SUMMARY OF REPORTS

ON

MENTAL HEALTH SERVICES

WITHIN THE

OHIO DEPARTMENT OF REHABILITATION AND CORRECTION

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Prepared by CIIC Staff

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Summary of Reports on Mental Health Services within the Ohio Department of Rehabilitation and Correction

Introduction

The concept of mental health services in a correctional system includes a matrix of individuals, policies, operations, procedures, programs, philosophies, and goals directed toward serving the mental health needs of incarcerated offenders while fulfilling the missions of the departments engaged in the work of corrections, mental health, and justice. This paper looks at mental health services within Ohio's prison system. The paper provides summaries of four previously published reports on mental health services provided to inmates in Ohio's correctional system. The four individual reports help create a chronological history of events, conditions, and responses contributing to the evolution and current status of mental health services in Ohio's prison system.

Summary of Reports on Mental Health Services in Ohio Prisons: History of Events and Evolution of Mental Health Services

Four individually authored reports provided a base from which to consider the delivery of mental health services. These reports provide a portrayal of the evolution of mental health services within the correctional setting in Ohio. A summary of each report is provided in the following sections so as to help construct an understanding of the past and a snapshot of the current state of operations. Upon reading the four summaries, some duplication of important information will be noticed. Rather than dilute the substantive content of any of the reports, this paper includes the key points from each, even though minimal repetition is created as a byproduct of the comprehensive inclusion of information.

The authorship of the four reports was provided by the former Director of the Ohio Department of Rehabilitation and Correction, the court appointed monitor in Dunn v Voinovich, a former Deputy Director of Mental Health Services in Ohio, and an organization known as Human Rights Watch, which conducts research and investigations, and publishes reports relevant to human rights issues, including issues inside prisons within the United States.

The purpose of this paper is not to analyze or make recommendations; rather, it is the intent of this paper to provide an overview of these four reports in one document. The accuracy in the historical account found in these four reports is perceived to be trustworthy and therefore, worthy of inclusion in any consideration or future development of systems designed to serve individuals who are mentally ill and incarcerated. Further, statistical data collected by the Correctional Institution Inspection Committee has been inserted at appropriate places within the report narrative and as Appendices.

Report 1.

Mental Health Care for Ohio State Prisoners: The View from the Director's Office. Correctional Mental Health Report, January/February 2000. Wilkinson, Reginald A., Ed.D., Director.

The report, Mental Health Care for Ohio State Prisoners: The View from the Director's Office (2000), offers a historical description and chronology of events at a time when the services to the incarcerated mentally ill were undergoing some evolution. For clarity, many of the headings in the summary of Report 1 are taken from that report.

As reported in Mental Health Care for Ohio State Prisoners, the long history in addressing mental illness in prisons and the goal of providing holistic health services became compromised by budget limitations during a time when security issues became a commanding priority. State appropriations for mental health services, while not ignored, were insufficient to keep pace with a growing number of incarcerants with serious mental illnesses.

Renaissance. The Ohio Department of Rehabilitation and Correction (ODRC) experienced two events that gave rise to a renaissance in prison mental health care: a prison riot at the Southern Ohio Correctional Facility in 1993 in which nine inmates and one employee were killed, and the Dunn v Voinovich lawsuit in October 1993 that resulted in a five-year decree as a means of addressing the constitutionally inadequate care for prisoners with serious mental illness in Ohio. The goal of the decree was to achieve organizational change and decision-making autonomy in the area of mental health services in Ohio's prison operations.

Following Dunn v Voinovich, mental health care responsibilities for inmates, which had been the responsibility of the Ohio Department of Mental Health (ODMH), became the responsibility of the ODRC. Under ODRC authority, the state's hospital for mentally ill prisoners, Oakwood Forensic Center (formerly for the criminally insane), was re-commissioned as the Oakwood Correctional Facility (OCF). There was agency commitment to creating the best possible correctional mental health system as it was acknowledged that good mental health was also good security for the inmates and for the community. In addition, the federal court made the treatment of the seriously mentally ill a constitutional requirement.

In Ohio, the court appointed a monitor, Fred Cohen, who identified in his fourth annual report (Dunn Consent Decree Monitoring Fourth Annual Report, 1999), at the conclusion of the five-year decree, that the Ohio system had indeed developed not only access to services, but also to refinement in the quality of care.

Comprehensive Care. In identifying the critical nature of operating a comprehensive and sound correctional mental health service delivery system, ODRC Director Reginald Wilkinson offered the following points in Mental Health Care for Ohio State Prisoners (2000).

1. Judicial mandates require a quality system.
2. There is an ethical 'right-thing-to-do' mindset about providing such a system.
3. Seriously mentally ill inmates present a prodigious problem, representing nearly 12% of ODRC's 47,000 inmates.
4. When mental health professionals work closely with security professionals it is possible to more accurately discern between behavior that is "mad" versus behavior that is "bad," thus, enabling appropriate responses to the behavior.
5. With a mission of preventing mental deterioration and ameliorating mental health problems, prison administration and staff remain concerned with how the methods of operating a prison and managing inmates may help or hinder the realization of the mission.
6. There is a constitutional duty to protect 'weak' or vulnerable inmates from physical or mental assaults of stronger inmates. The duty to treat and duty to protect are considered dual obligations.
7. Screening and evaluations are essential to inmate-appropriate housing assignments, classification, job assignments, and individual treatment plans. Both physical and mental limitations are identified through screening and evaluations.
8. A holistic mental health service delivery program is important to the effectiveness of inmate treatments and to inmates' inevitable transition back into the community. Transitioning occurs for 95% of all prisoners.

Organizational Structure. The Ohio Department of Rehabilitation and Correction established an Office of Correctional Healthcare (OCHC) in 1995 in order to effectively achieve a holistic approach to correctional mental health care in Ohio. Under OCHC, prisoner mental health care, medical and substance abuse treatment, and care for the mentally retarded are provided. Within OCHC, the Bureau of Mental Health Services (BOMHS) is responsible for planning, implementing, monitoring, and evaluating the correctional mental health system and to provide oversight to day-to-day clinical care of all mentally ill inmates within the prisons. Funding for all mental health programs and for Oakwood Correctional Facility is provided through appropriated funds in the state's operating budget. Appropriated funding is used for mental health care at Oakwood Correctional Facility and 11 "clusters" or catchment areas. Each of the state's prisons falls into one of the clusters, and each of the 11 clusters has a Residential Treatment Unit (RTU) for appropriate mental health care and never for disciplinary purposes.

As presented in Mental Health Care for Ohio State Prisoners (2000), RTUs offer care, treatment, and supervision on a graduated scale, with decreased supervision as the inmate's mental disability improves or stabilizes. Within the RTU, an individualized treatment plan is developed for each inmate with the goal of returning the inmate to general population. In 2000, there were reportedly 730 inmates housed in RTUs, with an average population at Oakwood Correctional Facility of 95 inmates.

Historically, the concept of a Residential Treatment Unit existed before the creation of the "clusters" per the Dunn case. It is the understanding of the Correctional Institution Inspection Committee that the Residential Treatment Unit that formerly existed at the

Mansfield Correctional Institution was closed post Dunn, reportedly as a cost cutting measure. However, the following clarification was provided by the ODRC:

> Historically, under the supervision of the ODMH there had been a Psychiatric Residential Unit (PRU) at CRC, which served the psychiatric residential treatment needs of all the institutions. Other step down type programs such as at CCI, were also under the supervision of the ODMH. The design of a Residential Treatment Unit serving a cluster of institutions was developed, but the number of inmates requiring that level of care was less than projected and the cluster plan evolved with more than one cluster feeding an RTU. By the end of Dunn, the system of comprehensive mental health care including outpatient services in all institutions was established and more inmates were maintained in the outpatient setting. The reduced number of inmates identified as requiring the more restrictive level of care of the RTU resulted in the closing of the RTU at Mansfield.

Aside from information taken from Mental Health Care for Ohio State Prisoners (2000), communication from the Ohio Department of Rehabilitation and Correction's Deputy Director of the Office of Health Care during 2004 indicated that inmates who need RTU services are transferred to an RTU of a similar security level when possible. Under this arrangement, minimum security or Level One inmates are included in the medium security or Level Two RTUs. If the RTU that normally accepts inmates from an institution is full, another RTU of the same security classification is used. As of October 8, 2004, it was the understanding of CIIC staff that RTU patients in the Ohio correctional system were served in institutions as shown in the following table.

Residential Treatment Units (RTU) – Distribution of Beds and Service Centers
Ohio Department of Rehabilitation and Correction
October 2004

INSTITUTION	SECURITY LEVEL	AVAILABLE BEDS	INSTITUTIONS SERVED
Allen Correctional Institution	2	80	Madison CI (Level 1) London CI Dayton CI Montgomery CI Toledo CI Camp
Chillicothe Correctional Institution	2	150	Belmont CI Hocking CF Noble CI Pickaway CI Southeastern CI
Grafton Correctional Institution	2	73	Lake Erie CI Lorain CI North Coast CF Marion CI North Central CI Richland CI
Correctional Reception Center	3	106	Madison CI Toledo CI Ross CI Correctional Medical Center (if medically stable) Pickaway CI
Trumbull Correctional Institution	3	77	Mansfield CI
Warren Correctional Institution	3	83	Lebanon CI
Southern Ohio Correctional Facility	4	80	(Also serves Level 5 inmates excluded from OSP due to mental illness)
Ohio Reformatory for Women	All security levels	74	Franklin PRC Northeast PRC

In addition, recent data made available to the Correctional Institution Inspection Committee from the Ohio Department of Rehabilitation and Correction's Bureau of Mental Health reveals the following averages based on calendar year 2005 (January through December 2005). For the year, there was a monthly average of 43,565.5 total inmates in the Ohio system and 7,066 inmates or 16.2% of the average monthly population on the psychiatric caseload. Inmates receiving psychiatric treatment, and therefore on the psychiatric caseload, are those with classifications of C1, and C2 within the department. An additional monthly average of 942 inmates, classified as C3, did not receive psychiatric services and were not on the psychiatric caseload, but were still receiving diagnosis and therapies from the Mental Health Services. All categories together, for the 12-month period, there was a monthly average of 8,016 inmates, representing 18.4% of the total inmate population, receiving some form of services from Mental Health Services. The data for the period also reveals that of the total monthly average of 8,016 inmates receiving mental health services, a monthly average of 382.33 or 4.8% of those inmates were residing in segregation. The following table displays the full range of data reflecting the psychiatric caseload and segregation numbers for each adult institution as well as the statewide summaries.

Ohio Department of Rehabilitation and Correction
Statewide Mental Health Services Delivered – 2005

Month	Institutional Population	Total Psychiatric Caseload (C1 + C2)	C3	Total Caseload	Inmates in Segregation	% of Caseload Inmates in Segregation
January	43,578	7,242	831	8,073	402	4.98
February	43,567	7,005	853	7,858	343	4.36
March	43,518	7,080	886	7,966	379	4.76
April	43,845	7,002	880	7,882	336	4.26
May	43,928	7,222	866	8,088	391	4.83
June	44,174	7,126	914	8,045	365	4.54
July	44,218	7,034	915	7,949	400	5.03
August	44,339	7,405	978	8,383	412	4.91
September	44,682	7,367	1,026	8,393	410	4.89
October	44,903	7,108	1,176	8,371	396	4.73
November	41,679	6,501	962	7,463	390	5.23
December	40,355	6,700	1,017	7,717	364	4.72
Annual TOTAL	522,786	84,792	11,304	96,188	4,588	4.77
Monthly AVERAGE	43,566	7,066	942	8,016	382	4.77

It is the understanding of the Correctional Institution Inspection Committee that mental health classifications are distinguished based on the presence of psychiatric care and the degree of significant mental illness. For example, an inmate classified as C1 is on the psychiatric caseload and has serious or severe mental illness or SMI. The criteria used to designate SMI includes a substantial disorder of thought or mood, which significantly impairs judgment, behavior, the capacity to recognize reality or cope with the ordinary demands of life within the prison environment, and has manifested by the presence of substantial pain or disability. An SMI designation requires a specific mental health diagnosis of schizophrenia, schizoaffective, etc. and/or functional assessment that required an RTU or inpatient hospitalization stay. According to follow-up communication from DRC staff, it does not require prognosis, appropriate treatment by the mental health staff, or psychiatric care. However, according to DRC policy 67-MNH-11 on "Mental Health Classification," C1 is defined as above, plus the policy states, "Serious mental illness requires a mental health diagnosis, prognosis and treatment, as appropriate, by mental health staff." The policy effective April 21, 2005, fully defines and describes C1 as follows:

> C1: Psychiatric Caseload (SMI) – the inmate is on the psychiatric caseload and meets criteria for SMI designation: a substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality or cope with the ordinary demands of life within the prison environment and which is manifested by substantial pain or disability. Serious mental illness requires a mental health diagnosis, prognosis and treatment, as appropriate, by mental health staff.

An inmate classified as C2 is on the psychiatric caseload, but does not meet the criteria for the most severe or deemed to have a serious/severe mental illness, thus is considered to be non-SMI. The C2 inmate receives mental health care and supportive services, which include the prescription and monitoring of medication, and can include the following based on identified treatment needs: individual and group counseling and therapy, crisis intervention, and behavior management. Last, an inmate classified as C3 receives no psychiatric treatment, but based on identified treatment needs can receive group or individual counseling, therapy, and skill building services.

The C3 inmate has a mental health diagnosis and treatment plan and is treated by the mental health staff other than the psychiatrist.

Further, as of this writing, the most recent data submitted to the Correctional Institution Inspection Committee from the individual adult institutions reveals the continuation of mental health services delivered to inmates for the five-month period January through May 2006. This data may be found in the tables in Appendices A through F of this Summary of Reports.

As reported in Mental Health Care for Ohio State Prisoners (2000), one area that presents a challenge to service delivery is the sometimes-blurry distinction that must be made between behavior that is prompted by sickness or is willfully deviant in nature. An inmate's mental condition is taken into account at disciplinary hearings as a way to determine their capacity to participate in the hearing and to construct a disposition consistent with the individual inmate's security and treatment needs.

Regarding cases where disciplinary action is warranted, Ohio State Penitentiary (OSP) functions as a "super-max" institution and is available as a disciplinary option. Per Ohio Department of Rehabilitation and Corrections policy, seriously mentally ill inmates are excluded from placement at the Ohio State Penitentiary, regardless of whether they have a security classification of level four or five.

The report continues to address key issues associated with the delivery of services to mentally ill offenders. Among those topics of importance are mental health staffing, administration of services, quality assurance as it applies to the department's need to meet the terms of the court ordered decree, and community reintegration of the ex-offender who is returned to a community.

Mental Health Staffing. Reportedly, diligent and continuous recruitment, competitive salaries, and time-consuming training are necessary for the Ohio Department of Rehabilitation and Correction to maintain professional mental health staff. In addition, specialized mental health training is provided for both mental health and non-mental health staff, such as corrections officers and clerical workers. Ongoing evaluations are conducted to assure that staff receive training that is appropriate to the specific work assignments.

Administration. The report relayed that administratively, the ODRC has instituted employee 'quality' teams to improve work processes, including those processes relevant to the delivery of quality mental health services. The staff teams were also responsible for compliance with the terms and conditions of the Dunn court order. The ODRC partnered with other organizations, such as the Ohio Department of Mental Health and community mental health agencies and boards, to augment delivery of services to offenders with mental disabilities. In order to aid maximum communication between the ODRC central office and personnel in the individual correctional institutions, regularly scheduled meetings for field administrative staff are held. The emphasis at these meetings was on the necessary correlation between good management and good clinical services.

Quality Assurance. Reportedly, a temporary Quality Assurance (QA) Program was authorized in ODRC Policy 321-01 effective June 28, 1998, and a ODRC Quality Assurance Transition Team (QATT) had the duty of preparing the agency for self-monitoring following the termination of the court-ordered decree so that quality improvements were continuous. In follow-up communication from DRC it was relayed that currently, the Department continues the self-monitoring/audits within the BOMHS through a process called mental health external reviews (MHERS) to ensure each mental health unit within the prison is in compliance with established policies and procedures.

In the communication from DRC, it was further relayed that in addition, an integrated healthcare Quality Assurance/Quality Improvement program was authorized in the ODRC Policy 69-OCH-01, Quality Assurance in Correctional Healthcare effective 6-18-04. The purpose of this policy is to implement the Quality Assurance Program and to facilitate the provision of high quality medical, mental health and recovery services care in a cost effective manner through a systematic approach of monitoring, evaluating and resolving health care issues.

Community Reintegration. Intra-agency coordination was acknowledged as a necessary component for effective offender/parolee transitioning into the community. Within the Ohio Department of Rehabilitation and Correction (ODRC), the Division of Parole and Community Services (DP&CS) is responsible for the supervision of released offenders, including those with mental illness. The DP&CS operates the Offender Services Network (OSN), which continues to ensure offender access to appropriate community treatment services and mental health service providers. An inter-agency agreement was reached in 1997 between the Ohio Department of Rehabilitation and Correction and the Ohio Department of Mental Health such that 12 ODMH community linkage social workers assigned to the state prisons work with ODRC mental health staff to coordinate and link community mental health services to released prisoners.

Conclusion. According to Mental Health Care for Ohio State Prisoners (2000), the numbers of individuals with mental illness or mental retardation who were entering the state prisons was increasing compared to those individuals who are entering mental hospitals. Therefore, the ODRC had to assume a role in the delivery of mental health services. At the heart of the issue, there continues to be a fundamental need for careful study directed at the process of prescribing the proper treatment in conjunction with the appropriate sanction for mentally ill offenders.

Report 2.

Mentally Ill Offender Treatment and Crime Reduction Act of 2003 (S. 1194). Oral Testimony to The United States Senate Judiciary Committee; July 2003. Wilkinson, Reginald A., Ph.D.

The Mentally Ill Offender Treatment and Crime Reduction Act of 2003 (S. 1194), was expected to help the Ohio Department of Rehabilitation and Correction implement programs and initiatives within the department into partnerships that would strengthen the delivery of services. The four components of the Mentally Ill Offender Treatment and Crime Reduction Act of 2003 (S. 1194) were believed to advance and benefit corrections and included: saving lives, increasing public safety, reducing state and local (county) government spending, and building on Ohio's successes.

In his testimony, the Director provided a brief history of Ohio's operations in dealing with problems associated with the mentally ill inmate. Included in Dr. Wilkinson's historical review were the 1993 riot at Southern Ohio Correctional Facility and the subsequent federal lawsuit, Dunn v Voinovich. The Dunn suit challenged the constitutionality of the Ohio Department of Rehabilitation and Correction's mental health delivery system in Ohio. It was decided that rather than fight the suit, the money would be better spent in concentrating on a five-year consent decree. Thus, it was decided in 1995 to concentrate on improving Ohio's mental health services for the mentally ill prisoner. Throughout the five-year consent decree period from 1995 through its settlement in 2000, all parties, including plaintiff's counsel, the court monitor, the state attorney(s), correctional administrators, and health care professionals, agreed to manage points of contention privately. The Director relayed to the Judiciary Committee in 2003 that he was proud of the mental health delivery system in Ohio and that, in his opinion, it represented a national benchmark as it related to prison mental health care.

Save Lives. According to the report, prisons and jails house more people with mental illnesses than do the country's mental health institutions and therefore, correctional administrators are de facto mental health directors. The corrections community readily acknowledges that a correctional environment is not conducive to recovery for a person with mental health problems, especially those with a serious mental illness. Untreated mental illness may put an inmate at risk of committing suicide or being victimized by predatory inmates. There is, therefore, an obligation to one of the core missions in correctional institutions: to ensure safety and humane conditions for staff and inmates alike through the improvement of screening procedures and in training staff to make correct identifications of the signs for suicide.

Increase Public Safety. Because most offenders, including those with mental illnesses, will be released to the community at some point, it is imperative to adequately prepare those individuals for release in a manner that they do not return to prison nor pose a threat to public safety. Recidivism among the released mentally ill offender is over 70%, as revealed in more than one study. There is a correlation between effective transition plans and inmate preparation and corresponding community safety.

Reportedly, S. 1194 promoted effective reentry planning for people with mental illness through efforts such as encouraging mental health providers to come into correctional facilities and connect with the offender prior to release and in ensuring that an adequate supply (more than merely a two weeks' supply) of medications are provided to the inmate at release. In addition, under the bill, there must be planned follow-up services.

Reduce Spending. Funds delegated to corrections have reportedly diminished nationally. Staff and operation budgets have experienced significant reductions. Capital budgets for building projects have also been reduced. According to the report on the Mentally Ill Offender Treatment and Crime Reduction Act of 2003 (S.B. 1194), correctional agencies must curb the rate of growth within the system to comply with state legislative and executive orders to cut costs. Per the report, the mentally ill remain in the prison system longer than other offenders and when they reenter the community, they do not have adequate community services to avail, so they frequently violate the law and are re-incarcerated. It is significantly more expensive to incarcerate the mentally ill offender than other offenders due to added costs for mental health services, medications, and additional staff. Pennsylvania, for example, estimates $80 per day for an average inmate, but $140 per day for a mentally ill inmate. A difficult burden rests with parole boards, which try to connect the parolee with community support. S. 1194 reportedly provides the tools to enable the Ohio Department of Rehabilitation and Correction to facilitate the design and implementation of risk assessment instruments, encouraging enrollment of ex-offenders in federal benefit programs, and promoting aspects of programs that prove effective in reducing recidivism.

Building on Ohio's Successes. For departments of corrections to simply create and expand hospitals for the mentally ill within correctional institutions is not a viable or economically sound solution to addressing the needs of mentally ill offenders. There are both state and local barriers to overcome, but interagency collaboration between corrections and mental health agencies and community mental health service providers is the key to successful re-entry. Reportedly, S. 1194 would help the Ohio Department of Rehabilitation and Correction translate fledgling initiatives into strong, sustainable partnerships that have a credible evidence base.

Based on current information from the Ohio Department of Rehabilitation and Correction relevant to carrying out the programs and initiatives under S. 1194, the U.S. Department of Justice's Office of Justice Programs' Bureau of Justice Assistance announced in April 2006 that it was seeking applications to receive grants to fund programs under the Justice and Mental Health Collaboration Program. The Justice and Mental Health Collaboration Program operates at the federal level to further the Department of Justice's mission by increasing public safety through innovative cross-system collaboration to reach and deliver programming to individuals with mental illness who also come into contact with the criminal or juvenile justice systems. Insomuch as the grant request for proposals (RFP) was released in April 2006 with an application deadline of June 2, 2006, the specific uses of the $5 million dollars that have been allocated for the grant are unknown at this writing.

Reportedly, several county boards in Ohio intend to apply for the funding and if awarded, will use their awarded share of the five million total grant dollars to fund appropriate programs in Ohio. For example, the Franklin County Alcohol, Drug Addiction, and Mental Health Board reportedly was planning to apply for some of the grant money.

Report 3.

Systems in Transition. Human Rights Watch: Ill Equipped: U. S. Prisons and Offenders with Mental Illness. <http://www.hrw.org/reports/2003/usa1003/6.htm>

This researched piece establishes that there are two key forces for change in the corrections environment applicable to offenders with mental illness, and that these two forces often oppose each other. On the one hand, litigation has been used to induce reform of mental health services, and on the other hand, funding pressures and cutbacks have made implementation of reforms more difficult. A synopsis of these two dynamic forces, as reported in Systems in Transition, is presented in the following sections.

Reform through Litigation. Litigation or the threat of it has reportedly become the prerequisite for systemic improvements in mental health services. Litigation has addressed the complete lack of mental health services and more recently, the need and development of improvements in existing systems. Ohio is among many states that have experienced class action suits and dealt with consent decrees and court orders instituting reforms and the court appointment of masters and monitors to oversee compliance. As reported in Systems in Transition, class action lawsuits have led to improvements in prison mental health care in many states, but progress to date is still far from enough. The following excerpt from Systems in Transition relays details of a lawsuit in Ohio that made a significant impact on the operational details associated with offenders with mental illness:

> In Ohio, for example, Dr. Reginald Wilkinson, the director of the Ohio Department of Rehabilitation and Correction, was confronted with a devastating expert assessment of Ohio's mental health services developed after prisoners brought suit in 1993 claiming the services were so poor as to be unconstitutional. After receiving this assessment, Wilkinson engaged in a remarkable collaboration with correctional mental health experts, plaintiffs' attorneys, and other stakeholders to develop the blueprint for a major overhaul of the state's prison mental health services. The suit ended in a settlement without extensive adversarial proceedings, and the department has remained committed to providing quality mental health services. Within three years of the settlement, full-time equivalent staff providing psychiatric services increased from 61 to 284; the number of hospital beds had increased dramatically; and the percentage of prisoners on the psychiatric outpatient caseload had increased from 7.4 percent of the prison population to 12.2 percent.

Systems in Transition makes a point of saying that successful litigation does not necessarily translate into actual improvement. There have been examples where directors of corrections accepted on-paper compliance with court decrees as a substitute for real, durable reforms. Simply, some correctional authorities have resisted putting reforms in place. This reluctance can stem from institutional inertia, bureaucratic obstacles, failure to understand the importance of adequate mental health services, or the lack of funding. The article provided examples from Texas, Iowa, and Rhode Island.

The Problem of Funding Mental Health Services in Prisons. The extra costs to provide adequate mental health services in prisons is an impediment to the delivery of those services. As reported in Systems in Transition and previously mentioned in this paper, Pennsylvania incurs costs of $80 per day to incarcerate the average prisoner, yet $140 per day to incarcerate inmates with mental illness. The additional expenses are incurred for medications, additional correctional and professional staff, and specific services that mentally ill inmates receive. Cost variables from state to state include decisions on quantity and quality of care provided and regional differences in salaries of mental health professionals. Budget cuts in Georgia, Florida, Michigan, Iowa, Massachusetts, and South Carolina have manifested in a variety of forms, including (a) reduced mental health professional staffing, (b) abandoning planned openings of new psychiatric units, (c) placing limitations/reductions on the use and type of psychotropic medications available to inmates, (d) reductions in intensive residential treatment programs by 25%–30%, (e) tightening criteria for outpatient eligibility, and (f) cuts in programs for the mentally ill.

Report 4.

Prison Mental Health Care: Dispute Resolution and Monitoring in Ohio. (July-August 1997) Criminal Law Bulletin, Volume 33, Number 4, pp 299-327. Cohen, Fred and Aungst, Sharon.

Report 4 provides details about the resolution of the class-action lawsuit, Dunn v Voinovich, in Ohio from the perspective of the court monitor of the decree and from the Deputy Director of Mental Health Services in Ohio at the time of the suit and resolution period. Fred Cohen, the monitor, and Sharon Aungst, the Deputy Director, worked collaboratively in a unique manner so as to redesign mental health services. Rather than follow a more typical adversarial relationship found in cases as this, the Ohio scenario modeled affirmative collaboration in the blending of law with organizational change.

The remainder of this Summary of Reports is a presentation of the key material found in Report 4: Prison Mental Health Care: Dispute Resolution and Monitoring in Ohio. The headings are the same as those in the report and the content reflects the writing of the monitor, Fred Cohen, and the Deputy Director, Sharon Aungst. The information represents, therefore, the thoughts and insights generated by these two individuals.

Background, Expert Team, and the Report. The Dunn suit was based on allegations that the mental health delivery system was "deliberately indifferent" to a degree that there was violation of the Eighth Amendment to the U.S. Constitution. The case delved into the language of the law and included considerations of the showing of care. The suit held that care was delivered in a deficient manner that imposed needless suffering and deterioration judicially associated with cruel and unusual punishment. The suit began with the filing of a complaint on October 6, 1993 in which the plaintiffs did not seek monetary damages, but rather systemic, injunctive relief responsive to the allegations of systemic failure. Typically, during the deposition and discovery phase of a case, there are adversarial dynamics, which can produce numerous costs and consume large amounts of time. At this phase in the process, dispute resolution becomes operative.

In the Dunn case, the discovery phase was held in a suspended state while a team of 'experts,' known as the Expert Team, on correctional mental health completed eight months of investigation. The Expert Team investigated the history of Ohio's prisons, interviewed large numbers of employees and others with relevant information, and reviewed thousands of documents and records within Ohio's correctional institutions. With an understanding of the traditional 'military mindset' and suspicion of outsiders that often exists among staff in prisons, the experts worked through the tension of the discovery phase. During the discovery phase, institutional staff experienced inevitable stress, yet staff dealt with media reports and inquiries, balanced fear associated with negative scrutiny, and still maintained hope that the situation would eventually improve.

The Expert Team's findings were provided in a report that was to focus on fact-finding, system adequacy, and recommendations for improvement as dictated by their findings. The Expert Team measured its findings in terms of "that which is minimally necessary to accomplish a particular objective or perform a given task." Applying the "minimally adequate" standard, the Expert Team concluded that the defendants were deficient in three basic areas of legally mandated prison mental health care: appropriate personnel (including quantity and training), treatment/bed space (including hospital, crisis, and chronic care beds), and access to care (ability and means available to inmates to reach available staff and appropriate treatment). After deficiencies were found, solutions were proposed. In addition to deficiencies in the three legally mandated provisions named above, the following list displays eleven other basic findings, none of which were challenged by the plaintiffs or the defendants.

1. Inadequate intake screening.
2. Inadequate referral system.
3. Paucity of residential care and crisis beds and under use of beds at the Oakwood Correctional Facility, which was a facility designed specifically for the most severe cases of mental illness.
4. Shortage of clinical staff coupled with conservative decision-making such that there were obstacles created in gaining access to psychiatric care.
5. Psychiatric care that was limited to psychotropic drugs without adequate monitoring of medications and lithium blood levels.
6. Shortage of space for mental health providers and staff, which compromised safety, confidentiality, and appropriate care.
7. Lock-down tactics applied to some of the most severely mentally ill, affording them no care, no activities, no opportunities to walk, exercise, or breathe fresh air.
8. Absence of staff training, especially training of security staff in the signs and symptoms of mental illness, crippled access to mental health care due to the ignorance of staff assigned to deal with inmates most frequently on a day-to-day basis.
9. Deficient mental health records and an absence of treatment plans, progress reports and notes, and comprehensible diagnoses.
10. Noncompliance in following the guidelines on basic aspects of mental health care, which resulted in ongoing friction and role confusion between the Ohio Department of Mental Health (providers of psychiatric care) and the Ohio Department of Rehabilitation and Correction (providers of psychological services).
11. Absence of remedial action in response to earlier studies that pointed to similar problems and solutions.

The Expert Team found that while Ohio's prison population, including a large and growing number of seriously mentally ill inmates, had expanded, there had been a simultaneous decline in resources, which led to the situation where minimally adequate care for seriously mentally ill inmates was being provided. The report indicated that the errors were of omission rather than commission, that both mental health specialists and security staff felt frustrated by their inability to systematically recognize and provide care

where it was plainly indicated, and that there was no evidence of intentional infliction of harm toward inmates. The case resolved itself into a case of systematic inability to meet minimal conditions rather than commission of wrongful acts. The Dunn case shaped itself into a collaborative-implementation model.

Report Acceptance. As anticipated, the report was given a favorable reception. The rehabilitation and corrections and mental health agencies pooled executive staff to develop a vision and Sharon Aungst of ODMH's Office of Psychiatric Services to Corrections developed this vision into a conceptual and operational model for service delivery. The Expert Team advocated for the Ohio Department of Rehabilitation and Correction to become the provider of mental health care in a unified system. In October 1994, at an Open Space Conference, Ohio's key stakeholders in the redesigning of the system met to design the "ideal" system. The "buy in" of all stakeholders was a significant component in the early success of the new system. Among the accepted system components was a "cluster" approach, which is a service delivery design whereby a group of two to five prisons in geographic proximity to one another provide for all mental health care (except hospital care) for their inmates. All prisons would provide outpatient care, but only one prison in each cluster would provide crisis stabilization and a Residential Treatment Unit. Action plans were developed following the conference in order to implement the system and negotiate settlement of the suit. Key to the success of the system was the timing with which the system was developed (prior to negotiations) and that the Ohio Department of Rehabilitation and Correction had created the system that it was to implement, rather than having a foreign system thrust upon the ODRC.

Negotiating the Consent Decree. Reportedly, in the post conference period, Fred Cohen was asked by the defendants to take on the role of facilitator. Mr. Cohen served simultaneously as a mediator and drafter of an agreement. Because the drafter of the report was also the facilitator of the drafting of the consent decree, the proposed decree aligned with the experts' report and with all parties in line, there was an early and amicable resolution. As reported in Prison Mental Health Care (1997), only a few points of the decree became difficult to resolve. For example, counsel for the plaintiffs insisted on a definition of "serious mental illness" that would include all DSM-IV, Axis I and II diagnosis as well as "alcoholic" and "drug addict," however, to make the definition that inclusive could potentially mandate that mental health care be provided to a possible 80 percent of the total prison population. With agreement of the goal to dramatically improve the quality of mental health care in Ohio's prisons, the negotiation and drafting of the consent decree was successful and void of many of the problems and manipulations that commonly accompanies such an effort.

The major participants in forming the consent decree, (Governor, ODRC Director, Attorney General, Legislature, and Counsel for the plaintiffs), worked together under the assumption that decent mental health care plays a proportionate role in the level of safety and security of a prison.

As the decree was undergoing fine-tuning, Fred Cohen provided monitoring and consultation so that the fine-tuning process was efficient and consensus would be reached

without unnecessary revisions. This phase lasted approximately 13 months extending from March 1995 through April 1996. The benefits of employing consultation during this phase included (a) the development of common understandings between the monitor and mental health and security staff concerning the expectations and the obstacles facing staff, (b) an increase in staff confidence due to the monitored visits being handled in a manner that presented "no surprises" to staff, (c) much collaboration between monitor and staff as they worked toward a common goal, and (d) a "buy-in" perspective on the process, which was supported by some key components including ODRC's provisions for first-class staff, resources necessary to the process, ODRC enthusiasm, and support from the top-most level.

Consent Decree. The Consent Decree established "substantial compliance" as the substantive goal for ending the judicial oversight and monitoring. The Ohio experience was notable in an absence of bitterness and contentiousness that has accompanied decrees in other states.

Monitoring Process. There were two phases of the Dunn monitoring process: consultative phase and oversight monitoring phase. The consultative phase took on two parts, the first in the few months prior to the formalization of the decree, and the second during the six months after the formalization of the decree. During the six-month period post-decree, ODRC held itself to develop and draft 11 policies and procedures – a step that engaged the monitor in a collaborative manner. The monitor had authority to provide oversight of ODRC institutions by gathering empirical data, obtaining written reports, onsite inspections, and providing oral and written reports to the parties. Additional rights provided to the monitor included privileged communication and access to data from internal investigations and other sensitive information. At the heart of monitoring were monthly site visits, which began with an initial staff meeting and included the submission of various types of institutional-specific data and statistics pertinent to operations and services rendered to offenders. Following the executive meeting, the monitor proceeded to hold similar sessions with other staff within the institution. The decree described monitoring as a combination of gathering empirical data, obtaining written reports from ODRC, on-site inspections, and providing oral and written reports to the parties. The monitor was given access to privileged information. ODRC prepared quarterly reports for the monitor with special emphasis on staff and on bed or treatment space.

Prior to a site visit, the monitor was provided with a package consisting of the names and status of inmates on the mental health caseload, the prison's rated and current population, names and job descriptions of relevant staff, security status information, segregation data, and a summary of any prior findings, recommendations, or news clippings about Ohio prisons. This information was supplied to the monitor prior to the executive session at the onsite visit so that discussions at the executive session could be more productive in revealing problems and prompting analysis as a result of the monitor having time to review the data prior to the meeting.

Following the executive session, there were similar sessions with key mental health staff: psychiatrists, psychologists, psychology assistants, social workers, nurses, and activity therapists. During the site visit, inmate health charts were examined and a session was held with Residential Treatment Unit (RTU) inmates to explore complaints. In addition, corrections officers and segregation staff met with the monitor. A site visit always included an attempt to sit in on a disciplinary hearing involving inmates on the mental health caseload.

A variety of issues associated with incarceration of the mentally ill were given consideration during the onsite visit. Some of the issues in this category included record-keeping, policy and procedure compliance, discretionary flexibility in the system relevant to inmate behavior, medication policy and inmate discretionary latitude, medications in general, and staff training, among others.

The site visit as part of the monitoring process included an exit interview, which was attended by representatives from Central Office, the warden(s), key staff, and some mental health personnel. The comments and notes generated by the site visit were taken seriously and staff welcomed the monitor as a partner in developing and improving their system. It was perceived that the monitor and agency shared the same goal: to improve the system for delivery of mental health services.

Finally, following the site visit and sessions, reports were generated to document the observations, findings, recommendations, etc.

Recommendations. The principles that were followed and the processes used in the implementation of the consent decree, in this case, offered some value to other jurisdictions contemplating a similar task requiring the enforcement of a judicial remedy within the correctional system. Fundamental principles that have been credited for the success in the Ohio case include communication, continuity, organizational and governmental support of "quality," clarity of roles, and the transition process from implementation of the components of the decree and requisite independent monitoring to a system that operates in compliance and monitors its own performance.

Communication was identified in the Ohio case (Dunn v Voinovich), as the key to building and maintaining the positive and productive relationships that were necessary to the success of the venture. Communication between the monitor and the state's Deputy Director of Mental Health Services occurred frequently and honestly to avoid surprises. Concerns and disagreements were discussed openly with the goal of understanding, clarifying, and finding common ground. It was discovered that face-to-face meetings produced more constructive and less misunderstood communication than written "discussions." The communication template, in this case, included the resolution of disagreements without any threat of litigation, regular feedback sessions, and a thorough sharing of paper documentation of the venture through reports and other written materials.

Continuity. In Prison Mental Health Care (1997), continuity was identified as a second important factor. Specifically, continuity was established by having Fred Cohen act as the author of the Expert Team Report, continue in a role as facilitator and author of the Consent Decree, then continue as a consultant, and finally serve as the monitor. The multiple roles filled by Mr. Cohen did much to assure that the process did not unravel or become misdirected during the various phases. Also, there was one consistent ODRC staff who assumed responsibility for psychiatric services, served as the "program expert' in negotiations, oversaw the transfer of psychiatric services from the Ohio Department of Mental Health to the Ohio Department of Rehabilitation and Correction, and was responsible for building a new integrated mental health system within the Ohio Department of Rehabilitation and Corrections. The continuous service of these two key players, the monitor and the Deputy Director, in the situation helped to prevent misunderstandings or disagreements that might have occurred if either of the two players had changed in the middle of the process.

Organizational and Governmental Issues. Reportedly, the perspective or philosophical framework held by the Ohio Department of Rehabilitation and Correction at the time of the case included a readiness to make changes, and a desire to embrace ownership of mental health services, thus controlling the future of those services within the ODRC rather than relying on another agency to provide those services. The leadership at ODRC was committed to improving service delivery and held a clear vision in that regard. A "quality-oriented" mode of business operations was encouraged from the executive branch such that all stakeholders in daily operations were encouraged to participate positively and constructively, rather than act as obstacles, in the cultivation and maintenance of operations that represented the highest quality. Staff training and support tools were given increased emphasis in cultivating a quality approach to doing business.

Clarity of Roles. While the attorneys were concerned with legal issues surrounding the consent decree and in achieving and maintaining the best legal position for the state, the program managers were concerned with providing quality services and ensuring that legal positioning did not interfere with providing appropriate care. Roles remained clear and distinct in the Dunn case, however, there was cross-consultation concerning both program design and legal issues. The monitor also exercised distinction in the dual roles of monitor and consultant so as to be able to clearly distinguish the monitoring process separately from suggesting "best practices" to enhance services within individual institutions.

Transition. A shift from development and implementation of the consent decree to day-to-day performance that met and maintained standards served as a transition point in the process of meeting the overall objective. In the Dunn case, the ODRC demonstrated its ability to monitor its own performance by hiring a compliance monitor and developing a quality assurance program. The role of the compliance monitor was to develop measures to track specific requirements of the decree and develop systems for the agency to self-monitor. The role of the quality assurance program was to monitor and evaluate the quality and appropriateness of mental health care, the resolution of specific problems,

and to ensure compliance to standards, which were integrated into the agency's operating standards and audited annually.

Acting on their authority in the post-transition period, the ODRC reportedly instituted a management information system to allow information to be available to staff when it was needed. Space, staff, and access were identified as the most critical elements in maintaining quality in the delivery of mental health services. It was identified that the previous ODRC system for delivery of mental health services essentially was ineffective even at reception because not all inmates were given assessments at reception. There was not, therefore, any initial screening for any mental concerns unless the individual was obviously symptomatic, in a crisis, or taking psychotropic medications.

Under the changes of the decree, operations were impacted. Under the decree, inmates now receive screening at reception and mental health staff make weekly rounds to inmates assigned to segregation and in general population. The structured and frequent presence of mental health staff to the units enhances inmates' access to care and strengthens the contribution that security staff may make in the identification step. Weekly contact with mental health staff helps to assure that inmates who may be exhibiting signs of serious mental illness are identified, referred, and given treatment in a timely manner. In addition, inmates are required to undergo a mental health screening whenever they make an institutional transfer so as to verify the inmates current mental health classification and level of care required.

In order for the credible delivery of services to occur, major initiatives were put in place. The major initiatives for improving service delivery included improvement of the treatment planning process, building treatment teams that include security staff, improving recruitment and developing a credentials process applicable to the hiring process, improving clinical skills of staff, fully implementing the involuntary medication policy, and fully implementing the quality assurance program.

The transition of prison mental health care from the Ohio Department of Mental Health (ODMH) to the Ohio Department of Rehabilitation and Corrections (ODRC) gave the ODMH the primary responsibility for linking inmates with mental illnesses to community providers of work upon inmates' release. Twelve social workers were hired to work within the prisons to identify those inmates with mental illnesses receive continuity of care when they are released into the community. A primary objective of these measures is to reduce the risk of recidivism and re-institutionalization of the inmate.

Relevant to the three criteria by which achievement may be measured: staffing, space, and access, reportedly, Ohio succeeded in all three categories. The data revealed that considerable achievements were made over a short period. Several hundred beds were added system-wide for inmates needing mental health services, mental health staff quadrupled within a few years, and mental health services were more prevalent at intake and delivered more frequently at other points during inmate incarceration. The accomplishments, as recognized by the monitor and the Deputy Director, were to be

shared among all participants in the process because it brought substantial recognition to Ohio.

The Conclusions published in Report 4, Prison Mental Health Care: Dispute Resolution and Monitoring in Ohio (1997), include five concepts that the Monitor and the Mental Health Deputy Director believed to have made an important contribution to the quality of mental health services to inmates in Ohio.

1. There must be support for the change at the top. It must be communicated throughout the organization, and front-line players – those in the trenches – must buy into the change.
2. The greater the contentiousness in the early stages and in the ultimate resolution of a lawsuit seeking systemic change, the greater the difficulty in implementing a change. Obviously, this principle implies a certain shared view of the problems and the need for resolution. This shared view need not exist at the initiation of litigation but must develop early in the process.
3. Continuity in the agents of change, whether the agents come from the institution or from outside it, is a major factor in achieving change.
4. The energy of a lawsuit can be converted to a positive force for change if a collaborative, mutually respectful posture is adopted early and consistently maintained.
5. Identities of interest can be located in apparent antagonistic positions, yet these interests may then be converted into mutual effort. Certain challenges to prison conditions, for example, correspondence, visiting, and discipline, are consistently viewed as threatening by prison officials. Other challenges, like health care, are not viewed in such a threatening manner. With mutual effort, it is relatively easy to sell the notion that decent mental health care enhances security and the work environment generally.

As identified in the fourth report, the trust began with the Director of the Ohio Department of Rehabilitation and Correction and was communicated and perpetuated throughout the levels of administration and staff to the correctional officers in segregation units. This trust was the dominant component in the success of complying with the court ordered mandate of the Dunn case. The ODRC executive staff and legal counsel made an initial decision to suspend discovery and look to a team of experts for an objective assessment of Ohio's prison mental health system. The Department continued with an open mind in beginning discussions on the need and direction for change, followed by the acceptance of the team's report. The Director repeatedly supported the inquiry and exploration process, giving it legitimacy at all levels of administration and staff and at all levels of operation. The early-established trust built upon itself and became a pivotal factor in accommodating change.

The fourth report acknowledged that while changes in Ohio took place in response to the Dunn case, the problems that were faced in the Dunn case would not simply disappear. It may be that Dunn-like solutions to problems will reappear in other situations, yet there is always the possibility that those problems will not be addressed with as much success or cooperation as happened in the Dunn case. Ultimately, it would be preferable that future issues could be dealt with in a similar and effective manner as the response to the Dunn case.

APPENDIX A

MONTHLY AVERAGE INSTITUTIONAL POPULATION

Monthly Average Inmate Population per Institution
Ohio Department of Rehabilitation and Correction
January – May 2006

Institution	Monthly Average Institutional Population (for the period)	January 2006	February 2006	March 2006	April 2006	May 2006	5-month Total
Chillicothe CI	2776	2712	2717	2788	2826	2838	13,881
Belmont CI	2404	2160	2466	2470	2453	2470	12,019
Richland CI	2352	2308	2311	2385	2381	2373	11,758
Noble CI	2295	2307	2279	2291	2313	2283	11,473
North Central CI	2272	2271	2296	2249	2269	2274	11,359
Ross CI	2249	2209	2242	2247	2272	2277	11,247
Mansfield CI	2205*	2184	2211	2200	2224	2205*	11,024*
Lebanon CI	2163	2125	2153	2182	2174	2179	10,813
London CI	2150	2182	2138	2167	2136	2128	10,751
Pickaway CI	2003	1903	2247	1945	1961	1958	10,014
Madison CI	1985	1989	1970	1941	1958	2067	9925
Ohio Reformatory for Women	1951	1925	1911	1954	1987	1980	9757
Marion CI	1777	1703	1708	1750	1873	1852	8886
Lorain CI	1706	1007	1828	1868	1828	1997	8528
Lake Erie CI	1457	1438	1462	1459	1470	1457	7286
Southeastern CI	1447	1438	1429	1450	1454	1463	7234
Grafton CI	1399*	1401	1399*	1396	1399*	1399*	6994*
Allen CI	1321	1320	1315	1326	1326	1318	6,605
Trumbull CI	1314	1523	1248	1248	1262	1291	6572
Southern Ohio Correctional Facility	1122	1091	1123	1128	1122	1146	5610
Warren CI	1043	1065	1046	1052	1034	1020	5217
Correctional Reception Center	832	1744	1830	1878	1870	1858	9180
Toledo CI	800	784	796	804	808	810	4002
North Coast Correctional Treatment Center	625*	628	632	619	620	625*	3124*
Northeast Pre-Release Center	573	564	564	593	562	582	2865
Ohio State Penitentiary	554	555	549	578	545	544	2771
Hocking Correctional Facility	472	468	482	466	477	468	2361
Dayton CI	417	420	409	420	416	422	2087
Montgomery Education and Pre-Release Center	334	328	322	332	352	337	1671
Corrections Medical Center	120	119	121	122	124	115	601
Oakwood Correctional Facility	110*	107	104	118	109	110*	548*
TOTAL	45,722*						
TOTAL (based on averaged monthly quantities statewide)	45,727 (variance of 5 due to rounding)	44,469	45,807*	45,924	46,094*	46,340*	228,634*

The * indicates an institutional entry or average total derived by using a calculated average due to incomplete institutional data available at the time of the report.

APPENDIX B

PERCENT of MONTHLY AVERAGE INSTITUTIONAL POPULATION on PSYCHIATRIC CASELOAD January – May 2006

Institution	Percent of Monthly Average Institutional Population on Psychiatric Caseload (C1 + C2)	Jan 2006	Feb 2006	Mar 2006	Apr 2006	May 2006	5 Month Total on Psychiatric Caseload	Monthly Average on Psychiatric Caseload	Monthly Average Institutional Population
Oakwood Correctional Facility	47.7	51	49	59	50	0	209	42	110*
Ohio Reformatory for Women	44.0	692	697	711	749	747	4288	858	1951
Franklin Pre-Release Center	42.1	208	216	211	203	204	1042	208	494
Northeast Pre-Release Center	39.4	214	214	237	231	234	1130	226	573
Corrections Medical Center	30.8	35	39	39	38	33	184	37	120
Southern Ohio Correctional Facility	27.9	314	320	311	308	314	1567	313	1122
Hocking Correctional Facility	22.7	107	107	107	108	104	533	107	472
Warren CI	21.7	227	224	227	229	223	1130	226	1043
Allen CI	21.3	284	278	281	280	286	1409	282	1321
Trumbull CI	20.5	268	264	269	264	278	1343	269	1314
Southeastern CI	18.1	257	269	265	258	260	1309	262	1447
Chillicothe CI	18.1	364	512	528	560	550	2514	503	2776
Belmont CI	16.5	406	397	399	383	395	1980	396	2404
Pickaway CI	16.0	325	314	315	337	314	1605	321	2003
Mansfield CI	15.6	339	342	348	344	343*	1716*	343*	2205*
Richland CI	14.6	336	322	336	357	366	1717	343	2352
Correctional Reception Center	14.2	238	267	286	252	257	1300	260	1832
North Central CI	13.5	298	297	303	312	322	1532	306	2272
Madison CI	13.4	280	275	258	244	272	1329	266	1985
Marion CI	12.8	210	219	226	245	240	1140	228	1777
Lebanon CI	12.6	260	275	270	274	281	1360	272	2163
Noble CI	12.2	292	286	280	270	272	1400	280	2295
Grafton CI	12.1	166	169*	171	169*	169*	337*	169*	1399
London CI	11.8	273	259	247	247	247	1273	255	2150
Toledo CI	11.6	86	86	94	94	104	464	93	800
Lake Erie CI	11.4	163	168	170	169	161	831	166	1457
Ross CI	10.6	231	242	228	241	248	1190	238	2249
North Coast Correctional Treatment Center	8.0	52	53	48	47	0	200	40	625*
Lorain CI	7.8	48	136	167	158	158	667	133	1706
Ohio State Penitentiary	3.6	17	20	23	20	21	101	20	554
Dayton CI	0	0	0	0	0	0	0	0	417
Montgomery Education and Pre-Release Center	0	0	0	0	0	0	0	0	334
TOTAL	16.3	7041	7316*	7414	7441*	7403*	36,615*	7462*	45,722*

The * indicates an institutional entry or average total derived by using a calculated average due to incomplete institutional data available at the time of the report.

APPENDIX C

PERCENT of INSTITUTIONAL POPULATION on MENTAL HEALTH CASELOAD
January – May 2006

Institution	Percent of Institutional Population on Mental Health Caseload (C1+C2+C3)	Jan 2006	Feb 2006	Mar 2006	Apr 2006	May 2006	5-Month Total of Inmates on Mental Health Caseload	Monthly Average of Inmates on Mental Health Caseload	Monthly Average Inmate Population
Oakwood Correctional Facility	48.2*	52	50	60	51	53*	266	53*	110*
Northeast Pre-Release Center	47.3	264	264	279	269	278	1354	271	573
Franklin Pre-Release Center	44.7	221	226	221	217	218	1103	221	494
Ohio Reformatory for Women	43.0	803	812	831	872	872	4190	838	1951
Corrections Medical Center	30.8	35	39	39	38	33	184	37	120
Southern Ohio Correctional Facility	29.2	331	338	326	322	322	1639	328	1122
Allen CI	23.8	320	313	313	311	315	1572	314	1321
Warren CI	22.9	243	237	239	241	236	1196	239	1043
Hocking Correctional Facility	22.7	107	107	108	109	105	536	107	472
Trumbull CI	22.6	288	290	301	292	315	1486	297	1314
Mansfield CI	20.5*	461	456	452	439	450	2258	452	2205*
Belmont CI	19.9	482	463	477	478	496	2396	479	2404
Southeastern CI	19.6	273	293	286	278	288	1418	284	1447
Chillicothe CI	19.3	395	542	559	595	590	2681	536	2776
Pickaway CI	16.7	343	326	333	346	323	1671	334	2003
Richland CI	16.4	378	362	379	395	410	1924	385	2352
Lebanon CI	16.4	342	356	355	356	365	1774	355	2163
Madison CI	16.4	334	333	319	312	331	1629	326	1985
North Coast Correctional Treatment Center	16.0*	108	109	91	92	100*	500	100*	625*
Marion CI	15.8	256	269	278	300	300	1403	281	1777
Noble CI	15.2	364	354	353	341	333	1745	349	2295
London CI	15.2	335	315	317	332	330	1629	326	2150
North Central CI	15.0	336	335	333	341	358	1703	341	2272
Correctional Reception Center	14.9	251	281	299	267	269	1367	273	1832
Ross CI	14.8	314	337	328	341	346	1666	333	2249
Toledo CI	14.8	107	112	121	122	130	592	118	800
Grafton CI	13.8*	189	193*	197	193*	193*	965	193*	1399
Lake Erie CI	12.8	182	186	189	188	183	928	186	1457
Lorain CI	11.2	60	169	226	223	276	954	191	1706
Ohio State Penitentiary	5.2	25	29	31	28	30	143	29	554
Dayton CI	0	0	0	0	4	4	8	2	417
Montgomery Education and Pre-Release Center	0	0	0	4	4	3	11	2	334
TOTAL	18.8*	8199	8496*	8644	8697*	8855*	42,891*	8580*	45,722*

The * indicates an institutional entry or average total derived by using a calculated average due to incomplete institutional data available at the time of the report.

APPENDIX D

MONTHLY AVERAGE of MENTAL HEALTH CASELOAD INMATES in SEGREGATION
January - May 2006

Institution	Monthly Average of Mental Health Caseload in Segregation	Jan 2006	Feb 2006	Mar 2006	Apr 2006	May 2006	5-Month Total in Segregation	Monthly Average Total Mental Health Caseload	Percent of Monthly Average Mental Health Caseload in Segregation
Ohio Reformatory for Women	54	42	60	71	47	52	272	838	6.4
Lebanon CI	34	37	30	28	30	44	169	355	9.6
Ross CI	33	29	31	30	35	42	167	333	10.0
Chillicothe CI	26	26	28	23	23	30	130	536	4.9
Southern Ohio Correctional Facility	26	18	22	32	28	29	129	328	7.9
Southeastern CI	24	23	23	24	28	22	120	284	8.5
Warren CI	23	21	20	27	22	23	113	239	9.6
North Central CI	21	17	11	6	71	0	105	341	6.2
Mansfield CI	16	19	21	17	21	0	78	452	3.5
Noble CI	15	23	11	14	16	10	74	349	4.3
Lake Erie CI	14	11	18	18	14	10	71	186	7.5
London CI	13	0	20	11	18	18	67	326	4.0
Allen CI	12	11	19	13	4	11	58	314	3.8
Marion CI	12	13	9	9	18	13	62	281	4.3
Trumbull CI	12	11	14	12	9	13	59	297	4.0
Pickaway CI	11	12	15	9	15	6	57	334	3.3
Richland CI	11	15	9	7	8	16	55	385	2.9
Belmont CI	10	16	14	6	9	7	52	479	2.1
Toledo CI	9	8	9	8	10	11	46	118	7.6
Correctional Reception Center	6	6	4	5	13	4	32	273	2.2
North Coast Correctional Treatment Center	4	4	6	7	3	0	20	100*	4.0
Grafton CI	4	12	0	9	0	0	21	193*	2.1
Lorain CI	4	1	7	2	3	9	22	191	2.1
Northeast Pre-Release Center	4	3	6	4	5	0	18	271	1.5
Madison CI	4	0	0	0	7	14	21	326	1.2
Hocking Correctional Facility	2	2	2	3	1	3	11	107	1.9
Franklin Pre-Release Center	2	5	3	0	0	3	11	221	1.0
Corrections Medical Center	0	0	0	0	0	0	0	37	0
Dayton CI	0	0	0	0	0	1	1	2	0
Montgomery Education and Pre-Release Center	0	0	0	0	0	0	0	2	0
Oakwood Correctional Facility	0	0	0	0	0	0	0	53*	0
Ohio State Penitentiary	0	0	0	0	0	0	0	29	0
TOTAL	406	385	412	395	458	391	2,041	8580*	4.7

The * indicates an institutional monthly entry or monthly total derived by using the calculated monthly average for select months in certain institutions due to incomplete institutional data available at the time of the report.