operating cost Excluded: equipment cost	Included: cost of visits to VCU, lab test duplication, radiographic exams, fewer emergency room visits	
Texas (Kessler & Balch, 1995)	University of Texas Medical Branch	Included: technology, net-work, support personnel, operational costs Excluded: overhead	Included: direct manpower and vehicle expense for transportation Excluded: all overhead	Costs lowered per unit by increased volume and shared network

or transport patients to local hospitals for routine mental health care (Brodey, Claypoole, Motto, Arias, & Goss, 2000). Studies have “strongly supported telepsychiatry’s efficiency, cost effectiveness, and high diagnostic reliability” (Ellis et al., 2001). Use of telepsychiatry at FMC-Lexington was thought to result in more effective medication and monitoring of mentally ill patients at the participating four institutions (“Prison Telemedicine,” 1998).

Emergency care is another common application of telemedicine. Ellis et al. (2001) summarize the positive outcomes identified in their review of 530 emergency care records in New York:

...126 telemedicine consultations [were] performed. Eighty one of 126 (64%) telemedicine patients remained at the facility following consultation with the remaining 45 (36%) being transported to the emergency department. Rates of return to the emergency department within 7 days following consultation were comparable, patient acceptance and satisfaction was high, and there were no untoward outcomes in the group. Average total time of telemedicine consultation was 30 minutes versus a 2-hour and 45-minutes turnaround time for an emergency department evaluation. A variety of emergency complaints were managed effectively using relatively low-cost computer-based telemedicine technology....

Before the introduction of telemedicine, all emergencies that occurred in the correctional facilities were sent to area hospitals. With the availability of remote monitoring of EKGs and vital signs, the number of outside trips due to chest pain, heart problems, broken bones, and CVA have decreased.

Other specialty areas shown to use telemedicine effectively include dermatology, surgery, medicine, gynecology, radiology, orthopedics, cardiology, and ophthalmology.

Table 4 summarizes programs in 12 states. The preference for T1 or broadband connections is apparent.

## Conclusion

Significant hurdles remain in establishing telemedicine as a standard procedure in correctional settings. Nevertheless, this tech-

Table 4 Characteristics of Selected Correctional Telemedicine Programs				
Location	Participants	Services provided	Connections & equipment	Notes
NC (Wilkinson & Gailiun, 1998)	East Carolina Univ; NC Central Prison	Emergency, specialty care (mostly dermatology, neurology, gastroenterology); limited to 2nd opinions based on PCP referrals	T1 connection. Videoconferencing unit, electronic steth, telephone for confidential conversations, document camera, derm camera.	ECU maintains responsibility for equipment. Paid under contract. Developed scheduling software.
VA ( <i>Telemedicine</i> , 1999)	VCU; UVa; individual prison sites	HIV, hepatology, cardiology, oral surgery, other specialty care	ATM connections thru central site. Videoconf unit, electronic steth, document camera, fax, handheld camera.	Modified hub and spoke. Care is geographically divided between health care facilities.
OH (Mekhjian, Warisse, Gailiun, & McCain, 1996)	Maximum security prison; prison hospital; Ohio State Univ Medical Center	Multiple specialty areas including psych	1/2 T1. Videoconferencing unit, room cameras, video monitors, document camera, electronic steth, VCR, fax.	
AZ (Caramanis, n.d.)	Univ of AZ, Phoenix; St. Mary's hospital; individual prison sites	Multiple specialty areas	ATM distributed statewide network. Video collaboration equipment.	Part of statewide Arizona Rural Telecommunications Network.
CA (Martin & McBeath, 1999)	20 of the 33 prisons; CA Medical Facility	Mostly psych, also HCV, dermatology, other specialties	ISDN (384 kbps). Videoconferencing.	Many prisons are rural.
MN ("Prison," 1998)	Two prisons	GI, orthopedics, dermatology, 12 other specialty groups	T1. Videoconferencing, handheld.	

**Table 4 (continued)**  
**Characteristics of Selected Correctional Telemedicine Programs**

Location	Participants	Services provided	Connections & equipment	Notes
TX (Martin & McBeath, 1999)	UTMB, Texas Tech University; individual prison sites	Psychiatry, emergency triage, specialty care	Texas Tech: T1 or satellite. (Equipment n/a.)	Local hub model, inmates transported to nearby site for telemedicine care. Capitated agreement. Decentralized telemedicine at UTMB.
WI (Appleby, 1995)	University Hospital, Madison; individual prisons	Inpatient and outpatient specialty care, postsurgical	POTS connection. Videoconferencing, medical image transfer.	
IA (Kienzle, 1998)	University of Iowa Hospitals and Clinics	Ortho, medicine, dermatology, general surgery, urology, otolaryngology	Statewide fiberoptic network. Videoconferencing, otoscopes, handheld.	State mandate to provide care to inmates and indigent population; UIowa reimbursed by state appropriation
KS (Zaylor, Whitten, & Kingsley, 2000)	Lyon County Jail	Telemental health, initial and follow-up	ISDN connection. PC-based videoconferencing.	
OK (Allen, 1998)	St. Francis Hospital, Tulsa; prison in Stringtown, OK	Emergency medicine	T1 connection. Rollabout unit, laser x-ray digitizer, steth. illumination platform, electronic otoscope, ECG.	Telemedicine suite near ED, clinic daily 1-3 p.m.
NY (Ellis et al., 2001)		Emergency, radiology		



nology holds the promise of improving access to health care in correctional systems, where unique barriers to access exist. This review of the literature suggests that its integration in correctional health care is expanding. In most federal and state prisons that have implemented it, telemedicine has evolved from a pilot project to a fully functional health care delivery system.

While telemedicine may not employ a traditional “face-to-face” health care model, there is no reason to believe this type of delivery system to be deficient or any less effective. In fact, studies have demonstrated its economy, efficiency, and effectiveness. Four features of telemedicine support its full integration into correctional health services:

1. Reduces cost to correctional facilities by saving on transportation and security costs
2. Provides improved quality of care to inmates by increasing access to specialty care with reduced wait times for appointments
3. Eliminates or decreases the number of trips to outside medical facilities, thereby decreasing the risk of escape
4. Reduces the threat to local community by not exposing them to dangerous offenders and communicable diseases

As more correctional systems recognize the potential for improved outcomes and reduced health care costs from telemedicine, especially as applied to complex chronic diseases such as HIV, the practice of telemedicine is likely to expand.

To further improve correctional telemedicine and to better understand its benefits and limitations, more studies are needed on outcomes as well as satisfaction of patients and practitioners.

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ATTACHMENT 13:

Can Telemedicine Reduce Spending and Improve  
Prisoner Health Care?

# Can Telemedicine Reduce Spending and Improve Prisoner Health Care?

## *An Evaluation of a Prison Telemedicine Network*

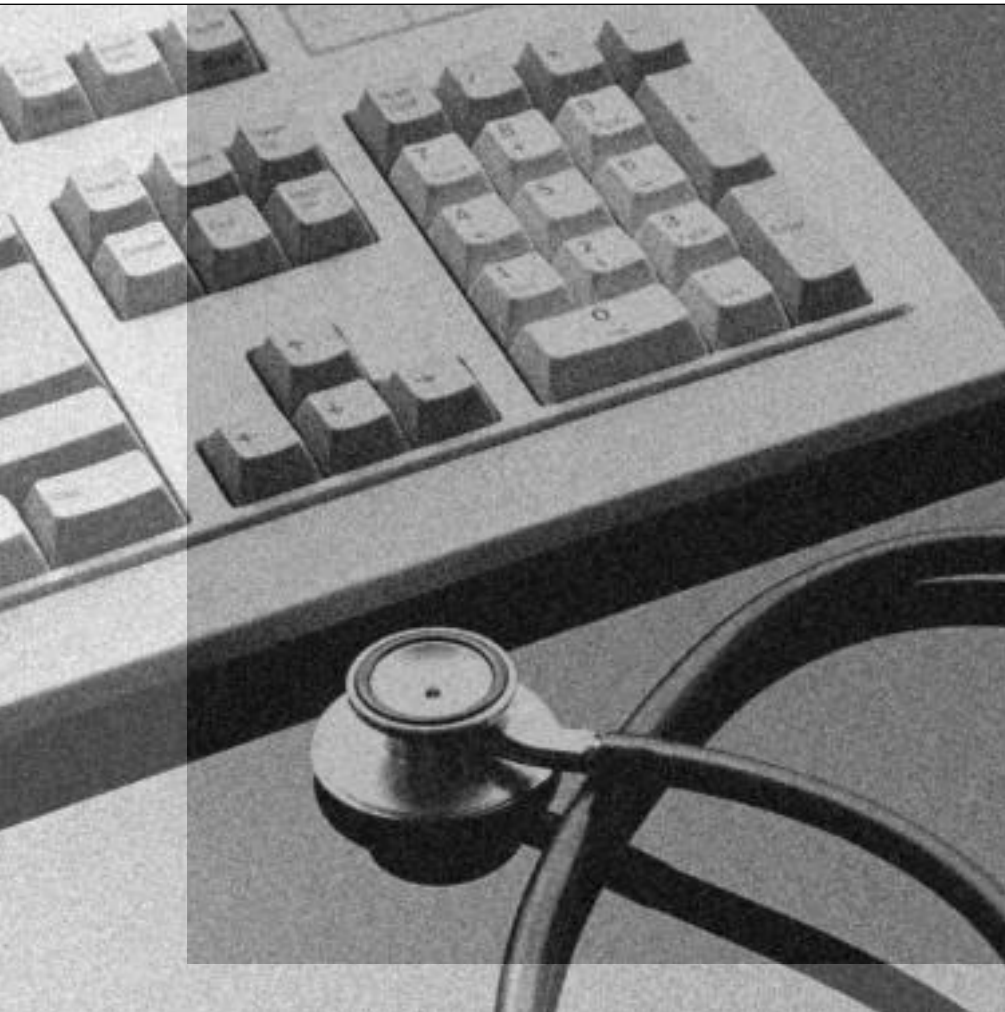
*by Douglas McDonald, Andrea Hassol, and Kenneth Carlson*

Imagine a physician conducting surgery on a prisoner from a remote facility thousands of miles away. Or a health care specialist examining a patient in another State. New telemedicine technologies now make these possible. In February 1999, for example, a physician in Washington, D.C., collaborated with a team in Ohio to perform laproscopic surgery using a miniature video camera that

beamed pictures of the patient's insides across a high-speed Internet connection. Although such long-distance surgery has not yet come to prisons, telemedicine—loosely defined as the remote delivery of health care via telecommunications—holds great promise for law enforcement and corrections officials seeking to provide high-quality health care at competitive prices.

Providing prisoners with adequate and cost-effective health care has long been challenging assignment for many correctional administrators. Federal courts have endowed prisoners with a constitutional right to adequate health care (a right the rest of the population lacks), and Federal judges have brought many correctional agencies under court order for failure to provide such care. Giving prisoners access to specialist physicians is especially difficult, because facilities are often located in rural areas where specialists are in short supply. Taking prisoners to specialists outside the prison poses a danger to law enforcement officials and to the community, as prisoners may orchestrate ambushes or try to escape by other means.

Telemedicine has been most useful in situations where physical barriers hinder contact between patients and doctors—where rural patients lack easy access to doctors found in urban areas, for example. Accordingly, the U.S. military has been especially interested in telemedicine for combat or other field settings and has sponsored much of the development of this new tech-



*Photo source: Corbis Images.*

nology. Prisons face unique physical barriers that are tailor-made for telemedicine technology. Relying upon telecommunication links makes it possible to find a larger number of physicians willing to serve prisoners because they do not have to bear the inconvenience of traveling to and from prisons. The inconvenience of taking prisoners to the physicians also is minimized because the prisoners live where the telemedicine equipment is housed.

To evaluate the extent to which telemedicine can improve health care in correctional settings and to estimate the associated costs and savings, the Federal Bureau of Prisons, NIJ, and the Defense Advanced Research Projects Agency, U.S. Department of Defense, embarked on a joint demonstration program to design, procure, install, and evaluate a telemedicine system. This demonstration linked three Federal prisons in Pennsylvania and one Federal prison medical center in Kentucky to the U.S. Department of Veterans Affairs Medical Center (VAMC) in Kentucky. (See "Participating Telemedicine Prisons," for the four prison sites.)

The evaluation showed that telemedicine was adopted rapidly by prison health care administrators and that it improved prisoners' access to medical specialists who were not otherwise available to them. It also showed that the costs of adding this new technology can be offset by substantial savings. This article summarizes the findings of the evaluation, which was conducted by Abt Associates Inc.

## The Demonstration

The demonstration of the telemedicine system lasted slightly longer than a year, from September 1996 to December 1997. It was not designed to replace the routine primary care

## about the authors

Douglas McDonald, Ph.D., Andrea Hassol, and Kenneth Carlson are researchers at Abt Associates Inc. a research-based consulting company headquartered in Cambridge, Massachusetts. They relied upon the substantial contributions of several other Abt Associates Inc. staff members, including Jeffrey McCullough, Elizabeth Fournier, and Jennifer Yap. Telemedicine coordinators at each facility collected and relayed data needed for the evaluation. Health services staff in each prison accommodated requests for information and access to medical records. The Federal Bureau of Prisons' Office of Research and Evaluation provided a large amount of data from automated patient records for the analysis.

The telemedicine demonstration and evaluation were made possible through a joint U.S. Department of Justice, Department of Defense Memorandum of Understanding to advance understanding of technology for law enforcement and corrections. The telemedicine suites were designed and installed by Tracor Systems Technologies, Inc., and SPAWAR Systems Center. The evaluation was conducted by Abt Associates Inc. under the direction of Douglas McDonald.

provided by prison employees. Rather, it was hoped that use of the new technology would reduce the use of three other types of care: in-prison consultations by specialist physicians who visit prisons on a regular schedule, prisoners' trips out to local hospitals or physicians, and long-distance transfers of prisoners to Federal medical centers (prison hospitals) for intensive, long-term treatment—an especially costly alternative.

The equipment leased for the demonstration included:

- Interactive videoconferencing equipment with multiple specialized medical cameras.
- Compatible medical peripheral devices, including an electronic stethoscope and a micro/intraoral camera.
- Telecommunications equipment and software.
- A PC-based computer workstation and software.

This equipment was located in a dedicated room in each prison. A telemedicine coordinator at each prison scheduled the sessions and managed the cameras and sound

## Participating Telemedicine Prisons

U.S. Penitentiary in Lewisburg, Pennsylvania. Maximum security, opened in 1932, houses an average of 1,300 male prisoners.

**U.S. Penitentiary in Allenwood, Pennsylvania.** Maximum security, opened in 1993, houses an average of 1,000 male prisoners.

Federal Correctional Institution in Allenwood, Pennsylvania. Low and medium security, opened in 1993 and located on the same campus as the U.S. Penitentiary in Allenwood, houses an average of 1,100 male prisoners.

Federal Medical Center in Lexington, Kentucky. Operated as a Federal correctional institution since 1974, converted to a medical center in 1991. Accepts patients requiring specialized health care from many Federal prisons. Its primary focus is medium and minimum security prisoners with chronic illnesses. Houses an average of 1,450 prisoners, mostly male.





Telemedicine exam area at USP Allenwood. Photo by Steve Brown (top). The telemedicine coordinator at FMC Lexington, Kathi Ramirez, prepares for a telemedicine clinic. Photo by Kathi Ramirez (bottom).

equipment. A prison clinician (usually a physician's assistant or psychologist) "presented" the patient to the specialist, assisting the examination by placing the electronic stethoscope on the patient, rotating the patient's limbs, or reviewing his case history, for example. At the other end of the telemedicine circuit, health care specialists had equipment to receive and display the audio and video information. Remote controls enabled the specialists, sitting in their location, to steer cameras located in the patient exam room.

### The Research Questions

The evaluators examined the practice of specialist consultations, both conventional and telemedical, during the demonstration period and the year preceding the demonstration. During the demonstration period, the evaluators also examined practices at other Federal

penitentiaries lacking telemedical capabilities. They focused on four principal questions:

- Was telemedicine used as a substitute for conventional consultations with specialists, and if so, at what rate?
- How expensive was telemedicine relative to the costs of conventional specialist consultations, either bringing specialists to the prisons or sending patients outside the prison for care?
- What are the net costs and savings that would accrue in a telemedicine system designed for ongoing operation, rather than for a test?
- Does the use of telemedicine bring other nonfinancial benefits?

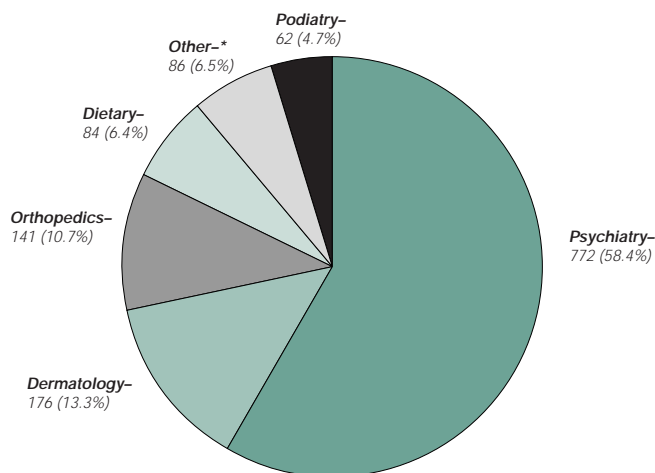
### Findings

During the demonstration, physicians made approximately 100 telemedicine consultations per month for a total of 1,321 consultations. Approximately 58 percent of the visits were for psychiatric consultations; nearly all of the others were for dermatology, orthopedics, podiatry, and dietary counseling. (See exhibit 1.)

To compare conventional and telemedicine consultations, researchers selected four specialties—psychiatry, dermatology, orthopedics, and cardiology—because Federal Bureau of Prisons data unambiguously identified these specialty encounters both during the telemedicine period and in the preceding year. These were also among the most frequently used specialties prior to the demonstration and, therefore, offered the greatest opportunity for the new technology to have an impact.

- **Psychiatry.** The telemedicine psychiatrists at the Federal

Exhibit 1: Telemedicine Consultations by Speciality

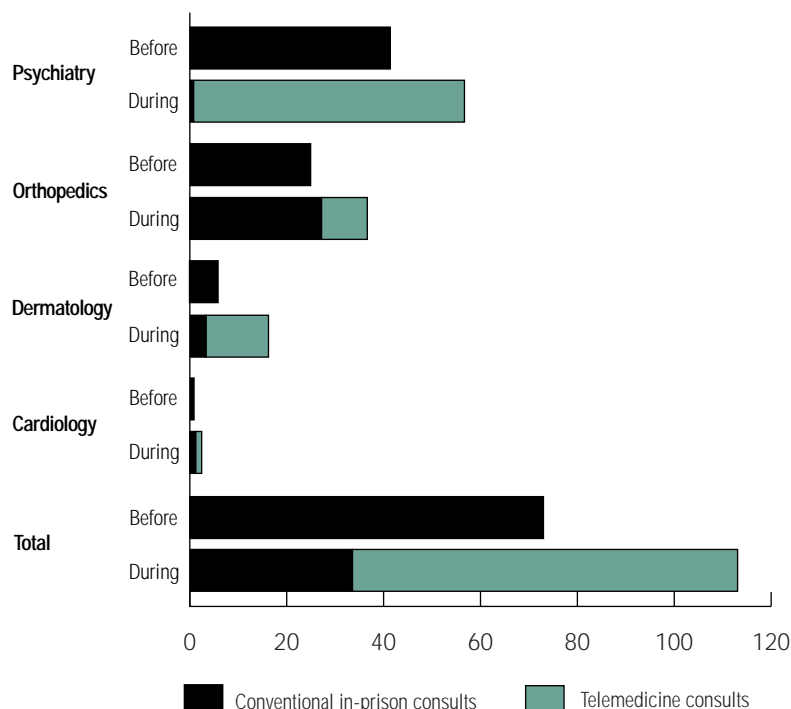


\* Other includes infectious diseases, cardiology, ENT, pulmonary, gastroenterology, and neurology.

Medical Center in Lexington, Kentucky, virtually replaced visits by Pennsylvania's local psychiatrists. Pennsylvania's prison officials found the Lexington psychiatrists to be more experienced at treating prisoners and more readily available when needed. (See exhibit 2.) This conversion to near-total reliance on telemedicine technology for psychiatric consultations occurred in part because psychiatry involves communication of visual and verbal information (as opposed to tactile information), which is accurately passed through the telemedicine equipment.

- **Dermatology.** There was an average of 6 dermatology consultations per month during the year preceding the demonstration and 14 per month during the demonstration. Seventy-six percent of the dermatology consultations during the demonstration were provided via telemedicine.
- **Orthopedics.** Telemedicine was used for orthopedic consultations in all facilities, but conventional in-prison orthopedic consultations continued as well. Telemedicine did not replace conventional in-person consultations because orthopedists rely on tactile information obtained in hands-on examinations. Technologies now in development may someday support the communication of kinesthetic experience in sufficient richness that orthopedists will accept it as a substitute for direct contact.
- **Cardiology.** Too few cardiology telemedicine consultations (only 18) were performed to draw conclusions about substitution rates for this specialty.

Exhibit 2: Average Number of Conventional and Telemedicine Consultations Per Month, By Specialty, Before and During\* the Demonstration



\* *During refers to the demonstration period following full implementation at all three Pennsylvania prisons.*

## Financial Costs and Savings

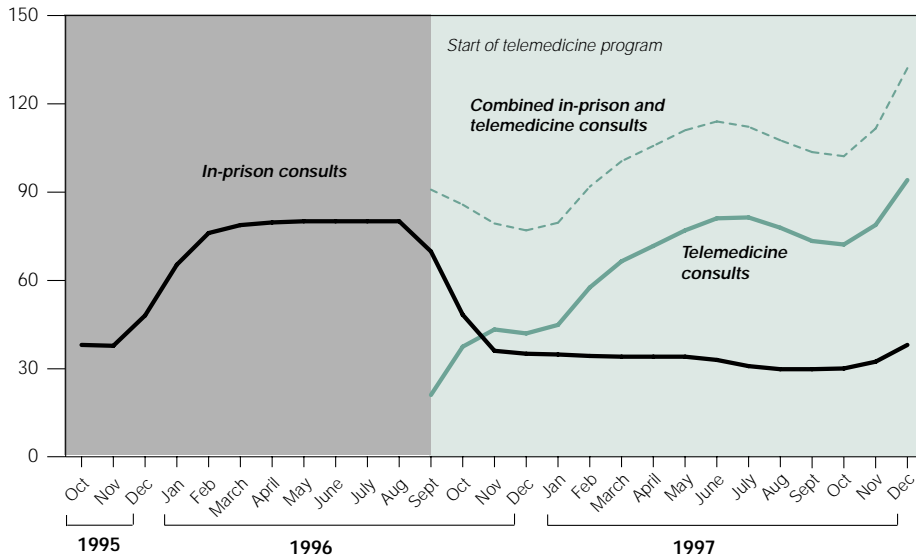
The demonstration suggests that telemedicine can generate significant savings and benefits if it is configured for ongoing operations. For example, if the equipment were purchased rather than leased, the capital investment would be recovered in less than 2 years.

Most of the telemedicine costs, including at least \$3,400 for setting up the telemedicine suites, are fixed and do not depend on the number of patients seen. Other costs vary, including telecommunications charges and payment to the Veterans Administration for the physicians' time.

- **In-Prison Consultations.** Consultation costs decreased

through telemedicine. A conventional consultation with a specialist costs approximately \$108 inside the Federal correctional facilities, whereas the per consultation cost for telemedicine was estimated at \$71—a full \$37 less. In an average month with 100 consultations, the prison would pay \$10,800 per month for conventional in-prison consultations or \$7,100 for telemedicine consultations—a monthly savings of \$3,700 if there were a perfect substitution of one for the other. However, there was not a one-for-one substitution during the demonstration, except in psychiatry. The total number of consults increased with the addition of telemedicine, which increased total

Exhibit 3: Number of Conventional In-Prison and Telemedicine Consultations



health care expenditures over levels that would result from one-for-one substitution. (See exhibit 3.)

■ **Trips to Local Providers.**

Approximately 30 to 35 trips for inmates to see local specialists outside prison walls were averted through telemedicine, saving approximately \$27,500. A large number of other trips were not averted, however, for inmates who needed invasive tests, surgery, trauma care, or other medical care not suited to telemedicine.

- **Transfers to Federal Medical Centers.** The Bureau of Prisons saved an additional \$59,134 by averting costly air transfers from the three Pennsylvania prisons to Federal medical centers, a result of treating prisoners telemedically. These averted transfers were nearly all psychiatric patients who required intensive monitoring and medication control that was not possible with a local

psychiatrist who only visited the prison 1 or 2 times per month.

**Other or Nonfinancial Benefits**

Financial savings were not the only benefits of telemedicine. Nonfinancial benefits included the following:

- Prisoners' waiting times to see specialists decreased.
- New services became available through telemedicine, particularly more specialized HIV/AIDS care.
- Anecdotal evidence showed that the quality of care, particularly psychiatric care, improved.
- Fewer acts of inmate aggression or use of force by guards were noted, but this decline began before telemedicine was introduced and only occurred in two of the three prisons, making it impossible to conclude that the reductions were due to telemedicine.

**Implications for Expanding Telemedicine to State and Local Prisons**

The demonstration in these Federal prisons shows that telemedicine, if used and managed well, can be successful in controlling health care costs (which can comprise 10–20 percent of total prison operating costs). It offers security advantages by reducing opportunities for escape and improves inmates' medical care by speeding up treatment that could take months to occur under normal circumstances. It has transitioned smoothly from the demonstration stage to the permanent stage, and utilization levels remain stable.

Many of the cost savings found in the demonstration stem from averted transfers to Federal medical centers—something that most State and local correctional agencies are less likely to need because the distances are shorter than in the Federal system. Thus, the largest single opportunity for cost saving in this analysis would have no counterpart in many jurisdictions.

State and local prison officials who are considering telemedicine should first identify other structural savings, such as air transfers. Telemedicine may save taxpayer dollars in systems hoping to reduce medical costs by accessing less costly specialists in distant locations and by being able to access them more often than is possible with visiting local specialists. The greatest savings are likely to occur in correctional systems that use costly air charters for individual medical trips over long distances.

Contrary to expectations, telemedicine did not greatly reduce the number or frequency of trips outside the prison to local health care

providers. Examination of medical records for such trips indicates that these were most commonly taken for hands-on diagnostic tests or surgical procedures, or for emergencies that would not be amenable to telemedicine. In jurisdictions where outside trips are less tightly rationed, opportunities to produce savings by using telemedicine may exist.

In prison systems that rely less heavily upon air transports and trips out, the average cost of telemedicine consultations will be approximately the same as the cost of conventional in-prison consultations.

Physician licensure and insurance issues did not arise in this demonstration but pose constraints elsewhere. (Both The Veterans Administration and the Bureau of Prisons are Federal Government agencies, and staff physicians are allowed to practice across State lines.) Indeed, dozens of States have formal barriers prohibiting remote physicians from providing care across State lines unless they also have licenses in the State where the patient is physically located. These issues could be relevant for State and local correctional systems wishing to access specialists beyond their States' borders.

As a result of the success of the telemedicine demonstration, the project has been expanded to determine the viability of telemedicine in jails. In addition, NIJ is testing videoconferencing technology for crime scene investigators and medical examiners.



*Dr. Luis Morales, Staff Psychiatrist at FMC Lexington, consults with the staff psychologist at FCI Allenwood. Photo by K. Caudiux.*

## For More Information

- The full report of the evaluation, Douglas McDonald, et al., *Telemedicine Can Reduce Spending for Prisoner Healthcare: An Evaluation of a Prison Telemedicine Network*, is forthcoming in spring 1999. (NCJ 175040)
- A 60-minute VHS videotape of Douglas McDonald's seminar, *Can Telemedicine Reduce Spending for Prisoner Healthcare? An Evaluation of a Prison Telemedicine Network*, is available for \$19 (\$24 in Canada and other countries). (NCJ 173390)

Order copies of the full report and the videotape by calling the National Criminal Justice Reference Service at 1-800-851-3420. In the Washington, D.C., metropolitan area, call 301-519-5500, or write P.O. Box 6000, Rockville, MD 20849-6000. Or e-mail [askncjrs@ncjrs.org](mailto:askncjrs@ncjrs.org) with questions. Download a copy of the full report by visiting the NIJ Web page at <http://www.ojp.usdoj.gov/nij>. Click on *Publications*.

- *Demonstrating the Viability of Telemedicine in Correctional Health Care* by Allan Turner, Pete Nacci, and Ronald Waldron in *Corrections Today*, February 1999.
- Government Accounting Office, "Telemedicine: Federal Strategy Is Needed to Guide Investments," Washington, D.C.: Government Accounting Office, February 1997. (GAO/NSIAD/HEHS-97-67)

ATTACHMENT 14:

Psychiatric Telemedicine for Rural New York

## Psychiatric Telemedicine for Rural New York

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“**P** sychiatric Telemedicine for Rural New York” is a project that provides psychiatric consultation to rural practitioners. Consultations are provided by teaching staff from the New York State Psychiatric Institute (NYSPI), who have faculty appointments at Columbia College of Physicians and Surgeons.<sup>1</sup> The project is funded jointly by grants from the United States Department of Agriculture’s Rural Utilities Service Distance Learning and Telemedicine (USDA/RUS/DLT) Program and by the New York State Office of Mental Health (OMH). The first consultation was delivered on November 6, 2000. Practice sites receiving these consultations include OMH clinics, community hospitals, and NYS Department of Corrections (DOC) mental health units. Six such sites are currently up-and-running; nine more will come “on-line” shortly; and considerable future expansion in the ensuing months is likely (see Figure 1).

### Background

The Project Director, (the first author), had inaugurated a program of on-site consultations to OMH hospitals for particularly challenging patients, using a core group of NYSPI/Columbia faculty, as well as faculty from New York State’s ten other departments of psychiatry. Since each consultation required essentially a full day of the consultant’s time (to allow for travel), the program was cost-effective if there were a substantial number of practitioners present at the receiving site, but it was not cost-effective for sites having only a few practitioners.

The telemedicine project was initiated specifically to meet the needs of such widely scattered rural practitioners, who often practice in isolation and do not have specialists—particularly, child and adolescent psychiatrists—available to provide consultations on difficult patients. Yet many of these rural practitioners’ patients suffer from severe Axis I disorders complicated by substance abuse, Axis II disorders, trauma, and neuropsychiatric conditions; there may also be forensic issues that need to be addressed.

### Costs

Because psychiatric assessment relies heavily on visual and auditory cues, the project would need tools that could approximate a live interview as closely as possible. The Project Co-director (second author) therefore determined that “high-end” equipment was essential to perform psychiatric evaluations on-line. The telemedicine equipment (PictureTel 4500) required for the host site and for the two

OMH clinic sites with which the program was inaugurated cost approximately \$25,000 per unit. More recently, the equipment, while being improved each year, has come down in price, so that the equipment (currently PictureTel 9500) for the first three rural county clinics, which was purchased with USDA/RUS/DLT grant money, cost approximately \$15,000 per unit. One community hospital, served by the program, and all of the DOC mental health units provide their own previously purchased equipment, which had already been used to secure consultations in medical specialties other than psychiatry.

The system attributes are:

- 35” monitor
- An omnidirectional microphone
- A robotic voice actuated video camera that pans and focuses on the person talking
- Remote control access that allows the consultant to control of the camera at the remote site
- A thoughtfully designed and compact control panel
- A “white board” and document-sharing capability.

The “recurring” cost for the project’s T-1 (broad bandwidth) lines, which is approximately \$100/month for each site, down from an anticipated \$2200/month when the project was initially conceived 2 years ago, is covered by OMH on an annual basis for both OMH and county clinics. This dramatic reduction in monthly T-1 costs resulted from a negotiated contract between OMH and AT&T, and from an agreement to pay additional usage costs, amounting to about \$0.17/minute of teleconferencing.

### Project Operation

Continual communication between the point-person at each end-user site, who serves as a conduit for facilitating the consultations, and the coordinators of consultations at the host site (the first and third authors) is crucial to the operation of this project. The initial request for a consultation includes a description of the clinical issues to be addressed, so that the appropriate consultant can be

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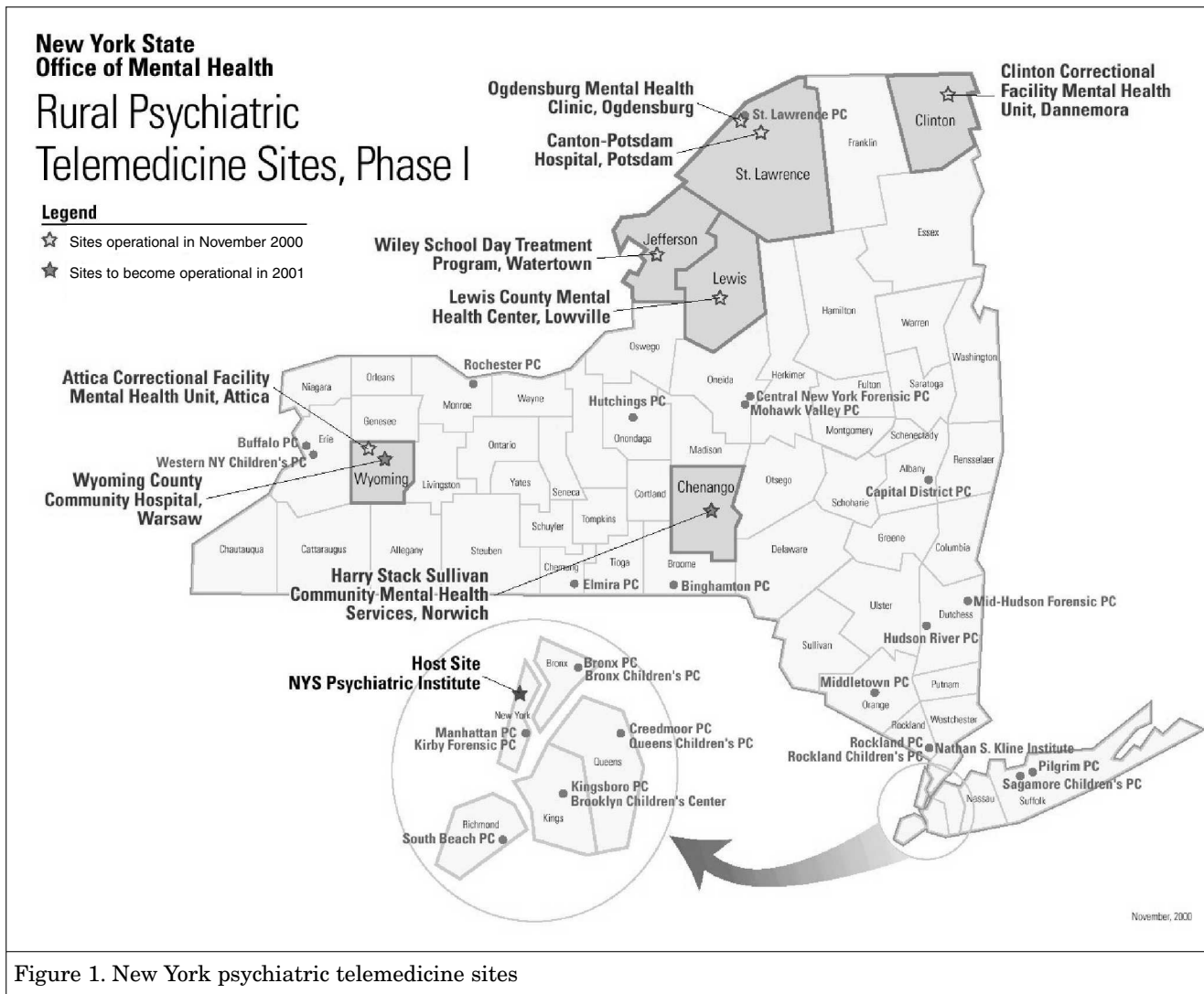


Figure 1. New York psychiatric telemedicine sites

selected. Next, matching the consultant's schedule with the availability of the equipment at each end-user site—not to mention the complexity of arranging for DOC staff to bring inmates from mental health to general health units, where the equipment is located—requires both determination and flexibility.

Consultations are scheduled for 1 hour. The first 20 minutes are generally devoted to a presentation of the case by the rural clinician or clinicians involved. Then the consultant interviews the patient (and family member, in the case of children) for the next 20 minutes. The final 20 minutes are spent summarizing issues and presenting and discussing treatment recommendations.

Patients are requested to sign videotape consent forms, so that the project can be used to teach the telemedicine consultation process; however, refusal to consent does not affect eligibility to receive consultation.

It is essential, for continuity of clinical care, general liability issues, and compliance with JCAHO standards (currently in evolution), that it be clear to all parties that the consultation is delivered to the rural practitioner—the person “on the ground” who is delivering the actual services—rather than to the patient.

### Initial Project Experience

Approximately 30 consultations have been delivered as of mid-June; the expected expansion of the program described above should lead to a rapid increase in the number of consultations in the near future.

The breadth and depth of the consultant pool have permitted some felicitous interventions that could hardly have been anticipated. For example, one patient with chronic substance abuse and a significant trauma history, after being given the term “dissociation” to help under-

stand her most disturbing symptomatology, as well as the assurance that she was not “crazy” (in response to her question), experienced a resolution of her suicidal impulses and was successfully discharged to a community residence. In another case, an African-American child, interviewed by an African-American child psychiatrist, appeared less disturbed than the description given prior to the interview, and his mother received both encouragement and concrete suggestions for managing him less restrictively. In the case of a third patient, who was incarcerated and confined to a stretcher, the differential diagnosis of conversion reaction versus malingering was clarified, with helpful consequences for the patient’s rehabilitation.

Although these results are preliminary, they suggest the potential advantages of selecting consultants not only for their expertise in the appropriate psychiatric subspecialty but also for their cultural compatibility, in order to achieve maximum benefit from the one “face-to-face” encounter these patients are likely to have with consultants over a prolonged course of treatment.

Finally, we have found—not unexpectedly—that what the technology achieves is essentially a confrontation between cultures, between the world of the “big-city,” academic specialist with multiple resources and that of the continuously involved, no-less-dedicated rural practitioner. To prevent misunderstandings, this confrontation requires continuous self-disclosure concerning each person’s context and goals. For example, some rural practitioners find it difficult to avoid feeling that they are somehow being evaluated, while some of the consultants need help envisioning the limited resources available in rural settings. Training to address these issues for both consultants and users is currently being developed.

### Next Steps

An important next step for the project will be to introduce an evaluation component. One possibility is to administer the Sheehan Disability Scale<sup>2</sup> at the time of the initial consultation and then 6 weeks after the consultation to determine the extent to which the consultation affected the patient’s self-assessment of his or her degree of functional disability.

Another important step will be to make the consultations to each end-user routine by scheduling the frequency and time of consultations in advance. Besides using available software, such as calendars, to facilitate such an extension of the project, it will clearly be necessary to obtain funding—perhaps through an additional grant—to encourage consultants to make time regularly available.

Third, it should be noted that unregulated and questionable “therapy” services available via e-mail and on the Internet are already being advertised, and it is anticipated that even more unregulated “therapeutic services” will be offered when the Internet can carry high-speed, real-time video. It is therefore essential that standards for the accrediting of qualified providers of telemedicine services, including, but not limited to, consultations, be developed. The American Psychiatric Association<sup>3</sup> and the Psychiatric Society for Informatics<sup>4</sup> are nationally-based organizations currently working on such standards.

### Conclusion

Anecdotal reports indicate that approximately 45 different telepsychiatry systems are operating currently, although the exact number would be hard to verify, since new programs may not be immediately publicized. For example, local systems to provide forensic psychiatric evaluations to local jails and prisons have been undertaken in several localities in New York State. It is not difficult to envision a time in the near future when university departments of psychiatry across the country will serve as major academic providers of training, research, and service to rural practitioners.

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ATTACHMENT 15:

Telepsychiatry's Untapped Potential: When Will It  
Pay to Deliver?

## **Telepsychiatry's Untapped Potential: When Will It Pay to Deliver?**

William Kanapaux

Telepsychiatry has been hailed as the future of psychiatry. Proponents have claimed that it can reduce costs and allow access to difficult-to-reach patients. What are the promises and pitfalls of this new technology?

Telepsychiatry holds the promise of providing a link between urban areas with a high concentration of psychiatrists and rural areas in dire need of specialists to provide consultations to clinicians and direct services to patients. Widespread adoption of telepsychiatry programs would allow specialists to consult on care to geriatric patients, children, prison populations, military veterans and others groups with access problems.

The technology continues to improve, and equipment costs have dropped dramatically in recent years. Video conferencing equipment that cost \$30,000 three years ago now costs about \$10,000. However, making the connection is not as easy as it might seem. The technology's potential remains largely untapped, in part, because payors are reluctant to embrace it. Consequently, many programs end when their grant funding ends.

The growth of telemedicine is very hard to follow, William Tucker, M.D., told *Psychiatric Times*. Tucker is director of the New York State Office of Mental Health (OMH) Telepsychiatry Project. Although the trend is clearly burgeoning, almost as many programs close as open. The problem is that almost all programs start on grants that include salaries. And when the grant runs out, so does the salary support, Tucker said.

The OMH Telepsychiatry Project, which is located at the New York State Psychiatric Institute in New York City, is unique in that all its staff and consultants are on salary with OMH or Columbia University's College of Physicians & Surgeons. In over three years, the program has provided about 200 consultations to 12 rural mental health clinics and 12 correctional facilities, drawing upon the expertise of about 94 psychiatrists. Each consultation takes about 90 minutes, Steven E. Hyler, M.D., project coordinator for the OMH program, told PT.

The consultant meets initially with the requesting clinicians. That is followed by a patient interview. Consultants then present their findings in a discussion with the requesting physicians.

For the last two years, members of the OMH project have offered a course in telepsychiatry at the American Psychiatric Association's annual conference. Both years it generated considerable interest and sold out, Tucker said. "People see very quickly the potential of the medium."

Telepsychiatry attracts three groups of people, said Tucker, who is deputy chief medical officer for OMH and an associate clinical professor of psychiatry at Columbia University. The first group includes a small number of psychiatrists in private practice who are interested in setting up systems in their offices for patients who can afford to buy their own hookups. A patient can buy a workable low-end camera recording system for as low as \$1,500.

Large health care systems, such as those for state prisons in Illinois and Iowa, are the second group and are turning to telepsychiatry to address the problem of recruiting psychiatrists to live in the small towns where prisons are located. They want to provide direct telepsychiatry services from urban areas, Tucker said. They have a definite need and a definite idea in mind about how they want to use this technology.

A third group comprises university-based specialists such as child psychiatrists. They often receive requests from clinics throughout their states to provide consultations in their areas of expertise. These systems would be partially funded by the university and partially by the state.

The APA has also expressed interest in telepsychiatry as a possible solution to the types of work force shortages in rural areas that have prompted New Mexico and Louisiana to establish laws allowing psychologists to prescribe medications, Tucker said.

### **Success in New York**

What has given the OMH project staying power, according to Tucker, is that its staff are salaried employees, who devote part of their workday to running the system, and consultants affiliated with Columbia University who offer consultations free of charge.

The OMH program began in November 2000 with funding from the U.S. Department of Agriculture, which has a distance-learning and telemedicine grants program, and a double-matching grant from the OMH. By the end of 2000, the telepsychiatry project had about \$335,000 to work with, enough to connect a total of 12 sites to the host site at the New York State Psychiatric Institute--nine county clinics, two state-operated outpatient clinics and a small hospital in the upstate town of Potsdam that had its own equipment but needed access to consultants for its substance abuse unit.

The project team and state officials were also interested in delivering consultations to state prisons, and the state Department of Corrections agreed to link to the OMH system through equipment it already possessed for other telemedicine consultations. That partnership began in January 2001, and the project has been conducting consultations at 12 state prisons ever since.

The program also serves as a teaching tool for the faculty at Columbia University. "We have a library of teaching tapes unlike basically anything in the world of usual and unusual psychopathology," he said.

But the OMH project is a high-end system that would not be easy to replicate. It has access to a large faculty at Columbia University who are willing to provide consultations for free. And the program is not a direct-service model, which allows it to avoid some of the complications with follow-up that can occur when providing services directly to the patient.

### **Cost Issues**

"The biggest hurdle is who's going to pay for this," Hyler said. Current procedural terminology (CPT) codes for telepsychiatry exist, "but I don't believe that anyone is paying for this yet."

The Center for Medicare & Medicaid Services (CMS) currently allows for reimbursement of telemedicine under Medicare for rural areas that meet the agency's stringent criteria. Any increasing willingness on the part of Medicare to reimburse telemedicine services would likely result in a growing acceptance of such services by third-party payors.

In the meantime, telepsychiatry programs must show that they are cost-effective in order to survive, Hyler and Dinu P. Gangure, M.D., wrote in "A Review of the Costs of Telepsychiatry," which appeared in the July 2003 issue of *Psychiatric Services* (54[7]:976-980). The decreasing cost of the technology will help make this happen, as will the sharing of telehealth systems among different medical disciplines.

Out of 12 studies published between 1995 and 2002 dealing specifically with the costs of telepsychiatry, seven demonstrated that telepsychiatry was worth the cost, Hyler and Gangure wrote. However, the studies used weak methodologies and lacked comparable data.

The authors for most of the studies also had a vested interest in the success of the programs they wrote about. And one study concluded that a lack of business plans made it difficult to determine whether any telepsychiatry program is cost-effective.

"We conclude that telepsychiatry can be cost-effective in selected settings," Hyler and Gangure wrote. "However, there is no assurance that any governmental or private health care agency will be willing to assume the cost."

The issue of cost depends on perspective, Hyler and Gangure pointed out in the literature review. Telepsychiatry can be less expensive for patients who no longer have to travel as far for treatment. Insurance companies, however, could find that their costs go up as the technology increases access to psychiatry services.

"Telepsychiatry's ultimate survival will depend on its finding its niche," Hyler and Gangure concluded.

### **The Need for Standards**

In order for payors to embrace telepsychiatry, standards of practice must be developed that are reasonable, fair and replicable, Tucker said. The Center for Medicare & Medicaid Services provides small pots of money for telemedicine but is very reluctant to open the floodgates, he said. The agency does not want people putting up a shingle and billing away for telepsychiatry without being answerable for the quality of services they deliver.

The Joint Commission on the Accreditation of Healthcare Organizations continues to revise its telemedicine standards, and the APA has also expressed interest in developing standards specifically for telepsychiatry, Tucker said. Australia and Canada, where telemedicine enjoys widespread support from their governments, have standards for telemedicine services that could serve as templates to adapt to U.S. health care systems.

Right now, he said, a lot of ad hoc arrangements exist for telepsychiatry, such as a single child psychiatrist contracting with a school system in a closed-loop arrangement. Eventually, however, telepsychiatry systems will take off nationwide. It could happen as soon as three or four years, but it will require some established method of oversight. If certification standards were established, payors would be more likely to agree to reimburse the service.

Tucker said the OMH project has been approached by executives at managed care companies looking for ways to introduce a second-opinion program into rural parts of the state. While the project is prohibited from contracting with these types of companies, the overtures demonstrate that interest for these services does exist in the private sector.

But anyone looking for data to support adopting a telepsychiatry program might be hard pressed to find any.

According to a literature review appearing in the December 2003 issue of *Psychiatric Services* (54[12]:1604-1609), methodologically sound studies of

telepsychiatry are infrequent, despite the rapid increase in information about the technology.

The authors of "Recent Advances in Telepsychiatry: An Updated Review" examined 68 studies published between March 2000 and March 2003. Overall, they found that the studies supported telepsychiatry as a useful means of conducting assessments and improving a patient's clinical status, but that "only a limited number of empirical studies have been reported over the past three years."

The review concluded that the field needs "reliable baseline data gathered before the implementation of programs, evaluation of clinical outcomes, randomized experimental design with appropriate control groups, cost analyses, and determination of the effectiveness and efficacy of telepsychiatry for specific patient populations."

### **Testing the Limits**

The OMH project's one ongoing cost is for broad bandwidth phone lines. Telepsychiatry systems use Integrated Services Digital Network (ISDN) lines, which offer far more confidentiality and reliability than would an Internet connection and allow for television-quality video and audio. Because the OMH has purchasing power, the project pays only \$104 a month for each ISDN line and a charge of only 16 cents per minute as a usage fee, so that a one-hour consultation costs less than \$10.

The state has agreed to fund the cost of the lines to the 12 county sites indefinitely, and the state has picked up the tab for the bridge connector fee that links the OMH system to the prisons' telemedicine system.

The technical quality of teleconferencing systems is quite good, Hyler said, and is mostly a function of line speed rather than hardware. Each ISDN line operates at a speed of 128 kilobytes per second (KBps). Together, three lines give the user 384 KBps, which is more than adequate for full-motion video and flowing audio with minimal delay. Newer equipment would be able to achieve the same effect at 256 KBps, meaning that only two ISDN lines would be needed.

Eventually systems will be able to do the same thing with one ISDN line, which will make it much more affordable, Hyler said.

The OMH staff has been able to do neurological consultations involving movement disorders and full-scale IQ tests. "We're testing the limits of what can and can't be done."

Overall, patients respond well to the technology, he said. Given a reasonable introduction about the experience of talking to a doctor over a television set,

patients do well, even when they have major mental disorders. And sometimes children and adolescents do better on the screen than in person.

After the first 30 seconds, it's like you're in the room, Hyler said.

ATTACHMENT 16:

Literature Review Summary on the Use of  
Telepsychiatry with Forensic Populations



# **Literature Review Summary on the Use of Telepsychiatry with Forensic Populations**

The American Psychiatric Association (APA) defines telepsychiatry as “the use of electronic communication and information technologies to provide or support clinical psychiatric care at a distance” (APA, 1998). The APA also describes possible applications for the use of video conferencing. For instance, the APA states that the technology could be used for clinical applications such as in diagnoses or for therapeutic interventions, as well as in forensic applications such as with commitment hearings, evaluations of competence and in forensic evaluations (APA, 1998). Specifically, the APA (1998) states that telepsychiatry can be applied in a variety of forensic uses including patient assessment for involuntary commitment and for conducting commitment hearings. However, before conducting a telepsychiatric evaluation for the purpose of involuntary commitment, it should be determined whether the state’s commitment laws allow for the use of telepsychiatry in this way (APA, 1998)<sup>1</sup>. Telepsychiatry is already implemented in a variety of settings, and as of 2004, slightly more than half of state correctional institutions and over one-third of federal institutions in the U.S. were using some sort of telemedical service, and at least 73 percent of these services provide mental health care (Schneider, 2006).

## **Federal prison program**

According to a federally-directed project conducted in 1996, a telemedicine network was implemented between four federal prisons to test the viability of remote telemedical consultations with prisons and to estimate the financial impact of implementing telemedical services in the federal prison system (McDonald, Hassol, Carlson, McCullough, Fournier & Yap, 1999). The authors stated that the preparation and planning involved with implementing the program was extensive, however, once implemented, the program was quickly adopted and used frequently for a variety of medical specialty areas (McDonald et al, 1999). Psychiatric services were used the most out of all the telemedicine specialties (McDonald et al, 1999). Inmates seemed satisfied with the telemedicine services (McDonald et al, 1999). Positive results of the project included a reduction in medical consult transports outside the facilities, shorter waiting times for inmates to see specialists, opportunities to see specialists that otherwise might not have been available, increased accessibility to bilingual services, availability of a psychiatrist on a weekly or more basis and better medication management.

## **State prison programs**

Regarding telemedicine services provided in different states, in 1996 there were over 160 telemedicine networks in operation in the U.S., the most actively used specialty being psychiatry (Miller, Burton, Hill, Luftman, Veltkamp & Swope, 2005). At the Child and Adolescent Forensic Clinic in the University of Kentucky Medical Center, telecommunications are used for educational seminars, weekly case presentations and clinical consultations (Miller et al, 2005). Surveyed customers reported being satisfied with the services, and providers were generally satisfied, though some reported anxiety related to the use of the equipment (Miller et al, 2005). In Ohio, telemedicine was

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<sup>1</sup> New York’s various commitment statutes are silent as to the use of telepsychiatry in commitment proceedings.

implemented in a prison environment to provide teleconsultations in a variety of medical specialties (Mekhjjan, Turner, Gailiun & McCain, 1999). Inmates readily accepted the system and were generally satisfied with the services (Mekhjjan et al, 1999). A financial analysis of a telemedicine project implemented in Ohio also reported positive impacts related to continuity of care, decreased delays in inmates receiving services and reduced costs in care (Brunicardi, 1998). In a pilot program launched in 2001 in South Carolina, video teleconferencing was implemented to provide forensic evaluations to correctional facilities, as well as expert testimony particularly for custody disputes and civil commitment proceedings (Schneider, 2006).

Washington State also attempted to use telepsychiatry with incarcerated youth in a minimum security setting, and reported its use to have a positive and useful impact on providing care and treatment (Myers, Valentine, Morgenthaler & Melzer, 2006). None of the youth involved refused these services, and overall patient satisfaction ranked high (Myers et al, 2006). The practicing psychiatrist also found that the telepsychiatry system provided adequate technical resolution to develop interpersonal rapport (Myers et al, 2006). Services provided include diagnostic evaluations, needs' assessments, and initial treatment and follow ups; when the model was changed slightly to alternately provide care technologically and in-person, the diagnoses made electronically remained consistent with the in-person evaluations, suggesting accuracy of telepsychiatric assessments (Myers et al, 2006).

### **Local and rural programs**

Telepsychiatry is also utilized in county and city jails. In Washington State, a study was conducted at a county jail in the Seattle, WA area to compare satisfaction levels of forensic psychiatric patients receiving telepsychiatric consults to those receiving similar, in-person evaluations (Brodey, Claypoole, Motto, Arias & Goss, 2000). Of the patients asked to participate in the video interviews, only one declined and satisfaction rates between the two groups did not differ significantly (Brodey et al, 2000). The interviewing psychiatrist also reported feeling comfortable with the use of the technology for diagnosis (Brodey et al, 2000). A project conducted between the University of Kansas Medical Center and a rural jail in Kansas also reported positive outcomes with the use of telepsychiatry (Zaylor, Nelson & Cook, 2001). Emergency consultations and long-term care through weekly appointments were provided, and patients reported experiencing less distress after receiving telepsychiatry services while psychiatrists also reported improvement in the patients they saw (Zaylor et al, 2001). In a separate project implemented in Kansas, inmates at a county jail were seen for consultation as well as ongoing care (Zaylor, Whitten & Kingsley, 2000). The services were well-received by the inmates, and jail personnel also stated that it saved time and reduced potential security issues with less transports outside of the facility (Zaylor et al, 2000).

### **Forensic telepsychiatry in the military**

A presentation at the annual meeting for the American Telemedicine Association in 2006 discussed military uses for forensic telepsychiatry (Schneider, 2006). Benefits from utilizing this service were reported as improved security, personnel safety, cost savings and access to specialists (Schneider, 2006). Barriers reported were costs of technology, resistance from medical personnel, lack of staff with technical expertise and difficulties coordinating services (Schneider, 2006). Video teleconferencing (VTC) has been used in a few legal military cases and to date none of these cases have been appealed based

on the use of VTC (Schneider, 2006). Schneider (2006) also reported that forensic psychiatrists are often asked to testify as expert witnesses based on viewing videos of defendants or witnesses, or of tapes taken during surveillance of alleged crimes, and this testimony is accepted in civilian and military courts of law. VTC evaluations may be seen as superior to this mode of testimony due to the psychiatrist performing their own evaluation of the patient, rather than simply commenting on an evaluation performed by another clinician or on past, recorded behavior on tape (Schneider, 2006).

### **CPA: Videoconference assessments for mental health legislation**

A survey was conducted in 2003 of Canadian psychiatrists' experiences and opinions on using videoconferencing for assessments required by mental health legislation (O'Reilly, Karlinsky, Tempier & Gray, 2003). Currently, the Canadian Psychiatric Association (CPA) does not have a position on the use of video conferencing for legislated assessments (O'Reilly et al, 2003). The Royal Australia and New Zealand College of Psychiatrists (RANZCP) currently sanction the use of videoconferencing for legislated assessments (RANZCP, 2007). Of the psychiatrists surveyed, few had used videoconferencing to conduct legislated assessments, and this is thought to be due to not having official legislation in place (O'Reilly et al, 2003). More than half (55 percent) stated that it would be appropriate to use an assessment by videoconference to determine whether an individual met committal criteria; 24 percent of those surveyed disagreed (O'Reilly, 2003). Physicians who were part of the Section of Telepsychiatry were more likely to endorse use compared to non-members (O'Reilly, 2003).

### **New York State**

A project being conducted in NYS involving OMH, DOC and Columbia University reveals that inmates receiving telepsychiatric services are generally satisfied with them, and 79 percent of those surveyed believe consultation this way is helpful and unlikely to be harmful, especially if feedback is offered in real time (Tucker, Ofelson, Simring, Goodman & Bienenfeld, 2006). Patients are reportedly comfortable with the system due to being accustomed to already sharing clinical information frequently with practitioners and experiencing parole hearings through video-consultation (Tucker et al, 2006).

NYS also conducted a telepsychiatric project in conjunction with a rural jail located in Franklin County in Malone, NY and SUNY Upstate Medical University in Syracuse, NY (Manfredi, Shupe & Batki, 2005). Services included diagnoses, treatment planning and medication prescription and management (Manfredi et al, 2005). The service was well received by the inmates, jail staff as well as the social worker and psychiatrist who reported the equipment as being easy to use (Manfredi et al, 2005).

OMH's Division of Forensic Services, Center for Information Technology and Evaluation and Research and Central New York Psychiatric Center are in the process of installing equipment to deliver telepsychiatry services at its existing corrections-based Satellite Mental Health Units. Ten OMH Satellite Units have operational VTC units with nine additional sites scheduled to become operational over the next several months. In March, 2007, OMH opened a telepsychiatry suite at the Capital District Psychiatric Center with four VTC units dedicated to the delivery of psychiatric services to OMH's Satellite Units. Presently five Central New York Psychiatric Center psychiatrists provide consultation, assessment and treatment services via VTCs to inmates throughout the DOCS system serving an active caseload of 520 inmates or approximately 6% of Central

New York Psychiatric Center's active corrections-based caseload. In addition to consultation, assessment and treatment services, Central New York Psychiatric Center staff use telepsychiatry for discharge planning and evaluations for commitment pursuant to Correction Law § 402 and Sex Offender Management pursuant to Article 10 of the Mental Hygiene Law.

Although OMH has used telepsychiatry for evaluations related to commitment and sex offender management proceedings, to date no court hearings have been conducted using video-conferencing. Approximately five years ago, OMH and the Office of Court Administration agreed to a pilot project using video-conferencing for court retention hearings at Mid-Hudson Forensic and Central New York Psychiatric Centers. Equipment was installed at each of these facilities as well as the Oneida and Orange County Courthouses. No actual hearings were conducted primarily for two reasons. During testing sessions, judges in the respective locations were not satisfied with the quality of the transmission (delayed and staccato movements and poor sound quality primarily due to "bridging") and limited field of vision. Specifically, video conferencing did not permit judges to view respondents' reactions to testimony.

### **Summary**

The use of VTCs in the delivery of medical and psychiatric services in correctional settings has increased dramatically during the past 15 years. Professional organizations recognize its value in diagnosis and assessment as well as services delivery. Studies demonstrate cost savings, improved timeliness in access to care and user satisfaction among providers and recipients of care.

Though not used in commitment proceedings within New York State, the APA recognizes its value in the completion of forensic evaluations and commitment proceedings.

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ATTACHMENT 17:

A Pilot Survey of Inmate Preferences for On-Site,  
Visiting Consultant, and Telemedicine

# CNS Spectrums – The International Journal of Neuropsychiatric Medicine

## A Pilot Survey of Inmate Preferences for On-Site, Visiting Consultant, and Telemedicine Psychiatric Services

*CNS Spectr.* 2006;11(10):783-787

### Abstract

**Objective:** *To assess inmate preferences for in-prison mental health services, outside psychiatric consultants, and telemedicine psychiatric consultation for 16 mental health services.*

**Methods:** *Structured interviews were conducted of the service modality preferences of 28 inmates who received psychiatric telemedicine consultations in New York State Department of Corrections facilities.*

**Results:** *For five of the 16 mental health services assessed, a significantly larger proportion of inmates preferred delivery of mental services by their on-site mental health team to an outside psychiatric consultant, whether visiting or using telemedicine. For another eight services, inmate preferences were approximately equal. For three services (treatment progress, evaluation of childhood sexual abuse, and sexual concerns), inmates reported a trend toward preference for outside consultation (visiting and telemedicine combined). For no service did inmates prefer telemedicine to a visiting consultant.*

**Conclusion:** *Although inmates prefer the use of on-site mental health professionals for many mental health services, some inmates prefer visiting or telemedicine consultants for the evaluation of safety and sexual issues. Because telemedicine is efficient and readily available, its role in these areas requires further evaluation.*

### Introduction

Although telemedicine is not yet widely supported by third-party payers as a mode of health-service delivery, its potential is receiving increasing attention. High-visibility projects have set out to develop and research the effectiveness of telemedicine in the treatment of several general medical conditions.<sup>1-3</sup>

For correctional populations with mental health needs, telemedicine is a promising medium for providing direct or consultative services, teaching psychiatric and other trainees, and conducting research. It can link academic medical centers, which are generally urban-based and rich in resources, with what in most states are far-flung networks of rural and less well-resourced correctional facilities. Since on any given day, there many more mentally ill people in prison in the United States than in state mental

hospitals,<sup>4</sup> academic psychiatrists and trainees wishing to see the bulk and range of those with mental illness may well support telepsychiatry. Practical considerations preclude even those academic psychiatrists with a potential interest in this population from making the necessary trip.

The current study elicited inmates' preferences for the delivery system for a range of specific, commonly provided mental health services, with the hypothesis that they would prefer some of these to be delivered by on-site mental health practitioners and others by outside consultants, whether visiting or via telemedicine.

## **Methods**

### **Background**

In early 2001, the New York State Office of Mental Health (NYS-OMH), which has been mandated since 1978 to provide mental health services to inmates, began providing case consultations to clinicians on mental health units at the state's 12 maximum-security correctional facilities,<sup>5</sup> which are operated by the New York State Department of Correctional Services (NYS-DOCS). A grant from the US Department of Agriculture's Distance Learning and Telemedicine program and matching funds from NYS-OMH provided telemedicine equipment at the host site (New York State Psychiatric Institute [NYSPI]), and NYS-DOCS provided access to similar equipment at the 12 downlink sites. Columbia University/NYSPI clinician-researchers provided psychiatric consultations without charge. Consultation requests were initiated by the treating clinicians seeking help with particularly challenging patients. With permission, interviews were videotaped for educational purposes. Over the ensuing 4 years, 67 such consultations were conducted by 45 clinician-researchers. The consultation format involved the inmate and his/her psychiatrist at the downlink site and the consulting psychiatrist, sometimes accompanied by a trainee, at the host site. Since inmates were accustomed to the sharing of clinical information routinely among on-site clinicians and to the video-consultation medium through parole hearings, the inmates did not express concerns about confidentiality.

### **Inmate Assessments**

A questionnaire was constructed to assess inmate preferences for the delivery of 16 commonly provided mental health services: basic mental health information; "talk" therapy; assessment of medication effects; assessment of treatment progress; assessment of medication side effects; review of criminal history; feelings of anxiety; feelings of sadness/depression; sexual concerns; fears for personal safety; fears of inability to adjust to prison life; fears that prison life is causing physical illness; fears that prison life is causing mental illness; concerns about childhood sexual abuse; feedback on overall progress with one's mental illness; and help with other symptoms. For each of these services, inmates were asked whether they preferred it to be delivered by the on-site mental health team; by an outside consultant visiting on-site; by an outside consultant



using telemedicine; or whether the inmate had no preference. Inmates were also asked about the degree of recollection of the telemedicine consultation, which may have occurred up to nearly 4 years prior to the study. Open-ended items were used to elicit narrative responses.

Institutional review board approval was obtained from Columbia University in New York City, from NYS-OMH, and from NYS-DOCS prior to soliciting inmate participation. All interviews were conducted between November 22, 2004, and May 20, 2005. Data were collected by a study team of correctional psychiatrists.

For each service, the proportion of inmates who preferred on-site, visiting consultant, and telemedicine psychiatric services was calculated with associated 95% confidence intervals.

## **Results**

### **Response Rate**

Of the 67 consultations conducted, 65 inmates provided permission for videotaping; the remaining two were not included in this follow-up study. At the time of the research interview, 22 inmates who had received consultations had been discharged from prison, either by release or parole, and their study participation was not solicited. Two of the consultations had been conducted in languages other than English and were therefore excluded. Of the 41 eligible inmates still or re-incarcerated, one was determined to be incompetent to provide informed consent and 12 refused to participate. Thus, 28 (68.3%) of those eligible agreed to participate.

### **Demographic Characteristics of Study Sample**

The demographic characteristics of the study sample were compared with the characteristics of the total inmate population in New York State.<sup>6</sup> Of the 28 study participants, 11 (39.3% vs 19.0% of the total inmate population) were white; 13 (46.4% vs 50.4% of the total inmate population), Black; 3 (10.4% vs 28.4% of the total inmate population), Hispanic; and 1 (3.6% vs 0.7% of the total inmate population) Native American. Twenty-six were male and two were female. Their mean age was 38.5 years (range=22–60 years). The average period of time between their consultation and their study interview was 24 months (range=9–44 months). The median number of months they had been incarcerated at the time of their consultation was 65 (range=1–178 months). Nineteen had never been married, two were currently married, two were divorced, and five were widowers. Six had some college education, another seven had graduated from high school, and of the remaining 15, the median level of educational attainment was ninth grade.

### **Clinical and Forensic Characteristics of Study Sample**

In terms of their mental health history, which was obtained by record review prior to the study interview, 25 (89.3%) had evidence of prior psychiatric hospitalization; 17 (60.7%) of at least one depressive episode; 10 (35.7%); 17 (60.7%) of a non-affective psychotic episode; 24 (85.7%) of a drug or alcohol abuse disorder; and 20 (71.4%) of one or more serious suicide attempts. At the time of the study interview, 24 (85.7%) were prescribed antipsychotics, antidepressants, or mood stabilizers. Seventeen (60.7%) had permanently injured another person, 21 (75.0%) had been victims of physical violence, and 15 (53.6%) had been homeless for >24 hours.

## **Inmate Preferences for Mode of Psychiatric Service Delivery**

A majority of inmates expressed a preference for receiving five mental health services from their on-site team: assessment of medication effects, assessment of anxiety, mental health information, assessment of sadness/depression, and fears of the inability to adjust to prison life. A significantly larger proportion of inmates expressed a preference for assessment of medication effects and of anxiety by their on-site team than a visiting or telemedicine consultant. Roughly equal numbers expressed preferences for services from the on-site team or from visiting consultants for another eight mental health services, though they generally preferred that the consultants visit in-person rather than consult by telemedicine. These were “talk” therapy; medication side effects; criminal history; fears for personal safety; fears that prison makes you physically ill; fears that prison makes you mentally ill; overall progress with mental illness; and help with other symptoms. Finally, they expressed a trend toward preference for the outside consultant, whether visiting or using telemedicine, for three other services: treatment progress, sexual concerns, and sexual abuse (Table).

**TABLE.****Inmate Preferences for Delivery Modalities for 16 Mental Health Services\***

<i>Mental Health Service</i>	<i>On-Site Team n (%; 95% CI)</i>	<i>Visiting Consultant n (%; 95% CI)</i>	<i>Telemedicine Consultant n (%; 95% CI)</i>
Mental health information (n=23)	14 (60.9; 40.9-80.9)	8 (34.8; 15.8-53.8)	1 (4.3; 0.0-12.3)
"Talk" therapy (n=23)	13 (56.7; 36.7-76.7)	7 (30.4; 11.4-49.4)	3 (13.0; 0.0-27.0)
Assessment of medication effects (n=24)	17 (70.8; 52.8-89.8)	4 (16.7; 1.7-31.7)	3 (12.5; 0.0-25.5)
Assessment of treatment progress (n=22)	8 (36.4; 15.4-57.4)	10 (45.5; 24.5-66.5)	4 (18.2; 2.2-34.2)
Assessment of medication side effects (n=23)	11 (47.8; 27.8-67.8)	7 (30.4; 11.4-49.4)	5 (21.7; 4.7-38.7)
Review of criminal history (n=18)	9 (50.0; 27.0-53.0)	8 (44.4; 21.4-67.4)	1 (5.5; 0.0-38.5)
Feelings of anxiety (n=22)	14 (63.6; 43.6-83.6)	4 (18.1; 2.1-34.1)	4 (18.1; 2.1-34.1)
Feelings of sadness (n=22)	13 (59.1; 38.1-80.1)	5 (22.7; 4.7-40.7)	4 (18.1; 2.1-34.1)
Sexual concerns (n=18)	5 (27.7; 6.7-48.7)	9 (50.0; 27.0-73.0)	4 (22.2; 3.2-41.2)
Fears for personal safety (n=22)	11 (50.0; 29.0-71.0)	10 (45.5; 24.5-66.5)	0 (0.0)
Inability to adjust to prison life (n=24)	14 (58.3; 38.3-78.3)	6 (25.0; 8.0-42.0)	4 (16.7; 1.7-31.7)
Fears that prison makes you physically ill (n=23)	11 (47.8; 27.8-67.8)	9 (39.1; 19.1-59.1)	3 (13.0; 0.0-27.0)
Fears that prison makes you mentally ill (n=22)	12 (54.5; 33.5-75.5)	8 (36.4; 15.4-57.4)	2 (9.1; 0.0-21.1)
Childhood sexual abuse (n=15)	5 (33.3; 9.3-57.3)	8 (53.3; 28.3-78.3)	2 (13.3; 0.0-30.3)
Overall progress with mental illness (n=22)	12 (54.5; 33.5-75.5)	7 (31.8; 12.8-50.8)	3 (13.6; 0.0-27.6)
Help with other symptoms (n=20)	9 (45.0; 23.0-67.0)	8 (40.0; 19.0-61.0)	3 (15.0; 0.0-31.0)

\*Number of respondents varies because unscored, doubly scored, and "no preference" responses are not included.

Tucker W, Olsson M, Simring S, Goodman W, Bienenfeld S. *CNS Spectr*. Vol 11, No 10. 2006.

## Narrative Responses

In response to open-ended questions, most inmates (79%) believed consultation by telemedicine to be generally helpful, particularly if feedback was provided in real time, and unlikely to be harmful (61%). There were also several examples of significant clinical information that inmates revealed to outside telemedicine consultants that they reported having not revealed to their on-site team during a mean treatment period of 5 years. These included "that I was thinking of suicide"; "basically everything, because I wasn't talking to 'them' at all"; "my father's abuse"; and "aspects of my depression and panic."

## Discussion

The principal finding is that a majority of inmates show equal preferences for on-site and for outside consultants (eight services) or prefers an outside consultant (three services) to existing on-site services for the delivery of 11 of 16 mental health services. Although inmates generally preferred that the outside consultant visit them on-site rather than consult via telemedicine, on-site expert consultants are unavailable and unlikely to become so. By eliciting significant new clinical information, outside telemedicine consultants may complement services routinely provided in prison.

Inmate preferences for on-site delivery of some services probably reflect their perception that these clinicians are more readily available and are more familiar with correctional system procedures and resources than outside consultants. Their preferences for the outside consultant may reflect not only their desire to access specialists' expertise, but, explicitly, their desire to relate their symptoms to someone outside the correctional system.

The study has several limitations. First, a substantial proportion of the inmates who received telemedicine consultations were excluded from this study because they had been released from prison; in the future it will be important to sample released inmates who may feel freer to express their preferences. Second, the survey was conducted after a significant time delay following the consultation; the effects of this delay on the pattern of survey responses remain unknown. Third, the study sample size (N=28) was modest; a larger sample size would have permitted greater opportunity to describe inmate characteristics that influence preferences for telemedicine consultation.

## Conclusion

The findings of this study support those of previous studies demonstrating acceptance of telemedicine by inmates.<sup>7,8</sup> Since there is little possibility that academic psychiatrists will be able to perform routine outside consultations on-site, telemedicine may have an important role to play. The leadership of correctional and affiliated mental health authorities will need to consider expanding the use of telemedicine, something that will require resources not only for equipment but for managing its use. Telemedicine may also help expand the capacity for delivering routine mental health services, thus addressing the larger unmet service need.<sup>9</sup> The expressed preferences of inmates suggest a high degree of tolerance for telemedicine services and, thus, a tailored role for this unique technology. Follow-up studies are needed to focus on the preferences of corrections officers and on-site mental health clinicians for these services, and for a more specific assessment of the place of telemedicine in the delivery of psychiatric services to inmates.

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*Disclosures: Drs. Tucker, Simring, Goodman, and Bienefeld do not have an affiliation with or financial interest in any organization that might pose a conflict of interest. Dr. Olfson is on the speaker's bureau of Janssen, a consultant to Bristol-Myers Squibb, Eli Lilly, and McNeil, has received honoraria from Pfizer, is on the advisory boards of Bristol-Myers Squibb and Pfizer, and has received research/grant support from Bristol-Myers Squibb and Eli Lilly. A preliminary version of this article was presented at the International Congress on Law and Mental Health held July 2–9, 2005, in Paris, France.*

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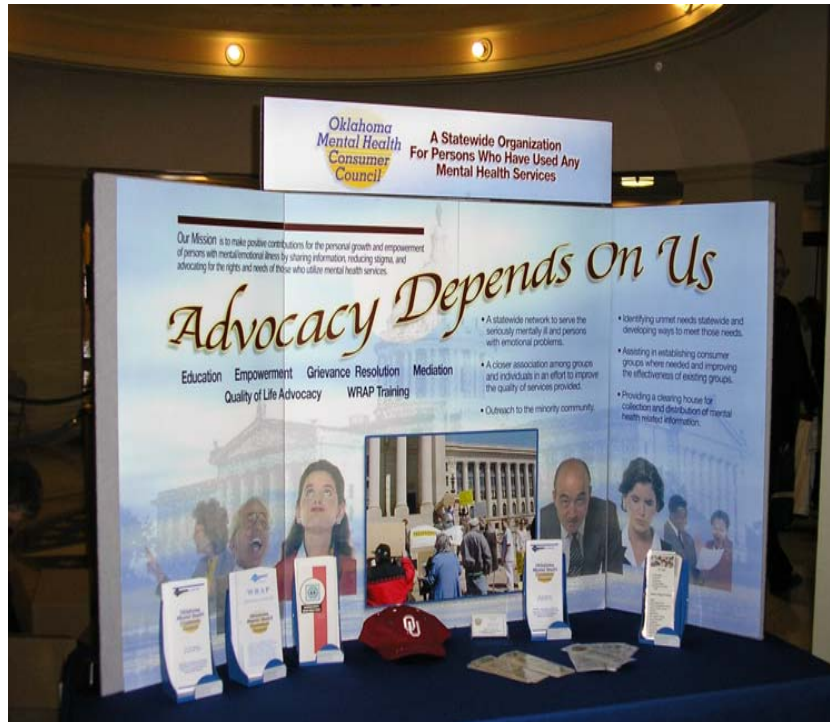
**ATTACHMENT 18:**

**Oklahoma Mental Health Consumer Council**



- o Statewide Consumer-Run Nonprofit Organization (501(c)3)
- o Established in 1991

# Recovery Is The Key



**Educate**

**Advocate**

**Empower**

**Network**

***"I'm out of prison, I've got a job, I'm buying a car, and I'm getting my kids back!"***



# Recovery is the Ultimate EBP

- Oklahoma Governor and Attorney General's Blue Ribbon Task Force on Mental Health, Substance Abuse and Domestic Violence, 2006
- Cross-Systems Collaboration (integrated health care)
- Governor's Transformation Advisory Board

# Criminal Justice Summits

- 2003
- 2005
- 2006
- 2007



# OMHCC's Criminal Justice Activities

- Involvement in CIT Training- *Role Plays-Communication with Consumers-Open Dialog*
- WRAP Classes to Inmates in County Jail
- WRAP Training to Inmates in State Prison and Reformatory
- Mental Health Court Task Force
- Ongoing Support for MHC Participants

# Advocacy

- Crisis Intervention Training for Law Enforcement-Direct Consumer Contact and Dialog
- Mental Health Court Initiated by NAMI-OK-At Least One Peer Supporter on Each Court Team
- Successful in Obtaining a Seat on the Board of ODMHSAS for a Consumer- Appointed by the Governor

# Advocacy

- Peer Support on Each Drug Court
- WRAP Training for DOC Professionals to Assist Inmates
- Expungement of Record for Successful Mental Health Court Graduates

**ATTACHMENT 19:**

**Peer Support within Criminal Justice Settings: The  
Role of Forensic Peer Specialists**

## Peer Support within Criminal Justice Settings: The Role of Forensic Peer Specialists

Larry Davidson, Ph.D.<sup>1</sup>, and Michael Rowe, Ph.D.<sup>2</sup>

The CMHS National GAINS Center

May, 2008

The past decade has witnessed a virtual explosion in the provision of peer support to people with serious mental illness, including those with criminal justice system involvement. Acting on one of the key recommendations of the President's New Freedom Commission on Mental Health, 30 states have developed criteria for the training and deployment of "peer specialists," while at least 13 states have initiated a Medicaid waiver option that provides reimbursement for peer-delivered mental health services.

### What Is Peer Support?

While people in recovery can provide conventional services, peer support *per se* is made possible by the provider's history of disability and recovery and his or her willingness to share this history with people in earlier stages of recovery. As shown in Figure 1, peer support differs from other types of support

in that the experience of having "been there" and having made progress in one's own personal recovery comprises a major part of the support provided.

Forensic peer support involves trained peer specialists with histories of mental illness and criminal justice involvement helping those with similar histories. This type of support requires special attention to the needs of justice-involved people with mental illness, including an understanding of the impact of the culture of incarceration on behavior. Recognition of trauma and posttraumatic stress disorder, prevalent among this population, is critical.

### What Do Forensic Peer Specialists Do?

Forensic Peer Specialists assist people through a variety of services and roles. Given the history of stigma and discrimination accruing to both mental illness and incarceration, perhaps the most

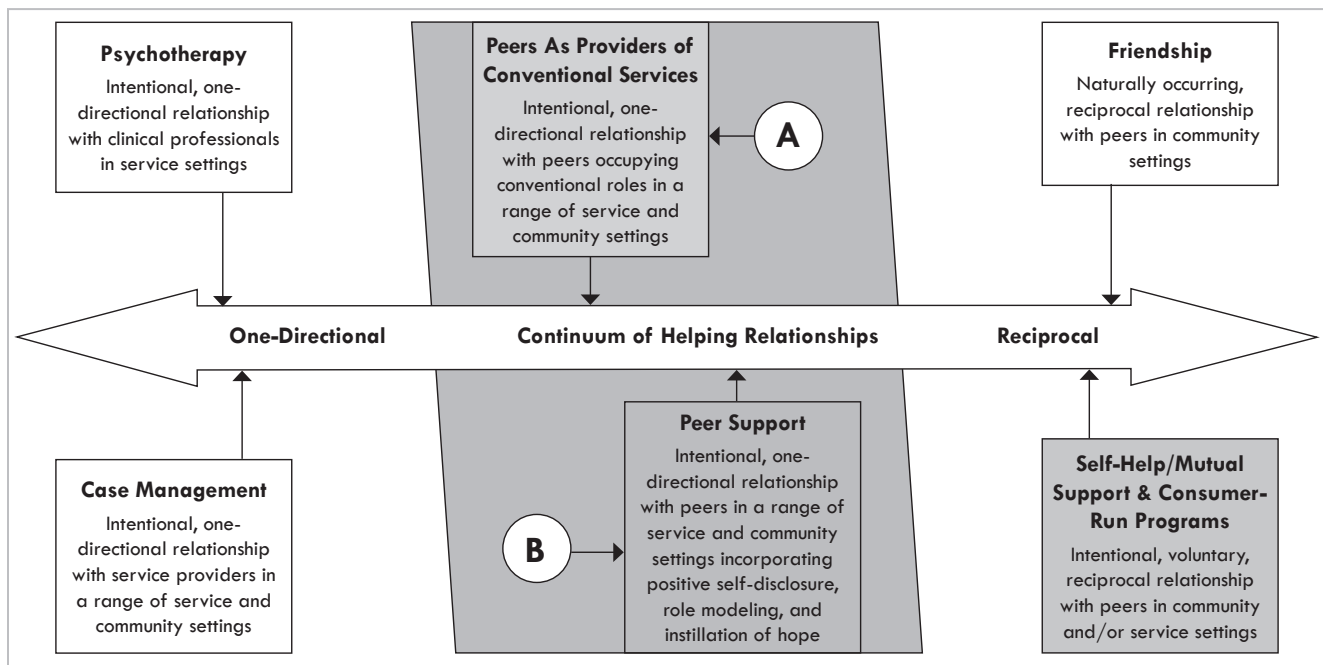


Figure 1. A Continuum of Helping Relationships

- 1 Associate Professor/Director, Program for Recovery and Community Health, Yale University School of Medicine and Institution for Social and Policy Studies
- 2 Associate Clinical Professor/Co-Director, Program for Recovery and Community Health, Yale University School of Medicine and Institution for Social and Policy Studies

important function of Forensic Peer Specialists is to instill hope and serve as valuable and credible models of the possibility of recovery. Other roles include helping individuals to engage in treatment and support services and to anticipate and address the psychological, social, and financial challenges of re-entry. They also assist with maintaining adherence to conditions of supervision.

Forensic Peer Specialists can serve as community guides, coaches, and/or advocates, working to link newly discharged people with housing, vocational and educational opportunities, and community services. Within this context, they can model useful skills and effective problem-solving strategies, and respond in a timely fashion to prevent or curtail relapses and other crises. Finally, Forensic Peer Specialists provide additional supports and services, including:

- Sharing their experiences as returning offenders and modeling the ways they advanced in recovery
- Helping people to relinquish attitudes, beliefs, and behaviors learned as survival mechanisms in criminal justice settings (such as those addressed by SPECTRM [Sensitizing Providers to the Effects of Incarceration on Treatment and Risk Management] and the Howie T. Harp Peer Advocacy Center)
- Sharing their experiences and providing advice and coaching in relation to job and apartment hunting
- Supporting engagement in mental health and substance abuse treatment services in the community, including the use of psychiatric medications and attending 12-step and other abstinence-based mutual support groups
- Providing information on the rights and responsibilities of discharged offenders and on satisfying criminal justice system requirements and conditions (probation, parole, etc.)
- Providing practical support by accompanying the person to initial probation meetings or treatment appointments and referring him or her to potential employers and landlords

*Forensic Peer Specialists embody the potential for recovery for people who confront the dual stigmas associated with serious mental illnesses and criminal justice system involvement.*

- Helping people to negotiate and minimize continuing criminal sanctions as they make progress in recovery and meet criminal justice obligations.
- Working alongside professional staff
- Training professional staff on engaging consumers with criminal justice history

### **How Forensic Peer Specialists Can Help Transform Mental Health Services and Linkages Between Systems**

Forensic Peer Specialists embody the potential for recovery for people who confront the dual stigmas associated with serious mental illnesses and criminal justice system involvement. Forensic peer specialists are able to provide critical aid to persons in the early stages of re-entry, in much the same way that peer specialists who support peers with mental illness alone (i.e., without criminal justice system involvement), have been able to engage into treatment persons with serious mental illnesses (Sells et al., 2006; Solomon, 2004). Beyond the initial engagement phase, however, little is known empirically about the value

Forensic Peer Specialists add to existing services. Nonetheless, in the limited number of settings in which they have been supported, case studies clearly suggest using Forensic Peer Specialists is a promising, cost effective practice.

### **Five Things Your Community Can Do to Integrate Forensic Peer Specialists in Services and Supports**

1. Identify and educate key stakeholders, including consumers, families, victims' rights organizations, mental health care providers, criminal justice agencies, and peer-run programs regarding the value of Forensic Peer Specialists.
2. Convene focus groups with these constituencies to assess the demand for trained Forensic Peer Specialists and to identify barriers to their employment.
3. Identify and contact potential funding sources such as state vocational rehabilitation agencies,



local and state departments of health, and the judiciary.

4. Work with human resources departments of behavioral health agencies to identify and overcome bureaucratic obstacles to hiring Forensic Peer Specialists, such as prohibitions to hiring people with felony histories.
5. Address stigma within both the local community and the larger mental health and criminal justice systems so that people with histories of mental illness and criminal justice involvement will be more readily offered opportunities to contribute to their communities.

### Future Directions

Little attention has been paid to the nature of training and supervision required by Forensic Peer Specialists. Study in this area would ensure that systems of care are able to reap the maximum benefit from the contributions of Forensic Peer Specialists. Future directions should involve systematic efforts to design and evaluate training curricula, and to build on and expand current knowledge about the effectiveness of forensic peer services through research and information sharing. Future work should also involve creating clear roles, job descriptions, and opportunities for advancement in this line of work. In addition, for this alternative and promising form of service delivery to mature, barriers to the implementation and success of Forensic Peer Specialist work, including non-peer staff resistance, the reluctance of behavioral health agencies to hire people with criminal justice histories, and state criminal justice system rules forbidding ex-offenders from entering prisons to counsel returning offenders, will need to be addressed.

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ATTACHMENT 20:

Chapter 269: SB262 – Final Version

CHAPTER 269

SB 262 – FINAL VERSION

03/09/06 1199s

19Apr2006... 1705h

05/24/06... 2375eba

2006 SESSION

06-2700

08/09

SENATE BILL **262**

AN ACT establishing the position of an administrator of women offenders and family services within the department of corrections and establishing an interagency coordinating council on women offenders.

SPONSORS: Sen. Larsen, Dist 15; Sen. D'Allesandro, Dist 20; Sen. Hassan, Dist 23; Sen. Fuller Clark, Dist 24; Sen. Roberge, Dist 9; Rep. Price, Hills 26; Rep. Dowling, Rock 5; Rep. Houde-Quimby, Sull 1; Rep. E. Blanchard, Merr 10; Rep. Wall, Straf 7

COMMITTEE: Judiciary

AMENDED ANALYSIS

This bill establishes an administrator of women offenders and family services and an interagency coordinating council on women offenders.

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Explanation: Matter added to current law appears in ***bold italics***.

Matter removed from current law appears [~~in brackets and struck through.~~]

Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

03/09/06 1199s

19Apr2006... 1705h

05/24/06... 2375eba

06-2700

08/09

STATE OF NEW HAMPSHIRE

*In the Year of Our Lord Two Thousand Six*

AN ACT establishing the position of an administrator of women offenders and family services within the department of corrections and establishing an interagency coordinating council on women offenders.

*Be it Enacted by the Senate and House of Representatives in General Court convened:*

269:1 New Sections; Administrator of Women Offenders and Family Services; Council Established. Amend RSA 21-H by inserting after section 14-a the following new sections:

21-H:14-b Administrator of Women Offenders and Family Services.

I. There is hereby created the position of administrator of women offenders and family services within the department of corrections. The administrator shall be responsible for programming and services for women offenders in the state adult correctional system including probation, parole, and state correctional facilities. The administrator of women offenders and family services shall be a classified position.

II. The administrator may:

(a) Establish goals and objectives for state correctional systems within the framework of the department's philosophy, including planning, organizing, implementing, directing, and monitoring state gender-responsive programs and services, as well as developing policies, procedures, and standards for the provision of such programs and services. The administrator shall participate in the development, implementation, and review of all policies, directives, and standards that involve supervision of women offenders. The administrator shall also coordinate continuum and continuation of gender-responsive services to women offenders moving from one setting to another, and re-entering their communities.

(b) Write standards for, execute, and monitor all non-clinical contracts with service providers who work exclusively with women offenders. The administrator shall review and provide feedback on an ongoing basis on all clinical contracts and services for women offenders regarding consistency with contract language and gender-responsive principles.

(c) Establish and coordinate partnerships, and maintain working relationships within the department of health and human services, with other government agencies, with communities, and with community-based organizations, volunteers, advocacy groups, the academic community, and other external stakeholders.

(d) Provide supervision and technical assistance to the women's facility warden and field managers regarding issues related to women offenders and gender-responsive programs, services, and practices. The administrator shall provide input into the evaluations of other facility wardens, field managers, and personnel relative to their roles in the supervision and provision of services for women offenders.

(e) Provide input regarding necessary data collection and evaluation to measure effective programming and supervision of women offenders. The administrator shall consult with and provide input with other directors regarding appropriate levels of staffing in both the field and institutions responsible for the management of women offenders. The administrator shall also confer with and make recommendations to the commissioner regarding women offender supervision and services, oversee the planning, development, and implementation of training guidelines for staff working with women offenders, and recommend changes in duties assigned to casework and security staff who work with women offenders.

(f) Act as a resource in cases of staff sexual misconduct involving women offenders and provide input into personnel actions for addressing misconduct involving staff who work with women offenders and misconduct involving women offenders.

III. The administrator shall:

(a) Prepare budget recommendations regarding women offenders' program services consistent with the departmental budget cycle. The administrator shall also engage in budget formation, grant applications, and resource allocation activities related to women offenders as assigned.

(b) Act as liaison to the interagency coordinating council for women offenders and the department of corrections.

21-H:14-c Interagency Coordinating Council for Women Offenders.

I. There is established an interagency coordinating council for women offenders.

II.(a) The members of the council shall be as follows:

- (1) One member of the governor's office, appointed by the governor.
- (2) One member of the senate, appointed by the president of the senate.
- (3) One member of the house of representatives, who shall be knowledgeable about county corrections, appointed by the speaker of the house of representatives.
- (4) The executive councilor representing district 5/Goffstown.
- (5) The commissioner of corrections.
- (6) The warden of the state prison for women.
- (7) The commissioner of health and human services, or designee.
- (8) The director of division of children, youth, and families, or designee.
- (9) The attorney general, or designee.
- (10) The chief justice of the superior court, or designee.
- (11) The chief justice of the supreme court, or designee.
- (12) The commissioner of the department of education, or designee with knowledge of Title IX, Carl Perkins Grants, and other federal funding sources.
- (13) One member from the Hillsborough county government, appointed by the New Hampshire Association of Counties.
- (14) One former inmate of the state prison for women who is no longer under correctional supervision, appointed by the governor.
- (15) A representative from the New Hampshire commission on the status of women, appointed by the governor.
- (16) A representative from the New Hampshire Coalition Against Domestic and Sexual Violence, appointed by the governor.
- (17) A representative from New Hampshire Task Force on Women and Addiction, appointed by the governor.
- (18) A representative from the Citizens Advisory Committee of the New Hampshire State Prison for Women, appointed by the governor.
- (19) A community member with knowledge of correctional practices with particular expertise with female offenders, appointed by the governor.

(b) Legislative members of the council shall receive mileage at the legislative rate when attending to the duties of the council.

III. The duties of the council shall be as follows:

- (a) Identify opportunities for interagency cooperation in the effective management of female offenders.
- (b) Develop memoranda of understanding outlining "in-kind" services or cooperation to provide services to incarcerated women and their children.

(c) Develop cross-training opportunities to foster understanding of system responses to the shared population across agencies of incarcerated women and their children.

(d) Develop gender-specific treatment for co-occurring conditions and a continuity of treatment from incarceration to community.

(e) Coordinate interagency case management and re-entry planning.

(f) Assess the impact of incarceration on family relations during and after incarceration.

(g) Apply for and administer federal and private sector grants for the furtherance of the

duties of the council and the development of gender-responsive, trauma-informed management of female offenders and their children.

IV. The council shall meet at least monthly during its first year, then at least quarterly thereafter. The members of the council shall elect a chairperson from among the members. The first meeting of the council shall be held within 45 days of the effective date of this section. The first meeting of the council shall be called by the senate member. The council shall convene at the call of the chairperson when deemed necessary by the chairperson.

V. The term of each member appointed under paragraph III who has a term of office shall be coterminous with his or her term in office. The terms of the remaining members shall be for 3 years. Vacancies shall be filled for the remainder of the term in the same manner and from the same group as the original appointment.

VI. The council shall report its findings and any recommendations for proposed legislation to the president of the senate, the speaker of the house of representatives, the senate clerk, the house clerk, the governor, and the state library annually on or before November 1.

269:2 New Classified Position; Funding. The position of administrator of women offenders and family services established under RSA 21-H:14-b, as inserted by section 1 of this act, shall be a classified position at labor grade 33. Funding for this position shall not affect the general fund appropriations reduction required in 2005, 176: 11. The funding for the administrator of women offenders and family services position shall be from the department of corrections' fiscal year 2007 operating budget.

269:3 Effective Date. This act shall take effect July 1, 2006.

Approved: June 9, 2006

Effective: July 1, 2006

## ATTACHMENT 21:

From Needles and Thread to Legislative Mandates

# From Needles and Thread To Legislative Mandates: New Hampshire Addresses the Needs Of Women in...

By Moses, Marilyn C, Kirschbaum, Ellen

*Authors' Note: This article does not necessarily represent the official position of the U.S. Department of Justice.*

Although a number of state correctional agencies do have or have had an administrator of female offenders (see Table 1), last year the New Hampshire General Court (the legislative branch of the New Hampshire state government) legislatively mandated the creation of this position. It all began with the donation of sewing needles and thread to the state women's prison.

When this donation was made to the New Hampshire State Prison for Women in 2003, Ruth Griffin of the New Hampshire Executive Council<sup>1</sup> wondered aloud whether sewing was a skill in demand in the labor market. The question generated a discussion among members of the executive council as to what educational and training programs were available to incarcerated women. Thus, Gov. Craig Benson tasked the New Hampshire Commission on the Status of Women with providing the answer.

## **Findings from the Commission**

New Hampshire's commission is not unlike many other such state commissions. It has a small budget, two paid staff members and 15 appointed commissioners who volunteer their time. The principal goal of these commissions is to identify and address inequities experienced by women and girls. The New Hampshire commission, similar to other state commissions for women, has also specifically addressed parity issues involving female offenders, through actions such as producing reports and influencing legislation.

Despite limited resources, the commission investigated and produced the report *Double Jeopardy: A Report on the Training and Educational Programs for New Hampshire's Female Offenders*.<sup>2</sup> The commission drew on a number of resources in developing its report, not the least of which was the professional expertise of three New Hampshire Department of Corrections commissioners and the staff and administrators from the State Prison for Women, located in Goffstown, N.H. Technical assistance from the National Institute of Corrections was deemed invaluable; however, "listening sessions" held with the incarcerated women were cited by all as the catalyst for the report. In these sessions, commission members and legislators met with female inmates to learn about their experiences, needs and what they thought was needed to increase their likelihood of success upon release. By learning about the problems women face, commission members discovered topic areas to focus on in their report - educational and vocational opportunities, reuniting with children, and finding jobs and housing. This process allowed



policy-makers to empathize with the inmates and inspired them to work to address the needs of female offenders.

After the conclusion of the listening sessions, consultations with correctional administrators and working with local academics to compile current research, the consensus was that the facility's administration and staff were talented and dedicated, but were under-resourced, as illustrated by the following conditions in 2003:

- \* The DOC spent \$4,564 less annually per female inmate at the State Prison for Women than male offenders at the New Hampshire State Prison for Men and \$1,906 less than males incarcerated at the Northern Correctional Facility;
- \* The women's prison was the only institution in the DOC system that did not offer a state-funded parenting program;
- \* There was no on-site medical unit in the women's prison;
- \* The women's prison was out of compliance with ADA regulations for its aging population;
- \* There was no state-funded programming for female victims of abuse, but state-run and state-funded domestic violence programs were provided to male inmates; and
- \* Female offenders were not afforded the opportunity to work in state-use industries, and there was a limited vocational program.

As the report revealed, it was not about what the men had but about what the women did not have. There was unanimity among members of the commission regarding the underlying reason for the lack of parity: Economies of scale through the years had led to a neglect of services for female offenders, who made up only a small fraction of the incarcerated population overall. Due to the size of the women's population (fewer than 200 in 2003), it was difficult for administrators to secure and retain resources to meet these offenders' needs. For example, if budgetary constraints required each institution to cut a single vocational program, the State Prison for Men would have seven remaining programs and the Northern Correctional Facility would have two. In contrast, the female institution's entire vocational program would be eliminated because the facility only had one program.

Beyond the findings, the report included three recommendations:

- \* Implement a comprehensive data-collection effort on female offenders to establish a foundation for targeting resources and building gender-responsive policy and practice;
- \* Establish a statewide planning initiative for the deliberate and gender-responsive management of female offenders, with membership drawn from all aspects of the criminal justice system and with the aim of effectively incorporating appropriate gender-responsive policies and procedures into the operational protocol of the DOC; and

\* Develop strategies for gender-specific training for all DOC personnel, especially those working with female offenders.

### **Capitalizing on Wie Reports Results**

After delivering the final report to the governor, the executive council, the DOC and the state Legislature, the commission used the report as a centerpiece of a public education campaign on the status of female offenders in the state. Among the efforts were a presentation at the attorney general's state-wide domestic violence conference; participating on a panel discussion at a New England seminar on incarcerated women's health, hosted by the U.S. Office of Women's Health; presenting the findings at an international conference in Washington, D.C, convened by the Institute for Women's Policy Research; hosting a policy briefing luncheon for female legislators; and hosting a breakfast meeting with high-level stakeholders from the DOC and national experts from the GAINS Center. The commission also established relationships with key community stakeholders such as the Citizen's Advisory Committee of the women's prison, the Task Force on Women and Addiction, and the Coalition Against Domestic and Sexual Violence.

These extensive outreach efforts resulted in building the political will within the state to act on the recommendations of the report. In November 2005, the DOC appointed a mental health program coordinator for female offenders at the women's prison and at Shea Farms, the women's halfway house in Concord, N.H. A grant from the Children's Trust Fund made an expansion of the Family Connections Center possible and allowed for implementation of an onsite parenting program for the halfway house. In addition, a four-day training program to address the needs of women in recovery from substance abuse, domestic or sexual violence, childhood trauma, and mental health disorders was implemented.

Seizing the opportunity to capitalize on the public support that had been generated by the commission, its report and outreach efforts, state Sen. Sylvia Larsen took the leadership role in moving the issue to the next level by sponsoring Senate Bill 262. This bill included the recommendations found in Double Jeopardy. It also mandated the creation of an administrator of women offenders and family services (see Figure 1 for responsibilities of the position) within the DOC and created an interagency coordinating council on women offenders (see Figure 2 for the council's composition). The legislation received bipartisan support, was passed by the Legislature and was signed into law on June 12, 2006, by Gov. John H. Lynch.

The rationale for legislatively mandating the creation of the administrator position was based on the economy of scale noted in Double Jeopardy. Supporters felt that the position had to be legislated in order to prevent it from being eliminated at a later time due to budgetary constraints or due to the changing priorities of future DOC commissioners.

### **The Council at Work**

The primary goal of the interagency coordinating council is to identify opportunities for interagency cooperation in the management of female offenders. Specifically, standing councils in New Hampshire have the power to leverage expertise and resources from

different executive branch agencies working with the same population at different times in the client's life course - before, during and after release. "We are a small state with limited resources; we get a lot done by way of standing councils," said Councilor Debora Pignatelli.

Other responsibilities of the council include:

- \* Identifying opportunities for interagency cooperation in the effective management of female offenders;
- \* Developing memoranda of understanding outlining in-kind services, or cooperation to provide services, to incarcerated women and their children;
- \* Developing gender-specific treatment for co-occurring conditions and a continuity of treatment from incarceration to community;
- \* Coordinating interagency case management and reentry planning;
- \* Assessing the impact of incarceration on family relations during and after incarceration; and
- \* Applying for and administering federal and private sector grants for furthering the duties of the council and the development of gender-responsive, trauma-informed management of female offenders and their children.

Although the DOC is currently recruiting for the administrator position, members of the interagency council have been appointed and have begun work in that capacity. Hopefully, a selection will be made by the end of summer 2007.

The council went to work within a month of the governor signing Senate

The council went to work within a month of the governor signing Senate Bill 262 into law. Council members spent the first few months educating themselves on the demographics and unique issues and concerns of female offenders in the state, such as the need for educational and vocational opportunities, medical and mental health services, and family reunification assistance. The council has solicited expert advice in these areas as well as conducted a tour of the women's prison and halfway house. Council members also were instrumental in creating the job description and requirements for the new administrator position. While recruitment for the administrator is under way, the council has focused on tracking proposed state legislation that will have an impact on the DOC and female offenders specifically. Proposed legislation currently under consideration involves bills related to alternative sentencing, community-based treatment and the DOC's operating budget.

### **Continuing Female Offender Awareness**

Throughout the United States, the creation of female offender administrator positions and state councils or task forces on female offenders has been a trend in the past decade. The administrative positions have in some cases been in response to a Civil

Rights of Institutionalized Persons Act or other lawsuit. Frequently, these positions are administratively situated so that the person reports directly to the secretary or commissioner of corrections. This is thought to be necessary to ensure that the needs of women in custody do not get overlooked due to their overall small percentage of the correctional population.

Given this trend, the next obvious research questions will be: Are these administrative positions and task forces necessary? Are they effective? And how can effectiveness be measured? Although the long-term answers to these questions are unknown, it is certain that state and local women's commissions can be a valuable ally and play an important role in supporting a variety of criminal justice issues. According to Theresa de Langis, executive director of the State Prison for Women, "The New Hampshire Commission on the Status of Women is about equity and parity for women - all women - including the least among us. That includes incarcerated women."

## ENDNOTES

1 The New Hampshire Executive Council has the authority and responsibility, together with the governor, to monitor the administration of the affairs of state as defined in the New Hampshire Constitution, the state statutes, and the advisory opinions of the state Supreme Court and attorney general. One duty of the executive council is that it must approve all receipts and expenditures for all state agencies, including donations to these agencies.

## AUTHOR\_AFFILIATION

Marilyn C. Moses, MS, is a social science analyst for the National Institute of Justice. Ellen Kirschbaum is the former administrator of women's services for the Arizona Department of Corrections. She currently is a program manager for the Arizona Supreme Courts' Administrative Office of the Courts.

ATTACHMENT 22:

Correctional Center of Northwest Ohio (CCNO)

## Correctional Center of Northwest Ohio (CCNO)

The Correctional Center of Northwest Ohio (CCNO) is the first regional correctional center of its type in the United States, and the first regional jail to be built in the State of Ohio. CCNO, which opened in July 1990, serves as a model not only in terms of its correctional programming and design, but also in terms of the level of intergovernmental cooperation that has been achieved by the six member jurisdictions, which include Defiance County, Fulton County, Henry County, Lucas County, Williams County, and the City of Toledo. As a result the Correctional Center is one of the most cost effective correctional facilities in the State of Ohio (with its 642 beds).

Since transitioning to a trauma-informed facility requires in-service training, the facility started with three hours of mandatory training for supervisors and for all staff who would have contact with the women in the TAMAR program to attend.

The *Training Evaluations* included the following comments:

- ✓ “Coming in on my day off [to attend the training], proved to be well worth it and I would do it again.” *Supervisor.*
- ✓ “Strongly suggest mandatory training for all staff, especially new hires.” *Supervisor.*
- ✓ [The training provided] “Ideas and real things I can do to help persons within the ABLE-GED classroom.” *Teacher.*
- ✓ [The training provided] “Valuable information to apply from a medical viewpoint.” *Nurse.*
- ✓ “Excellent training – trauma does not discriminate.” *Correctional Officer.*
- ✓ “Security will definitely be able to use this information.” *Correctional Officer.*

Being flexible in a correctional environment can be perceived as inconsistent or showing favoritism. At CCNO, staff pride themselves on consistency with policy, procedure and practice. For example, after a trauma in-service training and a TAMAR class for women offenders, a particular offender was very upset, crying and distraught. The TAMAR Therapist stayed in the unit classroom to counsel and advise the offender, but it was dinner time, and time for the unit to be cleared and offenders escorted to their meals. The Therapist advised the Officer of the offender’s condition. The Officer called her Supervisor for advice and direction. It was decided that the Therapist and offender could address the crisis and a meal would be returned with the rest of the unit. Six months earlier the staff would have never considered asking the question.

Another example is when a female offender was awakened by a female Correctional Officer. The offender awoke, startled, upset and ready to fight. When the offender realized she was okay and recognized the Correctional Officer she apologized. Further she explained that as a child a stepfather would stand over her bed, wake her, crawl into bed and abuse her. The Correctional Officer thanked her for the explanation and they worked out an accommodation on how to wake her to prevent a further aggressive reaction. The Correctional Officer logged it for the future. Six months ago the threatening action toward a Correctional Officer probably would have resulted in segregation or lockdown.

As an organization CCNO is evolving into a trauma-informed facility. CCNO provides a lot of programming and provides a clean and safe environment for staff. CCNO is one of six fully certified (compliant with all Ohio Minimum Jail Standards) and accredited by the American Correctional Association, as well as contracts with many organizations.

Uses of force, acts of self harm and suicide attempts are trending down at CCNO. Treatment staff has more credibility with security staff because of the trauma training, which only supports the change and evolution toward becoming a trauma-informed facility. CCNO sees a similar need for a trauma program for males, but funding prevents expansion of the women's program at this time.

**Additional information on the Correctional Center of Northwest Ohio can be found at [www.ccnoregionaljail.org](http://www.ccnoregionaljail.org).**

**ATTACHMENT 23:**

**Alternative Sentencing for Servicemembers with PTSD**



# PETE CONATY & ASSOCIATES

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## GOVERNMENTAL RELATIONS

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21 March 2007

By Kara M. Greene

### Alternative Sentencing for Servicemembers with PTSD

**Sacramento** – Governor Arnold Schwarzenegger signed into law the country's first state alternative sentencing program in the nation for Global War on Terrorism veterans suffering from post traumatic stress disorder (PTSD).

"Our veterans make so many sacrifices on this nation's behalf and many of them end up suffering from the long-term effects of combat," said Assemblywoman Nicole Parra in an office press release, author of AB 2586.

The law took effect January and provides judges the option of alternative sentencing for veterans diagnosed with PTSD, substance abuse, or other psychological problems stemming from a combat tour. The convicted veteran may be placed on probation and enter a voluntary treatment program at the federal, state or private nonprofit level.

Ten years after the Vietnam War, the legislature passed section 1170.9 of the Penal Code. However, this section doesn't apply to recent veterans of Iraq and Afghanistan.

According to the New England Journal of Medicine, one in six returning veterans of the Iraq war may have mental illness, said Pete Conaty of Pete Conaty & Associates.

*Thinking Strategically, Acting Tactically,  
With our client's best interests always our top priority*

ATTACHMENT 24:

S.F. No. 3376, as introduced – 2007-2008<sup>th</sup>  
Legislative Session (2007-2008)

1.1 A bill for an act

1.2 relating to public safety; requiring screening of certain defendants in criminal  
1.3 cases for posttraumatic stress disorder; authorizing mitigated dispositions for  
1.4 certain offenders suffering from posttraumatic stress disorder who receive  
1.5 treatment; requiring legislative reports and the collection of summary data;  
1.6 requiring the preparation and distribution of an informational pamphlet;  
1.7 proposing coding for new law in Minnesota Statutes, chapter 609.

1.8 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

1.9 Section 1. **[609.093] POSTTRAUMATIC STRESS DISORDER; REQUIRED**  
1.10 **SCREENING AND DISPOSITION OPTIONS; COLLECTION OF**  
1.11 **INFORMATION; REPORT TO LEGISLATURE.**

1.12 Subdivision 1. **Initial screening.** As early as is practicable in a misdemeanor, gross  
1.13 misdemeanor, or felony prosecution, the court shall ensure that the defendant has been  
1.14 asked whether the defendant is a military veteran or is currently in the military. If the  
1.15 defendant is a veteran or is in the military, the court shall ensure that the defendant has  
1.16 been asked if the defendant has served in a stressful military assignment and whether the  
1.17 defendant has ever experienced symptoms associated with posttraumatic stress disorder.  
1.18 The initial screening may be conducted by the court, the defense attorney, the prosecutor,  
1.19 or any other suitable individual within the court system. The screening may occur orally  
1.20 or in writing.

1.21 Subd. 2. **In-depth screening.** If the initial screening required in subdivision 1  
1.22 indicates that the defendant is a military veteran or is in the military and possibly may  
1.23 be suffering from posttraumatic stress disorder, the court, if the defendant agrees, shall  
1.24 refer the defendant to the Veterans Administration, the Department of Veterans Affairs,  
1.25 or another entity qualified to assess the defendant for posttraumatic stress disorder. The

2.1 entity to which the defendant is referred shall prepare a report to the court that does the  
2.2 following: (1) confirms whether the defendant is a military veteran or is in the military; (2)  
2.3 reviews the defendant's military record to determine the types of assignments in which the  
2.4 defendant served; (3) determines whether the defendant suffers from posttraumatic stress  
2.5 disorder that is related to the defendant's military service; and (4) recommends treatment  
2.6 options to address the defendant's posttraumatic stress disorder.

2.7 Subd. 3. **Independent evaluations.** The prosecutor and defense attorney each have  
2.8 the right to independently evaluate the defendant if they disagree with the findings of  
2.9 the report described in subdivision 2. The results of any independent evaluations must  
2.10 be reported to the court.

2.11 Subd. 4. **Consideration of report and evaluation; disposition options.** The court  
2.12 shall consider the report required in subdivision 2 and any independent evaluations  
2.13 conducted under subdivision 3 when determining how to proceed in the defendant's  
2.14 criminal case. Following the defendant's plea, if the court determines it is appropriate  
2.15 given the report's or evaluation's recommendations and the circumstances and severity of  
2.16 the offense, and is consistent with public safety, the court shall consider doing either of the  
2.17 following: (1) staying the adjudication of guilt, if the prosecutor consents; or (2) staying  
2.18 the imposition or execution of sentence, regardless of whether the prosecutor consents. If  
2.19 the court does this, the court, as a condition of the disposition and in addition to any other  
2.20 reasonable conditions of the type described in section 609.135, shall require the defendant  
2.21 to successfully complete the treatment recommended in the report or evaluation.

2.22 Subd. 5. **Data collecting; report.** (a) The court administrator of each judicial  
2.23 district shall report to the state court administrator in a manner and frequency determined  
2.24 by the state court administrator summary data on the number of initial screenings, in-depth  
2.25 screenings, independent evaluations, and mitigated dispositions occurring under this  
2.26 section within the district.

2.27 (b) By February 1 of each year, the state court administrator shall report a summary  
2.28 of the data received under paragraph (a) to the chairs and ranking minority members of  
2.29 the senate and house of representatives committees having jurisdiction over criminal  
2.30 justice policy.

2.31 **EFFECTIVE DATE.** This section is effective August 1, 2008.

2.32 Sec. 2. **INFORMATIONAL PAMPHLET.**

2.33 By September 15, 2008, the commissioner of veterans affairs shall publish a  
2.34 pamphlet summarizing the provisions of section 1 and make the pamphlet available to

**S.F. No. 3376, as introduced - 2007-2008th Legislative Session (2007-2008)**

- 3.1 veterans. Instead of publishing a separate pamphlet, the commissioner may include the
- 3.2 summary in another document relating to veterans' issues.
- 3.3 **EFFECTIVE DATE.** This section is effective August 1, 2008.