REPORT OF THE ADVISORY COMMITTEE ON GERIATRIC AND SERIOUSLY ILL INMATES

JUNE 22, 2005

General Assembly of the Commonwealth of Pennsylvania
JOINT STATE GOVERNMENT COMMISSION
108 Finance Building
Harrisburg, Pennsylvania 17120

The release of this report should not be interpreted as an endorsement by the members of the Executive Committee of the Joint State Government Commission of all the findings, recommendations and conclusions contained in this report.

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June 2005

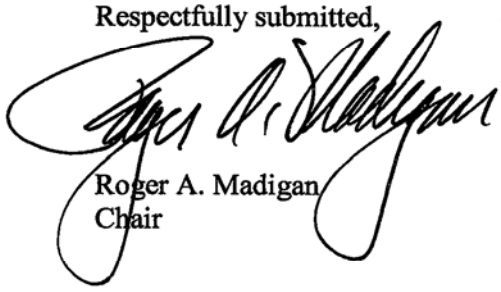
TO THE MEMBERS OF THE GENERAL ASSEMBLY:

The Joint State Government Commission is pleased to present this report of the Advisory Committee on Geriatric and Seriously Ill Inmates, which was prepared pursuant to 2002 Senate Concurrent Resolution No. 149.

The report provides background information and policy options in three broad areas: health/hospice, mental health and geriatric/lifer. Information on victim wrap around programs is also provided in the fourth chapter and the appendices.

The Commission acknowledges with gratitude the dedication of the advisory committee, whose members labored diligently for two years under the leadership of Scott Thornsley to develop this information for the General Assembly.

Respectfully submitted,



Roger A. Madigan
Chair

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EXECUTIVE SUMMARY

BACKGROUND

Senate Concurrent Resolution No. 149, Printer's No. 2175, of 2002 directed the Joint State Government Commission to establish a bipartisan legislative task force and an advisory committee to study the geriatric and seriously ill inmate populations in Pennsylvania State correctional institutions and make recommendations to the General Assembly. Because the 46-member advisory committee could not reach consensus on recommendations for various issues, it decided to provide the legislative task force with a compilation of information, policy options and draft statutory language which may be reviewed should the General Assembly decide to address issues regarding geriatric and seriously ill inmates.

Tracking the language of the resolution, the advisory committee formed three subcommittees, which developed policy options in the following areas: health/hospice, mental health and geriatric/lifer. The committee also gathered information on victim wrap around programs.

HEALTH/HOSPICE

The Commonwealth's State correctional institutions (SCIs) provide health care for inmates, and several SCIs are capable of providing care for geriatric and seriously or terminally ill inmates, with SCI Laurel Highlands, in Somerset County, being the most notable. In addition to general population inmates, SCI Laurel Highlands houses long-term care, wheelchair, geriatric and seriously or terminally ill inmates. Among other things, the facility provides these special classes of inmates with medical care for long-term illness, life skills programs, individualized recreational activities and psychological assessment and treatment.

Because the Department of Corrections does provide for the care of seriously or terminally ill inmates, the release of such inmates would most often not be sought because of a lack of care but rather for humanitarian or economic

reasons. In 2004, the average annual cost per inmate receiving long-term care at SCI Laurel Highlands was $63,500, while the average cost per patient in a publicly-funded county nursing home was $62,000. Cost would most likely be much less than that if the inmate could be released to a friend, family member or other individual, but not all inmates have family members or friends in the community, and not all family members or friends are willing or able to assume the responsibility of caring for the inmate. However, being paroled means the former inmate is entitled to Medicaid or Medicare benefits on the same basis as the rest of society, so federal funds that are unavailable to the incarcerated population might be available to help cover the cost of care for seriously or terminally ill inmates who are released on parole.

While cost savings or humanitarian goals would probably be realized with the release of a seriously or terminally ill inmate into society, very few community resources were found for former inmates. The now long-standing government policy of caring for individuals in the least restrictive setting possible, preferably in their homes, means that public nursing homes are not as available as resources as they once were. Private nursing homes often do not admit former inmates because of resistance from other patients and concern about behavioral problems the former inmate might have.

Policy Options

Draft legislation is provided in the report for the use of the members of the General Assembly should they wish to encourage the release of seriously or terminally ill inmates. The first draft allows for the medical release of an inmate through the trial court. This draft includes the repeal of the current Compassionate Release Act (the act of May 31, 1919 (P.L.356, No.170); 61 P.S. § 81), under which courts will not release an inmate unless that inmate can prove that he or she cannot get proper care in prison. The draft requires only that an inmate be seriously or terminally ill, as defined in the draft, and have a satisfactory risk assessment before a court could grant the petition for release. The second draft provides for expedited review by the Board of Probation and Parole of cases where the Department of Corrections has reported that an inmate is seriously or terminally ill and presents a minimal risk of reoffending.

A series of concepts regarding the establishment of an inter-agency committee on the medical release of inmates is also provided. Among other things, this committee would identify obstacles to the medical release of inmates and develop recommendations for overcoming the obstacles.

MENTAL HEALTH

The Department of Corrections provides care and treatment for mentally ill inmates, who often have co-occurring problems with drug and alcohol abuse. However, there is a question regarding whether some mentally ill inmates should be in prison. A growing trend across the country has been to establish specialized courts addressing offenders with either drug and alcohol abuse problems or mental illness or both, in attempts to provide the offenders with treatment rather than incarceration. Treatment courts and mental health courts and programs have apparently been effective in Philadelphia, Chester County, Lackawanna County, Allegheny County and Erie County. Evaluations of mental health courts in Anchorage, Alaska and King County, Washington also appear to be positive.

For mentally ill offenders who are in prison, re-entry into society upon release is a major concern. Having public benefits, such as Medicare, Medicaid and Supplemental Security Income, and treatment resources available upon release would greatly improve the situation of most mentally ill offenders re-entering society. Community-based re-entry programs may also be designed to help smooth the offender's transition from incarceration to living in the community. Notable re-entry initiatives across the Commonwealth include the Forensic Re-Entry Development program at SCI Muncy, Community Re-Integration of Offenders with Mental Illness and Substance Abuse programs (specialized Community Corrections Centers) in the Pittsburgh and Erie areas and the Cameron/Elk County Forensic Mental Health Program.

Policy Options

Draft legislation is included in the report for the use of the members of the General Assembly should they wish to encourage the establishment of mental health courts in the judicial districts of the Commonwealth. The draft lists the goals of mental health courts, which include reducing stress on the correctional system by utilizing an alternative to incarceration for mentally ill offenders when appropriate, improving the assessment of mentally ill offenders, improving access for mentally ill offenders to services and treatment in the community, ensuring compliance with individualized treatment plans and training law enforcement and judicial personnel to identify and address the needs of mentally ill offenders.

The report also includes concepts regarding the establishment of a multi-agency committee to strengthen communication between communities and prisons and between various agencies to ensure continuity of care for mentally ill offenders as they re-enter society.

GERIATRIC AND LIFE-SENTENCED INMATES

The number of inmates 50 years of age or older serving life sentences in Pennsylvania's State correctional institutions has grown from 795 in 2001 to 1,077 in 2004. Because inmates serving life sentences (lifers) grow old and often become seriously or terminally ill in prison, requiring costly care, they contribute to the growing cost of the Commonwealth's corrections system. Because lifers are not eligible for parole in Pennsylvania, a lifer may see the possibility of release from prison only if his application for commutation of sentence is recommended by the members of the Board of Pardons and approved by the Governor. The chances of that happening were already declining (e.g., 251 life sentences were commuted from 1971 through 1979, while 27 were commuted from 1987 through 1995) when the Commonwealth's Constitution was amended in 1997 to require the unanimous recommendation of the Board of Pardons before an application for commutation could proceed to the Governor. From 1995 to the present, only one life sentence has been commuted.

Adding to the Commonwealth's sentencing statutes the option of sentencing an individual to life in prison with the possibility of parole for first degree murder where the prosecution is not seeking the death penalty and for second degree murder might help reduce the costly geriatric and seriously or terminally ill inmate population. It would also give lifers hope that release might be possible, making them more manageable for the Department of Corrections.

Little recidivism data is available regarding inmates who were incarcerated for at least 25 years and released at the age of 50 or older. Ohio provided data showing that, of 21 offenders in that category who were released in 2000, none had committed a new crime during the following three years. The Pennsylvania Board of Probation and Parole provided data showing that, since the inception of parole in the Commonwealth, 99 commuted lifers have been released on parole at the age of 50 years or older, one of whom was recommitted to prison for a new crime. This individual was a sex offender with mental health issues whose new criminal conviction resulted from his falsification of his criminal record on a job application to obtain a job as a custodian in a private school with minor female students.

Policy Options

Draft legislation is included in the report for the use of the members of the General Assembly should they wish to consider adding a sentence of life with the possibility of parole to the Commonwealth's sentencing statutes. The draft

legislation provides for the prospective option of parole eligibility for lifers who reach the age of 50 (or 45 for offenders who committed their crime before the age of 21) and serve at least 25 years of their sentence in prison.

Should the General Assembly enact such legislation, the Board of Pardons might rely upon the policy behind the enactment to once again provide current lifers with some hope that they might have their sentence commuted and eventually be released from prison.

VICTIM WRAP AROUND PROGRAM

The main function of a victim wrap around program is offering confidential services to support the victim at the time of the offender's re-entry into the community. Victim wrap around services may include developing a safety plan for the victim and community and providing assistance to link the victim to other necessary services.

Information on existing programs in Washington state (where the first program began), Iowa, Ohio and Vermont is included in the appendices of the report for the use of the members of the General Assembly should they wish to encourage the development of victim wrap around programs in the Commonwealth.

INTRODUCTION

Senate Concurrent Resolution No. 149, Printer's No. 2175, of 2002 was adopted on September 26, 2002.[1] The resolution directed the Joint State Government Commission to establish a bipartisan legislative task force to study the geriatric and seriously ill populations in Pennsylvania State correctional institutions, review how other states deal with these populations and make recommendations to the General Assembly. The resolution authorized the task force to create an advisory committee to assist it in the study.

The task force consists of four members of the Senate and four members of the House of Representatives[2] and is chaired by Senator Stewart J. Greenleaf. The organizational meeting of the task force was held on February 24, 2003.

A 46-member advisory committee[3] was appointed over the course of several months. The advisory committee is chaired by W. Scott Thornsley, Ph.D., Mansfield University. The advisory committee includes staff from the Department of Corrections, the Pennsylvania Board of Probation and Parole, the Pennsylvania Board of Pardons, the Office of the Victim Advocate, the Pennsylvania Commission on Crime and Delinquency, the Commission on Sentencing, the Department of Aging, the Department of Health and the Department of Public Welfare. It also includes judges, attorneys, college professors, pastors, mental health advocates and a representative of each of the following: the County Commissioners Association of Pennsylvania, the Pennsylvania District Attorneys Association, the Pennsylvania State Corrections Officers Association, the American Civil Liberties Union of Pennsylvania, the Pennsylvania Prison Society and the Pennsylvania Institutional Law Project.

The advisory committee held its organizational meeting on May 30, 2003 and met again on September 18, 2003, May 21, 2004, January 28, 2005 and May 20, 2005. Members of the advisory committee also toured the following State correctional institutions (SCIs) and spoke with staff and inmates at each location:[4]

[1] A copy of the resolution is provided in Appendix A.
[2] See p. v for the task force roster.
[3] See p. vi for the advisory committee roster.
[4] A summary of the SCI visits is provided in Appendix K.

SCI Laurel Highlands	July 14, 2003
SCI Muncy	July 25, 2003
SCI Graterford	August 21, 2003

To accomplish its work, the advisory committee divided into the following three subcommittees, each representing a cross-section of the full committee:

Health/Hospice – Gordian V. Ehrlacher, Chair
Mental Health – The Honorable Michael J. Barrasse, Chair
Geriatric/Lifer – not chaired

Each subcommittee began its work on September 18, 2003 and met frequently during the following 13 months. The subcommittees reported the results of their work to the full advisory committee for further consideration of the issues.

This report reflects the work of the advisory committee members and does not reflect unanimity on all points. On several issues, the members were unable to develop policy options acceptable to all interested constituencies. Being a member of the advisory committee should not be interpreted as an endorsement by the member or the member's organization of all the findings, conclusions and statutory options contained in this report.

The task force met on June 13, 2005 and authorized the release of this report to the General Assembly and the public. The inclusion of any finding, conclusion or statutory option in this report does not necessarily reflect the endorsement of the task force or its members.

A note on recidivism. Recidivism of released inmates is commonly measured as the rearrest, reconviction and reincarceration of inmates within three years of their release. Reincarceration is generally specified as return to prison for technical parole violations or new criminal convictions. *See, e.g.,* Patrick A. Langan and David J. Levin, *Recidivism of Prisoners Released in 1994*, a Bureau of Justice Statistics Special Report published by the U.S. Department of Justice in June of 2002. Individuals in that study were tracked across state lines, and reincarcerations generally included a return to State or Federal prison, but not to a local jail.

The members of the advisory committee found that, in practice, recidivism is measured in various manners, from county to county, state to state and organization to organization. For example, when used in this report to refer to the recidivism of inmates released from Commonwealth prisons, the term does not include rearrest, reconviction or reincarceration in a state other than Pennsylvania. Therefore, whenever available, explanations of what "recidivism" means are provided where the term is used in this report.

MESSAGE FROM ADVISORY COMMITTEE CHAIR

MANSFIELD UNIVERSITY
Mansfield, PA 16933

May 24, 2005

The Honorable Stewart J. Greenleaf, Chair
Task Force on Geriatric & Seriously Ill Inmates
Senate of Pennsylvania
Main Capitol Building
Harrisburg, PA 17120

Re: Report of the Advisory Committee

Dear Senator Greenleaf:

On behalf of the forty-seven member Advisory Committee on Geriatric and Seriously Ill Inmates, as created by Senate Resolution #149 0f 2002, it is my privilege to submit the recommendations on behalf of the committee. This report accurately reflects the work of the Advisory Committee for the past two years.

For two years the Joint State Government Commission (JSGC) has labored to assist the Advisory Committee in scheduling and assisting with our meetings, tours, and subcommittee meetings. Their staff quickly came to appreciate the importance of our task as well as understanding the problems within the Pennsylvania Department of Corrections' (DOC) growing inmate population that prompted this investigative inquiry.

At no time during the inquiry was there ever a concern that the state DOC was insensitive to the problems the committee investigated, or that there was ever any evidence that they were not responding to those problems in a professional and timely matter. In fact, the DOC gave every indication that they were in many instances a national leader in responding to those problems. There was no better example than their pride in the operation of the State Correctional Institution at Laurel Highlands, a facility that provides specialized programs designed for the geriatric and seriously ill inmate. The Department is also acutely aware of the problems caused by the growing life-sentenced inmate population, and is no longer embracing the "life means life" philosophy imposed on them previously.

The most difficult task of the Advisory Committee was to balance the differing philosophies of the groups invited to participate within the committee. Senate Resolution #149 specifically charged the Advisory Committee to "... consider alternatives for addressing the geriatric and seriously ill inmate population..." Generally, most correctional professionals and special interest groups initially view such alternatives as being early release mechanisms for the seriously ill and geriatric inmate population, with the hope that the community will be better able to accommodate those inmates, and at considerably lower costs. Their reasoning is based in the belief that our prisons are not equipped to become hospitals and geriatric nursing facilities, and instead should be reserved for the most violent and dangerous offender. The committee's victim advocate members were diligent in constantly reminding the full committee that some of these seriously ill and geriatric offenders were in fact violent and dangerous offenders decades, and in

some instances, only years before. Additionally, they reminded the committee that for every seriously ill and geriatric offender, they left at the very least one, if not more, victims in the community. In virtually every letter submitted to the JSGC from victims and victim's rights groups, they believed that the inmate serve out the sentence imposed, regardless of their medical condition or advanced age, and that their condition should be considered a collateral consequence of their prior criminal behavior. I personally read each and every letter submitted to the JSGC, from individual victim and from victims' rights groups, to inmate letters pleading for relief from long sentences.

It is my personal belief that the committee membership was well balanced, as evidenced by the fact that the report's recommendations were not unanimous.

One of the most controversial portions of this report is that it contains recommendations as to what to do with the plight of the life-sentenced inmate population. In fact, the lifer population as a specific inmate population was removed in Senate Resolution #149, P.N 2175 of 2002 (page 2, line 27), and many committee members believed that the Advisory Committee had no right to examine the life sentenced inmate population. Ultimately, the majority of the Advisory Committee, in its very first full meeting, decided that Pennsylvania's lifer population was a major reason why the geriatric and seriously-ill inmate population would continue to pose both an operational and fiscal concern to the Commonwealth in the years ahead if not addressed.

Ultimately, individual members of the General Assembly will have to decide if they can politically defend themselves if they are labeled "soft on crime" by critics when voting favorably for such concepts as medical release of inmates or the inclusion of the life sentence with possibility of parole, (as long as the offender has attained the age of 50 and has served 25 years of their sentence). The proposed draft legislation for a change in the life without parole sentence was without question the most controversial recommendation contained in this report. Since 1997, when Pennsylvania's Constitution was changed as a result of the 1995 Reginald McFadden incident, few life-sentenced inmates have even been able to acquire a public hearing before the Board of Pardons, let alone receive a recommendation which requires a unanimous vote from its five Board members. The opinion shared by many, but not all, is that the proposed lifer legislation is necessary in order to provide some degree of hope to inmates since relatively few inmate applications have been able to reach the Governor's desk for review, having been rejected by failing to receive such a unanimous vote.

What is at issue is what to do with several specific inmate populations within the DOC– populations which are by their very nature extremely expensive to incarcerate. In its 2005 Budget Presentation package to the Senate and House Appropriations Committee, the DOC stated that its elderly (age 50 and older) population is increasing – from 370 in 1980 to 5,082 in 2004. Currently the cost to incarcerate an inmate in the DOC is $30,000 per year, with inmates incarcerated at SCI Laurel Highlands costing $63,500. It cost the DOC approximately three times as much to incarcerate an inmate age 50 or older.

In closing, the General Assembly will be faced with having to decide whether to endorse legislation which will permit the release of geriatric and seriously ill inmates even though their sentence has not been fulfilled, in order for them to spend their last days in a community setting

which is more conducive to responding to their medical problems, or should the Commonwealth continue to incarcerate inmates who are no longer a threat to the community simply to satisfy the sentence imposed? That is a question even a 47 member Advisory Committee could not come to agreement on.

The report which follows represents literally hundreds, if not thousands, of hours of effort from members of the Advisory Committee and staff of the Joint State Government Commission. Our recommendations are not made lightly, and we wish the members of the Task Force well in reviewing them. I am certain I speak for each and every member of the Advisory Committee that if the Task Force desires an explanation or clarification of any aspect of this report, please do not hesitate to contact the staff of the Joint State Government Commission so they may in turn identify which Advisory Committee member or members can respond to your specific questions.

As for myself, I considered it an honor and privilege to once again serve the Commonwealth of Pennsylvania and its General Assembly.

Respectfully Submitted,

W Scott Thornley

W. Scott Thornsley, Ph.D., Chair
Advisory Committee

Associate Professor of Criminal Justice
Mansfield University of Pennsylvania

HEALTH/HOSPICE

BACKGROUND

The health/hospice subcommittee studied geriatric and seriously ill inmates in Pennsylvania's State correctional institutions (SCIs). As required by Senate Resolution 149 of 2002, the subcommittee began its study of geriatric inmates by examining inmates who are 55 or older. However, the Pennsylvania Department of Corrections (DOC) defines a geriatric inmate as one who is 50 or older because inmates have a physiological age 5 to 10 years older than their chronological age. Therefore, the subcommittee used 50 or older for purposes of the study. The following table compares the inmate population in years 2001 and 2004 by age 50 or older and 55 or older, including the number of such inmates serving life sentences, and shows a growth in those populations.

INMATES 50 OR OLDER AND 55 OR OLDER
AND THOSE SERVING LIFE SENTENCES

	50 or older		55 or older		Life sentences 50 or older		Life sentences 55 or older	
	Number of inmates	Percentage of population	Number of inmates	Percentage of population	Number of inmates	Percentage of life-sentenced population	Number of inmates	Percentage of life-sentenced population
Total population of 36,475 in September 2001	3,430	10.4%	1,892	5.0%	795	21.0%	415	11.0%
Total population of 39,984 in December 2004	5,031	12.4%	2,520	6.2%	1,077	26.0%	480	12.4%

SOURCE: Pennsylvania Department of Corrections.

In Pennsylvania, a life sentence means life in prison without the possibility of parole, and an inmate serving a life sentence has little hope for pardon or commutation of sentence.[5] As noted in the foregoing table, the inmate population in all categories reviewed has grown between September 2001 and December 2004. The subcommittee focused its attention on geriatric inmates and inmates of any age who have a serous or terminal illness. Furthermore, not only does the inmate population continue to grow, but the cost of caring for elderly and infirm inmates also continues to grow.

SUBCOMMITTEE PROCESS

The subcommittee met monthly and focused on the following tasks:

- Developing definitions for "hospice," "medical release," "serious illness" and "terminal illness."
- Reviewing other jurisdictions for information on geriatric and seriously or terminally ill inmates.
- Reviewing the care available to geriatric and seriously or terminally ill inmates in Pennsylvania's SCIs and the care available in Pennsylvania's communities for geriatric and seriously or terminally ill inmates who are released from prison.
- Drafting legislation that will facilitate the release of seriously and terminally ill inmates and provide for the continuing care of such inmates upon their release from prison.
- Developing the concept of an inter-agency committee to monitor the number of geriatric and seriously or terminally ill inmates released, identify community resources for such individuals, identify obstacles to their release and make recommendations.
- Addressing concerns that are related to, but are not part of, the study.

[5] See "Background – Life Sentences and Commutation" on p. 82.

DEFINITIONS

The subcommittee labored over definitions for "hospice," "medical release," "serious illness" and "terminal illness" and was able to reach consensus on the following definitions:

- "Hospice." A special concept of care designed to provide comfort and support to a patient with a terminal illness. Hospice addresses all symptoms of a disease, with special emphasis on controlling pain and discomfort. Hospice addresses the emotional, social and spiritual impact of the disease on the patient.

- "Medical release." The release of an inmate with a serious illness or terminal illness, through modification of sentencing, for medical or hospice care.

- "Serious illness." A disease process including chronic illness that requires care and treatment over a long period of time, is usually not cured, whether due to a physical or cognitive impairment, and has progressed to the degree that the inmate meets Department of Aging Area Agency on Aging criteria for nursing facility clinical eligibility.[6] The condition may have existed before incarceration.

- "Terminal illness." An incurable, irreversible medical condition, in an advanced state, which will in the opinion of the attending physician, to a reasonable degree of medical certainty, result in death regardless of the continued application of life-sustaining treatment within six months or less and has progressed to the degree that the inmate meets Department of Aging Area Agency on Aging criteria for nursing facility clinical eligibility.

During full advisory committee discussions, the definition of "serious illness" was amended to include injury and mental condition, and the definition of "terminal illness" was amended to remove the six-month requirement as being impossible to ascertain.

[6] A copy of the MA-51 Medical Evaluation form used in determining the physician recommended level of care is provided in Appendix B.

OTHER JURISDICTIONS

The subcommittee reviewed a comprehensive chart which shows the number of inmates age 50 years and over and their percentage of the total inmate population for each of the 50 states.[7] The chart also provides information on the types of illnesses prevalent in the total population of the nation's correctional institutions, such as tuberculosis, AIDS and HIV; whether inmates are cared for by the institutional staff or a private vendor under contract; the correctional institution's budget for medical attention; the average daily cost of inmate care; whether inmates are charged for medical attention and state statutes or regulations providing for medical release.

The subcommittee also reviewed a chart provided by DOC that detailed various forms of pre-release and post-release planning for geriatric and seriously ill inmates and included information on medical release statutes from other states, including Colorado, Connecticut, Florida, Georgia, Idaho, Kentucky, Minnesota, Mississippi, Missouri, Montana, New York, Ohio, Oregon, Rhode Island, Texas, Vermont and Washington.[8] The Texas Council on Offenders with Mental Impairments (TCOMI) model, that provides for early release of inmates, was of interest to the subcommittee.

Texas Council on Offenders with Mental Impairments

The TCOMI model includes a Special Needs Parole Program (SNP) that provides for the early parole review of certain categories of offenders who are elderly, terminally ill, physically impaired, mentally ill or retarded. The purpose of SNP is to identify eligible special needs offenders in State correctional

[7] A copy of the chart is provided in Appendix C. The chart is based on information provided in *The Corrections Yearbook: 2001*, published by Criminal Justice Institute, Inc. in 2002. Criminal Justice Institute, Inc. has recently decided to discontinue publication of the *Yearbook*, partly because of problems involved in attempting to collect comparable data from all 50 states when each state has its own particular terminology and practices which do not lend themselves to comparison. For example, the states vary on the length of sentence that can be served at the county level. Where Pennsylvania requires offenders with maximum sentences of less than two years to be sent to county prison and allows offenders with sentences of more than two but less than five years to be sent to county prison, *see* 42 Pa.C.S. § 9762, most other jurisdictions only send offenders with sentences of less than one year to county prison. So, because thousands of the inmates housed in Pennsylvania's county prisons would be housed in state prisons in most of the other states, a comparison of the numbers and incarceration rates listed in the *Yearbook* based on state prison populations is not valid.

[8] Statutes, models and publications from the following were also reviewed: the Federal Government, California, Wisconsin, Wyoming, the Correctional Service of Canada, New South Wales, the Northern Territory of Australia, the American Geriatrics Society, Project Grace and the Committee on Care at the End of Life, Division of Health Care Services, Institute of Medicine.

institutions or county prisons who could be diverted from incarceration to more cost effective and appropriate treatment alternatives. The legislation excludes offenders sentenced to serve aggravated convictions, and the parole board determines which offenders are no longer a threat to public safety. In order to be eligible for consideration, an offender must meet at least one of the following criteria: have a terminal illness that is incurable and that would inevitably result in death within six months, be 60 years of age or older with a medical condition requiring 24 hours nursing care or specialized medical support services or have a physical disability defined to include any medical condition that results in significant limitations to functional abilities.

The SNP was established in 1991 and is administered by TCOMI. However, throughout its 13-year history, SNP has provided for the release of few former inmates. In 1998, for instance, of the 3,213 inmates potentially eligible for release on special needs parole, 51 were approved for release by the parole panel and only one was elderly. The subcommittee concluded, therefore, that the cost of implementing such a council and program in Pennsylvania would not justify the savings incurred by the potential release of so few inmates.

PENNSYLVANIA

Care While Incarcerated

The subcommittee noted that some of the Commonwealth's SCIs, notably Laurel Highlands, provide care for geriatric and seriously ill inmates. SCI Laurel Highlands, situated in Somerset County, was formerly the Somerset State Mental Hospital, administered by the Department of Public Welfare. It was renovated and re-opened in 1996 as SCI Laurel Highlands and houses long-term care, wheelchair and geriatric inmates as well as general population inmates. The facility provides for specialized programs that meet the needs of geriatric and seriously ill inmates, including medical care for long-term illness, life skills programs, recreational activities that are individualized to meet the needs of older or physically challenged inmates, substance abuse programs, psychological assessment and treatment and religious services.

Care Upon Release

Availability of Care

The subcommittee reviewed the availability of alternative forms of care for geriatric and seriously or terminally ill inmates who may be eligible for medical release and found that community care for such inmates is limited in Pennsylvania. Publicly run nursing homes are not as available as resources as they might have been previously because of the government policy of encouraging geriatric and seriously or terminally ill patients to be cared for in their homes or by their families instead of residing in public nursing facilities. Additionally, private nursing homes are often unable to admit former inmates from the State correctional institutions as patients because of resistance from other patients or their family members. Residents "may voice grievances and recommend changes in policies and services to the facility staff or to outside representatives of the resident's choice."[9] Another concern relates to possible behavioral problems that former inmates might have since "only residents whose nursing care and physical needs can be provided by the staff and facility" can be admitted.[10] Furthermore, the facility may limit access to a resident when it is determined that "it may be a detriment to the care and well-being of the resident in the facility."[11]

Cost of Care

Long term care is costly no matter where it is provided. The subcommittee found that the cost is not significantly greater for care provided in prison than for care provided outside prison. While the Department of Corrections had not previously tracked the costs of long term care, it did so for 2004 so that a meaningful cost comparison could be obtained for this study. The department found that the cost per inmate receiving long term care at SCI Laurel Highlands was $63,500 in 2004, while the average cost per patient in a county nursing home was $62,000.

The subcommittee notes that inmates are not entitled to Medicaid or Medicare, but when an inmate is paroled, he or she is entitled to Medicaid or Medicare on the same basis as the rest of the population. As a result, the Commonwealth might realize some savings upon the release of geriatric and seriously or terminally ill inmates since federal funds that Pennsylvania would otherwise not receive become available.

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[9] 28 Pa. Code § 201.29(i).
[10] 28 Pa. Code § 201.24(c).
[11] 28 Pa. Code § 201.30(a).

The subcommittee found that paroling an inmate with a serious illness or injury, geriatric condition or terminal illness to the care of family members or friends appears to be the only way to accomplish real cost savings. Unfortunately, not all inmates have family members or friends, and not all family members or friends are willing or able to assume this responsibility.

As shown below, the subcommittee reviewed several possible alternatives for care of former inmates – the South Mountain Restoration Center, AmeriHealth Mercy/Mercy Health System of Southeastern Pennsylvania and Warren State Hospital – but costs could not be determined and other obstacles to the alternatives were found.

South Mountain Restoration Center. The subcommittee toured the South Mountain Restoration Center, a facility operated by the Department of Public Welfare and licensed by the Department of Health.

Since 1901, the Center has provided services to a variety of residents: tuberculosis patients, military victims of mustard gas in World War I, women with mental retardation and older individuals with mental illness. The Center's mission is to provide the highest quality of care and services to residents in order to assist them to achieve their full potential. Since 1965, the Center has specialized in serving special needs individuals who cannot be cared for by other facilities and has developed a great deal of experience in meeting their unique needs. Patients admitted to the Center must be certified as needing nursing facility care and would typically be individuals who have dementia, another brain disease or traumatic brain injury with current or past behavior disturbance. The Center accepts referrals from a variety of sources throughout the Commonwealth.[12]

The subcommittee envisaged the Center as a possibly appropriate placement for geriatric and seriously or terminally ill inmates who might be released from SCIs. The number of former inmates who were residents of the Center in December 2004 was eleven. However, the subcommittee became aware of several concerns that might prevent the potential release of eligible inmates to the Center in the future, for instance, the cost of taking care of a resident at the Center. Another concern is the requirement that residents be eligible for medical assistance; only inmates paroled by the Pennsylvania Board of Probation and Parole (the Parole Board) are eligible for such assistance. Furthermore, although the staff at the Center is adequate for the number of current residents, additional medical and support staff would be required if a number of geriatric and seriously ill inmates are released to the facility. The Department of Public Welfare must

[12] Kathryn Yelinek. *The History of South Mountain Restoration Center: 1901-2001*. Commonwealth of Pennsylvania, 2001.

also follow the policy laid out by the United States Supreme Court in *Olmstead v. L.C.,* 119 U.S. 2176 (1999) of caring for individuals in the least restrictive setting possible. This discourages the department from increasing the population at institutions like the Center. Finally, although the Center has more than 200 beds, only 125 are currently occupied. As previously indicated, additional staff would be required if all beds were filled. However, it is also noted that DPW plans to close Harrisburg State Hospital by the end of 2005 thus closing another possible resource for eligible inmates.

AmeriHealth Mercy/Mercy Health System of Southeastern Pennsylvania. AmeriHealth Mercy submitted a proposal for a pilot program for hospice inmates from southeastern Pennsylvania to the subcommittee. This program would attempt to achieve cost savings by placing inmates who are receiving hospice level care in a secure community-based, medically focused correctional unit. Such a program would guarantee cost savings through a fee arrangement based on a percentage of current funding levels or a shared savings arrangement. AmeriHealth Mercy would pay DOC to provide corrections officers. Furthermore, AmeriHealth Mercy would coordinate the delivery of supportive and spiritual services to inmates and families. Finally, managed care principles would be applied to the delivery of health care and palliative care to manage the cost of care while maximizing quality of life. The subcommittee suggested that AmeriHealth Mercy focus on inmates who would be eligible for parole if such a facility existed to care for the inmates. However, as of the date of this report, the subcommittee has not received any additional information from AmeriHealth Mercy.

Warren State Hospital. The subcommittee entertained a suggestion from Warren County that the unused portions of Warren State Hospital be converted to a geriatric prison. As an alternative, the subcommittee inquired as to whether Warren County might consider using the unused portions of Warren State Hospital as a community resource for inmates who are released from prison to a community facility because of serious or terminal illness. The subcommittee has not received any additional information on the proposal.

Release of Geriatric and Seriously Ill Inmates

In addition to release upon serving his maximum sentence, a seriously or terminally ill inmate of any age may be released from prison through the Compassionate Release Act or parole.

Compassionate Release Act

The act of May 31, 1919 (P.L.356, No.170) is commonly referred to as the Compassionate Release Act.[13] If it is shown that an inmate "is seriously ill, and that it is necessary that he or she be removed from [prison]," the Act gives a trial court the power to "modify its sentence . . . and provide for the confinement or care of such . . . person in some other suitable institution where proper treatment may be administered." The Act also provides that, "[u]pon the recovery of such person, the court shall recommit him . . . to the institution from which he . . . was removed."

The Superior Court reviewed the legislative history of the Act and found that the intent of the language "modify its sentence," particularly when read together with the requirement to "recommit" the inmate upon his recovery, was to give the trial court the power to modify the *place* of sentence, not the length of sentence. *Commonwealth v. Reefer*, 816 A.2d 1136, 1143 – 44 (Pa.Super.2003). The court continued its analysis by providing that in order for an inmate to show that it is necessary for him to be removed from prison to receive medical treatment, he "must allege that his facility lacks the resources to treat him or that its collective health is endangered by his illness" and "must go beyond quality or neglect in treatment and address the inability of the prison facility to provide adequate care." *Reefer*, 816 A.2d at 1145 (footnote11) (citing *Commonwealth v. Dunlavey*, 805 A.2d 562, 564 – 65 (Pa.Super.2002)).

No inmate has been released from SCI Laurel Highlands under the Compassionate Release Act. However, five inmates were released under the Act from other State correctional institutions in 2004 and, thus far, one inmate has been released in 2005.[14]

Parole

Attaining parole eligibility offers geriatric and seriously or terminally ill inmates the chance of release from prison. However, obstacles, including lack of community bed space for skilled care and personal care and lack of state funding, inhibit the release on parole of otherwise eligible inmates. A joint committee comprised of representatives from DOC and the Parole Board is currently examining the parole process to determine what improvements may be made.

[13] The Compassionate Release Act is found in Purdon's Pennsylvania Statutes Annotated at 61 P.S. § 81. A copy is presented in Appendix D.

[14] Statistics supplied by the Pennsylvania Department of Corrections.

The subcommittee wanted to know how many seriously ill inmates have been paroled in the past several years and what their recidivism rate is, but found that an inmate's status as seriously ill is not tracked once he is paroled by the Parole Board and released by the DOC.[15] Therefore, the subcommittee suggests that DOC and the Parole Board coordinate their operations so that statistics on seriously ill paroled inmates can be compiled.

DRAFT LEGISLATION

The members agreed that, although SCI Laurel Highlands has the ability to care for geriatric and seriously ill inmates, releasing such inmates to private facilities or to the care of their families through a court-sanctioned medical release procedure or parole would reflect both humanitarian and, in a few instances, economic concerns. The members also acknowledged, however, that the safety of the community to which seriously or terminally ill inmates are released is paramount.

The subcommittee drafted legislation that will give more seriously or terminally ill inmates the possibility of being released from prison by deleting the requirement that the SCI be unable to care for the inmate, by providing for release to receive hospice care and by requiring expedited consideration of requests for release.

The first draft provides for medical release through the courts and is intended to give the court maximum discretion. It includes the repeal of the current Compassionate Release Act. The second draft provides for medical release through the Parole Board.

Medical Release Through The Courts

AN ACT

Amending Title 42 (Judiciary and Judicial Procedure) of the Pennsylvania Consolidated Statutes, providing for medical release of inmates.

[15] See Appendix E for statistics provided by the Pennsylvania Board of Probation and Parole.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Title 42 of the Pennsylvania Consolidated Statutes is amended by adding a section to read:

§ 9774. Medical release.

(a) Short title of section.—This section shall be known and may be cited as the Medical Release Act.

(b) Legislative findings.—

(1) The number of inmates 50 years of age or older in State correctional institutions is increasing and, by December 2004, represented more than 12% of the total inmate population in State correctional institutions.

(2) A number of inmates suffer from serious or terminal illnesses that require costly care.

(3) Because of serious or terminal illness, inmates of any age may no longer pose a threat to the safety of the community.

(4) Recidivism is inversely related to the age of the inmate at the time of release: the older the inmate, the lower the rate of recidivism.

(5) As the inmate population increases, the number of inmates with serious or terminal illness increases and strains the facilities and resources of Pennsylvania's State correctional institutions.

(6) Alternatives must be found outside Pennsylvania's State correctional institutions for providing medical or hospice care for inmates with serious or terminal illness.

(7) Victim and community safety will be given the highest priority before an inmate is released to receive medical or hospice care outside Pennsylvania's State correctional institutions.

Note: Statistics in subsection (b)(1) were provided by the Pennsylvania Department of Corrections. The conclusion regarding recidivism in subsection (b)(4) is based on the Bureau of Justice Statistics Special Reports, *Recidivism of Prisoners Released in 1983,* by Allen J. Beck, Ph.D. (1989) and *Recidivism of Prisoners Released in 1994,* by Patrick A. Langan, Ph.D. and David J. Levin, Ph.D. (June 2002), both published by the U.S. Department of Justice.

(c) Definitions.—The following words and phrases when used in this section shall have the meanings given to them in this subsection unless the context clearly indicates otherwise:

"Department." The Department of Corrections of the Commonwealth.

"Government agency." The term shall have the meaning given to it in 42 Pa.C.S. § 102 (relating to definitions).

"Hospice." A special concept of care designed to provide comfort and support to a patient with a terminal illness. Hospice addresses all symptoms of a disease, with special emphasis on controlling pain and discomfort. Hospice addresses the emotional, social and spiritual impact of the disease on the patient.

"Inmate." An individual confined in a State or county correctional institution.

"Medical release." The release of an inmate with a serious illness or terminal illness, through modification of sentencing, for medical or hospice care.

"Serious illness." A disease process or injury, including chronic illness, whether due to a physical or cognitive impairment or mental condition, that requires care and treatment over a long period of time, is usually not cured and has progressed to the degree that the inmate meets Department of Aging Area Agency on Aging criteria for nursing facility clinical eligibility. The disease process or injury may have existed before incarceration.

"Terminal illness." An incurable, irreversible medical condition in an advanced state, which will in the opinion of the attending physician, to a reasonable degree of medical certainty, result in death regardless of the continued application of life-sustaining treatment and has progressed to the degree that the inmate meets Department of Aging Area Agency on Aging criteria for nursing facility clinical eligibility.

(d) General rule and exception.—

(1) Notwithstanding any other provision to the contrary, upon petition for the medical release of an inmate, the court shall hold an expedited hearing and determine whether a medical release will be granted as provided in this section.

(2) An inmate who is under a sentence of death shall not be eligible for medical release under this section.

(e) Procedure.—

(1) Upon diagnosing an inmate with a serious illness or terminal illness, the attending physician shall report the diagnosis to the department or county correctional institution.

(2) A petition for medical release of a seriously or terminally ill inmate may be filed by the following with the sentencing judge:

(i) The inmate or the inmate's designee as shown in the facility's records.

(ii) The department or county correctional institution upon the request of one or more of the following:

(A) The attending physician, with the support of the superintendent of the correctional institution housing the inmate.

(B) A staff member in the correctional institution housing the inmate, with the support of the superintendent of that correctional institution.

(C) The superintendent of the correctional institution on behalf of the inmate.

(3) When a petition for medical release is filed by any individual designated in subsection (e)(2) a waiver of the inmate's medical confidentiality is presumed.

(4) Upon the petition of an inmate or the inmate's designee under paragraph (2)(i) or the request of an individual under paragraph (2)(ii), the

department or county correctional institution may assess whether the inmate is seriously or terminally ill and perform the standardized needs and risk assessment on the inmate. If the medical assessment and needs and risk assessment are performed, the following apply:

Note: The use of the word "may" in the third line is intended to show that the Department of Corrections may limit the frequency of such requests.

(i) If the inmate is determined to be seriously or terminally ill and the needs and risk assessment is satisfactory, either:

(A) the petition under paragraph (2)(i) may continue; or

(B) the department or county correctional institution shall file the petition requested under paragraph (2)(ii).

(ii) If the inmate is determined not to be seriously or terminally ill or the needs and risk assessment is unsatisfactory, no further action shall be required from the department or county correctional institution.

(5) Government agencies shall cooperate with the department or county correctional institution in performing a medical assessment and developing a medical release plan.

(6) Certain documents are required as follows:

(i) If a petition is filed by an inmate or the inmate's designee under paragraph (2)(i), and the inmate is determined to be seriously or terminally ill and the needs and risk assessment under paragraph (4) is satisfactory,

documents containing evidence of the following shall be requested of the department or county correctional institution by the court:

(A) The inmate's medical condition and prognosis.

(B) The inmate's institutional performance.

(C) The inmate's classification according to the department or county correctional institution.

(D) The inmate's needs and risk assessment.

(E) A medical release plan for the inmate, which shall state the following, among other things:

(I) Whether the inmate will be placed with an individual, in a facility in the community or in a facility operated by a government agency.

(II) The date when the placement under subclause (I) can be accomplished.

(ii) If a petition is filed by the department or county correctional institution under paragraph (2)(ii), documents containing evidence of the items listed under subparagraph (i) shall be attached to the petition.

(7) If an inmate is determined to be seriously or terminally ill and the needs and risk assessment is satisfactory, the petitioner shall provide notice of the petition for medical release and the impending hearing to the following:

(i) The district attorney of the county of record who shall provide notice of the petition to the victim.

(ii) The public defender or defense counsel.

(iii) The Office of the Victim Advocate.

(iv) The Pennsylvania Board of Probation and Parole.

(v) The county probation officer.

(vi) The sentencing judge of each judicial district in which the inmate was sentenced.

(8) The petitioner shall include with the notice provided under paragraph (7) a request for comments and testimony. The request for comments shall state that comments must be received by the district attorney of the county of record and the court no later than the specified date, which shall be 30 days after the date of the request. If the inmate is in a State correctional institution, the notice shall also state that victim's comments shall also be submitted to the Office of the Victim Advocate.

(f) Hearing and order.—The court shall schedule an expedited hearing to take place within five business days after the date specified for the receipt of comments under subsection (e)(8). If more than one sentencing court is involved, the courts shall coordinate the scheduling of the hearings. The court shall consider the documents presented under subsection (e)(6), comments received under subsection (e)(8) and testimony presented during the hearing. At the conclusion of the hearing, the court shall enter an order granting or denying the petition. If the petition is granted, the order shall:

(1) modify the inmate's place of confinement to effectuate the inmate's release in accordance with the medical release plan;

(2) specify how the inmate will be supervised;

(3) specify whether periodic status reports and medical assessments are required; and

(4) specify that, upon recovery, the inmate shall be recommitted to a State or county correctional institution.

(g) Monthly report.—

(1) Beginning one year after the effective date of this act, the Monthly Statistical Report of the department shall include the number of petitions that have been brought under this section, the number granted, the number denied, the nature of the illnesses involved in the petitions, the types of placements involved for granted petitions, the nature of the placement plans and the reasons for petition denials.

(2) The counties shall submit to the department similar statistical information which will be included in the Monthly Statistical Report of the department.

(h) Rules and regulations.—The department shall promulgate the rules and regulations necessary to implement this section.

Section 2. The act of May 31, 1919 (P.L.356, No.170), entitled "An act authorizing courts of record to remove convicts and persons confined in jails, workhouses, reformatories, reform or industrial schools, penitentiaries, prisons,

houses of correction or any other penal institutions, who are seriously ill, to other institutions; and providing penalties for breach of prison," is repealed.

Section 3. This act shall take effect in 60 days.

Medical Release Through the Pennsylvania Board of Probation and Parole

> **Note: The draft covers only those inmates with serious or terminal illnesses who present a minimal risk of re-offending based on a standardized needs and risk assessment and have served their minimum sentence and, thus, achieved parole eligibility.**

AN ACT

Amending the act of August 6, 1941 (P.L.861, No.323), entitled, as amended, "An act to create a uniform and exclusive system for the administration of parole in this Commonwealth; providing state probation services; establishing the 'Pennsylvania Board of Probation and Parole'; conferring and defining its jurisdiction, duties, powers and functions; including the supervision of persons placed upon probation and parole in certain designated cases; providing for the method of appointment of its members; regulating the appointment, removal and discharge of its officers, clerks and employes; dividing the Commonwealth into administrative districts for purposes of probation and parole; fixing the salaries of members of the board and of certain other officers and employes thereof; making violations of certain provisions of this act misdemeanors; providing penalties therefor; and for other cognate purposes, and making an appropriation," providing for medical release of inmates.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. The act of August 6, 1941 (P.L.861, No.323), referred to as the Pennsylvania Board of Probation and Parole Law, is amended to read:

Section 19. Consideration upon commitment.

It shall be the duty of the board, upon the commitment to prison of any person whom said board is herein given the power to parole, to consider the nature and circumstances of the offense committed, any recommendations made by the trial judge and prosecuting attorney, the general character and background of the prisoner, participation by a prisoner who is serving a sentence for a crime of violence as defined in 42 Pa.C.S. § 9714(g) (relating to sentences for second and subsequent offenses) in a victim impact education program offered by the Department of Corrections and the written or personal statement of the testimony of the victim or the victim's family submitted pursuant to section 22.1. The board shall further consider the notes of testimony of the sentencing hearing, if any, together with such additional information regarding the nature and circumstances of the offense committed for which sentence was imposed as may be available. The board shall further cause the conduct of the person while in prison and his physical, mental and behavior condition and history, his history of family violence and his complete criminal record, as far as the same may be known, to be reported and investigated. All public officials having possession of such records or information are hereby required and directed to furnish the same to the board upon its request and without charge therefor so far as may be practicable while the case is recent.

Section 20. Duty of prison officials.

It shall be the duty of all prison officials at all reasonable times to grant access to any prisoner whom the board has power to parole to the members of said board or its properly accredited representatives, and all prison officials shall at all reasonable times provide for the board or its properly accredited representatives facilities for communicating with and observing such prisoner while imprisoned, and shall furnish to the board from time to time such reports concerning the conduct of prisoners in their custody as the board shall by general rule or special order require, together with any other facts deemed pertinent in aiding the board to determine whether such prisoners shall be paroled.

Section 21. Release on parole.

(a) General rule.—The board is hereby authorized to release on parole any convict confined in any penal institution of this Commonwealth as to whom power to parole is herein granted to the board, except convicts condemned to death or serving life imprisonment, whenever in its opinion the best interests of the convict justify or require his being paroled and it does not appear that the interests of the Commonwealth will be injured thereby. Parole shall be subject in every instance to the Commonwealth's right to immediately retake and hold in custody without further proceedings any parolee charged after his parole with an additional offense until a determination can be made whether to continue his parole status. The power to parole herein granted to the Board of Parole may not be exercised in the board's discretion at any time before, but only after, the

expiration of the minimum term of imprisonment fixed by the court in its sentence or by the Pardon Board in a sentence which has been reduced by commutation.

(a.1) Expedited review.—

(1) The board shall provide expedited review of every case where the Department of Corrections has reported that the inmate being considered for parole:

(i) has a serious or terminal illness as defined in 42 Pa.C.S. § 9774 (relating to medical release);

(ii) is receiving treatment or hospice care; and

(iii) presents a minimal risk of reoffending, based on the department's standardized needs and risk assessment of the inmate.

(2) Nothing in this subsection shall entitle any inmate to be paroled or to establish a presumption that an inmate is entitled to be paroled.

(3) Cooperation of government agencies.—Government agencies, as defined in 42 Pa.C.S. § 101 (relating to definitions), shall assist the board and the Department of Corrections in developing a plan to house and treat any inmate the Department of Corrections has identified as suffering from a serious or terminal illness.

Note: "Government agency" is defined in 42 Pa.C.S. § 101 to mean any Commonwealth agency (defined to include executive agencies and independent agencies, such as boards) or any political subdivision or municipal or other local authority, or any officer or agency of any such political subdivision or local authority.

(b) Drug testing.—The board may not release a person on parole unless the person achieves a negative result within forty-five days prior to the date of release in a screening test approved by the Department of Health for the detection of the presence of controlled substances or designer drugs under the act of April 14, 1972 (P.L.233, No.64), known as "The Controlled Substance, Drug, Device and Cosmetic Act." The cost of these pre-parole drug screening tests for inmates subject to the parole release jurisdiction of the board, whether confined in a State or local correctional facility, shall be paid by the board. The board shall establish rules and regulations for the payment of these costs and may limit the types and cost of these screening tests that would be subject to payment by the board. The board shall establish, as a condition of continued parole for a parolee who, as an inmate, tested positive for the presence of a controlled substance or a designer drug or who was paroled from a sentence arising from a conviction under "The Controlled Substance, Drug, Device and Cosmetic Act," or from a drug-related crime, the parolee's achievement of negative results in such screening tests randomly applied. The random screening tests shall be performed at the discretion of the board, and the parolee undergoing the tests shall be responsible for the costs of the tests. The funds collected for the tests shall be applied against the contract for such testing between the board and a testing laboratory approved by the Department of Health. The board may waive the requirements of this subsection for any inmate identified by the Department of Corrections as:

(1) having a serious or terminal illness as defined in 42 Pa.C.S. § 9774 (relating to medical release);

(2) receiving treatment or hospice care; and

(3) presenting a minimal risk of reoffending, based on the department's standardized needs and risk assessment of the inmate.

(b.1) Victim Awareness Education.—The board may not release a person who is serving a sentence for a crime of violence as defined in 42 Pa.C.S. § 9714(g) (relating to sentences for second and subsequent offenses) on parole unless the person has received instruction from the Department of Corrections on the impact of crime on victims and the community. The board may waive the requirements of this subsection for any inmate identified by the Department of Corrections as:

(1) having a serious or terminal illness as defined in 42 Pa.C.S. § 9774 (relating to medical release);

(2) receiving treatment or hospice care; and

(3) presenting a minimal risk of reoffending, based on the department's standardized needs and risk assessment of the inmate.

(c) Recommitment and reparole.—The board shall have the power during the period for which a person shall have been sentenced to recommit one paroled for violation of the terms and conditions of his parole and from time to time to reparole and recommit in the same manner and with the same procedure as in the case of an original parole or recommitment, if, in the judgment of the board, there

is a reasonable probability that the convict will be benefited by again according him liberty and it does not appear that the interests of the Commonwealth will be injured thereby.

(d) Notice to county probation office.—When the board releases a parolee from a State or local correctional facility, the board shall provide written notice to the probation department located in the county where the sentencing order was imposed of the release and new address of the parolee.

INTER-AGENCY COMMITTEE ON THE MEDICAL RELEASE OF INMATES

Although the members were not generally in favor of creating another bureaucracy, they agreed that some kind of oversight of the medical release of inmates is necessary and developed the concept of the inter-agency committee. The inter-agency committee would be comprised of private and public individuals, including representatives from various named government agencies. The duties of the committee would include meeting periodically, developing an educational training program for judges, reporting on individual agency progress and statistics regarding the medical release of inmates and annually submitting a report and recommendations to the individual agencies, the Governor and the General Assembly.

While draft legislation has not been prepared, the subcommittee developed the following concepts regarding an inter-agency committee on the medical release of inmates.

Concepts

A committee on the medical release of inmates shall be established. At a minimum, the following shall be represented on the committee:

(1) The Office of the Governor

(2) The Department of Corrections

(3) The Pennsylvania Board of Probation and Parole

(4) The Office of the Victim Advocate

(5) The Office of the Attorney General

(6) The Department of Public Welfare

(7) The Department of Aging

(8) The Department of Health

(9) The Department of Military and Veterans Affairs

(10) The Administrative Office of Pennsylvania Courts

(11) Common Pleas Judges

The Secretary of the Department of Corrections, or a designee, shall organize the first meeting of the committee to be held within 60 days after the effective date of the enabling legislation.

The committee shall meet quarterly for the first year and at least annually thereafter.

The committee shall develop an educational training program for judges. Such a program will enable judges to expedite the medical release of inmates who are seriously or terminally ill.

During each meeting, each member shall report on his agency's progress and statistics regarding the medical release of inmates through the courts and through the Board of Probation and Parole.

The committee shall submit a report and recommendations to the represented agencies, the Governor and the General Assembly. The first report shall be submitted within 15 months after the committee's first meeting, and reports shall be submitted annually thereafter for the next three years. After the fourth annual report, the committee shall continue to report annually to the agencies it represents and biennially to the Governor and General Assembly. Without identifying individual inmates, the report shall include the following:

(1) The number of inmates who were considered for release.

(2) The illness suffered by each inmate considered.[16]

(3) The number of inmates who were released.

(4) The number of inmates who were not released and the reason for the denial.

(5) Identification of the obstacles to medical release.

(6) Recommendations for overcoming the obstacles to medical release.

The head of each agency represented on the committee is responsible for implementing the recommendations identified annually by the committee that impact his agency, as long as the recommendations are consistent with the agency's mission. If the agency does not have adequate funding to implement the recommendations, it will take the necessary action to attain the funding.

Expanding the Inter-Agency Committee on Medical Release of Inmates

If the General Assembly were to enact legislation providing for an Inter-Agency Committee on Medical Release of Inmates, the subcommittee suggests that the composition of the agency be expanded to include nursing home administrators, business people, medical personnel and others. The members also suggest that the scope of the committee's interest be expanded to include an investigation of the existence of community resources that provide services to former inmates with special needs, including those related to health, mental health, aging or other needs. The special needs inmate population might also include inmates who have served their full sentences. While the members recognize that these suggestions are outside the scope of Senate Resolution 149, the suggestions are offered to complete the picture of what the Inter-Agency Committee could address.

[16] Data to be compiled by the Department of Corrections for court releases and by the Board of Probation and Parole for parole releases.

MENTAL HEALTH

Charged with examining all mentally ill prisoners regardless of physical health, age or sentence, the mental health subcommittee covered a wide range of issues spanning the entire length of a mentally ill inmate's incarceration in a State correctional institution. The members shared a commitment to improving the lives of the state's mentally ill inmate population and creating the best possible treatment and access mechanisms for them in an efficient, cost-effective manner. This chapter presents the work of the subcommittee, including the compilation of information and the drafting of legislation.

The subcommittee reviewed several reports covering the entire spectrum of care for mentally ill offenders. In 2002, the Consensus Project of the Council of State Governments released a report[17] which was the result of many meetings among leading criminal justice and mental health policymakers and practitioners from across the country, surveys administered to state and local government officials in communities in 50 states, hundreds of hours of interviews with administrators of innovative programs and thousands of hours reviewing materials describing research, promising programs, policies and legislation. Human Rights Watch, an international humanitarian organization, published a similar report in October 2003.[18] Both of these reports cover every aspect related to the mentally ill in the prison system, from entry to exit and continued treatment in the community. The flowchart in Appendix G provides an overview of the manner in which a mentally ill offender and the criminal justice system may interact according to the Consensus Project.

The first section of this chapter provides information on mentally ill inmates in Pennsylvania's State correctional institutions (SCIs) and the services provided to them by the Department of Corrections (DOC).

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[17] Council of State Governments. *Criminal Justice/Mental Health Consensus Project*. NY: June 2002. http://www.consensusproject.org/the_report. Senator Robert J. Thompson, a member of the Task Force on Geriatric and Seriously Ill Inmates, was a member of the Law Enforcement Advisory Board and served as co-chair of the Consensus Project.

[18] Human Rights Watch. *Il-Equipped: U.S. Prisons and Offenders with Mental Illness*. NY: 2003. http://www.hrw.org/reports/2003/usa1003.

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The department states in its mental health services literature that one in every six individuals in the State correctional system has mental health needs and that DOC is committed to meeting the needs of all inmates who need services, no matter how basic or intensive. Mental health services are provided in all SCIs.[19]

Appendix F contains information on individuals within the State correctional system who are on either the Mental Health/Mental Retardation (MH/MR) or the Psychiatric Review Team roster. The MH/MR roster includes inmates who suffer from mental illness or mental retardation or both. The Psychiatric Review Team roster is a subset of the MH/MR roster and includes inmates who suffer from serious mental illness. DOC defines serious mental illness as "a substantial disorder of thought or mood which significantly impairs judgment, behavior and capacity to recognize reality, or cope with the ordinary demands of life."[20]

Table 1 in Appendix F shows that the total SCI inmate population on November 21, 2003 was 39,855. Of that total, 6,979 were on the active MH/MR roster, meaning the percentage of mentally ill in the State correctional system was 17.5% at that time. One year later, on November 21, 2004, the active percentage was about 18%. Table 2 shows that, of the 6,979 on the MH/MR roster, nearly one-quarter (1,560) were on the Psychiatric Review Team roster. The Psychiatric Review Team population was about 4% of the total SCI inmate population.

Mental Health Services[21]

All inmates who enter the system are assessed at diagnostic classification centers at SCI Camp Hill (males) and SCI Muncy (females). Those with mental health problems receive further psychiatric assessments and are placed on the MH/MR roster, if appropriate. SCI Camp Hill also has a 20-bed observation area for newly committed inmates who are experiencing stress and are suspected of having mental health problems.

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[19] Appendix F provides data by institution, offense, age, sentence and specific diagnosis. The data are cross-referenced by offense and specific mental illness, specific illness and sentence, and by diagnosis at specific institution.

[20] Pennsylvania Department of Corrections, "Mental Health Services." February 2003. http://www.cor.state.pa.us/stats/lib/stats/mental%20health.pdf. Accessed August 6, 2003.

[21] "Mental Health Services," February 2003, as updated by Department of Corrections personnel, is the source of much of the information provided in this section.

A wide range of services is currently available to inmates in the State correctional system who suffer from mental illness. Outpatient psychology and psychiatry services are provided at all SCIs. Five SCIs currently have Mental Health Units, small inpatient psychiatric units licensed by the Department of Public Welfare's Office of Mental Health and Substance Abuse Services (OMHSAS) and run by vendors, which provide short-term emergency and voluntary mental health commitments.

The department's Forensic Treatment Center at SCI Waymart has a 120-bed psychiatric hospital, licensed by OMHSAS, which provides long-term inpatient treatment and accepts inmates from all SCIs and the correctional institutions of the surrounding three counties. In addition, SCI Waymart has a 50-bed Intermediate Care Unit for inmates with a serious mental illness and those in need of psychiatric hospitalizations. SCI Waymart also prepares inmates for living in a Special Needs Unit, which is a housing unit where inmates with mental illness, medical problems, mental retardation and handicaps receive enhanced treatment services, supervision and protective services. As of May 23, 2005, Special Needs Units were located in 20 SCIs.

In addition, several new services have been introduced in the past year to further address the needs of the SCIs' expanding mental health population. The Special Assessment Unit is a five-bed psychiatric unit at SCI Waymart that conducts assessments on inmates in long-term disciplinary custody. Secure Special Needs Units provide safe and secure settings and specialized treatment services for inmates identified as being unable to function in general housing and regular Special Needs Units. Secure Special Needs Units are currently available at SCI Cresson (12 beds) and SCI Graterford (24 beds), and a 10-bed unit is scheduled to open soon at SCI Camp Hill. Therapeutic Communities for inmates with alcohol and drug problems, Sexual Offender Treatment Units and Dual Diagnosis Therapeutic Communities for inmates with substance abuse and mental illness have also been developed to meet specialized needs.

In contrast, on their way out of the DOC system, only a limited number of mentally ill inmates are provided a broad range of community reintegration services through specialized Community Corrections Center pilot programs. *See* "DOC Initiatives" under the "Re-Entry" section of this chapter.

Data Collection

It is difficult to get a clear picture of the current dynamics of mentally ill parolees because DOC and the Pennsylvania Board of Probation and Parole (the Parole Board) maintain different categories of statistics and use different unique

identifiers to track inmates and parolees. The data systems are maintained independently and are not easily integrated, which makes identifying parolees who are mentally ill difficult. Through great effort, the Parole Board's data personnel were able to determine the following. The number of parolees released in 2003 for whom parole outcome data could be obtained is 8,211.[22] Mentally ill inmates comprise 19.5% of that total; 717 inmates were paroled from the MH/MR roster, 778 from the Inactive MH/MR roster[23] and 106 from the Psychiatric Review Team roster, for a total of 1,601. Forty-one of these individuals were paroled to State mental hospitals.

Of the 1,601 mentally ill inmates paroled, 492 were 50 years of age or older at release. Two of the 492 were recommitted to prison on new convictions: one for simple and aggravated assault and one for robbery. This represents a new conviction recidivism rate for mentally ill inmates released at age 50 or older of 0.4% over the one-year period studied.

It was difficult to determine these numbers, and several other statistics requested by the members were impossible to determine. Therefore, the members suggest that DOC and the Parole Board cooperate in developing data systems that will assist both agencies to better track individuals as they move from corrections to parole. The process has begun with ongoing discussions between DOC and the Parole Board.

DOC and the Parole Board are currently collaborating on the Offender Management System initiative. The Offender Management System is an information sharing initiative which includes a system that will enable an individual to be tracked in the same computer system by both departments, rather than each department maintaining its own separate data bank with different categories of data, as is the current practice. The goal is to eliminate redundancies and improve efficiency by tying these two separate business practices together under one umbrella. The Offender Management System is currently in Phase 1, with a request for proposals regarding further work scheduled for release by the end of June 2005.

[22] The total number paroled in 2003 is 8,821. See Appendix E for a breakdown of the 8,211 parolees for whom outcome data could be obtained by MH/MR status, age at parole and recidivism.

[23] The Inactive MH/MR roster includes inmates who were – but no longer are – on the MH/MR roster.

Making Improvements

Annual Operations Inspections are conducted by staff from the department's central office and other DOC facilities. These inspections cover the overall operation of DOC facilities including, security, food service, maintenance and treatment programs. Reports are prepared and submitted to the responsible Regional Deputy Secretary, citing areas of concern or noncompliance with policy. The Facility Manager must prepare a remedial plan of action and submit the plan to the Regional Deputy Secretary for approval. The Regional Deputy Secretary must then follow-up to ensure that corrective action is taken. Each Regional Deputy Secretary is also required to visit each facility under his or her supervision once per quarter and prepare a report containing findings. One of the specific items in the report is the follow-up status of the Annual Operations Inspection.

The American Correctional Association (ACA) establishes accreditation standards for the operation of adult correctional facilities. Except for the two most recently activated facilities (SCI Fayette and SCI Forest), all Pennsylvania correctional institutions, including the central office and the training academy, are ACA-accredited. Pennsylvania is one of only six states in the country to be fully accredited.

The accreditation inspections are conducted by experienced auditors from other state correctional systems, using both mandatory and non-mandatory standards. In order to achieve accreditation, facilities must earn 100% compliance on all mandatory standards and a minimum of 90% on non-mandatory standards. Once the facility earns initial accreditation, it must be re-accredited every three years in order to maintain accreditation status. ACA accreditation is a rigorous process guided by nationally recognized standards.

Department personnel are also involved with various task forces, visit institutions in other states, welcome officials from other states to their facilities and participate in national corrections conferences and workshops. Thus, they are constantly learning about the latest in prison technology and treatment methods.

County Prisons

The advisory committee reviewed county prisons because, if improvements are not made and services expanded, mentally ill offenders who could otherwise be incarcerated at the county level will continue to be sent to the state correctional system in order to receive appropriate mental health services.

The Deputy Secretary of Administration within the DOC has the responsibility of inspecting Pennsylvania's county prisons. The DOC Office of County Inspection and Services conducts an annual inspection of each county's correctional facilities and all DOC-operated community corrections centers and checks for compliance with the regulations found at 37 Pa. Code §§ 95.220-95.247. The inspection also "determines prison/center compliance with controlling commonwealth statutes and regulations . . . with judicial decisions, with DOC policy/procedures and with national standards established by such organizations as the American Correctional Association."[24] Among other things, inspection includes the review of various documents, interviews with inmates, staff and administrators and a physical tour of the facility.[25]

A county prison may be determined to be 100% compliant; deficient, if it is substandard in only a few areas; or in citation, if many deficiencies are noted. The department works with each jail to improve and has the authority to declassify a county prison, meaning it may no longer hold inmates with sentences between six months and five years minus one day. However, the department has never declassified a county prison. In 2004, 14 of the 63 counties with jails earned certificates of 100% compliance.[26] County prisons, however, are funded and staffed by the county, not the State, so they continue to operate with or without a certificate of 100% compliance.

DOC should offer additional incentives to counties which strive to meet the standards of compliance. Since the department cannot withhold funding or close county facilities, the department might provide an incentive by working with the County Commissioners Association of Pennsylvania to lower liability insurance premiums for counties in full compliance. Another incentive for county prisons that achieve 100% compliance two years in a row could be less frequent inspections, moving to every other year as long as 100% compliance is maintained.

The members suggest that a study be conducted to determine how the county prisons can achieve 100% compliance. County and county prison officials would be invited to participate in the study. The lack of a standardized mental health assessment tool for county prisons should be addressed. Ways to improve

[24] "Office of County Inspection and Services," Pennsylvania Department of Corrections. www.cor.state.pa.us/county/site/default.asp. Accessed February 4, 2005.

[25] *Id.*

[26] Source of statistics: Tom Schlager, Inspections Supervisor, Office of County Prison Inspectors, Pennsylvania Department of Corrections, February 4, 2005 and "County Prisons Statistical Sheet," April 27, 2004, Pennsylvania Department of Corrections, http://www.cor.state.pa.us/portal/lib/county/countystatistics.pdf. Accessed February 4, 2005.

the communication between the department and the counties must be developed so that ideas can be shared and each county is encouraged to strive for the best facility it can provide.[27]

MENTAL HEALTH COURTS

To aid counties, and ultimately the department, the focus must be placed on the front end of the spectrum in the counties – when mentally ill offenders have their initial contact with law enforcement but before they get into the criminal justice system. Therefore, the members propose that mental health courts be considered in each judicial district across the Commonwealth. Mental health courts are generally intended to promote cooperation between the criminal justice and mental health treatment systems, improve access to mental health services, increase treatment services, improve coordination and delivery of services and increase social services to allow mentally ill individuals to remain in the community while receiving treatment.

Draft legislation is provided at the end of this section. It does not require counties to establish mental health courts, but offers tools for counties to use if they wish to initiate a court or modify an existing one to cover offenders who are diagnosed with mental illness. The draft allows each judicial district to consider the needs, size and financial position of the county in developing a mental health court program. A judicial district may choose to implement any, all or none of the aspects of this legislation.

Pennsylvania's Mental Health, Drug and Treatment Courts

Interviews with officials in each of the listed courts indicated that, to be successful, a treatment, drug or mental health court must have a judge who is passionate and knowledgeable about the issue and committed to encouraging the cooperation of all agencies and individuals involved with mentally ill individuals and the criminal justice system. Various funding streams exist to help start – and expand – specialized court programs. A description of selected specialty courts in Pennsylvania follows.

[27] Telephone interview with William M. Reznor, currently with the National Alliance for the Mentally Ill and former DOC Deputy Secretary of Administration, April 15, 2004.

City of Philadelphia Treatment Court[28]

Philadelphia's treatment court, established in April 1997, treats about 300 individuals each year and has achieved a 14% recidivism rate, with 8% being new convictions and 6% being technical parole violations. This court was the first of its kind in the Commonwealth, and it represents a collaborative effort of the Court of Common Pleas, the District Attorney's Office, the Defender Association of Philadelphia, the Department of Health, the Philadelphia Police Department and the Philadelphia Prison System. The treatment court is designed as an alternative to normal case processing which provides treatment to substance-abusing defendants. The goal of the court is to reduce a defendant's likelihood of recidivism while increasing his or her chances of functioning as a more productive member of society. The structure draws on a network of treatment services to respond to the needs of participants and offers a central role for the judge. In this model, the court is the hub for delivery of treatment and other supportive services to more fully address the range of treatment, health, housing, literacy, educational and other social service needs presented by drug-abusing individuals.

Chester County Drug Court/Mental Health Protocol[29]

The Chester County Drug Court is a 12 to 24 month program, which employs a team approach, made possible by the cooperation of all interested agencies including the court, district attorney, public defender, Office of Drug & Alcohol Services, Bail Agency and the Office of Adult Probation and Parole. The program was started in the late 1990s to reduce prison overcrowding. The program, which is designed to treat nonviolent drug offenders, has resulted in lower recidivism rates and significantly lower numbers of seriously mentally ill inmates in the county prison. In 1997, 17.03% of Chester County prison inmates were seriously mentally ill. The percentage dropped to 7.13% in 1999 and 6.90% in 2000. The year 2003 saw an increase to 10.51%, which is still a substantial reduction from 1997's starting point of 17.03%.

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[28] Telephone interview with Linda DeGregorio, Philadelphia Treatment Court Coordinator, March 30, 2004. "Municipal Court of Philadelphia," http://fjd.phila.gov/municipal/. Accessed March 23, 2004. "2001-2002 Biennial Report," http://fjd.phila.gov/pdf/report/2001-2002/Cover.pdf. Accessed March 23, 2004.

[29] Telephone interview with Tim Waltz, Chester County Adult Probation and Parole Department. March 9, 2004. "Chester County Adult Probation: Programs," 2002. Court of Common Pleas, Chester County http://www.chesco.org/adprob/programs.html. Accessed November 22, 2004. "Mental Health Protocol," March 4, 2004, Court of Common Pleas, Chester County, Adult Probation and Parole Department. Senate Resolution 125 of 2003, sponsored by Senator Robert J. Thompson, directed the Legislative Budget and Finance Committee to evaluate the county-based mental health diversion program in Chester County, among others. The results of the evaluation will be available in the near future.

Chester County also offers a mental health protocol program, which is a collaborative effort between the Office of Adult Probation and Parole, the MH/MR Board and Base Service Units. To be eligible, offenders must be placed on probation or sentenced to a period of incarceration in a county prison followed by county parole supervision. An offender is generally ordered to participate in this program by the sentencing judge as a condition of probation. A treatment plan is developed for the offender by a forensic treatment team, and the offender is supervised by a mental health specialist probation officer. Compliance with the plan is enforceable as a condition of probation or parole.

Lackawanna County Treatment Court[30]

Lackawanna County's treatment court program is a court-supervised comprehensive treatment program for nonviolent offenders, which was established in July 2000. It is a voluntary program that includes regular court appearances before a designated district court judge. To enter and participate in the treatment court program, an individual must do the following: meet the eligibility requirements; apply; receive approval from the district attorney; participate in a clinical assessment; participate in treatment and ancillary/collateral services; attend mandatory court hearings; and submit to random and scheduled drug testing. The court currently serves 125 individuals, and over half of them have received mental health treatment in the past. It is structured as a post-plea, rehabilitative court and is sponsored by an array of community resources that provide various types of support and services, from treatment and mental health counseling to job placement and training. The goals of the court are to provide a cost-effective alternative to incarceration and facilitate the treatment of offenders. The program for each participant lasts from 12 to 18 months. Eight percent of the 125 total participants in the program were arrested on new charges between July 2000 and March 2004.

Allegheny County Mental Health Court[31]

Allegheny County set up a mental health court in June 2001 to provide a countywide, community-based integrated system of treatment and care for individuals with mental disabilities who are involved in the criminal justice

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[30] "Treatment Court Snapshot," 2003, fax transmittal dated March 4, 2004 from the Office of Judge Michael Barrasse. On file at the Joint State Government Commission.

[31] Telephone interview with Amy Kroll, Program Director, Forensic Services, Office of Behavioral Health, Allegheny County Department of Human Services, March 18, 2004. "Allegheny County Mental Health Court: Semi-Annual Report," September 15, 2004. Senate Resolution 125 of 2003 charged the Legislative Budget and Finance Committee to evaluate the Allegheny County Mental Health Court. The Legislative Budget and Finance Committee is being assisted by the Technical Assistance and Policy Analysis Center (a branch of the National GAINS Center which studies jail diversion).

system, while ensuring public safety. The court's start-up money came from federal, OMHSAS and private grants and the court currently has an annual budget of about $500,000. The program sees an average of 100 participants each year. Of the 239 participants through December 2003, only 13, or 5%, were arrested on new charges. Success can be attributed to the collaborative efforts of all interested parties who are fully committed to the court. The court accepts individuals who have committed violent or nonviolent misdemeanors or felonies, on a case-by-case basis. A screening process determines who will be allowed to participate in the court program.

Erie County Treatment Court[32]

The treatment court in Erie County consists of two components: a drug and alcohol component, known as the drug court, and a mental illness component, known as the mental health court. The court has been developed to handle cases involving nonviolent seriously mentally ill offenders and nonviolent drug-abusing offenders through intensive, comprehensive supervision, case management and treatment. The court program is a partnership between the judge, prosecutor, defense counsel, case manager, treatment specialist, probation officer and law enforcement and corrections personnel. This is a voluntary program and, to gain admission to the court, an individual must meet certain eligibility requirements. Timely identification of candidates through screening and referral, a multidisciplinary team approach and continued judicial supervision are key components of the court process. The court's goals are to reduce the criminal activity of seriously mentally ill, substance-abusing and dual diagnosis offenders, reduce recidivism and relapse and help the participant become a more productive member of society. Since its inception in 2000, the court has been able to treat at least 35 individuals a year in each component and has achieved a recidivism rate of 10% (all technical parole violations) among graduates. This alternative to incarceration has reduced the number of individuals in prison and decreased the number of psychiatric hospital admissions.

[32] Telephone interview with Jeff Shaw, Erie County Department of Adult Parole and Probation, March 3, 2004. "2003 Annual Report," Erie County Court of Common Pleas, http://www.eriepa.us/dept/courtadmin/pdg/AnnualReport2003.pdf. Accessed December 21, 2004. "Erie County Treatment Court Policy and Procedures Manual," Erie County Court of Common Pleas, March 2002.

Bucks County Forensics Panel[33]

A mental health or drug court is currently in the planning stages in Bucks County. A forensics panel has met and published a list of recommendations to address the needs of the mentally ill within the corrections system. In addition, an implementation panel has met several times to discuss the possibility of establishing a behavioral health court within the county.

Evaluations of Mental Health Courts

The members agreed that evaluations of existing mental health courts might aid the General Assembly in determining whether to enact legislation regarding mental health courts. Summary data from evaluations on mental health courts in Anchorage, Alaska and King County, Washington are provided below.

Anchorage, Alaska Court Coordinated Resources Project[34]

Background. In July 1998, the Mental Health Trust Authority funded the Court Coordinated Resources Project (CRP) and the Department of Corrections' Jail Alternative Services program. Both projects are designed to provide individualized programs of treatment, housing, medication and other services to mentally disabled persons convicted of misdemeanor offenses. The funding is anticipated through fiscal year 2005.

The CRP held its first hearing in 1999 and is a post-conviction/post-plea sentencing court, not a trial court. It is available to defendants charged with misdemeanors and diagnosed with or exhibiting obvious symptoms of mental illness, organic brain syndrome or developmental disability. Defendants are referred by judges, jail personnel, attorneys, police officers, family members and others. A defendant's decision to enter the CRP must be voluntary and is made

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[33] Telephone interview with Carol Bamford, Director of Case Management and Crisis Services, County of Bucks, Division of Human Services, Department of Mental Health-Mental Retardation, March 3, 2003. "Final Report," Bucks County Forensic Mental Health Panel, August 2003.

[34] Much of the background information on the Anchorage project was obtained from the *Alaska Justice Forum*, University of Alaska Anchorage, Winter 2002. The rest of the information is from *Court Coordinated Resources Project Evaluation Report*, Alaska Judicial Council, Anchorage, January 2003. The Alaska Judicial Council is an independent citizen's commission created by the Alaska Constitution. The Judicial Council has constitutional and statutory duties in three areas: screening and nominating applicants for judicial vacancies for appointment by the governor; evaluating the performance of judges and providing evaluation information and recommendations to voters; and conducting research and publishing reports to improve the administration of justice in Alaska.

with the assistance of counsel. In most cases, the defendant enters a plea of guilty or no contest to misdemeanor charges in exchange for a plea agreement that the sentence will not involve incarceration.

A case manager monitors the progress of CRP participants. The aim of the court is to provide an alternative to incarceration by establishing a treatment plan as part of a suspended sentence with a probationary term. Plans vary based on the individual participant's needs but commonly include provisions regarding taking necessary medication, establishing continuing contact with a mental health treatment provider, meeting periodically with the case manager and appearing at periodic status hearings. Plans also guide participants in finding housing and building a daily structure of activities to help guard against the instability that could lead to future offenses. The CRP recognizes that the stability of the life of an individual with mental illness ebbs and flows, so setbacks are expected and failures in following the plan or new offenses trigger a reassessment, rather than immediate discharge from the CRP. It is common for participants to need treatment for co-occurring mental illness and substance abuse problems; however, few such treatment resources are available.

In setting up the CRP, some court system resources and personnel were redirected and new procedures were developed. Other agencies and individuals also made adjustments in order to make the CRP a reality. For example, more court appearances are required of attorneys, case managers and treatment providers, and one prosecutor and one defense attorney stay on the case throughout an individual's participation in the CRP.

The Jail Alternative Services program is limited to 40 participants at a time and was not included in the evaluation.

Evaluation. The evaluation was performed by looking at data on 175 defendants who participated in the CRP between April 2001 and October 2001. About 47% of those participants arrived in the CRP after a violent offense, ranging from arson 1 to violating a domestic violence order. Thirty percent of the participants were female, in comparison to 17% in a 1999 felony study of 2,331 individuals. The ethnic breakdown of the CRP participants was virtually the same as the ethnic breakdown in the 1999 felony study. Ninety percent of the participants were represented by a public defender or the Office of Public Advocacy, compared to 83% of the defendants in the 1999 felony study. Nearly all the participants had entered a no contest plea.

Days of commitment to the Alaska Psychiatric Institute. Participants averaged 10.4 days of commitment during the one-year period before the first CRP hearing and 8.8 days of commitment during the follow-up period after the first CRP hearing (the length of time each participant was followed by the Institute varied).

Number of admissions to the Alaska Psychiatric Institute. Participants averaged 1.5 admissions during the one-year period before the first CRP hearing and .7 admissions during the follow-up period after the first CRP hearing (the length of time each participant was followed by the Institute varied).

Number of arrests. Participants averaged 1.5 arrests during the six-month period before CRP disposition and .6 arrests during the six-month period after CRP disposition. No substantial difference was shown in number of arrests based on the number of CRP hearings held.

Days of incarceration. Participants who received the most service from CRP (eight or more hearings) averaged 31.1 days of incarceration during the six-month period before CRP disposition and 19.5 days during the six-month period after CRP disposition. There was no change in number of incarceration days for participants who had seven or fewer hearings. The overall average for all participants was 27.8 days of incarceration during the six-month period before CRP disposition and 23.3 days during the six-month period after CRP disposition.

Cost savings.

1. For the 142 participants for whom data are available, a total of 653 incarceration days were saved. At an average daily incarceration cost of $113.31, the total monetary savings was at least $73,991.[35] (However, the cost to incarcerate an inmate with mental illness is probably much higher than the average daily incarceration cost of $113.31.)

2. The reduction by over 50% in the number of arrests also resulted in time savings and cost savings for police departments, jails, prosecutors, defense attorneys and courts.

[35] Using the average daily cost of incarceration to determine "cost savings" when one person is kept out of the system is too simplistic. The facility will use the same amount of utilities, have the same maintenance costs and employ the same number of staff if its inmate population is reduced by a relatively small number. Cost savings of – or close to – $113.31 per day per individual not incarcerated would only be achieved through a major change such as the closure of an entire facility. Based on Pennsylvania Department of Corrections experience, for the 653 incarceration days avoided by the CRP program, the average cost savings per day is probably closer to $11. The total actual cost savings for the 653 incarceration days avoided would then be about $7,183 (less than 10% of the savings determined for the program).

3. For the 100 participants for whom data are available, a total of 160 days of commitment time at the Alaska Psychiatric Institute were saved. At an average daily cost of $732.27, the total monetary savings was $117,163.[36]

4. Having fewer arrests suggests that fewer crimes were committed, resulting in fewer victims.

King County, Washington[37]

Background. The first hearing of the King County Mental Health Court was held in February of 1999. The court has seen a significant increase in its caseload since then, with the number of cases at times doubling from year to year. The goal of the mental health court is to increase public safety and deal humanely with individuals having significant mental disorders[38] who enter the criminal justice system for misdemeanors. Defendants are referred to the court by police officers, attorneys, family members, advocacy groups or probation officers.[39]

Participation is voluntary, as defendants might be asked to waive their rights to a trial and enter a diversion or plea agreement with a community-based treatment emphasis. Defendants are placed on probation and the case is assigned to a "mental health court mental health specialist probation officer." These special probation officers have graduate degrees in mental health and carry substantially reduced caseloads. A court liaison to the treatment community attends all hearings and links the defendant with appropriate services and develops the initial treatment plan with the treating agency. Successful participation in the court-ordered treatment plan may result in dismissed charges, early case closure or reduced sentencing. Incarceration is the exception for defendants in the mental health court.

[36] As explained in the previous footnote, this analysis is too simplistic. The actual cost savings per commitment day avoided would be a figure less than the average daily cost of $732.27.

[37] *Executive Summary of Evaluation of Outcomes for King County Mental Health Court*, John R. Neiswender, Washington State University, January 2004.

[38] Individuals with significant mental illness have been diagnosed, for example, with schizophrenia or other psychotic disorder, bipolar disorder, major depression or other disabling mental illness that affects judgment and causes erratic behavior. The mental health court also accepts individuals with dementia, brain injury or developmental disabilities on a case-by-case basis. "Criteria for Eligibility/Admission to the MHC." King County District Court. http://metrokc.gov/kcdc/mhccrit.htm. Accessed February 23, 2004.

[39] The court also handles all cases in King County in which competency is an issue.

Evaluation

Days of incarceration. For the 114 mental health court graduates for whom data are available, the average number of incarceration days was reduced from 15.54 days during the one-year period prior to opting into the mental health court to 2.19 days during mental health court. The average number of days incarcerated was further reduced to 1.8 days during the one-year period after graduation from the mental health court.

Number of offenses. For the 114 mental health court graduates for whom data are available, more than 50% had two or more offenses during the one-year period prior to opting into the mental health court. Over 75% had no offense during the one-year period after graduation from the mental health court.

De-escalation of offense. Of 114 mental health court graduates, 58% had committed a violent offense prior to opting into the mental health court. Seven percent have committed a violent offense since graduating from the mental health court.

Client satisfaction. No formal complaints have been filed. Twelve individuals responded to a client satisfaction survey, with 61.5% rating the program "very good" overall and 38.5% rating it "good." Over 90% said that their life was better after involvement with the mental health court.

DRAFT LEGISLATION
MENTAL HEALTH COURTS

The members developed the following draft legislation regarding mental health courts.

Note: * Subsections and paragraphs preceded by an asterisk are based on provisions found in Senate Bill 73 of 2003, Printer's No. 69, which were amended to include concepts from subcommittee discussions.

AN ACT

Amending Title 42 (Judiciary and Judicial Procedure) of the Pennsylvania Consolidated Statutes, providing for a mental health court division.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Section 951 of Title 42 of the Pennsylvania Consolidated Statutes is amended to read:

§ 951. Court divisions.

(a) Philadelphia County.—The Court of Common Pleas of Philadelphia County shall have the following divisions:

(1) Trial division.

(2) Orphans' court division.

(3) Family court division.

(b) Allegheny County.—The Court of Common Pleas of Allegheny County shall have the following divisions:

(1) Civil division.

(2) Criminal division.

(3) Orphans' court division.

(4) Family division.

(c) Other separate orphans' court divisions.—The courts of common pleas of Beaver, Berks, Bucks, Cambria, Chester, Dauphin, Delaware, Erie, Fayette, Lackawanna, Lancaster, Lehigh, Luzerne, Montgomery, Schuylkill, Washington, Westmoreland and York counties shall each have a separate orphans' court division.

(d) Judicial districts having no separate orphans' court division.—In each judicial district having no separate orphans' court division, there shall be an orphans' court division composed of the court of common pleas of that judicial district.

(e) Change in size of divisions.—The number of judges constituting a division may be increased or reduced by order of the governing authority.

(f) Mental health court division.—The court of common pleas of any county or judicial district may establish a separate mental health court division as provided under section 954 (relating to mental health court divisions).

Section 2. Title 42 is amended by adding a section to read:

§ 954. Mental health court division.

(a) Establishment of mental health court division.—

(1) The court of common pleas of a county or judicial district shall consider establishing a mental health court division. To aid the determination of whether to establish a mental health court division, the court of common pleas may establish a working group which may consist of the following individuals:

(i) A judge of the court of common pleas.

(ii) A mental health treatment expert or advocate.

(iii) A consumer of mental health services.

(iv) A family member of a consumer of mental health services.

(v) The district attorney or a designee.

(vi) The public defender or a designee or a defense attorney.

(vii) A chief of police or a designee.

(viii) The chief probation or parole officer of the county or a designee.

(ix) A representative of the local victim services program.

(x) A representative of the county mental health authority.

(xi) A representative of the county mental retardation authority.

(xii) A representative of the local housing authority.

(xiii) A representative of the county Area Agency on Aging.

(xiv) A representative of the local Intermediate Unit.

(xv) A representative of the county Children and Youth agency.

(xvi) A representative of the local office of the United States Department of Veterans Affairs.

(xvii) A representative of the county general assistance office.

(xviii) Any other individual or agency the court deems necessary.

(2) If a working group is established, it shall submit a recommendation regarding the establishment of a mental health court division to the court of common pleas of the county or judicial district. If the working group recommends that a mental health court division be established, it may also develop a mission statement for the mental health court division.

*(3) The court of common pleas of a county or judicial district may apply for a grant under subsection (h) to establish a mental health court division.

(b) Objectives.—The mental health court division shall have the following objectives:

(1) Reducing stress on the correctional system by utilizing an alternative to incarceration for mentally ill offenders when appropriate.

*(2) Continuing judicial supervision, including periodic review, of a mentally ill offender.

*(3) Providing a single point of contact where a mentally ill offender may receive court-ordered treatment and support services in connection with a term of probation or parole, a sentencing alternative or a diversion from prosecution.

*(4) Increased cooperation between the criminal justice and mental health systems.

(5) Improved assessment of a mentally ill offender.

*(6) Faster case processing time for a mentally ill offender.

*(7) Improved access for a mentally ill offender to necessary services and support in the community.

*(8) Increased services for a mentally ill offender.

*(9) Reduced recidivism by a mentally ill offender.

*(10) Specialized training of law enforcement and judicial personnel to identify and address the needs of a mentally ill offender.

*(11) Coordinated delivery of services for a mentally ill offender, including the following:

(i) Voluntary outpatient or inpatient treatment, in the least restrictive manner appropriate as determined by the court, that carries with it the possibility of dismissal of charges or reduced sentencing upon successful completion of treatment.

(ii) Centralized case management which consolidates all a mentally ill offender's cases, including violations of probation, and coordinates all the offender's mental health treatment plans and social services, including life skills training, housing placement, vocational training, education, job placement, health care and relapse prevention.

(iii) Continuing supervision of treatment plan compliance for a term not to exceed the maximum allowable sentence or probation for the charged offense.

(12) Providing a point of contact in the judicial system where victim issues related to a mentally ill offender may be individually addressed.

(c) Components and criteria.—A court of common pleas that establishes a mental health court division pursuant to this section may provide for the following, among other things, through the adoption of local rules:

*****(1) Mental health court program participation and completion requirements.

(2) Referral of a mentally ill offender to the mental health court program by any of the following:

(i) A judge of the court of common pleas.

(ii) A mental health treatment expert or advocate.

(iii) A family member of the mentally ill offender.

(iv) The district attorney or a designee.

(v) The public defender or a designee or a defense attorney.

(vi) A chief of police or a designee.

(vii) A superintendent of a correctional facility or a designee.

(viii) The chief probation or parole officer of the county or a designee.

(ix) A representative of the county mental health authority.

(x) A representative of the county mental retardation authority.

(xi) A representative of the county Area Agency on Aging.

(xii) A representative of the local Intermediate Unit.

(xiii) A representative of the county Children and Youth agency.

(xiv) A representative of the local office of the United States Department of Veterans Affairs.

(xv) A representative of the county general assistance office.

(xvi) Any other individual or agency the court deems necessary.

(3) Criteria for accepting a mentally ill offender into the mental health court program, including the following:

(i) Voluntary participation by the mentally ill offender with the advice of counsel.

(ii) Approval of the district attorney or a designee.

(iii) An opportunity for the victim of the crime to be heard.

(iv) The level of crime for which a mentally ill offender will be allowed into the program based on an assessment of public safety within the county or judicial district.

(4) Whether to permit participation in the mental health court program without requiring a guilty or no contest plea, considering whether such a plea will affect a mentally ill offender's employment or public benefits.

(5) Whether to impose a fee on a mentally ill offender for participation in the mental health court program.

(6) Whether to require a mentally ill offender to sign an agreement regarding participation in the mental health court program.

(7) Determining what the penalty will be for failure of a mentally ill offender to fulfill the requirements of the mental health court program.

(8) Goal of referral and assessment of a mentally ill offender within one week and a mental health court hearing within two weeks after commission of the offense.

*****(9) Utilization of designated staff, including, but not limited to, the following:

(i) A judge of the court of common pleas.

(ii) A mental health court program case manager.

(iii) A mental health review officer of the court.

(iv) The district attorney or a designee.

(v) The public defender or a designee or a defense attorney.

(vi) The chief probation or parole officer of the county or a designee.

(vii) A substance abuse counselor.

(viii) A representative of the local victim services program.

(ix) A representative of the county mental health authority.

(x) A representative of the county mental retardation authority.

(xi) A representative of the local Intermediate Unit.

(xii) A representative of the county Children and Youth agency.

Comment: Subparagraph (vii) is included in recognition of the fact that a large percentage of individuals who are mentally ill also have co-occurring substance abuse disorders. It is intended that a mental health court program will ensure that treatment for both mental health disorders and substance abuse disorders is provided to a mentally ill offender.

***(10) Initial and ongoing training for designated staff on the nature of mental illness, the treatment and supportive services available in the community, the needs of victims and the roles of those involved in the mental health court program.

***(11) Utilization of community mental health treatment providers and other agencies to provide a mentally ill offender access to individualized treatment services.

(12) For each mentally ill offender accepted into the mental health court program, the development of an individualized treatment plan which addresses the following:

(i) Mental and physical health care, including necessary medication.

(ii) Housing.

(iii) Education.

(iv) Substance abuse treatment.

(v) Psychosocial services.

(vi) Employment, public benefits or other means of support.

(13) A requirement that a mentally ill offender accepted into the mental health court program must participate in the mental health court program and the individualized treatment plan for a minimum of six months.

(14) A requirement that a minimum of one hearing be held per month during a mentally ill offender's participation in the mental health court program.

(15) Evaluation of the mental health court program.

(d) Review team.—

(1) The court of common pleas of a county or judicial district may establish a review team and may assign it the following responsibilities, among others:

(i) Determining whether a mentally ill offender will be accepted into the mental health court program.

(ii) Reviewing a mentally ill offender's progress throughout participation in the treatment plan with the agencies involved in providing services to the offender.

(iii) Determining whether a mentally ill offender who has violated his treatment plan will be allowed to continue in the program or be removed from the program and transferred to criminal court.

Comment: While a review team is recognized as a valuable component of a mental health court program, it is acknowledged that not all courts of common pleas or judicial districts will be able to establish one. Lack of a review team should not deter the establishment of a mental health court program.

(2) If a review team is established, individuals who shall be given an opportunity to participate on the review team shall include, but not be limited to, the following:

(i) A judge assigned to the mental health court division.

(ii) A mental health court program case manager.

(iii) A mental health review officer of the court.

(iv) The district attorney or a designee.

(v) The public defender or a designee or a defense attorney.

(vi) The chief probation or parole officer of the county or a designee.

(vii) A mental health treatment expert or advocate.

(viii) A representative of the local victim services program.

(ix) A representative of the county mental health authority.

(x) A representative of the county mental retardation authority.

(xi) A representative of the county Area Agency on Aging.

(xii) A representative of the local Intermediate Unit.

(xiii) A representative of the county Children and Youth agency.

(e) Cooperation of government agencies.—Government agencies shall cooperate with the mental health court division as necessary to obtain the best results for the mentally ill offender, the victim and the community.

*(f) Application of law.—Proceedings conducted by a judge of the court of common pleas or a mental health review officer pursuant to Article IV of the act of July 9, 1976 (P.L.817, No.143), known as the Mental Health Procedures Act, may be conducted by the mental health court division.

*(g) Grants.—The Administrative Office, in consultation with the Department of Public Welfare Office of Mental Health and Substance Abuse Services, the Department of Corrections, the Pennsylvania Commission on Crime and Delinquency and the Pennsylvania Board of Probation and Parole, shall establish minimum standards, funding schedules and procedures for awarding grants for the establishment of mental health court divisions, which shall take into consideration, but not be limited to, the following:

(1) Percentage of the incarcerated or supervised population with mental illness.

(2) Demonstrated ability to administer the program.

(3) Demonstrated ability to develop effective responses to provide treatment and stability for persons with mental illness.

(4) Demonstrated history of maximizing Federal, State, local and private funding sources.

(5) Likelihood that the program will continue to operate after State grant funding ends.

(h) Definition.—As used in this section, the term "mentally ill offender" means an offender who has been diagnosed with or exhibits obvious symptoms of mental illness. An offender with dementia, a brain injury or a developmental disability may also be included on a case by case basis.

Section 3. This act shall take effect in 60 days.

RE-ENTRY

Issues

Increased planning and preparation for a mentally ill offender's move from the DOC system into the community, well in advance of the actual date, is key to a successful transition back into the community. In addition, resources must be increased in community settings to provide mentally ill offenders with the necessary supervision and treatment to prevent their return to the prison system. Lines of communication must be established between the prison and the community or county to better coordinate services and facilitate a successful transition. Establishing or restarting funding streams before release, paroling inmates with mental illness before they reach their maximum sentence, better coordination of treatment and monitoring and establishing specific treatment teams to ensure continuity of care for these individuals are important concepts to implement.

Many individuals received benefits, such as medical assistance and Supplemental Security Income (SSI), before entering prison, and those benefits must be restored before the individual is released. Other inmates will be newly eligible for benefits upon their release from prison, and applications should be filed and determinations made early enough that benefits will begin upon release. Having assistance and benefits available upon an inmate's release enhances his ability to successfully re-enter society. Current DPW policy allows for the application process to begin 30 days prior to release, but the final determination regarding assistance is not made by the county assistance office until an individual is residing in the county. DOC and DPW are currently working

together to streamline the application process and establish a mechanism that would activate these funding streams upon an inmate's release. This will greatly improve the services and treatment options available for mentally ill offenders upon re-entry into the community.

Community education is also important. Community members should be helped to understand, for example, that since it was that community that sent the individual to prison, that community should welcome the person back and help make his re-entry into the community successful. It is more beneficial to the offender and the community for the offender to be paroled with supervision and services rather than to serve his full sentence and re-enter the community with no help at all.[40]

Community-Based Programs

Community-based re-entry programs across the State were examined and are recommended for review by municipalities or counties that recognize a need for such intervention. Various concepts and plans were discussed concerning re-entry, but the overall implication is clear: improvements are needed. Community-based re-entry programs should be evaluated to measure their level of success. With the goal of reducing recidivism by treating all those who need support upon their transition back into society, successful programs should be expanded and replicated.

The goals of any mental health community-based program are to ensure safety in our communities, enhance the quality of life for mentally ill individuals, improve the outcomes for each offender and reduce recidivism. Meeting these goals takes planning and preparation long before the inmate is released.

Prison In-Reach

In-reach from the community into the prisons is a new approach that was designed to put a model of treatment in place for each individual before he is released. Once they are released from prison, continuity of care is important. A transition accountability plan should be established for each individual to create consistency for their treatment and lifestyle. This would also enable those who are coordinating their treatment and supervision to be knowledgeable of the

[40] Likewise, probation may be more appropriate than a prison sentence for a mentally ill offender, because of the community-based services that can be offered and the probation supervision that will be provided.

specifics of their case. Prison in-reach is important to establish productive members of society who, with proper treatment and care, will stay on the outside of prison walls.

Notable Initiatives

Regardless of the type of specific treatment or placement option utilized, community programs should be designed to meet the needs of the clientele. With this goal in mind, various local and regional task forces and programs have been established to address a wide range of community issues. The following provides a description of selected programs across the Commonwealth, some of which may serve as models for other communities in Pennsylvania.

Cameron/Elk County Forensic Mental Health Program[41]

The Cameron/Elk County Forensic Mental Health Program began in October 2001, starting up with the assistance of an OMHSAS Forensic Pilot Project Grant. The program as it currently exists is funded through this original grant, some CHIPPS dollars and County MH/MR supplemental funding. This comprehensive program currently works with offenders who are mentally ill, addicted or both housed in either the Elk County Prison or any State correctional institution which may be returning an offender to one of the two involved counties. This program provides jail-based psychiatric intervention, assessment services, intensive pre-release services and post-release outreach for this targeted population. The program goals include improving attendance and compliance with community based services; decreasing recidivism for the ex-offender; decreasing psychiatric hospital admissions and improving collaboration and service coordination among the human service agencies that serve these two counties. The recently added Outreach program follows the newly released inmate through the re-entry process with a coordinated Treatment Team consisting of a forensic mental health specialist, a forensic caseworker, a psychiatric nurse and a psychiatrist.

To date the program has served 176 individuals, 164 (93%) of whom reported a co-occurring substance abuse concern. During the application period since inception, the re-arrest rate for individuals served by the program is 19%. The re-incarceration rate on probation/parole violations is 16%. Both of these statistics were substantially higher prior to program inception. The program

[41] E-mail from Dave Webster, Forensic Mental Health Specialist, Cameron/Elk County Forensic Mental Health Program, Dickinson Mental Health Center, Inc., May 25, 2005.

serves as a model for appropriate and necessary treatment throughout all phases of the legal/incarceration process and is expected to demonstrate increased efficacy with the addition of the Outreach portion in March of 2005.

DOC Initiatives[42]

The Forensic Re-Entry Development program, located at SCI Muncy, serves female offenders who have co-occurring disorders and who are being paroled or released into the community upon the completion of their sentence. It employs a specialized caseworker for the inmates, advocates for them with other agencies and connects them with resources in the community.

Forensic Integration and Recovery – State (FIRST), is a specialized Community Corrections Center[43] that serves inmates with mental illness, dual diagnosis and co-occurring disorders who are returning to the community in the Philadelphia area.

The Department of Corrections, the Parole Board and several county MH/MR agencies have developed policies and procedures to reintegrate inmates with mental illness and substance abuse back into their communities. DOC and Parole Board staff endeavor to reconnect these offenders with MH/MR and other services at the end of their sentences. DOC mental health and medical staff help offenders apply for federal and other entitlements (e.g., Medicaid, Temporary Assistance for Needy Families and Supplemental Security Income) which they will need in the community. As of January 28, 2005, Pennsylvania has 56 Community Corrections Centers (CCCs), with 14 operated by DOC and 42 operated by contractors. Of the 56 CCCs, only four are prepared to offer services to individuals with mental illness. Very few of the approximately 2,700 beds in the CCCs are set aside for treatment of the mentally ill. Thus, only a small number of mentally ill offenders – from Philadelphia, Allegheny and Erie Counties – return home via placement in specialized Community Corrections Centers.

In Philadelphia, there are three Community Corrections Centers, all of which dedicate only a small percentage of their beds for the mentally ill. The Gaudenzia FIRST Center,[44] which offers a wide range of programs at its multi-level facility, offers 25 beds on one floor, the Coleman Center devotes only 20 of its 300 beds, and the Diagnostic and Rehabilitation Center devotes only 21

[42] These programs are currently reviewed by the Department of Corrections during their annual internal reviews.

[43] The Community Corrections Centers are currently inspected on an annual basis by the Office of County Prison Inspectors, Department of Corrections.

[44] The evaluation of the Guadenzia FIRST Center under Senate Resolution 125 of 2003 is currently ongoing, and a report will be released in the near future.

of its 165 beds to the mentally ill. In addition, Allegheny and Erie Counties dedicate 20 beds in their facilities to the mentally ill. These are programs that help the offender make the difficult transition from institutional to community living. These programs are currently being evaluated, and if found to be successful they should be expanded to increase bed capacity and new programs should be established in other parts of the Commonwealth, especially in rural counties, so that more mentally ill inmates have access to the services they need.

Community Re-Integration of Offenders with Mental Illness and Substance Abuse (CROMISA) programs are Community Corrections Centers for residents and parolees with co-occurring disorders who are returning to counties in the Pittsburgh and Erie areas.

DOC's Continuity of Care Committee reviews health continuity of care processes within the department and redesigns them to be more effective and consistent. The Hard to Place Offenders Committee was established by DOC and the Parole Board to address the large numbers of inmates with significant health and mental health problems and would receive support to be paroled if community resources were available to them.

Other Initiatives

The National Alliance for the Mentally Ill of Pennsylvania established the Forensic Inter-Agency Task Force in July 1996 to bring together representatives of community organizations, law enforcement and government agencies in Pennsylvania who are interested in the continuity of care for mentally ill inmates. The task force is intentionally structured informally to encourage open and frank discussion of issues which cross agency boundaries and responsibilities. The task force also acts as a conduit for sharing information regarding programs and ideas of interest to its members.

The Southeastern Regional Inter-Agency Task Force, comprised of individuals from Delaware, Bucks, Chester, Philadelphia and Montgomery Counties, was formed in 2001. Representatives of a wide variety of agencies and organizations were also involved, including DOC and OMHSAS personnel, district attorneys, local legislative leaders, probation officers, city solicitors, community mental health providers and members of advocacy groups. The task force identified five major points within the criminal justice system at which an individual might be diverted from the system. Their goal was to identify barriers and recommend steps to remove them to effectively serve this population.[45]

[45] The Southeastern Regional Inter-Agency Task Force completed its work in 2002 and published a report of its finding and recommendations. Each individual county now has a task force which continues that work.

Another example in southeastern Pennsylvania is the Philadelphia Forensic Task Force, which sought ways to improve services for persons with severe mental illness and co-occurring substance abuse disorders involved in the criminal justice system.

The Service Area Planning Initiative was developed by OMHSAS and its nine State psychiatric hospitals who convened regional planning forums in partnership with all the counties and stakeholders in each hospital service area. The charge was to begin collaborative, long-range planning to envision and plan a community-based system that provides treatment and supports sufficient to enable people with serious mental illness to live in non-institutional settings and avoid contact with the criminal justice system. This regional planning process is ongoing.

Lastly, the Prisoner Re-entry Task Force established by the Governor's Office is identifying the systemic barriers to the effective reintegration of offenders into communities and will eventually propose strategies to remove those barriers. It is comprised of members from the following agencies: the Governor's Policy Office; the Departments of Aging, Community and Economic Development, Corrections, Education, Health, Labor and Industry, Military and Veterans Affairs and Public Welfare; PBPP; the Pennsylvania Commission on Crime and Delinquency; the Juvenile Court Judges' Commission and the Pennsylvania Commission on Sentencing. The work of this task force is ongoing.

A re-entry program has recently been implemented in Erie County and one is planned for York County. The Erie Pennsylvania Re-entry Program is DOC's response to the US Department of Justice Serious Violent Offender Re-entry Initiative, for which DOC received a $2 million grant to implement. This comprehensive program involves assessing individual needs, developing targeted treatment to meet those needs and ensuring community care through an intensive case management system. The York County model is similar, although York County is attempting the initiative with existing funds. These programs seem to hold promise, however at this time, not enough information is known about each and no practical application can be reviewed to pass judgment and recommend them as models. The development of these programs should be monitored and evaluated to determine if they might provide models for the rest of the Commonwealth in the future.

Multi-Agency Committee

In addition to the Joint State Government Commission's Task Force and Advisory Committee on Geriatric and Seriously Ill Inmates, other voluntary groups have been established to bring experts in the field together to discuss better solutions for mentally ill offenders returning to communities as noted in the previous section. The fact that these groups are voluntary reinforces the need for a permanent committee in Pennsylvania with the authority to act as needed. Therefore, the members developed the concept of an appointed multi-agency committee comprised of representatives from all stakeholders which would meet on a regular basis. The multi-agency committee would also strengthen communication between communities and prisons and establish and maintain dialogue between various agencies to ensure continuity of care for individuals as they re-enter society.

Concepts

The multi-agency committee, composed of members who are mandated to participate and collaborate, would have considerable authority to recommend policy initiatives. The committee should include, but not be limited to, representatives of the following: the Governor's Policy Office; the General Assembly; the Pennsylvania Commission on Sentencing; the Departments of Aging, Community and Economic Development, Corrections, Health,[46] Military & Veterans Affairs, and Public Welfare;[47] the Pennsylvania Board of Probation and Parole; the Pennsylvania Commission on Crime and Delinquency; National Alliance for the Mentally Ill of Pennsylvania; Pennsylvania Protection & Advocacy, Inc.; the County Commissioners Association of Pennsylvania; county prison officials; County Offices of Drug and Alcohol Services; mental health court officials; county MH/MR administrators; and the Pennsylvania Mental Health Consumers' Association.

The head of each agency represented on the committee would also be responsible for implementing the recommendations identified annually by the committee that impact his agency, as long as the agency has appropriate funding and the recommendations are consistent with the agency's mission. In the event that an agency does not have sufficient funds to meet its obligations, it would submit a request for the funds in its next budget request.

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[46] Offices under the Department of Health should include the Bureau of Drug and Alcohol Programs.

[47] Offices under the Department of Public Welfare should include OMHSAS, Office of Mental Retardation, Office of Social Programs and Office of Income Maintenance.

SUMMARY OF MENTAL HEALTH POLICY OPTIONS

- The Department of Corrections and the Pennsylvania Board of Probation and Parole should cooperate in developing data systems that assist both agencies to better track individuals as they move from corrections to parole.

- The Department of Corrections should consider offering additional incentives to counties who strive to meet the standard of compliance within their prisons.

- A study should be undertaken to determine how county prisons can achieve `compliance under Department of Correction inspections.

- Mental health courts should be considered in each judicial district.

- Increased planning and preparation should be made for a mentally ill offender's move from a State correctional institution into the community.

- The application process for benefits and medical assistance should be streamlined, and a mechanism should be established that would automatically activate or re-activate these funding streams upon an individual's release from prison.

- The number of community-based programs should be increased and existing programs should be expanded to reach more areas across the Commonwealth in need of such re-entry programs.

- If found to be successful, Community Corrections Centers should be expanded to reach other parts of the Commonwealth, and the number of beds dedicated to inmates with mental illness should be increased at Community Corrections Centers where the need warrants.

- The York County and Erie County re-entry program models should be monitored and evaluated to determine if they might provide future archetypes for the rest of the Commonwealth.

- The concept of a multi-agency committee, comprised of representatives appointed from all major mental health issue stakeholders, should be considered. It would meet on a regular basis to maintain communication between all stakeholders and discuss a wide-range of issues relating to the mental health community.

GERIATRIC AND LIFE-SENTENCED INMATES

SUBCOMMITTEE PROCESS

As its name implies, the geriatric/lifer subcommittee was charged with the task of examining issues relevant to the Commonwealth's older inmates as well as its life-sentenced inmates – two populations with often intertwined and overlapping issues.

After an initial brainstorming session, the subcommittee gradually began to narrow its list of topics for consideration. Specifically, the subcommittee targeted the issue of sentencing for first degree and second degree murder and decided to draft an alternative life sentence which would entail the possibility of parole in order to address the effect life sentences have on the future prison population.

Subcommittee members representing the Office of the Victim Advocate and the Pennsylvania District Attorneys Association steadfastly opposed this direction of the subcommittee. *See* "Statement of the Office of the Victim Advocate and the Pennsylvania District Attorneys Association" on page 108.[48]

[48] The various opinions received by mail, phone call and e-mail of members of the public (including, among others, family and friends of victims, family and friends of inmates, victim advocates and inmate advocates) are summarized in Appendices J-1 and J-2. Also see the Mansfield University State Survey results regarding public opinion on parole eligibility for inmates servicing life sentences in Appendix H.

RECIDIVISM

Most of the members were cognizant of statistical data which supported the contention that older inmates, who had served longer sentences, were less likely to be returned to prison for the commission of serious crimes than younger inmates who had served shorter sentences.[49] To test its supposition in regard to age and length of sentence, the subcommittee reviewed a number of reports and data compilations, including the following:

- *A Study of Recidivism Among Individuals Granted Executive Clemency in Pennsylvania 1968-1981*, prepared by the Criminal Justice Statistics Division, Bureau of Planning, Pennsylvania Commission on Crime and Delinquency; Principal Author: Phillip Renninger.

- A Bureau of Justice Statistics (BJS) Special Report entitled *Recidivism of Prisoners Released in 1994*, by BJS Statisticians Patrick A. Langan, Ph.D. and David J. Levin, Ph.D., June 2002.

- A report entitled *The Meaning of "Life": Long Prison Sentences in Context*, by Marc Mauer, Ryan S. King, and Malcolm C. Young, The Sentencing Project, May 2004.

- A Pennsylvania Department of Corrections report entitled *Recidivism in Pennsylvania State Correctional Institutions 1995-2000*, October 2002.

- A Bureau of Justice Statistics Special Report entitled *Recidivism of Prisoners Released in 1983*, by BJS Statistician Allen J. Beck, Ph.D. and BJS Program Manager Bernard E. Shipley, April 1989.

- A report from the West Virginia Division of Corrections entitled *Recidivism in West Virginia Corrections Prisoners Released in 1994-1997*, January 2003.

- Recidivism data from Ohio as prepared by the Ohio Department of Rehabilitation and Correction at the special request of the subcommittee. This study reviewed recidivism data over a three-year period for inmates released in 1999 and for inmates released in 2000.

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[49] *See, e.g.*, Patrick A. Langan and David J. Levin, *Recidivism of Prisoners Released in 1994*, Bureau of Justice Statistics Special Report, U.S. Department of Justice, June 2002. "Those who served the longest time – 61 months or more – had a significantly lower rearrest rate (54.2%) than every other category of prisoners defined by time in confinement." *Id.* at 11.

- *Reports with Recommendations to the ABA Houses of Delegates*, August 2004, American Bar Association, Justice Kennedy Commission. This document includes reports on punishment, incarceration and sentencing; racial and ethnic disparity in the criminal justice system; clemency, sentence reduction and restoration of rights; and prison conditions and prison re-entry.

The reports and data reviewed by the subcommittee generally supported the contention stated earlier that older, life-sentenced inmates were less likely to become recidivists but did not provide data on both age and length of sentence. It was the subcommittee's request for information from the six states bordering Pennsylvania, which led to the Ohio data (as noted above), which does include both variables.

Ohio

As seen in the following table, the Ohio data compilation indicated that, of the 21 offenders who had served at least 25 years in prison and were age 50 or older at the time of their release in the year 2000, none committed a new crime during the three-year period for which they were monitored. This compared to a new crime recidivism rate of 25.4% for all other offenders who were paroled and monitored during the same period of time. A few of the older prisoners (3 of the 21 who were released in 2000) were returned to prison for technical parole violations, but none were returned to prison for new crimes. One caveat to the Ohio data is that it involved only a small number of inmates (21 of the total 22,867 released in 2000), who fit the profile of being 50 years old or older and serving 25 years or more in prison at the time of release in 2000. Thus, the subcommittee acknowledged that the Ohio data was insufficient to base its conclusions upon it alone. However, the data did buttress the position in regard to an overall lower threat of recidivism among older life-sentenced inmates who re-enter society.

ODRC inmates released in 2000 – 3 year recidivism rates by offenders who served at least 25 years who were age 50+ at release

	NRET3				
	.00 no recid	1.00 par viol	2.00 prc viol	3.00 new crime	Total
all other offenders	13991 61.2%	1548 6.8%	1502 6.6%	5805 25.4%	22846 100.0%
offenders who served at least 25 years who were age 50+ at release	18 85.7%	3 14.3%	0 .0%	0 .0%	21 100.0%
Total	14009 61.3%	1551 6.8%	1502 6.6%	5805 25.4%	22867 100.0%

NOTE: par viol = parole violation (a technical violation of parole supervision). prc viol = post-release control violation (a return for violating the condition of post-release control). new crime = a new conviction for a new offense.

SOURCE: Ohio Department of Rehabilitation and Correction (ODRC).

The subcommittee also acknowledged the following data from Ohio which shows that one of the 81 inmates released in 2000, who had served a sentence of 25 years or more, committed a new crime within three years of release from prison. This represents a new conviction recidivism rate of 1.2% over the three-year period studied. The data also shows that as the amount of time incarcerated increased, the recidivism rate decreased.

ODRC inmates released in 2000 – 3 year recidivism rates by length of sentence served

	NRET3				
	.00 no recid	1.00 par viol	2.00 prc viol	3.00 new crime	Total
up to 6 months	4013 61.6%	292 4.5%	333 5.1%	1881 28.9%	6519 100.0%
6 mo up to 1 year	3309 62.8%	153 2.9%	366 7.0%	1437 27.3%	5265 100.0%
1 year up to 4 years	3534 57.9%	217 3.6%	798 13.1%	1551 25.4%	6100 100.0%
4 years up to 10 years	2163 61.6%	639 18.2%	4 .1%	704 20.1%	3510 100.0%
10 years up to 25 years	916 65.8%	244 17.5%	1 .1%	231 16.6%	1392 100.0%
25 years and up	74 91.4%	6 7.4%	0 .0%	1 1.2%	81 100.0%
Total	14009 61.3%	1551 6.8%	1502 6.6%	5805 25.4%	22867 100.0%

NOTE: par viol = parole violation (a technical violation of parole supervision). prc viol = post-release control violation (a return for violating the condition of post-release control). new crime = a new conviction for a new offense.

SOURCE: Ohio Department of Rehabilitation and Correction (ODRC).

Pennsylvania

The advisory committee members requested recidivism data for inmates who were paroled at age 50 or older and for parolees who are commuted lifers from the Pennsylvania Board of Probation and Parole (the Parole Board).

Parolees Released at 50 or Older

The Parole Board was able to determine that, of the 8,211 parolees released in 2003 for whom parole outcome data could be obtained, 492 were released at the age of 50 or older.[50] Of those 492 parolees, 39 were recommitted to prison on technical parole violations and 7 were recommitted on new criminal convictions during the follow-up period.[51] This represents a new criminal conviction recidivism rate of 1.40% over the follow-up period.[52] As stated in the Mental Health chapter, two of the individuals recommitted on new convictions were mentally ill. One was recommitted for assault and the other for robbery. The other five were recommitted for forgery, retail theft, possession of a firearm by a felon, criminal mischief and grand larceny.

Commuted Lifers on Parole

The following table shows that, since the inception of parole, 285 commuted lifers have been released on parole. Of the total, 186 were under the age of 50 when released and 99 were 50 years of age or older. Of the commuted lifers paroled at 50 or older, one was recommitted to prison for a crime[53] and none are unconvicted criminal violators, resulting in an aggregate criminal conviction recidivism rate of 1.01%.

[50] See Appendix E for all the data provided by the Pennsylvania Board of Probation and Parole.

[51] Status of the parolees was determined in October 2004, so the follow-up period varied from individual to individual, with an approximate range of 10 months to 22 months.

[52] The data in Appendix E also show that 9 of the parolees who were released at 50 or older are unconvicted criminal violators in detention awaiting a Parole Board hearing.

[53] This commuted lifer was paroled in 1992 and recommitted to prison in 2003 for forgery and tampering with public records. He was a sex offender and had mental health issues. Between 1992 and 2003, he was returned to prison multiple times, each time for technical parole violations, including putting himself in positions where he had contact with minor females. His criminal conviction for tampering with public records resulted from falsifying his criminal record on a job application to obtain a job as a custodian in a private school having minor female students.

COMMUTED LIFERS ON PAROLE
INCEPTION OF PAROLE TO PRESENT

Status	Under 50 when released	50 or older when released	Total
Current Supervision	102	44	146
UCV – Technical	5	3	8
UCV – Criminal	2	0	2
Absconder	1	4	5
Recommit when available	3	0	3
Recommit – Technical	6	8	14
Recommit – Criminal	6	1	7
Death – Crime related	3	3	6
Death – No crime	19	33	52
Closed	39	3	42
Total	186	99	285

NOTE: UCV – Unconvicted violator in detention awaiting Parole Board hearing.

SOURCE: Pennsylvania Board of Probation and Parole, June 3, 2005.

LIFE WITH THE POSSIBILITY OF PAROLE

After examining the recidivism data, the focus of the subcommittee shifted to establishing a system which would allow older, life-sentenced prisoners who had served considerable prison terms to gain *eligibility* for parole – something not provided under current sentencing law in Pennsylvania.

Background — Life Sentences and Commutation

There has been a tremendous increase in the number of life sentences being imposed throughout the country. This increase has resulted in greater scrutiny of sentencing statutes and a willingness to provide for more sentencing options, even for those convicted of homicide. Currently 36 states provide both life with the possibility of parole and life without the possibility of parole as sentencing options. This represents an increase of six states providing for both

options since 1990. Three states (Alaska, New Mexico and Texas) have only life with the possibility of parole. Pennsylvania is one of 11 states[54] that provides only for life without the possibility of parole.

Because inmates serving life sentences are not eligible for parole, a commutation of sentence recommended by the Board of Pardons and approved by the Governor is necessary before release from prison becomes a possibility. An examination of the recent history of the Commonwealth shows that commutations have been granted to inmates serving life sentences in diminishing numbers and with less frequency than they once were. The following table illustrates that during the 12 years from January 1967 to January 1979 commutations were granted to 346 life-sentenced inmates. In the 25-½ years since then, a total of 35 commutations have been granted to life-sentenced inmates. Thus, it is apparent that the use of this release valve for returning life-sentenced individuals into society has been curtailed in recent years.

Governor	Term(s) January to January, unless otherwise specified	Number of life sentences commuted
Raymond Shafer	1967 – 1971	95
Milton Shapp	1971 – 1979	251
Dick Thornburgh	1979 – 1987	7
Robert Casey	1987 – 1995	27
Tom Ridge	1995 – October 2001	0
Mark Schweiker	October 2001 – 2002	1
Ed Rendell	2003 –	0

SOURCE: Pennsylvania Board of Pardons, May 25, 2005.

Although the number of life sentence commutations had been on a rather steady decline since 1979, the notorious case of Reginald McFadden instigated a change to the Commonwealth's Constitution and fear of making a mistake which further reduced the number of commutations over the past ten years to only one.

Reginald McFadden had served 24 years of his life sentence when, in 1992, the Board of Pardons voted 4 – 1 to recommend that his life sentence be commuted, and Governor Casey signed the commutation in 1994. In accordance with the recommendations of the Department of Corrections and the Board of Pardons, rather than being released outright from prison, McFadden should have

[54] The other ten states are Arkansas, Illinois, Iowa, Louisiana, Maine, Minnesota, North Carolina, South Dakota, Washington and Wyoming.

been required to serve about two years in a Community Corrections Center to help him readjust to life outside of prison – which had been his place of residence since he was 16 years old. Unfortunately, this did not happen.

Instead, McFadden was released directly from prison to the community in July of 1994 and arrested three months later in New York for rape and two killings. The fact that Lt. Governor Mark Singel had voted for McFadden's commutation became an issue in the last weeks of the gubernatorial campaign, and he lost the election. This is often cited as the beginning of the end for the commutation of life sentences, as individuals became afraid of having their political careers end if they recommended or approved commutation.

In addition, the General Assembly's Special Session No. 1 of 1995 yielded a change to Article IV, Section 9, of the Constitution of Pennsylvania by requiring the unanimous recommendation of the members of the Board of Pardons in the case of an inmate sentenced to death or life imprisonment.[55] This raised the threshold for commutations from the previous requirement that a majority of the Board members support the petition and further reduced the likelihood that a commutation would reach the Governor's desk for final approval.

If the draft language regarding parole for lifers were to become law, it would re-establish the possibility for release of future inmates by statute and, in turn, create a new standard upon which Pardons Board members might rely in reaching a decision on current petitions for commutation.

Subcommittee Approach

To help Pennsylvania cope with the problem of an increasing number of geriatric inmates and bring Pennsylvania's sentencing scheme in line with those of the vast majority of states, the subcommittee developed statutory amendments that would permit a jury or judge to sentence an offender convicted of first or second degree murder to life in prison with parole eligibility once the inmate serves 25 years and, in most cases, reaches age 50.

[55] An amendment to the Constitution of the Commonwealth of Pennsylvania must be advertised, approved by two successive sessions of the General Assembly and approved by the majority of citizens voting upon it when it appears as a ballot question in a general election. *See* Section 1 of Article XI of the Constitution of Pennsylvania. The Constitutional amendment regarding commutation of a life sentence was passed by the General Assembly for the first time during the First Special Legislative Session of 1995 – 96 and for the second time during the Legislative Session of 1997. It was then approved by the electorate on November 4, 1997 by a vote of 1,182,067 to 811,701.

The subcommittee decided upon a minimum term of at least 25 years, as it is in the middle range of the minimum term of those states offering the option of life with the possibility of parole. Currently, two states have parole eligibility under 10 years (Utah and California), two states have 40 and 50 year terms (Colorado and Kansas) and 13 states have terms in the 20-year range (Arizona, Georgia, Indiana, Kentucky, Maryland, Michigan, New Jersey, Ohio, Rhode Island, Tennessee, Virginia, Washington and Wisconsin). Accordingly, the subcommittee determined that a minimum term of 25 years for parole eligibility is reasonable and consistent with the trend throughout the country.

The 50 years of age requirement is a unique creation of the subcommittee. It is based on studies, such as Ohio's survey, that show a significant drop in recidivism in general and in those receiving life sentences in particular as inmates grow older. [56]

Retroactivity

After determining that changes to the sentencing laws would be unlikely to pass Constitutional muster if an attempt were made to apply them retroactively, the subcommittee decided to direct its efforts toward drafting changes to sentencing for first degree and second degree murder, prospectively, with the hope that these changes would be viewed as stating the policy of the Commonwealth and lead to criteria which Pardons' Board members could rely upon in rendering decisions in the case of current lifers seeking release.

The subcommittee justified its draft language, primarily, on four grounds: 1) life sentences without parole are contributing to a rising geriatric prison population whose care is costing the Commonwealth's taxpayers more and more money each year; 2) limiting the discretion of juries and judges in first and second degree murder sentencing has contributed to certain inequities in the system (e.g., instances in which "the driver of the getaway vehicle" is serving a harsher sentence than the "triggerman"); 3) giving hope of release to life-sentenced inmates makes it easier for the Department of Corrections to manage the lifer population; and 4) the limited data available suggests that older inmates who have served lengthy sentences are less likely to return to prison due to the commission of a serious crime than are younger inmates who have served shorter sentences.

[56] Much of the correspondence received from individuals supporting parole eligibility for lifers asserts that the maturity and change in attitude that comes after many years of participating in educational programs, work training and other programs in prison, in addition to an individual's age, help establish to prison personnel that an inmate is trustworthy and not a risk to society. It further asserts that the same positive changes developed during imprisonment will stay with an individual when he is released from prison.

Summary

The following draft amends the Commonwealth's sentencing laws for those convicted in the future of first degree murder by adding the option for the jury or the judge to consider life with the possibility of parole in cases where the State is not seeking the death penalty. Currently, the only option in instances where the State is not seeking the death penalty is life without the possibility of parole. This amendment would allow those sentenced to 25 years to life to become ***eligible*** for parole upon serving 25 years in prison and attaining a minimum age of 50. "Parole eligibility" means that an inmate may be *considered* for parole. It does not mean that the inmate will be immediately released or ever granted parole.

In addition, the draft amends the sentencing law as it applies to murder of the second degree by adding a provision which would allow consideration of a sentence of life imprisonment with the possibility of parole when an inmate reaches a minimum of 50 years of age and has served 25 years of his sentence.

For both first and second degree murder, the draft provides that a person who committed the crime prior to age 21 may be eligible for parole upon turning age 45, as long as he serves a minimum of 25 years of his sentence.

The draft also makes concomitant changes to the law regarding instructions to the jury under murder of the first and second degree.

In addition, the draft amends the Parole Act to require hearings as part of the Board of Probation and Parole's consideration of a life-sentenced inmate's application for release on parole to ensure that the inmate has a viable home and work plan prior to his release on parole.

Furthermore, the draft contains pre-release detention requirements for individuals convicted of first or second degree murder who approach the threshold of parole eligibility. For example, the draft precludes anyone convicted of first or second degree murder, and sentenced to life with the possibility of parole, from gaining eligibility for pre-release upon reaching the halfway point of his minimum sentence. In each instance, service of the mandatory minimum term of 25 years would be required, although an inmate sentenced for second degree murder would become eligible for pre-release within twelve months of completion of his mandatory minimum term.

Draft Legislation

Note: Nothing in this act is intended to effect the rights or responsibilities of crime victims under the Act of November 24, 1998 (P.L.882, No.111), known as the Crime Victims Act.

AN ACT

Amending Titles 18 (Crimes and Offenses) and 42 (Judiciary and Judicial Procedure) of the Pennsylvania Consolidated Statutes and the Act of August 6, 1941 (P.L.861, No.323), known as the Pennsylvania Board of Probation and Parole Law to provide for a sentence of life imprisonment with the possibility of parole for certain individuals convicted of murder of the first degree or murder of the second degree.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Section 1102 of Title 18 of the Pennsylvania Consolidated Statutes is amended to read:

§ 1102. Sentence for murder and murder of an unborn child.

(a) First degree.—

(1) A person who has been convicted of a murder of the first degree shall be sentenced to death [or to], a term of life imprisonment without parole or a maximum term of life imprisonment and a minimum term of 25 years in accordance with 42 Pa.C.S. § 9711 (relating to sentencing procedure for murder of the first degree in capital cases) or 9711.1 (relating to sentencing procedure for murder of the first degree in noncapital cases). A person convicted of murder of the first degree and sentenced to life imprisonment with a minimum term of 25 years must serve a minimum term of 25 years in prison and must also attain the age of 50 years prior to becoming eligible for

parole, unless the defendant was under the age of 21 years at the time of the offense, in which instance, eligibility for parole would begin upon the attainment of the age of 45 years and service of no less than 25 years in prison.

(2) The sentence for a person who has been convicted of first degree murder of an unborn child shall be the same as the sentence for murder of the first degree, except that the death penalty shall not be imposed. This paragraph shall not affect the determination of an aggravating circumstance under 42 Pa.C.S. § 9711(d)(17) for the killing of a pregnant woman.

(b) Second degree.—A person who has been convicted of murder of the second degree or of second degree murder of an unborn child shall be sentenced to a term of life imprisonment without parole or to a maximum term of life imprisonment and a minimum term of 25 years in accordance with Pa.C.S. § 9711.2 (relating to sentencing procedure for murder of the second degree). A person convicted of murder of the second degree and sentenced to life imprisonment and a minimum term of 25 years must serve a minimum term of 25 years and must also attain the age of 50 years prior to becoming eligible for parole, unless the defendant was under the age of 21 years at the time of the offense, in which instance, eligibility for parole would begin upon the attainment of the age of 45 years and service of no less than 25 years.

(c) Attempt, solicitation and conspiracy to commit murder or murder of an unborn child.—Notwithstanding section 1103(1) (relating to sentence of imprisonment for felony), a person who has been convicted of attempt,

solicitation or conspiracy to commit murder or murder of an unborn child where serious bodily injury results may be sentenced to a term of imprisonment which shall be fixed by the court at not more than 40 years. Where serious bodily injury does not result, the person may be sentenced to a term of imprisonment which shall be fixed by the court at not more than 20 years.

(d) Third degree.—Notwithstanding section 1103, a person who has been convicted of murder of the third degree or of third degree murder of an unborn child shall be sentenced to a term which shall be fixed by the court at not more than 40 years.

Section 2. Section 9711 of Title 42 of the Pennsylvania Consolidated Statutes is amended to read:

§ 9711. Sentencing procedure for murder of the first degree in capital cases.

(a) Procedure in jury trials.—

(1) [After] In a case where the Commonwealth is seeking a sentence of death, after a verdict of murder of the first degree is recorded, and before the jury is discharged, the court shall conduct a separate sentencing hearing in which the jury shall determine whether the defendant shall be sentenced to death [or], a term of life imprisonment without the possibility of parole or a maximum term of life imprisonment and a minimum term of 25 years.

(2) In the sentencing hearing, evidence concerning the victim and the impact that the death of the victim has had on the family of the victim is admissible. Additionally, evidence may be presented as to any other matter that the court deems relevant and admissible on the question of the sentence to

be imposed. Evidence shall include matters relating to any of the aggravating or mitigating circumstances specified in subsections (d) and (e), and information concerning the victim, and the impact that the death of the victim has had on the family of the victim. Evidence of aggravating circumstances shall be limited to those circumstances specified in subsection (d).

(3) After the presentation of evidence, the court shall permit counsel to present argument for or against the sentence of death. The court shall then instruct the jury in accordance with subsection (c).

(4) Failure of the jury to unanimously agree upon a sentence shall not impeach or in any way affect the guilty verdict previously recorded.

(b) Procedure in nonjury trials and guilty pleas.—[If] In a case where the Commonwealth is seeking a sentence of death, if the defendant has waived a jury trial or pleaded guilty, the sentencing proceeding shall be conducted before a jury impaneled for that purpose unless waived by the defendant with the consent of the Commonwealth, in which case the trial judge shall hear the evidence and determine the penalty in the same manner as would a jury as provided in subsection (a).

(c) Instructions to jury.—[(1) Before] In a case where the Commonwealth is seeking a sentence of death, before the jury retires to consider the sentencing verdict, the court shall instruct the jury on the following matters:

[(i)] (1) The aggravating circumstances specified in subsection (d) as to which there is some evidence.

[(ii)] (2) The mitigating circumstances specified in subsection (e) as to which there is some evidence.

[(iii)] (3) Aggravating circumstances must be proved by the Commonwealth beyond a reasonable doubt; mitigating circumstances must be proved by the defendant by a preponderance of the evidence.

[(iv)] (4) The verdict must be a sentence of death if the jury unanimously finds at least one aggravating circumstance specified in subsection (d) and no mitigating circumstance or if the jury unanimously finds one or more aggravating circumstances which outweigh any mitigating circumstances. [The verdict must be a sentence of life imprisonment in all other cases.] If the jury cannot agree unanimously that the aggravating circumstances proved outweigh the mitigating circumstances, then their verdict must be a term of life in prison without the possibility of parole.

[(v)] (5) The court may[, in its discretion,] discharge the jury if it is of the opinion that further deliberation will not result in a unanimous agreement as to the sentence of death, in which case the court shall sentence the defendant to life [imprisonment] in prison without the possibility of parole.

(6) If the jury does not unanimously find at least one aggravating circumstance specified in subsection (d) to have been proven by the Commonwealth beyond a reasonable doubt, then the verdict must be a term of life imprisonment without the possibility of parole or a maximum term of life imprisonment and a minimum term of 25 years.

(7) In determining the sentence, the jury must consider all the evidence presented and proved in the sentencing phase of the case. In addition, the jury must also consider the following:

(i) The evidence received, if any, concerning the victim and the impact of the offense on the victim's family.

(ii) The defendant's potential for rehabilitation.

(iii) That the minimum amount of time to be served on any sentence of life imprisonment with a minimum term of 25 years is 25 years and that the defendant must also attain the age of 50 years prior to becoming eligible for parole, unless the defendant was under the age of 21 years at the time of the offense, in which instance, eligibility for parole would begin upon the attainment of the age of 45 years and service of no less than 25 years in prison.

(iv) That in Pennsylvania there is no right to parole and that parole eligibility after 25 years served does not mean automatic release on parole.

(v) That the Pennsylvania Board of Probation and Parole will, at that time, make a determination regarding release on parole upon application made by the defendant and a hearing held by the board.

(vi) The Prisoner Pre-Release Plan Law does not apply to the defendant.

Comment: This paragraph refers to the act of July 16, 1968 (P.L.351, No.173), referred to as the Prisoner Pre-Release Plan Law.

[(2)] (8) [The court shall instruct the jury that if it] If the jury finds at least one aggravating circumstance and at least one mitigating circumstance, it shall consider, in weighing the aggravating and mitigating circumstances, any evidence presented about the victim and about the impact of the murder on the victim's family. [The court shall also instruct the jury on any other matter that may be just and proper under the circumstances.]

(9) A sentence of life imprisonment without the possibility of parole must be a unanimous decision of the jury, otherwise the verdict must be a maximum term of life imprisonment and a minimum term of 25 years.

(10) Any other matter that may be just and proper under the circumstances.

(d) Aggravating circumstances.—[Aggravating] In a case where the Commonwealth is seeking a sentence of death, aggravating circumstances shall be limited to the following:

(1) The victim was a firefighter, peace officer, public servant concerned in official detention, as defined in 18 Pa.C.S. § 5121 (relating to escape), judge of any court in the unified judicial system, the Attorney General of Pennsylvania, a deputy attorney general, district attorney, assistant district attorney, member of the General Assembly, Governor, Lieutenant Governor, Auditor General, State Treasurer, State law enforcement official, local law enforcement official, federal law enforcement official or person employed to assist or assisting any law enforcement official in the performance of his

duties, who was killed in the performance of his duties or as a result of his official position.

(2) The defendant paid or was paid by another person or had contracted to pay or be paid by another person or had conspired to pay or be paid by another person for the killing of the victim.

(3) The victim was being held by the defendant for ransom or reward, or as a shield or hostage.

(4) The death of the victim occurred while defendant was engaged in the hijacking of an aircraft.

(5) The victim was a prosecution witness to a murder or other felony committed by the defendant and was killed for the purpose of preventing his testimony against the defendant in any grand jury or criminal proceeding involving such offenses.

(6) The defendant committed a killing while in the perpetration of a felony.

(7) In the commission of the offense the defendant knowingly created a grave risk of death to another person in addition to the victim of the offense.

(8) The offense was committed by means of torture.

(9) The defendant has a significant history of felony convictions involving the use or threat of violence to the person.

(10) The defendant has been convicted of another Federal or State offense, committed either before or at the time of the offense at issue, for which a sentence of life imprisonment or death was imposable or the

defendant was undergoing a sentence of life imprisonment for any reason at the time of the commission of the offense.

(11) The defendant has been convicted of another murder committed in any jurisdiction and committed either before or at the time of the offense at issue.

(12) The defendant has been convicted of voluntary manslaughter, as defined in 18 Pa.C.S. § 2503 (relating to voluntary manslaughter), or a substantially equivalent crime in any other jurisdiction, committed either before or at the time of the offense at issue.

(13) The defendant committed the killing or was an accomplice in the killing, as defined in 18 Pa.C.S. § 306(c) (relating to liability for conduct of another; complicity), while in the perpetration of a felony under the provisions of the act of April 14, 1972 (P.L.233, No.64), known as The Controlled Substance, Drug, Device and Cosmetic Act, and punishable under the provisions of 18 Pa.C.S. § 7508 (relating to drug trafficking sentencing and penalties).

(14) At the time of the killing, the victim was or had been involved, associated or in competition with the defendant in the sale, manufacture, distribution or delivery of any controlled substance or counterfeit controlled substance in violation of The Controlled Substance, Drug, Device and Cosmetic Act or similar law of any other state, the District of Columbia or the United States, and the defendant committed the killing or was an accomplice to the killing as defined in 18 Pa.C.S. § 306(c), and the killing resulted from

or was related to that association, involvement or competition to promote the defendant's activities in selling, manufacturing, distributing or delivering controlled substances or counterfeit controlled substances.

(15) At the time of the killing, the victim was or had been a nongovernmental informant or had otherwise provided any investigative, law enforcement or police agency with information concerning criminal activity and the defendant committed the killing or was an accomplice to the killing as defined in 18 Pa.C.S. § 306(c), and the killing was in retaliation for the victim's activities as a nongovernmental informant or in providing information concerning criminal activity to an investigative, law enforcement or police agency.

(16) The victim was a child under 12 years of age.

(17) At the time of the killing, the victim was in her third trimester of pregnancy or the defendant had knowledge of the victim's pregnancy.

(18) At the time of the killing the defendant was subject to a court order restricting in any way the defendant's behavior toward the victim pursuant to 23 Pa.C.S. Ch. 61 (relating to protection from abuse) or any other order of a court of common pleas or of the minor judiciary designed in whole or in part to protect the victim from the defendant.

(e) Mitigating circumstances.—[Mitigating] In a case where the Commonwealth is seeking a sentence of death, mitigating circumstances shall include the following:

(1) The defendant has no significant history of prior criminal convictions.

(2) The defendant was under the influence of extreme mental or emotional disturbance.

(3) The capacity of the defendant to appreciate the criminality of his conduct or to conform his conduct to the requirements of law was substantially impaired.

(4) The age of the defendant at the time of the crime.

(5) The defendant acted under extreme duress, although not such duress as to constitute a defense to prosecution under 18 Pa.C.S. § 309 (relating to duress), or acted under the substantial domination of another person.

(6) The victim was a participant in the defendant's homicidal conduct or consented to the homicidal acts.

(7) The defendant's participation in the homicidal act was relatively minor.

(8) Any other evidence of mitigation concerning the character and record of the defendant and the circumstances of his offense.

(f) Sentencing verdict by the jury.—

(1) [After] In a case where the Commonwealth is seeking a sentence of death, after hearing all the evidence and receiving the instructions from the court, the jury shall deliberate and render a sentencing verdict. In rendering the verdict, if the sentence is death, the jury shall set forth in such form as designated by the court the findings upon which the sentence is based.

(2) Based upon these findings, the jury shall set forth in writing whether the sentence is death [or] , a term of life imprisonment without the possibility

of parole or a maximum term of life imprisonment and a minimum term of 25 years**.**

(g) Recording sentencing verdict.—[Whenever] In a case where the Commonwealth is seeking a sentence of death, whenever the jury shall agree upon a sentencing verdict, it shall be received and recorded by the court. The court shall thereafter impose upon the defendant the sentence fixed by the jury.

(h) Review of death sentence.—

(1) A sentence of death shall be subject to automatic review by the Supreme Court of Pennsylvania pursuant to its rules.

(2) In addition to its authority to correct errors at trial, the Supreme Court shall either affirm the sentence of death or vacate the sentence of death and remand for further proceedings as provided in paragraph (4).

(3) The Supreme Court shall affirm the sentence of death unless it determines that:

(i) The sentence of death was the product of passion, prejudice or any other arbitrary factor; or

(ii) The evidence fails to support the finding of at least one aggravating circumstance specified in subsection (d).

* * *

Section 3. Title 42 of the Pennsylvania Consolidated Statutes is amended by adding section 9711.1 to read:

§ 9711.1 Sentencing procedure for murder of the first degree in noncapital cases.

(a) Procedure in jury trials.—

(1) In a case where the Commonwealth did not seek the death penalty, after a verdict of murder of the first degree is recorded and before the jury is discharged, the court shall conduct a separate sentencing hearing on the matter of parole eligibility during the term of life imprisonment. If the prosecution waives the hearing, a maximum sentence of life imprisonment and a minimum term of 25 years shall be imposed.

(2) In the sentencing hearing, evidence concerning the victim and the impact that the death of the victim has had on the family of the victim is admissible. Additionally, evidence may be presented as to any other matter that the court deems relevant and admissible on the question of the sentence to be imposed.

(3) Aggravating circumstances must be proved by the Commonwealth beyond a reasonable doubt; mitigating circumstances must be proved by the defendant by a preponderance of the evidence.

(4) After the presentation of evidence, the court shall permit counsel to present argument for or against a sentence of life imprisonment with the possibility of parole. The court shall then instruct the jury in accordance with subsection (c).

(5) After having been presented with the above and having duly deliberated, the jury shall set forth in writing whether the sentence is life imprisonment without parole, or a maximum of life imprisonment and a minimum term of 25 years.

(6) Failure of the jury to unanimously agree upon a sentence shall not impeach or in any way affect the guilty verdict previously recorded.

(7) The court shall thereafter impose on the defendant the sentence fixed by the jury.

(b) Procedure in nonjury trials and guilty pleas.—If the defendant has waived a jury trial or pleaded guilty, the sentencing proceeding shall be conducted before a jury impaneled for that purpose unless waived by the defendant with the consent of the Commonwealth, in which case the trial judge shall hear the evidence and determine the penalty in the same manner as would a jury as provided in subsection (a). The court shall thereafter impose upon the defendant the penalty so determined.

(c) Instructions to the jury.—Before the jury retires to consider the sentencing verdict, the court shall instruct the jury on the following matters:

(1) The evidence of the impact of the offense on the victim's family.

(2) The record and character of the defendant, the age of the defendant when the crime was committed, the defendant's ties to the community and the defendant's potential for rehabilitation.

(3) That the minimum amount of time to be served on any sentence of life imprisonment with the possibility of parole is 25 years and that the defendant must also attain at least the age of 50 years prior to becoming eligible for parole**,** unless the defendant was under the age of 21 years at the time of the offense, in which instance, eligibility for parole would begin upon the

attainment of the age of 45 years and service of no less than 25 years in prison.

(4) That in Pennsylvania there is no right to parole and that parole eligibility after 25 years served does not mean automatic release on parole and that the Pennsylvania Board of Probation and Parole will at that time, make a determination of parole upon application made by the defendant and a hearing held by the board.

(5) A sentence of life imprisonment without the possibility of parole must be a unanimous decision of the jury otherwise the verdict must be life imprisonment with the possibility of parole.

(6) That the Prisoner Pre-Release Plan Law does not apply to the defendant.

Comment: This paragraph refers to the Act of July 16, 1968 (P.L.351, No.173), referred to as the Prisoner Pre-Release Plan Law.

(7) Any other matters as may be relevant under the circumstances of each individual case.

§ 9711.2 Sentencing procedure for murder of the second degree.

(a) Procedure in jury trials.—

(1) In a case where the Commonwealth sought a term of life imprisonment without the possibility of parole, after a verdict of murder of the second degree is recorded and before the jury is discharged, the court shall conduct a separate sentencing hearing on the matter of parole eligibility

during the term of life imprisonment. If the prosecution waives the hearing, the sentence shall be imposed with the possibility of parole.

(2) In the sentencing hearing, evidence concerning the victim and the impact that the death of the victim has had on the family of the victim is admissible. Additionally, evidence may be presented as to any other matter that the court deems relevant and admissible on the question of the sentence to be imposed. That evidence which is introduced by the Commonwealth in aggravation shall be proved beyond a reasonable doubt; mitigating evidence introduced by the defendant shall be proved by a preponderance of the evidence.

(3) After the presentation of evidence, the court shall permit counsel to present argument for or against a sentence of life imprisonment with the possibility of parole. The court shall then instruct the jury in accordance with subsection (c).

(4) After having been presented with the above and having duly deliberated, the jury shall set forth in writing whether the sentence is life imprisonment without parole or life imprisonment with parole eligibility.

(5) The court shall thereafter impose on the defendant the sentence fixed by the jury.

(b) Procedure in nonjury trials and guilty pleas. —If the defendant has waived a jury trial or pleaded guilty, the sentencing proceeding shall be conducted before the trial judge who shall hear the evidence and determine the penalty in the same

manner as would a jury under subsection (a). The court shall then impose upon the defendant the penalty determined.

(c) Instructions to the jury. —Before the jury retires to consider the sentencing verdict, the court shall instruct the jury on the following matters:

(1) The evidence of the impact of the offense on the victim's family.

(2) The record and character of the defendant, the age of the defendant when the crime was committed, the defendant's ties to the community and the defendant's potential for rehabilitation.

(3) That the minimum amount of time to be served on any sentence of life imprisonment with the possibility of parole is 25 years and that the defendant must also attain at least the age of 50 years prior to becoming eligible for parole, unless the defendant was under the age of 21 years at the time of the offense, in which instance, eligibility for parole would begin upon the attainment of the age of 45 years and service of no less than 25 years.

(4) That in Pennsylvania there is no right to parole and that parole eligibility after 25 years does not mean automatic release on parole and that the Pennsylvania Board of Probation and Parole will at that time, make a determination of parole upon application made by the defendant and a hearing held by the board.

(5) A sentence of life imprisonment without possibility of parole must be a unanimous decision of the jury. If such unanimous decision is not obtained, the verdict must be life imprisonment with the possibility of parole.

(6) That the Prisoner Pre-Release Plan Law applies no earlier than twelve months before the date the defendant becomes eligible to apply for parole.

Comment: This paragraph refers to the act of July 16, 1968 (P.L.351, No.173), referred to as the Prisoner Pre-Release Plan Law.

(7) Any other matters that may be relevant under the circumstances of each individual case.

Section 4. Section 9715 or Title 42 of the Pennsylvania Consolidated Statutes is amended to read:

§ 9715. Life imprisonment for homicide.

(a) Mandatory life imprisonment.—Notwithstanding the provisions of section 9712 (relating to sentences for offenses committed with firearms), 9713 (relating to sentences for offenses committed on public transportation) or 9714 (relating to sentences for second and subsequent offenses), any person convicted of murder of the third degree in this Commonwealth who has previously been convicted at any time of murder or voluntary manslaughter in this Commonwealth or of the same or substantially equivalent crime in any other jurisdiction shall be sentenced to life imprisonment without the possibility of parole, notwithstanding any other provision of this title or other statute to the contrary.

Section 5. Section 21 of the Act of August 6, 1941 (P.L.861, No.323), known as the Pennsylvania Board of Probation and Parole Law is amended to read:

Section 21. Release on parole. (a) The board is hereby authorized to release on parole any convict confined in any penal institution of this Commonwealth as to whom power to parole is herein granted to the board, except convicts condemned

to death or serving life imprisonment without the possibility of parole, whenever in its opinion the best interests of the convict justify or require his being paroled and it does not appear that the interests of the Commonwealth will be injured thereby. The board shall not grant parole to an individual convicted of first or second degree murder and sentenced to a maximum term of life imprisonment and a minimum term of 25 years prior to holding a hearing. Parole shall be subject in every instance to the Commonwealth's right to immediately retake and hold in custody without further proceedings any parolee charged after his parole with an additional offense or a technical parole violation, until a determination can be made whether to continue his parole status. [The] Except as provided in subsection (a.1), the power to parole herein granted to the [Board of Parole] board may not be exercised in the board's discretion at any time before, but only after, the expiration of the minimum term of imprisonment fixed by the court in its sentence or by the [Pardon] Board of Pardons in a sentence which has been reduced by commutation. However, no person convicted of murder in the first or second degree will be released prior to residing in a pre-release facility, under the jurisdiction of the Department of Corrections, for a minimum period of one year, beginning on the date upon which parole is granted by the board. A person convicted of murder in the second degree will become eligible for release to a pre-release facility under the jurisdiction of the Department of Corrections no sooner than twelve months prior to attaining parole eligibility. Persons convicted of murder in the second degree who have served one or more years in a pre-release facility, under the jurisdiction of the Department of Corrections, will

be considered to have fulfilled their post-release requirement to reside in a pre-release facility for a period of one year after being granted parole.

(a.1) The minimum amount of time to be served on a sentence of life imprisonment and a minimum term of 25 years is 25 years. In addition, the defendant must also attain the age of 50 years prior to becoming eligible for parole, unless the defendant was under the age of 21 years at the time of the offense, in which instance, eligibility for parole would begin upon the attainment of the age of 45 years and service of no less than 25 years.

***

(e) The board shall promulgate the rules and regulations, including a statement of criteria to guide the board's discretion for the granting of the parole application, necessary to carry out this section.

MERITORIOUS LIFER PROGRAM AND APPLICATIONS FOR CLEMENCY

As noted previously, the subcommittee recognized a constitutional problem with applying its draft language regarding parole eligibility for lifers to inmates who are currently serving life sentences and, therefore, specified that the life with possibility provisions are prospective only. In order to address the current lifer population, the subcommittee focused on the commutation process.

The Department of Corrections should develop a program for identifying and preparing lifers who are "meritorious" (i.e., meriting possible recommendation for commutation) for review of their sentences by the Board of Pardons. In addition, the Board of Pardons should revise its application for clemency for inmates who seek to have their life sentences commuted so that it captures comprehensive information about an applicant's post-release work plan and home plan (with expanded details about each attached to the application as necessary) in order to address potential Board concerns in this regard.

While the pardon process is distinct from the function performed by the Board of Probation and Parole, the subcommittee noted that the Board of Probation and Parole could investigate, evaluate and make recommendations to the Board of Pardons regarding the applicant's post-release work and home plans.

Because the goals are to provide lifers with the hope of release and assist the Department of Corrections with its management of the lifer population, these options regarding commutation should be implemented only if the draft language regarding life with the possibility of parole is enacted. Strengthening the meritorious lifer program in the current atmosphere where commutations are not genuine possibilities would give current lifers a false hope of release.

The members also noted that each of these recommendations would require additional staffing and increase the budgetary needs of community service agencies and departments, including the Department of Corrections, the Board of Pardons and the Board of Probation and Parole. The members do not intend these recommendations to become unfunded mandates for the affected agencies, and in that regard, recommend that adequate funding and staffing be provided to accomplish each of these recommendations.

"Families of murder victims suffer a life sentence of grief which is not relieved by the passage of time or illness."
– K.P.

"How can they ignore my transformation?"
– J.T. (lifer)

ISSUES OUTSIDE THE SCOPE OF SENATE RESOLUTION 149 WHICH CONTRIBUTE TO THE BURGEONING PRISON POPULATION

The geriatric/lifer subcommittee considered many issues – including whether the Post-Conviction Relief Act should be amended, whether there are options (aside from releasing lifers) which may be viable, whether the issue of discharge planning and whether the General Assembly should commission a study of broader criminal justice issues – which appear to exceed the scope of the present study. The subcommittee also decided that issues it had originally identified as possible matters for further discussion – such as mandatory impact statements, prison camps, determinate versus indeterminate sentencing, mandatory sentences and consecutive/concurrent sentencing – either went beyond the scope of the resolution or presented issues it could not fully explore given the other issues before it.

STATEMENT OF THE
OFFICE OF THE VICTIM ADVOCATE AND THE
PENNSYLVANIA DISTRICT ATTORNEYS ASSOCIATION

Revising the Commonwealth's sentencing provisions for those convicted of first degree murder and second degree murder by providing the judge or jury another sentencing option of life with the possibility of parole was not agreed upon by all members of the subcommittee. Representatives of the Office of the Victim Advocate and the Pennsylvania District Attorneys Association, as members of the subcommittee, were steadfastly opposed to any revision of the sentencing provisions.

A majority of the constituents represented by the Office of the Victim Advocate and the Pennsylvania District Attorneys Association are vehemently opposed to any revision in the sentencing provisions that would change the meaning of life imprisonment in Pennsylvania. They also oppose any change to existing laws relating either to convictions for first, second or third degree murder or to the Parole Act. At its most fundamental level, there are two lives involved in this discussion: the life of the offender and the extinguished life of the murdered victim. The voice of the deceased victim and the offender's accountability to that victim must not be lost in this discussion.

The available sentences for murder that afford various degrees of culpability are already present in the Commonwealth's sentencing provisions. These range from involuntary manslaughter to third degree murder to first degree murder. Adding more sentencing provisions seems, at best, incongruous.

It should also be noted that creating parole eligibility for certain life-sentenced inmates does nothing to alleviate the current population of geriatric and seriously ill inmates or provide alternatives to incarceration. Such a change to the sentencing statutes would not affect the prison population for at least 25 years.

VICTIM WRAP AROUND PROGRAM

The main function of a victim wrap around program is offering confidential services to support the victim at the time of the offender's re-entry into the community.[57] Among other things, victim wrap around services may include the following:

> (1) The development of a safety plan to enhance victim and community safety when an offender is in the community. The safety plan may provide for the delineation of geographic conditions that address both the needs of the offender and the safety needs of the victim; the examination of the victim's home to identify and address crime prevention needs; obtaining civil orders (e.g., a protection from abuse order) that address safety, residence and custody issues; identifying victim notification needs; and planning for intervention by police and other law enforcement agencies to ensure the safety of the victim.
>
> (2) Assistance in obtaining information on the status of the offender.
>
> (3) Assistance in the exchange of information between the victim and the offender as deemed appropriate and necessary by both parties.
>
> (4) Assistance in obtaining restitution.
>
> (5) Assistance in linking the victim to other needed services.

The mental health subcommittee first considered including provisions authorizing victim wrap around programs in its mental health court draft legislation. While the subcommittee members recognized the value of a victim wrap around program, they ultimately decided not to include it in the mental health court legislation, as placement there seemed to discriminate against the mentally ill.

[57] See Appendix I for information on various victim wrap around programs in Washington (credited with starting the concept), Iowa, Ohio and Vermont.

In order to avoid the appearance of such discrimination in legislation,[58] the members considered drafting victim wrap around legislation that would apply in all cases of an offender – not only a mentally ill offender – in the community; however, consensus was not reached on this issue.

The General Assembly might consider authorizing the court of common pleas of a county or judicial district to establish a victim wrap around program. If such authorization were enacted and a victim wrap around program were established in a county, the program could be devised so that services are delivered by a victim service provider in collaboration with a review team.

[58] While acknowledging that certain categories of offenders are singled out for a procedure that is different than the procedure that applies in all criminal cases, the members noted that those differences are based on the crime itself, not the offender's health. For example, offenders who committed a crime listed under 42 Pa.C.S. § 9795.1(a), (b)(1) or (b)(2) and sexually violent predators must register information regarding current or intended residences, employment and enrollment as a student and any changes to this information with the Pennsylvania State Police. 42 Pa.C.S. § 9795.2(a). Listed crimes include, among others, kidnapping a minor, institutional sexual assault, sexual exploitation of children, cases of incest where the victim is under 18, involuntary deviate sexual intercourse and rape. Some offenders must register for ten years and others must register for life. 42 Pa.C.S. § 9795.1.

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APPENDIX A

2002 SENATE RESOLUTION NO. 149, PRINTER'S NO. 2175

HOUSE AMENDED
PRIOR PRINTER'S NOS. 1653, 1837, 2032 PRINTER'S NO. 2175

THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE RESOLUTION

No. 149 Session of 2002

INTRODUCED BY GREENLEAF, COSTA, LEMMOND, BOSCOLA, EARLL, HELFRICK, KUKOVICH, O'PAKE, SCHWARTZ, M. WHITE, MELLOW, DENT, ERICKSON, FUMO, HOLL, HUGHES, LOGAN, MOWERY, MURPHY, STACK, TARTAGLIONE, THOMPSON, D. WHITE, C. WILLIAMS, KITCHEN, WOZNIAK AND A. WILLIAMS, JANUARY 10, 2002

AS AMENDED, HOUSE OF REPRESENTATIVES, JUNE 28, 2002

A CONCURRENT RESOLUTION

Directing the Joint State Government Commission to establish a bipartisan task force with an advisory committee to study and make recommendations regarding ~~the geriatric, seriously ill and lifer populations~~ CERTAIN SEGMENTS OF THE PRISON POPULATION in Pennsylvania State correctional institutions.

WHEREAS, In State correctional institutions as of September 2001 there were 1,892 inmates 55 years of age or older, comprising 5% of the total inmate population of 37,407; and

WHEREAS, In State correctional institutions as of September 2001 there were 3,718 inmates serving life sentences, comprising 10% of the total inmate population; and

WHEREAS, Of the total ~~lifer population~~ NUMBER OF INMATES SERVING LIFE SENTENCES as of September 2001, 415 inmates, or 11%, were 55 years of age or older; and

WHEREAS, In Pennsylvania, life imprisonment means life in prison without consideration for parole; and

WHEREAS, As of September 2001, 892 inmates in State

correctional institutions convicted of second degree murder are serving life sentences even though their culpability may not be the same as someone who committed a deliberate and intentional first degree murder; and

WHEREAS, The ~~lifer population~~ NUMBER OF INMATES SERVING LIFE SENTENCES in State correctional institutions continues to grow, with 2,291 ten years ago, 2,973 five years ago and 3,718 as of September 2001; and

~~WHEREAS, The lifer population continues to age, with 55% of the lifer population between 35 to 54 years of age, and has~~

WHEREAS, THE SEGMENT OF THE PRISON POPULATION SERVING LIFE SENTENCES CONTINUES TO AGE; 55% OF THAT POPULATION IS BETWEEN 35 AND 54 YEARS OF AGE AND HAS little hope for pardon or commutation of sentence; and

WHEREAS, Many inmates suffer from serious long-term mental or physical illnesses which require costly care; and

WHEREAS, The average cost of housing an inmate at SCI-Laurel Highlands, the State correctional institution charged with caring for older and infirm inmates, is currently $65,985 per year per inmate; and

WHEREAS, Because of age, illness or rehabilitation, many inmates, including some ~~lifers~~ SERVING LIFE SENTENCES, no longer pose a threat to society and are being held in State correctional institutions at considerable expense to taxpayers; and

WHEREAS, The General Assembly should consider alternatives for addressing the geriatric~~, seriously ill and lifer~~ AND SERIOUSLY ILL populations in State correctional institutions AND SHOULD IDENTIFY PROBLEMS AND SPECIAL ISSUES RELATED TO SUCH INMATES, WHETHER SUCH PROBLEMS AND ISSUES ARE PRESENT NOW OR ARE

ANTICIPATED TO ARISE; therefore be it

RESOLVED (the House of Representatives concurring), That the General Assembly direct the Joint State Government Commission to establish a bipartisan task force consisting of two members appointed by the President pro tempore of the Senate, two members appointed by the Minority Leader of the Senate, two members appointed by the Speaker of the House of Representatives and two members appointed by the Minority Leader of the House of Representatives; and be it further

RESOLVED, That the task force create an advisory committee composed of representatives of the Department of Corrections, THE DEPARTMENT OF AGING, the Pennsylvania Board of Probation and Parole AND THE OFFICE OF VICTIM ADVOCATE, the Pennsylvania Prison Society, THE PENNSYLVANIA COMMISSION ON CRIME AND DELINQUENCY, THE PENNSYLVANIA DISTRICT ATTORNEYS ASSOCIATION, THE PENNSYLVANIA STATE CORRECTIONS OFFICER'S ASSOCIATION, MENTAL HEALTH ADVOCATES, criminal justice experts and additional members as the task force deems appropriate; and be it further

RESOLVED, That the task force study the geriatric~~, seriously ill and lifer~~ AND SERIOUSLY ILL populations in Pennsylvania State correctional institutions, review how other states deal with these populations and make recommendations to the General Assembly.

APPENDIX B

MA-51 MEDICAL EVALUATION

INSTRUCTIONS FOR COMPLETING
MA-51 MEDICAL EVALUATION

NOTE: THE MA-51 IS VALID AS LONG AS IT REFLECTS THE CURRENT CONDITIONS FOR THE APPLICANT

At the top of the page, mark if this is a new or updated MA-51.

Questions 1-7 are self-explanatory.

8. **Physician License Number.** Enter the physician license number, not the Medical Assistance number.

9. **Evaluation At.** Enter 1-5 to describe where evaluation took place. If 5 is used, specify where evaluation was completed.

10. **Signature.** Applicant should sign if able to. If unable, legal guardian or responsible party may sign.

11. **Essential Vital Signs.** Self-explanatory.

12. **Medical Summary.** Include any medical information you feel is important for determination of level of care. **Please list patient's known allergies in this section.**

13. **Vacating of building.** How much assistance does the patient require to vacate the building?

14. **Medication Administration.** Is the patient capable of being trained to self-administer medications?

15. **Diagnostic Codes and Diagnoses.** ICD-9-CM diagnostic codes should be put in the blocks, then written by name in the space next to the block. List diagnoses starting with primary, then secondary, and finally tertiary. There is room for any other pertinent diagnoses.

16. **Professional and Technical Care Needs.** Indicate care needed. Examples of "other" include mental health and case management.

17. **Physician Orders.** Orders should meet needs indicated in box 16. Medications should have a diagnoses to support their use.

18. **Prognosis.** Indicate patient's prognosis based on current medical condition.

19. **Rehabilitation Potential.** Indicate based on current condition. Should be consistent with box 18.

20A. **Physician's Recommendation.** Physician must recommend patient's level of care. If the box for "other" is checked, write-in level of care. In order to provide assistance to a physician in the level of care recommendation, the following definitional guidelines should be considered:

Nursing Facility Clinically Eligible (NFCE)	Personal Care Home	ICF/MR Care	ICF/ORC Care	Inpatient Psychiatric Care
Requires health-related care and services because the physical condition necessitates care and services that can be provided in the community with Home and Community Based Services or in a Nursing Facility.	Provides Personal Care services such as meals, housekeeping, & ADL assistance as needed to residents who live on their own in a residential facility.	Provides health-related care to MR individuals. More care than custodial care but less than in a NF.	Provides health-related care to ORC individuals. More care than custodial care but less than in a NF.	Provides inpatient psychiatric services for the diagnoses and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

20B. **Complete only if Consumer is NFCE and will be served in a Nursing Facility.** Check whether the patient will be eventually be discharged from facility based on current prognosis. If yes, check expected length of stay.

20C. **The physician must sign and date the MA-51. A licensed physician must sign the MA-51.** It may not be signed by a "physician in training" (a Medical Doctor in Training [MT] or an Osteopathic Doctor in Training [OT].

Questions 21 and 22 completed by OPTIONS site.

MA 51 - 2/03

MEDICAL EVALUATION ☐ NEW ☐ UPDATED

1. MA RECIPIENT NUMBER	2. NAME OF APPLICANT (Last, first, middle initial)	3. SOCIAL SECURITY NO.	4. BIRTHDATE	5. AGE	6. SEX

7. ATTENDING PHYSICIAN	8. PHYSICIAN LICENSE NUMBER

9. EVALUATION AT (Description and code) ☐

01 Hospital
02 NF
03 Personal Care/Dom Care
04 Own House/Apartment
05 Other (Specify) _____

10. For the purpose of determining my need for TITLE XIX INPATIENT CARE, Home and Community Based Services, and if applicable, my need for a shelter deduction, I authorize the release of any medical information by the physician to the County Assistance Office, State Department of Public Welfare or its agents.

SIGNATURE - APPLICANT OR PERSON ACTING FOR APPLICANT _____ DATE _____

11. HEIGHT	WEIGHT	BLOOD PRESSURE	TEMPERATURE	PULSE RATE	CARDIAC RHYTHM

12. MEDICAL SUMMARY

13. IN EVENT OF AN EMERGENCY THE PATIENT CAN VACATE THE BUILDING
☐ 1. Independently ☐ 2. With Minimal Assistance ☐ 3. With Total Assistance

14. PATIENT IS CAPABLE OF ADMINISTERING HIS/HER OWN MEDICATIONS
☐ 1. Self ☐ 2. Under Supervision ☐ 3. No

15. ICD-9-CM DIAGNOSTIC CODES

PRIMARY (Principal)
SECONDARY
TERTIARY

16. PROFESSIONAL AND TECHNICAL CARE NEEDED - CHECK ✓ EACH CATEGORY THAT IS APPLICABLE

☐ Physical Therapy ☐ Speech Therapy ☐ Occupational Therapy ☐ Inhalation Therapy ☐ Special Dressings ☐ Irrigations
☐ Special Skin Care ☐ Parenteral Fluids ☐ Suctioning ☐ Other (Specify) _____

17. PHYSICIAN ORDERS

Medications _____
Treatment _____
Rehabilitative and Restorative Services _____
Therapies _____
Diet _____
Activities _____
Social Services _____
Special Procedures for Health and Safety or to Meet Objectives _____

18. PROGNOSIS - CHECK ✓ ONLY ONE
☐ 1. Stable ☐ 2. Improving ☐ 3. Deteriorating

19. REHABILITATION POTENTIAL - CHECK ✓ ONLY ONE
☐ 1. Good ☐ 2. Limited ☐ 3. Poor

20A **PHYSICIANS RECOMMENDATION** To the best of my knowledge, the patient's medical condition and related needs are essentially as indicated above. I recommend that the services and care to meet these needs can be provided at the level of care indicated - check ✓ only one

☐ Nursing Facility Clinically Eligible Services to be provided at home or in a nursing facility
☐ Personal Care Home Services provided in a Personal Care Home
☐ ICF/MR Care Services to be provided at home or in an Intermediate care facility for the mentally retarded
☐ ICF/ORC Care Services to be provided at home or in an Intermediate care facility for consumers with ORCs
☐ Inpatient Psychiatric Care
☐ Other (Please Specify) _____

20B. **COMPLETE ONLY IF CONSUMER IS NURSING FACILITY CLINICALLY ELIGIBLE AND WILL BE SERVED IN A NURSING FACILITY.**
ON THE BASIS OF PRESENT MEDICAL FINDINGS THE PATIENT MAY EVENTUALLY RETURN HOME OR BE DISCHARGED. ☐ YES ☐ NO If Yes, Check ✓ Only One ☐ 1. Within 180 days ☐ 2. Over 180 days

20C. **PHYSICIAN'S SIGNATURE**

PHYSICIAN (PRINTED NAME) _____ DATE _____ PHYSICIAN SIGNATURE _____ DATE _____

FOR DEPARTMENT USE Medical and other professional personnel of the Medicaid agency or its designee MUST evaluate each applicant's or recipient's need for admission by reviewing and assessing the evaluations required by regulations.

21A. **MEDICALLY ELIGIBLE** ☐ Yes ☐ No ☐ Medically Appropriate for Waiver Services

22 **Comments. Attach a separate sheet if additional comments are necessary.**

REVIEWER'S SIGNATURE AND TITLE _____ DATE _____

MA 51 - 2/03

APPENDIX C

CHARTS ON OTHER STATES

HEALTH STATISTICS
MENTAL HEALTH STATISTICS

State	Inmates age 50 or over in adult correctional agencies on 1/1/01[1]	Percentage of total inmates on 1/1/01[1]	TB infection detected in 2000[2]	HIV confirmed on 1/1/01[3]	AIDS confirmed on 1/1/01[4]	Institutional care	Private vendor care	Correctional agency medical budget FY 01[5]	Average cost of health care per inmate per day in 2000[6]	Agency health care on 1/1/01[6,7]	Statutes/regulations providing for early release
Alabama	1,925	6.3%	3	243	63	No	Yes	$28,528,515	na	$3 max. $3 min.	na
Alaska	361	8.7%	39	14	4	na	na	$15,218,700	$16.69	$4 max. $4 min.	na
Arizona	2,377	8.9%	403	110	10	Yes	No	$73,479,900	$7.75	$3 max. $3 min.	na
Arkansas	870	6.8%	301	71	25	No	Yes	$21,601,135	$5.34	na	Act 771 of 1991 provides for early release of terminally ill inmates
California	12,426	7.6%	na	1,638	556	Yes[8]	Yes	$522,959,791	$1.02	$5 max. $5 min.	Terminally ill inmates eligible for "compassionate release" re-sentencing statute
Colorado	1,417	8.4%	434	150	25	na	na	$38,940,262	$9.09	$3 max. $.50 min.	na
Connecticut	849	4.5%	561	340	243	Yes[9]	No	$65,583,653	$9.41	$3 max.	CGS §§ 54-131a through g provides for medical parole
Delaware	326	5.4%	63	135	38	Yes	No	$15,098,000	$5.80	$4 max. $4 min.	Medical release available to terminally ill through court sentence modification

State	Inmates age 50 or over in adult correctional agencies on 1/1/01[1]	Percentage of total inmates on 1/1/01[1]	TB infection detected in 2000[2]	HIV confirmed on 1/1/01[3]	AIDS confirmed on 1/1/01[4]	Institutional care	Private vendor care	Correctional agency medical budget FY 01[5]	Average cost of health care per inmate per day in 2000[6]	Agency health care on 1/1/01[6,7]	Statutes/regulations providing for early release
Florida	5,873	8.2%	2,742	2,640	na	Yes	No	$245,520,272	$9.76	$4 max. $4 min.	na
Georgia	3,426	7.8%	1,691	938	na	Yes	Yes	$107,592,756	$6.90	$5 max.	Medical Reprieve Process to evaluate eligibility for medical reprieve in cases of cancer, AIDS
Hawaii	458	8.9%	726	8	2	Yes	No	$9,788,366	$10.00	$3 max. $0 min.	na
Idaho	508	9.6%	20	10	4	Yes	No	$9,065,000	$6.29	$3 max. $2 min.	na
Illinois	2,392	5.3%	2,561	603	116	na	na	$69,535,700	$4.13	$2 max. $2 min.	--
Indiana	1,636	8.1%	239	75	na	Yes	No	na	$3.66	$5 max.	na
Iowa	468	5.8%	na	31	10	Yes	No	$13,980,854	$5.24	$3 max.	Governor can commute "life sentence" to "term of years" and board of parole can parole inmate if seriously ill
Kansas	727	8.6%	477	43	6	Yes	Yes	$22,818,003	$6.88	$2 max. $2 min.	Substitute for SB 339 of 2002 provides for release of inmates who are functionally incapacitated

State	Inmates age 50 or over in adult correctional agencies on 1/1/01[1]	Percentage of total inmates on 1/1/01[1]	TB infection detected in 2000[2]	HIV confirmed on 1/1/01[3]	AIDS confirmed on 1/1/01[4]	Institutional care	Private vendor care	Correctional agency medical budget FY 01[5]	Average cost of health care per inmate per day in 2000[6]	Agency health care on 1/1/01[6,7]	Statutes/regulations providing for early release
Kentucky	1,156	7.7%	444	na	na	Yes	No	$28,500,000	$7.89	$2 max.	na
Louisiana	2,787	8.0%	900	525	171	Yes[7,9]	No	$6,226,153	$5.13	$3 max. $2 min.	L.A.R.S. 15:833 provides for inmate medical furloughs; L.A.R.S. 15:574.20 provides for parole for permanently incapacitated or terminally ill
Maine	179	10.3	na	na	na	Yes	No	na	$6.00	na	Maine provides for a terminally ill inmate to be released to a community placement with permission of the commissioner and if medically necessary. § 3036-A
Maryland	1,509	6.5%	1,747	1,024	278	Yes	No	$46,734,748	$5.64	$2 max. $2 min.	Maryland provides for medical parole to terminally ill inmates or inmates who are in need of care not available at the institution
Massachusetts	1,274	11.1%	404	305	123	Yes	No	$53,457,000	$7.76	$5 max.	na
Michigan	4,436	9.2%	394	585	585	Yes	No	$226,836,000	$6.96	$3 max.	na

State	Inmates age 50 or over in adult correctional agencies on 1/1/01[1]	Percentage of total inmates on 1/1/01[1]	TB infection detected in 2000[2]	HIV confirmed on 1/1/01[3]	AIDS confirmed on 1/1/01[4]	Institutional care	Private vendor care	Correctional agency medical budget FY 01[5]	Average cost of health care per inmate per day in 2000[6]	Agency health care on 1/1/01[6,7]	Statutes/regulations providing for early release
Minnesota	389	6.1%	164	42	2	Yes[9]	No	$25,204,760	$9.65	$3 max. $3 min.	Conditional medical release policy allows department to conditionally release an inmate to a community facility, e.g., nursing home, hospital
Mississippi	1,171	5.8%	na	296	296	Yes	Yes	$25,843,327	$5.43	$3 max. $3 min.	Mississippi Code of 1972, as amended, § 47-7-5 provides that the parole board can, with approval and consent of the commissioner of corrections, parole an inmate suffering from a terminal illness
Missouri	2,054	7.3%	370	221	48	Yes	No	$57,388,644	$4.74	na	§ 217.250, Revised Statutes of Missouri authorizes Missouri board of probation and parole to grant or deny medical parole
Montana	250	8.1%	0	7	0	Yes	No	na	$3.69	$2 max. $2 min.	MCA 46-23-210 provides that the parole board may release on medical parole an inmate suffering from an incapacitating medical condition, disease or syndrome
Nebraska	294	7.6%	45	22	2	Yes	No	$9,260,468	$6.75	na	na

State	Inmates age 50 or over in adult correctional agencies on 1/1/01[1]	Percentage of total inmates on 1/1/01[1]	TB infection detected in 2000[2]	HIV confirmed on 1/1/01[3]	AIDS confirmed on 1/1/01[4]	Institutional care	Private vendor care	Correctional agency medical budget FY 01[5]	Average cost of health care per inmate per day in 2000[6]	Agency health care on 1/1/01[6,7]	Statutes/regulations providing for early release
Nevada	1,099	10.8%	382	92	27	Yes	No	$33,836,772	$8.20	$4 max. $4 min.	na
New Hampshire	277	12.1%	30	17	6	Yes	No	$6,471,990	$8.07	$5 max. $0 min.	na
New Jersey	1,854	6.4%	425	610	161	Yes[9]	No	$79,863,000	$7.84	na	na
New Mexico	399	7.5%	0	28	0	na	na	$21,580,800	$11.91	na	na
New York	5,111	7.3%	3,017	na	1,340	Yes	No	$190,959,300	$8.29	na	Statutory provision for medical parole of inmates diagnosed with terminal disease who are significantly debilitated
North Carolina	2,258	7.2%	1,486	588	213	na	na	na	na	na	NCGS § 148-4 permits the secretary of corrections to extend the limits of confinement for terminally ill and permanently and totally disabled inmates
North Dakota	63	5.4%	49	0	0	Yes	No	$2,439,148	$5.97	$0.15 min.	na
Ohio	4,338	9.5%	373	34	138	Yes	No	$113,164,886	$6.79	$3 max. $3 min.	Ohio provides for the governor to parole inmates who are in imminent danger of death. Ch. 2967 §§ 2967.01 thru 2967.31

State	Inmates age 50 or over in adult correctional agencies on 1/1/01[1]	Percentage of total inmates on 1/1/01[1]	TB infection detected in 2000[2]	HIV confirmed on 1/1/01[3]	AIDS confirmed on 1/1/01[4]	Institutional care	Private vendor care	Correctional agency medical budget FY 01[5]	Average cost of health care per inmate per day in 2000[6]	Agency health care on 1/1/01[6,7]	Statutes/regulations providing for early release
Oklahoma	2,072	8.9%	402	111	34	Yes	No	$38,478,320	$3.87	$2 max. $2 min.	Pardon and parole board establishes criteria to determine the eligibility of inmates for clemency consideration. Criteria includes medical parole
Oregon	1,078	9.3%	161	28	na	na	na	$37,003,892	$6.51	na	na
Pennsylvania	3,653	9.9%	671	653	247	Yes	Yes	$138,874,000	$9.81	$2 max. $2 min.	Act 170 of 1919
Rhode Island	239	6.9%	325	49	20	Yes	No	$12,857,137	$11.00	na	na
South Carolina	1,333	6.1%	756	327	232	Yes	No	$55,060,023	$7.03	na	South Carolina provides for a medical furlough that allows a terminally ill inmate to be furloughed
South Dakota	202	7.7%	0	4	4	na	na	$4,982,073	$5.01	$2 max. $2 min.	na
Tennessee	1,514	6.8%	295	180	45	Yes	No	$39,194,800	$5.68	$5 max. $3 min.	Commissioner of corrections may grant a medical furlough to an inmate whose medical condition is such that he cannot function in an institutional environment and is no longer a threat to the community

State	Inmates age 50 or over in adult correctional agencies on 1/1/01[1]	Percentage of total inmates on 1/1/01[1]	TB infection detected in 2000[2]	HIV confirmed on 1/1/01[3]	AIDS confirmed on 1/1/01[4]	Institutional care	Private vendor care	Correctional agency medical budget FY 01[5]	Average cost of health care per inmate per day in 2000[6]	Agency health care on 1/1/01[6,7]	Statutes/regulations providing for early release
Texas	13,064	8.7%	3,803	1,595	903	Yes	No	$330,691,847	$6.55	$3 max. $3 min.	Under the Texas Medically Recommended Intensive Supervision Program eligible offenders may apply for early release. TGC, Ch. 508 § 146
Utah	490	8.5%	6	38	17	na	na	$5,890,226	$11.15	$4 max. $0 min.	na
Vermont	122	6.7%	0	15	5	Yes	No	na	$8.85	na	VSA Title 28, Ch. 11, § 808 and Furlough Policy 372 provides for inmates who are incapacitated by age or illness to transfer to home, hospice or nursing home
Virginia	2,688	8.0%	331	550	186	Yes	No	$94,100,377	$5.61	$5 max. $2 min.	Parole Board Conditional Release Policy provides for release of felons 65 or older who have served 5 years or 60 or older who have served 10 years
Washington	1,352	9.0%	565	82	18	Yes	No	$43,887,008	$8.01	$3 max. $3 min.	Extraordinary Medical Placement (EMP) Policy Directive 350.270 provides for alternative care; Extraordinary Release Policy Directive 350.275 provides for release

State	Inmates age 50 or over in adult correctional agencies on 1/1/01[1]	Percentage of total inmates on 1/1/01[1]	TB infection detected in 2000[2]	HIV confirmed on 1/1/01[3]	AIDS confirmed on 1/1/01[4]	Institutional care	Private vendor care	Correctional agency medical budget FY 01[5]	Average cost of health care per inmate per day in 2000[6]	Agency health care on 1/1/01[6,7]	Statutes/regulations providing for early release
West Virginia	372	9.6%	0	12	2	Yes	No	$8,500,000	$5.75	$5 max. $3 min.	"medical respite" at governor's discretion for seriously ill inmates
Wisconsin	1,382	6.6%	162	108	53	Yes	No	$29,358,900	$6.72	$2.50 min.	na
Wyoming	183	10.9%	1	3	2	na	na	$11,035,800	$10.62	na	na

1. The Corrections Yearbook 2001, pp. 34-35.
2. The Corrections Yearbook 2001, pp. 48-49.
3. The Corrections Yearbook 2001, p. 50.
4. The Corrections Yearbook 2001, p. 51.
5. The Corrections Yearbook 2001, p. 98.
6. The Corrections Yearbook 2001, pp. 105-106.
7. Thirty-nine agencies charged inmates for health care as of January 1, 2001.
8. Community-based General Acute Care Hospitals (GACHs) under contract.
9. Hospice and Palliative Care Program for terminally-ill inmates. Similar programs to that in Connecticut are located in Louisiana, Minnesota and New Jersey.

SOURCE: The Corrections Yearbook 2001.

MENTAL HEALTH STATISTICS ON JANUARY 1, 2001

State	Inmates in mental health programs[1]	Percentage of total inmates[1]	Mental health and counseling staff[2]	Contracted mental health services[3,4]	Contracted mental health care[3,4]
Alabama	na	na	157	na	na
Alaska	286	10.4%	21	na	na
Arizona	350	1.4	179	na	na
Arkansas	na	na	100	na	na
California	21,088	14.0	2,695	na	na
Colorado	1,900	14.6	107	na	na
Connecticut	2,312	12.8	132	20	20
Delaware	39	0.7	64	5	na
Florida	580	0.9	493	5	5
Georgia	5,486	13.7	680	na	na
Hawaii	160	4.4	298	na	na
Idaho	140	3.7	na	7	7
Illinois	1,300	2.9	547	na	na
Indiana	89	0.5	315	24	na
Iowa	na	na	223	na	na
Kansas	171	2.1	71	8	8
Kentucky	150	1.5	90	na	na
Louisiana	189	1.2	89	na	na
Maine	25	1.4	35	na	na
Maryland	375	1.6	372	na	na
Massachusetts	90	0.8	98	22	22
Michigan	2,886	6.1	202	na	na
Minnesota	90	1.5	215	na	na
Mississippi	na	na	116	na	1
Missouri	277	1.0	79	na	na
Montana	na	na	6	3	na
Nebraska	44	1.2	315	na	na
Nevada	682	7.2	152	na	na
New Hampshire	na	na	15	na	na
New Jersey	260	1.1	2,397	na	na
New Mexico	1,631	51.0	117	na	na
New York	589	0.8	547	na	na
North Carolina	na	na	na	na	na
North Dakota	na	na	18	na	na
Ohio	7,000	16.1	813	2	4
Oklahoma	104	0.7	35	na	na
Oregon	116	1.1	121	na	na
Pennsylvania	152	0.4	631	26	26
Rhode Island	16	0.5	39	1	na
South Carolina	1,688	7.7	412	na	na
South Dakota	52	2.0	33	7	7
Tennessee	384	2.1	60	na	na
Texas	1,959	1.5	2,299	93	na
Utah	872	20.2	33	na	na
Vermont	28	2.0	na	na	na
Virginia	553	1.9	556	4	2
Washington	477	3.2	140	na	na
West Virginia	28	0.9	na	1	1
Wisconsin	na	na	386	na	na
Wyoming	na	na	37	na	na

1. The Corrections Yearbook 2001, pp. 134-135.
2. The Corrections Yearbook 2001, pp. 176-179. Includes psychiatrists, psychologists, social workers, caseworkers, rec. therapists, counselors and others.
3. The Corrections Yearbook 2001, p. 109.
4. Number of prisons.

SOURCE: The Corrections Yearbook 2001

APPENDIX D

REMOVAL OF ILL PRISONERS TO OTHER INSTITUTIONS AUTHORIZED
Act of May 31, 1919, P.L.356, No.170

AN ACT

Authorizing courts of record to remove convicts and persons confined in jails, workhouses, reformatories, reform or industrial schools, penitentiaries, prisons, houses of correction or any other penal institutions, who are seriously ill, to other institutions; and providing penalties for breach of prison.

(Title amended Jan. 26, 1966 (1965), P.L.1593, No.561)

Section 1. Be it enacted, &c., That whenever any convict or person is confined in any jail, workhouse, reformatory, or reform or industrial school, penitentiary, prison, house of correction or any other penal institution, under conviction or sentence of a court, or is so confined while awaiting trial or confined for any other reason or purpose and it is shown to a court of record by due proof that such convict or person is seriously ill, and that it is necessary that he or she be removed from such penal institution, the court shall have power to modify its sentence, impose a suitable sentence, or modify the order of confinement for trial, as the case may be, and provide for the confinement or care of such convict or person in some other suitable institution where proper

treatment may be administered. Upon the recovery of such person, the court shall recommit him or her to the institution from which he or she was removed.

(1 amended Jan. 26, 1966 (1965), P.L.1593, No.561)

Section 2. If any person so removed under an order of court, as provided in the first section of this act, shall escape, he or she, so offending, shall, upon conviction thereof, be guilty of the crime of breach of prison.

APPENDIX E

STATISTICS – PENNSYLVANIA BOARD OF PROBATION AND PAROLE

Offender 2003 Release Cohort
Mental Health Roster Performance Outcome
Age Breakdown of Release Cohort

This study resulted from a request for information by the Joint State Government Commission for the Advisory Committee on Geriatric and Seriously Ill Inmates. The request was for parole recidivism information and age-related information that delineated population characteristics in terms of mental illness. Since the Department of Corrections uses a standard system of classifying mental health problems, a list of offenders released in 2003 was provided to the Parole Board with release date and mental health roster status in order to determine case performance after release. Parole status was determined effective October 2004, meaning that nearly all cases were followed for a year after release from prison. Parole outcome data was successfully obtained for 8,211 offenders in the original data set of 8,821. Since each monthly release group was followed for the same amount of time but not every group had the same overall follow-up length, percentage recidivism level was computed instead of a rate for a fixed period.

The detail tables enable specific questions to be answered regarding the composition and performance of 8,211 offenders. As requested, the data is presented without analysis or interpretation so that committee members may study and draw conclusions at their discretion. Summary tables are presented on the first page, and detailed breakdowns for 8,211 offenders and a subset of 492 offenders who were 50 years of age or older at release are also provided. Technical violators are separated from convicted violators.

Age Characteristics of 2003 Release Cohort and Mental Health Roster

Age Group	Psychiatric Review Team		Active Mental Health Roster		Inactive Mental Health Roster		NO MH\MR Issue		Total Releases	
	number	% total	number	% total	number	% total	number	% total	number	% total
25 or less	10	9%	91	13%	135	17%	1,712	26%	1,948	24%
26 to 49	81	76%	555	77%	587	75%	4,548	69%	5,771	70%
over 50	15	14%	71	10%	56	7%	350	5%	492	6%
Total	106	100%	717	100%	778	100%	6,610	100%	8,211	100%

Overall Outcome Performance of 2003 Release Cohort and Mental Health Roster

Outcome Performance	Psychiatric Review Team		Active Mental Health Roster		Inactive Mental Health Roster		NO MH\MR Issue		Total Releases	
	number	% total	number	% total	number	% total	number	% total	number	% total
Processing	74	70%	499	70%	524	67%	4,569	69%	5,666	69%
Violation Techs	13	12%	71	10%	89	11%	679	10%	852	**10%**
Violation Crimes	5	5%	32	4%	46	6%	409	6%	492	**6%**
Recidivism TV	11	10%	97	14%	100	13%	720	11%	928	**11%**
Recidivism CV	3	3%	18	3%	19	2%	233	4%	273	**3%**
Total	106	100%	717	100%	778	100%	6,610	100%	8,211	100%
% Recidivism	30%		30%		33%		31%		31%	

Overall Outcome Performance of 2003 Release Cohort Over 50 Years and Mental Health Roster

Outcome Performance	Psychiatric Review Team		Active Mental Health Roster		Inactive Mental Health Roster		NO MH\MR Issue		Total Releases	
	number	% total	number	% total	number	% total	number	% total	number	% total
Processing	12	80%	55	77%	46	82%	283	81%	396	80%
Violation Techs	1	7%	6	8%	6	11%	28	8%	41	8%
Violation Crimes	0	0%	3	4%	2	4%	4	1%	9	2%
Recidivism TV	1	7%	6	8%	2	4%	30	9%	39	8%
Recidivism CV	1	7%	1	1%	0	0%	5	1%	7	1%
Total	15	100%	71	100%	56	100%	350	100%	492	100%
% Recidivism	20%		23%		18%		19%		20%	

Follow Up Outcome of Releases in 2003 - Mental Health Roster Status

Outcome		Statistic	Psychiatric Review Team	Active Mental Health Roster	Inactive Mental Health Roster	NO MH\MR Issue	Total Releases
Supervision	Within 1st Year	*number cases*	11	96	113	777	997
		Avg release age	43	38	36	34	35
	After 1st Year	*number cases*	23	214	251	2,151	2,639
		Avg release age	43	39	37	34	35
	Total	***number cases***	**34**	**310**	**364**	**2,928**	**3,636**
		Avg release age	43	39	37	34	35
Absconder	Within 1st Year	*number cases*	1	9	9	74	93
		Avg release age	21	34	35	30	31
	After 1st Year	*number cases*	1	23	20	233	277
		Avg release age	44	37	36	31	32
	Total	***number cases***	**2**	**32**	**29**	**307**	**370**
		Avg release age	32	36	36	31	32
UCV technical violation	Within 1st Year	*number cases*	9	30	27	172	238
		Avg release age	36	36	34	33	34
	After 1st Year	*number cases*	4	41	62	507	614
		Avg release age	35	37	37	34	34
	Total	***number cases***	**13**	**71**	**89**	**679**	**852**
		Avg release age	36	37	36	34	34
UCV new crime	Within 1st Year	*number cases*	3	8	14	97	122
		Avg release age	39	41	36	31	33
	After 1st Year	*number cases*	2	24	32	312	370
		Avg release age	32	36	35	31	31
	Total	***number cases***	**5**	**32**	**46**	**409**	**492**
		Avg release age	37	37	35	31	32
Recomitment Technical Violation	Within 1st Year	*number cases*	5	34	38	219	296
		Avg release age	31	34	34	32	32
		Avg Years to close	0.6	0.7	0.6	0.7	0.7
	After 1st Year	*number cases*	6	63	62	501	632
		Avg release age	36	35	34	33	33
		Avg Years to close	1.1	1	1	1.1	1.1
	Total	***number cases***	**11**	**97**	**100**	**720**	**928**
		Avg release age	34	35	34	33	33
		Avg Years to close	0.9	0.9	0.9	1	0.9
Recomitment New Conviction	Within 1st Year	*number cases*	2	2	7	46	57
		Avg release age	26	35	33	33	33
		Avg Years to close	0.7		0.8	0.8	0.8
	After 1st Year	*number cases*	1	16	12	187	216
		Avg release age	51	37	35	31	32
		Avg Years to close		1.2	1.2	1.2	1.2
	Total	***number cases***	**3**	**18**	**19**	**233**	**273**
		Avg release age	34	37	34	31	32
		Avg Years to close	0.7	1.2	1	1.2	1.2
Maximum expiration of sentence	Within 1st Year	*number cases*	6	17	15	116	154
		Avg release age	38	33	32	33	33
		Avg Years to close	0.7	0.6	0.6	0.6	0.6
	After 1st Year	*number cases*	20	109	76	687	892
		Avg release age	38	40	36	34	35
		Avg Years to close	0.8	0.8	0.8	0.9	0.9
	Total	***number cases***	**26**	**126**	**91**	**803**	**1,046**
		Avg release age	38	39	36	34	35
		Avg Years to close	0.7	0.8	0.8	0.8	0.8
Other Case Closure	Within 1st Year	***number cases***	2	8	12	123	145
		Avg release age	34	34	36	32	33
		Avg Years to close			0.6	0.6	0.6
	After 1st Year	*number cases*	10	23	28	408	469
		Avg release age	41	36	37	33	33
		Avg Years to close	0.5	0.8	0.7	0.8	0.8
	Total	*number cases*	**12**	**31**	**40**	**531**	**614**
		Avg release age	40	36	37	33	33
		Avg Years to close	0.5	0.8	0.6	0.8	0.7
	Total	*number cases*	**106**	**717**	**778**	**6,610**	**8,211**
		Avg release age	39	38	36	33	34
		Avg Years to close	0.7	0.8	0.8	0.9	0.9

Follow Up Outcome of Releases in 2003 that were 50 or more years old

Outcome		Statistic	Psychiatric Review Team	Active Mental Health Roster	Inactive Mental Health Roster	NO MHMR Issue	Total Releases
Supervision	Within 1st Year	*number cases*	3	9	11	58	81
		Avg release age	53	54	54	56	55
	After 1st Year	*number cases*	5	33	23	158	219
		Avg release age	56	56	55	56	56
	Total	*number cases*	8	42	34	216	300
		Avg release age	55	55	54	56	56
Absconder	Within 1st Year	*number cases*	0	0	0	2	2
		Avg release age	0	0	0	51	51
	After 1st Year	*number cases*	0	0	0	9	9
		Avg release age	0	0	0	53	53
	Total	*number cases*	0	0	0	11	11
		Avg release age	0	0	0	52	52
UCV technical violation	Within 1st Year	*number cases*	1	2	1	5	9
		Avg release age	51	57	50	54	54
	After 1st Year	*number cases*	0	4	5	23	32
		Avg release age	0	52	52	56	55
	Total	*number cases*	1	6	6	28	41
		Avg release age	51	54	52	56	55
UCV new crime	Within 1st Year	*number cases*	0	1	1	2	4
		Avg release age	0	58	53	51	54
	After 1st Year	*number cases*	0	2	1	2	5
		Avg release age	0	53	51	53	53
	Total	*number cases*	0	3	2	4	9
		Avg release age	0	55	52	52	53
Recomitment Technical Violation	Within 1st Year	*number cases*	0	3	1	9	13
		Avg release age	0	53	54	52	53
		Avg Years to close	0	0.9		0.6	0.7
	After 1st Year	*number cases*	1	3	1	21	26
		Avg release age	50	51	61	54	54
		Avg Years to close	0.9	1.0		1.1	1.0
	Total	*number cases*	1	6	2	30	39
		Avg release age	50	52	58	54	53
		Avg Years to close	0.9	1.0		0.9	0.9
Recomitment New Conviction	Within 1st Year	*number cases*	0	0	0	2	2
		Avg release age	0	0	0	57	57
		Avg Years to close	0	0	0	0.8	0.8
	After 1st Year	*number cases*	1	1	0	3	5
		Avg release age	51	52	0	56	55
		Avg Years to close		1.0	0.0		1.0
	Total	*number cases*	1	1	0	5	7
		Avg release age	51	52	0	56	55
		Avg Years to close		1.0	0.0	0.8	0.9
Maximum expiration of sentence	Within 1st Year	*number cases*	0	0	0	2	2
		Avg release age	0	0	0	54	54
		Avg Years to close	0	0	0	0.9	0.9
	After 1st Year	*number cases*	4	11	5	30	50
		Avg release age	55	55	57	57	56
		Avg Years to close	0.9	0.9	0.9	1.0	1.0
	Total	*number cases*	4	11	5	32	52
		Avg release age	55	55	57	56	56
		Avg Years to close	0.9	0.9	0.9	1.0	1.0
Other Case Closure	Within 1st Year	*number cases*	0	1	1	7	9
		Avg release age	0	54	68	59	60
		Avg Years to close	0		0.9	0.7	0.8
	After 1st Year	*number cases*	0	1	6	17	24
		Avg release age	0	50	58	56	56
		Avg Years to close	0	1.2	0.7	0.9	0.8
	Total	*number cases*	0	2	7	24	33
		Avg release age	0	52	59	57	57
		Avg Years to close	0	1.2	0.8	0.8	0.8
	Total	*number cases*	15	71	56	350	492
		Avg release age	54	55	55	56	55
		Avg Years to close	0.9	0.9	0.8	1	0.9

APPENDIX F

MENTAL HEALTH STATISTICS ON NOVEMBER 21, 2003

PENNSYLVANIA
STATE CORRECTIONAL INSTITUTIONS

Table 1

PERCENTAGE OF PENNSYLVANIA INMATES ON THE ACTIVE MENTAL HEALTH ROSTER

Institution	Number of inmates on mental health roster	Total number of inmates	Percentage of inmates on mental health roster
Muncy[1,2,3]	414	872	47.5%
Cambridge Springs[1,3*]	412	887	46.4%
Pittsburgh[2,3]	297	1,264	23.5%
Albion[3]	544	2,316	23.5%
Cresson[2,3]	296	1,346	22.0%
Frackville[2,3]	228	1,068	21.3%
Waymart[4,5]	270	1,380	19.6%
Retreat[3,7]	170	875	19.4%
Rockview[3]	379	2,011	18.8%
Somerset[3]	429	2,315	18.5%
Graterford[2,3]	572	3,259	17.6%
Coal Township[3]	332	1,919	17.3%
Greene County[3]	313	1,879	16.7%
Dallas[3]	344	2,098	16.4%
Greensburg[3]	147	927	15.9%
Camp Hill[3,6]	504	3,307	15.2%
Huntingdon[3]	318	2,088	15.2%
Smithfield[3]	183	1,209	15.1%
Houtzdale[3]	334	2,346	14.2%
Mercer	125	1,067	11.7%
Mahanoy[3]	252	2,313	10.9%
Pine Grove[8]	42	629	6.7%
Chester[9]	40	1,006	4.0%
Laurel Highlands[10]	28	889	3.1%
Fayette[3]	2	276	0.7%
Quehanna[11]	2	309	0.6%
Other	2	922	0.2%
Grand total	6,979	39,855	17.5%

1. Women's Prison
2. Mental Health Unit, Licensed Inpatient Psychiatric Unit
3. Special Needs Unit (* - Does not quite meet all policy guidelines of a special needs unit)
4. Psychiatric Hospital
5. Intermediate Care Unit
6. Special Observation Unit
7. Therapeutic Community for Dual Diagnosis Offenders (mental Illness/substance abuse)
8. Houses Juvenile Offenders
9. Houses Substance Abusers
10. Houses Geriatric/Nursing Care
11. Boot Camp

Table 2

NUMBER OF INMATES ON THE MENTAL HEALTH ROSTER, BROKEN DOWN BY ACTIVE MHR AND PRT AT EACH INSTITUTION IN PENNSYLVANIA

Institution	Active MHR	PRT	Total MHR
Graterford	430	142	572
Albion	478	66	544
Camp Hill	336	168	504
Somerset	358	71	429
Muncy	240	174	414
Cambridge Springs	370	42	412
Rockview	290	89	379
Dallas	255	89	344
Houtzdale	306	28	334
Coal Twp	232	100	332
Huntingdon	239	79	318
Greene Cnty	274	39	313
Pittsburgh	177	120	297
Cresson	275	21	296
Waymart	220	50	270
Mahanoy	183	69	252
Frackville	159	69	228
Smithfield	135	48	183
Retreat	137	33	170
Greensburg	117	30	147
Mercer	103	22	125
Pine Grove	37	5	42
Chester	37	3	40
Laurel Highlands	28	0	28
Fayette	2	0	2
Other	0	2	2
Quehanna	1	1	2
Grand total on mental health roster	5,419	1,560	6,979
Percentage of grand total on mental health roster	77.6%	22.4%	100.0%
Percentage of total PA prison population	13.3%	3.8%	17.1%

Table 3

NUMBER OF ACTIVE MHR AND PRT INMATES BY AGE IN PENNSYLVANIA
(NUMBERS IN PARENTHESIS INDICATE THE RANK OF THE TOP TEN AGES WITHIN EACH COLUMN)

Age	Active MHR	PRT	Total
16	1	0	1
17	10	0	10
18	8	7	15
19	32	8	40
20	64	21	85
21	96	28	124
22	129	28	157
23	133	33	166
24	164	37	201
25	155	35	190
26	153	49	202
27	161	32	193
28	126	34	160
29	146	33	179
30	150	36	186
31	197 (3)	38	235 (7)
32	158	37	195
33	184 (7)	51	235 (7)
34	171 (10)	47	218
35	177 (9)	53 (9)	230 (9)
36	148	57 (7)	205
37	202 (2)	53 (9)	255 (4)
38	213 (1)	57 (7)	270 (1)
39	192 (5)	71 (1)	263 (2)
40	178 (8)	59 (4)	237 (6)
41	189 (6)	58 (5)	247 (5)
42	196 (4)	66 (2)	262 (3)
43	171 (10)	58 (5)	229 (10)
44	159	61 (3)	220
45	135	50	185
46	158	44	202
47	121	42	163
48	128	33	161
49	106	46	152
50	73	26	99
51	97	21	118
52	74	29	103
53	76	19	95
54	79	17	96
55	40	11	51
56	52	10	62
57	38	8	46
58	31	12	43
59	24	7	31

Table 3 (continued)

Age	Active MHR	PRT	Total
60	20	7	27
61	19	6	25
62	16	4	20
63	16	6	22
64	6	2	8
65	6	2	8
66	9	1	10
67	6	0	6
68	6	1	7
69	4	1	5
70	2	1	3
71	0	0	0
72	3	2	5
73	1	4	5
74	1	1	2
75	1	0	1
76	1	0	1
77	2	0	2
78	2	0	2
79	0	0	0
80	0	0	0
81	1	0	1
82	0	0	0
83	0	0	0
84	0	0	0
85	1	0	1
86	0	0	0
87	0	0	0
88	1	0	1
Average age	37.5	38.3	37.7
Grand total	5,419	1,560	6,979

Table 4

AVERAGE AGE OF MENTALLY ILL INMATES BY RACE AND SEX IN PENNSYLVANIA

Race	Average age of males	Average age of females	Total average age
White	38	36	38
Black	38	37	38
Hispanic	36	34	36
Asian	37	40	38
Indian	42	43	42
Other	36	34	34
Total	38	36	38

Table 5

NUMBER OF ACTIVE MHR AND PRT INMATES BY COUNTY IN PENNSYLVANIA
COMPARED TO THE TOTAL NUMBER OF INMATES BY COUNTY

County	Active MHR	PRT	Total active MHR and PRT Inmates	Total inmate population[1]	Total active MHR and PRT inmates as a percent of total inmate population
Philadelphia	1,812	470	2,282	15,276	14.9%
Allegheny	400	142	542	3,584	15.1%
Erie	227	62	289	1,366	21.2%
Dauphin	204	60	264	1,797	14.7%
Berks	159	53	212	1,381	15.4%
Lehigh	158	39	197	1,061	18.6%
York	147	49	196	1,247	15.7%
Montgomery	132	54	186	1,192	15.6%
Delaware	127	47	174	1,321	13.2%
Lancaster	104	38	142	941	15.1%
Chester	100	23	123	807	15.2%
Fayette	91	28	119	454	26.2%
Luzerne	99	20	119	556	21.4%
Lackawanna	86	23	109	565	19.3%
Bucks	83	24	107	658	16.3%
Northampton	80	15	95	540	17.6%
Mercer	70	19	89	352	25.3%
Venango	64	22	86	268	32.1%
Franklin	64	20	84	400	21.0%
Lycoming	68	15	83	450	18.4%
Lebanon	57	22	79	370	21.4%
Westmoreland	62	15	77	422	18.2%
Clearfield	64	12	76	261	29.1%
Butler	58	17	75	269	27.9%
Northumberland	54	21	75	299	25.1%
Blair	47	16	63	283	22.3%
Crawford	43	14	57	219	26.0%
Cumberland	46	11	57	271	21.0%
Beaver	35	17	52	293	17.7%
Washington	37	10	47	244	19.3%
Cambria	32	9	41	210	19.5%
Monroe	27	14	41	212	19.3%
Centre	34	6	40	200	20.0%
Lawrence	29	10	39	217	18.0%
Adams	34	4	38	188	20.2%
Schuylkill	28	10	38	164	23.2%
Indiana	24	10	34	140	24.3%
Snyder	29	5	34	134	25.4%
Somerset	27	7	34	136	25.0%

Table 5 (continued)

County	Active MHR	PRT	Total active MHR and PRT Inmates	Total inmate population[1]	Total active MHR and PRT inmates as a percent of total inmate population
Wayne	26	7	33	143	23.1%
Jefferson	23	7	30	99	30.3%
Bradford	18	9	27	158	17.1%
Armstrong	18	7	25	73	34.2%
Susquehanna	19	4	23	77	29.9%
Warren	14	8	22	86	25.6%
Carbon	18	3	21	81	25.9%
Columbia	15	6	21	110	19.1%
Wyoming	15	5	20	62	32.3%
Union	18	1	19	87	21.8%
Bedford	15	3	18	53	34.0%
Clarion	14	4	18	62	29.0%
Greene	10	8	18	90	20.0%
Huntingdon	18	0	18	73	24.7%
Mckean	15	3	18	91	19.8%
Tioga	12	6	18	92	19.6%
Perry	15	2	17	93	18.3%
Pike	15	2	17	66	25.8%
Mifflin	12	4	16	89	18.0%
Clinton	9	5	14	54	25.9%
Elk	9	4	13	42	31.0%
Fulton	13	0	13	55	23.6%
Juniata	9	4	13	36	36.1%
Unknown/Other	7	2	9	64	14.1%
Potter	7	1	8	35	22.9%
Montour	6	1	7	26	26.9%
Forest	5	1	6	19	31.6%
Sullivan	2	0	2	16	12.5%
Cameron	0	0	0	13	0.0%
Grand total	5,419	1,560	6,979	40,793	17.1%

1. The total inmate population is as of January 2004.

Table 6

NUMBER OF MHR AND PRT INMATES BY
MINIMUM SENTENCE IN PENNSYLVANIA

Sentence	Active MHR	PRT	Total (percent of total)
Less than one year	638	231	869 (12.5%)
One - two years	1,074	321	1,395 (20.0%)
Two - three years	726	180	906 (13.0%)
Three - five years	953	278	1,231 (17.6%)
Five - ten years	839	233	1,072 (15.4%)
Ten - twenty years	437	114	551 (7.9%)
Over 20 years	174	39	213 (3.1%)
Life	548	151	699 (10.0%)
Execution	28	12	40 (0.6%)
Unknown	2	1	3 (a)[1]
Grand total	5,419	1,560	6979 (100.0%)

1. a=less than 0.1%

Table 7

NUMBER OF MHR AND PRT INMATES BY
MAXIMUM SENTENCE IN PENNSYLVANIA

Sentence	Active MHR	PRT	Total (percent of total)
Less than two years	3	6	9 (0.1%)
Two years	275	104	379 (5.8%)
Two - five years	1,409	400	1,809 (27.4%)
Five - ten years	1,388	393	1,781 (27.0%)
Ten - twenty years	1,029	304	1,333 (20.2%)
Twenty - thirty years	326	84	410 (6.2%)
Thirty - forty years	194	55	249 (3.8%)
Forty - fifty years	77	21	98 (1.5%)
Over fifty years	136	29	165 (2.5%)
Life	552	152	704 (10.7%)
Execution	28	12	40 (0.6%)
Unknown	2	0	2 (a)[1]
Grand total	5,419	1,560	6,979 (100.0%)

1. a=less than 0.1%

Table 8

NUMBER OF MHR AND PRT INMATES BY OFFENSE IN PENNSYLVANIA

Offense	Active MHR	PRT	Total
Robbery	779	167	946 (13.6%)
Drugs	645	134	779 (11.2%)
Agg. Assault	507	206	713 (10.2%)
Rape	558	137	695 (10.0%)
Other - Part 2	476	154	630 (9.0%)
Burglary	405	114	519 (7.4%)
Murder 1	401	118	519 (7.4%)
Murder 3	280	94	374 (5.4%)
Other Sex Crimes	219	74	293 (4.2%)
Theft	219	66	285 (4.1%)
Other Assault	128	66	194 (2.8%)
Murder 2	113	33	146 (2.1%)
DUI	111	25	136 (1.9%)
Arson	67	43	110 (1.6%)
Stolen Property	91	18	109 (1.6%)
Fraud	69	21	90 (1.3%)
Forgery	65	16	81 (1.2%)
Murder - Unspc.	49	20	69 (1.0%)
Weapons	45	14	59 (0.8%)
Prison Breach	53	5	58 (0.8%)
Statutory Rape	47	9	56 (0.8%)
Kidnapping	31	9	40 (0.6%)
Homicide - Motor Vehicle	29	8	37 (0.5%)
Vol. Manslaughter	24	7	31 (0.4%)
Involuntary Manslaughter	6	2	8 (0.1%)
Unknown	2	0	2 (a)[1]
Grand total	5,419	1,560	6,979 (100.0%)

1. a=less than 0.1%

Table 9

NUMBER OF INMATES BY PRIMARY, SECOND AND THIRD MENTAL ILLNESS DIAGNOSIS WITH THE PRIMARY MENTAL ILLNESS DIAGNOSIS BROKEN DOWN BY ACTIVE MHR AND PRT IN PENNSYLVANIA

Mental illness diagnosis	Active MHR (primary mental illness)	PRT (primary mental illness)	Primary mental illness total	Second mental illness total	Third mental illness total
Depression NOS	777	114	891	190	84
Major Depressive Disorder, Recurrent Episodes	591	168	759	112	63
Adjustment Disorder	565	43	608	146	88
Schizophrenia, Paranoid Type	261	244	505	73	51
Schizoaffective Disorder	228	231	459	86	60
Anxiety Disorder, NOS	322	17	339	132	47
Brief Psychotic Disorder	215	76	291	39	21
Drug Dependence	251	28	279	1,326	513
Dysthymic Disorder	214	17	231	81	41
Mood Disorder, Not Otherwise Specified	192	28	220	52	16
Psychotic Disorder, NOS	139	78	217	56	28
Antisocial Personality Disorder	143	20	163	411	281
Bipolar I Disorder, Most Recent Episode Mixed	103	49	152	10	10
Post Traumatic Stress Disorder	125	19	144	89	33
Major Depressive Disorder, Single Episode	123	13	136	25	10
Personality Disorder NOS	111	19	130	206	81
Schizophrenia, Undifferentiated Type	62	64	126	29	25
Conduct Disorder	93	24	117	74	40
Schizophrenia	44	59	103	28	28
Not Classified Elsewhere	93	7	100	57	24
Substance Withdrawal	81	16	97	21	18
Bipolar I Disorder, Most Recent Episode Hypomanic	56	32	88	12	8
Borderline Personality Disorder	52	27	79	109	35
Bipolar I Disorder, Most Recent Episode Depressed	47	26	73	10	5
Unsp Mtl/Beh Prob	55	5	60	29	12
Alcohol Dependence	52	5	57	533	269
Delirium Due to General Medical Condition	37	18	55	12	7
Bipolar II Disorder	40	12	52	5	4
Delusional Disorder, NOS	32	10	42	9	4
Attention-Deficit, Hyperactivity	31	2	33	20	5
Mild Mental Retardation	22	6	28	40	14
Schizophrenia, Residual type	14	11	25	3	2
Anxiety Disor/ Obsessive Compulsive Disorder	21	3	24	27	3

Table 9 (continued)

Mental illness diagnosis	Active MHR (primary mental illness)	PRT (primary mental illness)	Primary mental illness total	Second mental illness total	Third mental illness total
Dementia Due to General Medical Condition	12	10	22	8	3
Paranoid Personality Disorder	19	3	22	12	10
Social Phobias	17	2	19	14	4
Sexual Deviations	16	3	19	80	28
Non-Dependent Drug Abuse	15	3	18	146	80
Schizophrenia, Disorganized type	5	12	17	5	5
Bipolar I Disorder, Recurrent Manic Episodes	12	5	17	4	2
Malingering	13	3	16	11	6
Schizotypal Personality Disorder	12	2	14	12	4
Cyclothymic Disorder	12	0	12	4	5
Psycho/Physical	7	3	10	0	2
Acute Stress Disorder	7	2	9	2	3
Nonpsy Org Brain	7	2	9	2	3
Alcohol Intoxication/Withdrawal Delirium	7	0	7	1	2
Bipolar I Disorder, Single Manic Episode	7	0	7	4	4
Schizoid Personality Disorder	7	0	7	5	2
Schizophrenoform Disorder	4	3	7	3	1
Borderline Intellectual Functioning	6	0	6	22	10
Dementia	4	1	5	4	1
Narcissistic Personality Disorder	4	1	5	4	1
Personality Disord/ Obsessive Compulsive Disorder	3	1	4	2	1
Somatization Disorder NOS	2	2	4	1	2
Schizophrenia, Catatonic type	1	2	3	2	0
Conversion Disorder	1	1	2	1	2
Dependant Personality Disorder	2	0	2	3	1
Moderate Mental Retardation	2	0	2	2	2
Distrb Spec Ch/Adl	0	1	1	0	1
Hypochondriasis	1	0	1	1	1
Learning Disorders	1	0	1	6	2
Asoc W/Disb Elsw	0	0	0	1	0
Histronic Personality Disorder	0	0	0	1	1
Mental Retardation, Severity Unspecified	0	0	0	1	1
No Diagnosis Recorded	21	7	28	2,563	4,859
Grand total	5,419	1,560	6,979	6,979	6,979

Table 10

NUMBER OF INMATES BY PRIMARY, SECOND AND THIRD MENTAL ILLNESS DIAGNOSIS WITH THE PRIMARY MENTAL ILLNESS DIAGNOSIS BROKEN DOWN BY ACTIVE MHR AND PRT IN PENNSYLVANIA (SORTED BY DIAGNOSIS CATEGORIES)

Mental illness diagnosis	Active MHR (primary mental illness)	PRT (primary mental illness)	Primary mental illness total	Second mental illness total	Third mental illness total
Dementias					
Dementia	4	1	5	4	1
Alcohol Intoxication/Withdrawal Delirium	7	0	7	1	2
Substance Withdrawal	81	16	97	21	18
Delirium Due to General Medical Condition	37	18	55	12	7
Dementia Due to General Medical Condition	12	10	22	8	3
Total	141	45	186	46	31
Schizophrenias and Other Psychotic Disorders					
Schizophrenia	44	59	103	28	28
Schizophrenia, Catatonic type	1	2	3	2	0
Schizophrenia, Disorganized type	5	12	17	5	5
Schizophrenia, Paranoid type	261	244	505	73	51
Schizophrenia, Residual type	14	11	25	3	2
Schizophrenia, Undifferentiated type	62	64	126	29	25
Schizophrenoform Disorder	4	3	7	3	1
Schizoaffective Disorder	228	231	459	86	60
Total	619	626	1,245	229	172
Mood Disorders					
Bipolar I Disorder, Single Manic Episode	7	0	7	4	4
Bipolar I Disorder, Recurrent Manic Episodes	12	5	17	4	2
Major Depressive Disorder, Single Episode	123	13	136	25	10
Major Depressive Disorder, Recurrent Episodes	591	168	759	112	63
Bipolar I Disorder, Most Recent Episode Hypomanic	56	32	88	12	8
Bipolar I Disorder, Most Recent Episode Depressed	47	26	73	10	5
Bipolar I Disorder, Most Recent Episode Mixed	103	49	152	10	10
Brief Psychotic Disorder	215	76	291	39	21
Bipolar II Disorder	40	12	52	5	4
Mood Disorder, Not Otherwise Specified	192	28	220	52	16
Delusional Disorder, NOS	32	10	42	9	4
Psychotic Disorder, NOS	139	78	217	56	28
Dysthymic Disorder	214	17	231	81	41
Cyclothymic Disorder	12	0	12	4	5
Depression NOS	777	114	891	190	84
Total	2,560	628	3,188	613	305

Table 10 (continued)

Mental illness diagnosis	Active MHR (primary mental illness)	PRT (primary mental illness)	Primary mental illness total	Second mental illness total	Third mental illness total
Anxiety Disorders					
Anxiety Disorder, NOS	322	17	339	132	47
Social Phobias	17	2	19	14	4
Anxiety Disor/Obsessive Compulsive Disorder	21	3	24	27	3
Acute Stress Disorder	7	2	9	2	3
Post Traumatic Stress Disorder	125	19	144	89	33
Nonpsy Org Brain	7	2	9	2	3
Total	499	45	544	266	93
Adjustment Disorder					
Adjustment Disorder	565	43	608	146	88
Total	565	43	608	146	88
Dissociative Disorders					
Depersonalization Disorder	0	0	0	0	0
Total	0	0	0	0	0
Personality Disorder: Odd and Eccentric Personality Types					
Paranoid Personality Disorder	19	3	22	12	10
Schizoid Personality Disorder	7	0	7	5	2
Schizotypal Personality Disorder	12	2	14	12	4
Total	38	5	43	29	16
Personality Disorder: Dramatic, Emotional & Eccentric Behavior					
Antisocial Personality Disorder	143	20	163	411	281
Borderline Personality Disorder	52	27	79	109	35
Histronic Personality Disorder	0	0	0	1	1
Narcissistic Personality Disorder	4	1	5	4	1
Total	199	48	247	525	318
Personality Disorder: Anxious and Fearful					
Avoidant Personality Disorder	0	0	0	0	0
Dependant Personality Disorder	2	0	2	3	1
Personality Disord/Obsessive Compulsive Disorder	3	1	4	2	1
Personality Disorder NOS	111	19	130	206	81
Total	116	20	136	211	83
Substance Abuse Disorders					
Alcohol Dependence	52	5	57	533	269
Drug Dependence	251	28	279	1,326	513
Non-Dependent Drug Abuse	15	3	18	146	80
Psycho/Physical	7	3	10	0	2
Total	325	5	364	2,005	864

Table 10 (continued)

Mental illness diagnosis	Active MHR (primary mental illness)	PRT (primary mental illness)	Primary mental illness total	Second mental illness total	Third mental illness total
Somatoform Disorders					
Conversion Disorder	1	1	2	1	2
Hypochondriasis	1	0	1	1	1
Somatization Disorder NOS	2	2	4	1	2
Total	4	3	7	3	5
Sexual and Gender Identity Issues					
Sexual Deviations	16	3	19	80	28
Total	16	3	19	80	28
Fictitious Disorders					
Malingering	13	3	16	11	6
Unsp Mtl/Beh Prob	55	5	60	29	12
Total	68	8	76	40	18
Learning Disorders					
Learning Disorders	1	0	1	6	2
Asoc W/Disb Elsw	0	0	0	1	0
Total	1	0	1	7	2
Attention-Deficit and Disruptive Behavior Disorders					
Attention-Deficit, Hyperactivity	31	2	33	20	5
Conduct Disorder	93	24	117	74	40
Distrb Spec Ch/Adl	0	1	1	0	1
Total	124	27	151	94	46
Mental Retardation					
Borderline Intellectual Functioning	6	0	6	22	10
Mild Mental Retardation	22	6	28	40	14
Moderate Mental Retardation	2	0	2	2	2
Severe Mental Retardation	0	0	0	0	0
Profound Mental Retardation	0	0	0	0	0
Mental Retardation, Severity Unspecified	0	0	0	1	1
Total	30	6	36	65	27
Not Classified Elsewhere					
Not Classified Elsewhere	93	7	100	57	24
No Diagnosis Recorded	21	7	28	2,563	4,859
Total	114	14	128	2,620	4,883
Grand total	5,419	1,543	6,979	6,979	6,979

Table 11

SUMMARY OF MENTALLY ILL INMATES IN PENNSYLVANIA

Number of inmates with a mental illness but has no diagnosis recorded	28
Number of inmates with one mental illness listed	2,535
Number of inmates with two mental illnesses listed	2,296
Number of inmates with three or more mental illnesses listed	2,120
Grand total	6,979

Table 12

NUMBER OF MENTALLY ILL INMATES BY THEIR OFFENSE AND MENTAL ILLNESS DIAGNOSIS
(TOP TEN PRIMARY MENTAL ILLNESSES UNDER EACH OFFENSE) IN PENNSYLVANIA

Offense/Mental illness	Number listed as primary diagnosis	Number listed as second diagnosis	Number listed as third diagnosis	Total
Agg. Assault				
Schizophrenia, Paranoid Type	69	7	5	81
Schizoaffective Disorder	69	15	8	92
Major Depressive Disorder, Recurrent Episodes	68	11	6	85
Depression NOS	63	17	7	87
Adjustment Disorder	53	13	10	76
Brief Psychotic Disorder	37	5	2	44
Psychotic Disorder, NOS	28	5	3	36
Anxiety Disorder, NOS	24	20	4	48
Bipolar I Disorder, Most Recent Episode Mixed	23	1	0	24
Drug Dependence	22	110	63	195
Total (all mental illnesses)	713	713	713	2,139
Arson				
Schizophrenia, Paranoid Type	16	2	2	20
Major Depressive Disorder, Recurrent Episodes	12	2	2	16
Depression NOS	9	2	0	11
Distrb Cndt Ntels	7	4	0	11
Schizoaffective Disorder	7	2	3	12
Anxiety Disorder, NOS	6	1	0	7
Mood Disorder, Not Otherwise Specified	5	2	0	7
Schizophrenia	5	2	0	7
Schizophrenia, Undifferentiated Type	4	1	1	6
Brief Psychotic Disorder	3	0	0	3
Total (all mental illnesses)	110	110	110	330
Burglary				
Depression NOS	82	9	8	99
Major Depressive Disorder, Recurrent Episodes	58	8	7	73
Schizophrenia, Paranoid Type	34	5	1	40
Schizoaffective Disorder	32	9	3	44
Adjustment Disorder	30	9	6	45
Anxiety Disorder, NOS	23	11	6	40
Brief Psychotic Disorder	23	4	2	29
Mood Disorder, Not Otherwise Specified	23	5	1	29
Dysthymic Disorder	17	5	0	22
Antisocial Personality Disorder	15	35	25	75
Total (all mental illnesses)	519	519	519	1,557

Table 12 (continued)

Offense/Mental illness	Number listed as primary diagnosis	Number listed as second diagnosis	Number listed as third diagnosis	Total
Drugs				
Depression NOS	136	34	11	181
Adjustment Disorder	89	17	4	110
Drug Dependence	74	254	73	401
Major Depressive Disorder, Recurrent Episodes	66	10	5	81
Anxiety Disorder, NOS	42	9	7	58
Schizoaffective Disorder	37	3	2	42
Psychotic Disorder, NOS	28	4	2	34
Brief Psychotic Disorder	26	4	0	30
Post Traumatic Stress Disorder	25	14	3	42
Mood Disorder, Not Otherwise Specified	24	6	0	30
Total (all mental illnesses)	779	779	779	2,337
DUI				
Depression NOS	24	3	1	28
Major Depressive Disorder, Recurrent Episodes	18	1	0	19
Anxiety Disorder, NOS	15	7	0	22
Adjustment Disorder	13	0	0	13
Alcohol Dependence	7	54	11	72
Drug Dependence	7	22	6	35
Brief Psychotic Disorder	6	1	0	7
Post Traumatic Stress Disorder	6	0	2	8
Schizoaffective Disorder	6	1	1	8
Mood Disorder, Not Otherwise Specified	5	2	0	7
Total (all mental illnesses)	136	136	136	408
Forgery				
Depression NOS	13	2	1	16
Major Depressive Disorder, Recurrent Episodes	12	1	0	13
Drug Dependence	10	21	5	36
Adjustment Disorder	6	0	0	6
Cyclothymic Disorder	4	0	0	4
Dysthymic Disorder	4	2	0	6
Anxiety Disorder, NOS	3	1	3	7
Bipolar I Disorder, Most Recent Episode Mixed	3	0	0	3
Distrb Cndt Ntels	3	1	0	4
Mood Disorder, Not Otherwise Specified	3	1	0	4
Total (all mental illnesses)	81	81	81	243

Table 12 (continued)

Offense/Mental illness	Number listed as primary diagnosis	Number listed as second diagnosis	Number listed as third diagnosis	Total
Fraud				
Depression NOS	18	2	0	20
Major Depressive Disorder, Recurrent Episodes	10	1	0	11
Adjustment Disorder	8	1	0	9
Drug Dependence	8	19	7	34
Anxiety Disorder, NOS	5	2	0	7
Schizoaffective Disorder	5	0	1	6
Bipolar I Disorder, Most Recent Episode Mixed	4	0	0	4
Post Traumatic Stress Disorder	4	3	1	8
Alcohol Dependence	2	9	4	15
Bipolar I Disorder, Most Recent Episode Hypomanic	2	0	0	2
Total (all mental illnesses)	90	90	90	270
Homicide - Motor Vehicle				
Depression NOS	8	2	1	11
Major Depressive Disorder, Recurrent Episodes	6	0	0	6
Adjustment Disorder	4	0	1	5
Anxiety Disorder, NOS	3	1	0	4
Mood Disorder, Not Otherwise Specified	3	0	0	3
Bipolar I Disorder, Most Recent Episode Mixed	2	0	0	2
Post Traumatic Stress Disorder	2	0	1	3
Bipolar I Disorder, Most Recent Episode Depressed	1	0	0	1
Brief Psychotic Disorder	1	1	0	2
Drug Dependence	1	6	7	14
Total (all mental illnesses)	37	37	37	111
Involuntary Manslaughter				
Anxiety Disorder, NOS	1	0	1	2
Bipolar I Disorder, Most Recent Episode Depressed	1	0	0	1
Bipolar II Disorder	1	0	0	1
Brief Psychotic Disorder	1	0	0	1
Depression NOS	1	0	0	1
Major Depressive Disorder, Recurrent Episodes	1	0	0	1
Post Traumatic Stress Disorder	1	0	0	1
Unsp Mtl/Beh Prob	1	0	0	1
Not Listed	0	3	4	7
Alcohol Dependence	0	1	0	1
Total (all mental illnesses)	8	8	8	24

Table 12 (continued)

Offense/Mental illness	Number listed as primary diagnosis	Number listed as second diagnosis	Number listed as third diagnosis	Total
Kidnapping				
Adjustment Disorder	4	3	2	9
Post Traumatic Stress Disorder	4	0	0	4
Schizoaffective Disorder	4	1	0	5
Anxiety Disorder, NOS	3	1	0	4
Depression NOS	3	1	0	4
Brief Psychotic Disorder	2	0	0	2
Borderline Personality Disorder	2	0	0	2
Major Depressive Disorder, Single Episode	2	0	0	2
Psychotic Disorder, NOS	2	1	0	3
Schizophrenia, Paranoid Type	2	0	0	2
Total (all mental illnesses)	40	40	40	120
Murder - Unspc.				
Adjustment Disorder	7	4	2	13
Depression NOS	6	1	1	8
Major Depressive Disorder, Recurrent Episodes	5	0	0	5
Schizophrenia, Paranoid Type	5	2	0	7
Anxiety Disorder, NOS	4	0	1	5
Dysthymic Disorder	4	0	0	4
Distrb Cndt Ntels	3	3	1	7
Mood Disorder, Not Otherwise Specified	3	0	0	3
Post Traumatic Stress Disorder	3	2	0	5
Schizoaffective Disorder	3	1	0	4
Total (all mental illnesses)	69	69	69	207
Murder 1				
Schizophrenia, Paranoid Type	80	15	15	110
Adjustment Disorder	62	19	13	94
Depression NOS	48	8	9	65
Major Depressive Disorder, Recurrent Episodes	45	12	6	63
Schizoaffective Disorder	38	12	11	61
Psychotic Disorder, NOS	23	8	3	34
Dysthymic Disorder	21	8	4	33
Anxiety Disorder, NOS	20	9	2	31
Major Depressive Disorder, Single Episode	16	5	2	23
Personality Disorder NOS	13	19	6	38
Total (all mental illnesses)	519	519	519	1,557

Table 12 (continued)

Offense/Mental illness	Number listed as primary diagnosis	Number listed as second diagnosis	Number listed as third diagnosis	Total
Murder 2				
Major Depressive Disorder, Recurrent Episodes	23	5	3	31
Schizophrenia, Paranoid Type	18	3	3	24
Depression NOS	14	3	2	19
Adjustment Disorder	13	4	3	20
Dysthymic Disorder	10	5	6	21
Anxiety Disorder, NOS	8	3	3	14
Antisocial Personality Disorder	6	18	7	31
Psychotic Disorder, NOS	6	2	2	10
Mood Disorder, Not Otherwise Specified	5	0	0	5
Schizoaffective Disorder	5	2	0	7
Total (all mental illnesses)	146	146	146	438
Murder 3				
Schizophrenia, Paranoid Type	53	9	6	68
Depression NOS	42	7	5	54
Major Depressive Disorder, Recurrent Episodes	42	5	6	53
Adjustment Disorder	40	0	7	47
Schizoaffective Disorder	30	7	5	42
Psychotic Disorder, NOS	16	2	4	22
Anxiety Disorder, NOS	15	2	2	19
Schizophrenia, Undifferentiated Type	14	1	0	15
Dysthymic Disorder	11	8	0	19
Drug Dependence	10	43	17	70
Total (all mental illnesses)	374	374	374	1,122
Other - Part 2				
Depression NOS	85	12	4	101
Major Depressive Disorder, Recurrent Episodes	75	11	3	89
Adjustment Disorder	53	10	7	70
Schizoaffective Disorder	44	5	1	50
Schizophrenia, Paranoid Type	36	3	2	41
Anxiety Disorder, NOS	35	7	1	43
Brief Psychotic Disorder	30	2	2	34
Drug Dependence	24	151	55	230
Dysthymic Disorder	21	9	2	32
Mood Disorder, Not Otherwise Specified	21	4	2	27
Total (all mental illnesses)	630	630	630	1,890

Table 12 (continued)

Offense/Mental illness	Number listed as primary diagnosis	Number listed as second diagnosis	Number listed as third diagnosis	Total
Other Assault				
Depression NOS	16	4	1	21
Schizoaffective Disorder	15	4	2	21
Adjustment Disorder	14	3	1	18
Brief Psychotic Disorder	14	1	2	17
Major Depressive Disorder, Recurrent Episodes	14	2	1	17
Mood Disorder, Not Otherwise Specified	13	3	1	17
Drug Dependence	12	51	22	85
Psychotic Disorder, NOS	12	2	2	16
Anxiety Disorder, NOS	10	7	1	18
Distrb Cndt Ntels	10	1	1	12
Total (all mental illnesses)	194	194	194	582
Other Sex Crimes				
Depression NOS	53	11	2	66
Major Depressive Disorder, Recurrent Episodes	43	4	1	48
Adjustment Disorder	19	4	2	25
Schizoaffective Disorder	15	2	2	19
Anxiety Disorder, NOS	14	9	2	25
Brief Psychotic Disorder	14	2	0	16
Dysthymic Disorder	14	1	0	15
Mood Disorder, Not Otherwise Specified	13	3	0	16
Schizophrenia, Paranoid Type	12	1	0	13
Psychotic Disorder, NOS	11	1	2	14
Total (all mental illnesses)	293	293	293	879
Prison Breach				
Major Depressive Disorder, Recurrent Episodes	12	1	2	15
Adjustment Disorder	5	0	1	6
Antisocial Personality Disorder	4	2	7	13
Brief Psychotic Disorder	4	1	0	5
Depression NOS	4	3	1	8
Drug Dependence	4	9	4	17
Anxiety Disorder, NOS	3	2	0	5
Mood Disorder, Not Otherwise Specified	3	1	0	4
Alcohol Dependence	2	5	2	9
Delirium Due to General Medical Condition	2	0	0	2
Total (all mental illnesses)	58	58	58	174

Table 12 (continued)

Offense/Mental illness	Number listed as primary diagnosis	Number listed as second diagnosis	Number listed as third diagnosis	Total
Rape				
Major Depressive Disorder, Recurrent Episodes	111	15	9	135
Depression NOS	77	18	11	106
Schizophrenia, Paranoid Type	62	9	5	76
Schizoaffective Disorder	50	9	6	65
Adjustment Disorder	43	13	10	66
Dysthymic Disorder	38	11	7	56
Anxiety Disorder, NOS	29	10	5	44
Brief Psychotic Disorder	26	4	4	34
Mood Disorder, Not Otherwise Specified	19	3	1	23
Personality Disorder NOS	17	38	12	67
Total (all mental illnesses)	695	695	695	2,085
Robbery				
Depression NOS	111	29	15	155
Adjustment Disorder	95	23	17	135
Major Depressive Disorder, Recurrent Episodes	94	17	7	118
Schizoaffective Disorder	63	9	11	83
Schizophrenia, Paranoid Type	60	10	7	77
Anxiety Disorder, NOS	48	18	7	73
Brief Psychotic Disorder	40	7	3	50
Antisocial Personality Disorder	36	59	39	134
Mood Disorder, Not Otherwise Specified	35	8	5	48
Drug Dependence	32	208	79	319
Total (all mental illnesses)	946	946	946	2,838
Statutory Rape				
Depression NOS	12	4	0	16
Anxiety Disorder, NOS	8	0	1	9
Bipolar I Disorder, Most Recent Episode Mixed	5	1	0	6
Adjustment Disorder	4	0	0	4
Brief Psychotic Disorder	4	1	0	5
Schizophrenia, Paranoid Type	4	1	0	5
Drug Dependence	2	7	5	14
Major Depressive Disorder, Recurrent Episodes	2	1	0	3
Post Traumatic Stress Disorder	2	2	1	5
Alcohol Dependence	1	7	1	9
Total (all mental illnesses)	56	56	56	168

Table 12 (continued)

Offense/Mental illness	Number listed as primary diagnosis	Number listed as second diagnosis	Number listed as third diagnosis	Total
Stolen Property				
Depression NOS	20	6	1	27
Adjustment Disorder	11	2	2	15
Brief Psychotic Disorder	10	0	0	10
Major Depressive Disorder, Recurrent Episodes	9	3	0	12
Schizoaffective Disorder	8	0	0	8
Anxiety Disorder, NOS	5	5	0	10
Antisocial Personality Disorder	4	9	11	24
Bipolar I Disorder, Most Recent Episode Mixed	4	0	1	5
Drug Dependence	4	28	5	37
Mood Disorder, Not Otherwise Specified	4	1	0	5
Total (all mental illnesses)	109	109	109	327
Theft				
Depression NOS	32	9	2	43
Drug Dependence	32	86	20	138
Adjustment Disorder	22	5	0	27
Brief Psychotic Disorder	22	2	1	25
Major Depressive Disorder, Recurrent Episodes	21	1	5	27
Schizoaffective Disorder	19	2	1	22
Anxiety Disorder, NOS	11	4	1	16
Schizophrenia, Paranoid Type	11	2	0	13
Dysthymic Disorder	10	2	3	15
Distrb Cndt Ntels	9	2	2	13
Total (all mental illnesses)	285	285	285	855
Unknown				
Adjustment Disorder	1	0	0	1
Major Depressive Disorder, Recurrent Episodes	1	0	0	1
Not Listed	0	1	2	3
Sexual Deviations	0	1	0	1
Total (all mental illnesses)	2	2	2	6

Table 12 (continued)

Offense/Mental illness	Number listed as primary diagnosis	Number listed as second diagnosis	Number listed as third diagnosis	Total
Vol. Manslaughter				
Depression NOS	6	0	0	6
Major Depressive Disorder, Recurrent Episodes	4	0	0	4
Adjustment Disorder	3	0	0	3
Anxiety Disorder, NOS	2	0	0	2
Brief Psychotic Disorder	2	0	0	2
Major Depressive Disorder, Single Episode	2	0	0	2
Mood Disorder, Not Otherwise Specified	2	2	1	5
Post Traumatic Stress Disorder	2	0	0	2
Bipolar I Disorder, Most Recent Episode Depressed	1	0	0	1
Distrb Cndt Ntels	1	0	0	1
Total (all mental illnesses)	31	31	31	93
Weapons				
Depression NOS	8	3	1	12
Adjustment Disorder	7	1	0	8
Major Depressive Disorder, Recurrent Episodes	6	0	0	6
Brief Psychotic Disorder	4	0	1	5
Psychotic Disorder, NOS	4	1	0	5
Antisocial Personality Disorder	3	6	4	13
Alcohol Dependence	2	6	4	12
Anxiety Disorder, NOS	2	3	0	5
Bipolar I Disorder, Most Recent Episode Hypomanic	2	0	0	2
Dysthymic Disorder	2	2	0	4
Total (all mental illnesses)	59	59	59	177
Grand total	6,979	6,979	6,979	20,937

Table 13

TOP TEN PRIMARY MENTAL ILLNESSES AT EACH INSTITUTION IN PENNSYLVANIA

Institution/ Primary mental illness diagnosis	Number of inmates
Albion	
Depression NOS	75
Maj. Dep. Disor., Recur. Episodes	64
Anxiety Disorder, NOS	52
Brief Psychotic Disorder	41
Schizoaffective Disorder	32
Adjustment Disorder	30
Dysthymic Disorder	22
Maj. Dep. Disor., Single Episode	22
Not Classified Elsewhere	22
Schizophrenia, Paranoid Type	22
Total (all primary illnesses)	544
Cambridge Springs	
Drug Dependence	99
Depression NOS	67
Maj. Dep. Disor., Recur. Episodes	46
Adjustment Disorder	45
Borderline Personality Disorder	20
Anxiety Disorder, NOS	19
Not Classified Elsewhere	18
Dysthymic Disorder	17
Antisocial Personality Disorder	11
Maj. Dep. Disor., Single Episode	10
Total (all primary illnesses)	412
Camp Hill	
Depression NOS	97
Maj. Dep. Disor., Recur. Episodes	49
Adjustment Disorder	31
Mood Disorder, NOS	30
Schizophrenia, Paranoid Type	29
Brief Psychotic Disorder	26
Schizoaffective Disorder	26
Anxiety Disorder, NOS	19
Substance Withdrawal	18
Psychotic Disorder, NOS	17
Total (all primary illnesses)	504
Chester	
Depression NOS	15
Maj. Dep. Disor., Recur. Episodes	7
Schizophrenia, Paranoid Type	4
Mood Disorder, NOS	3
Anxiety Disorder, NOS	2
Borderline Personality Disorder	2
Psychotic Disorder, NOS	2
Personality Disorder NOS	2
Bipol I Dis, Most Recent Epsd Dep	1
Bipol I Dis, Mst Recent Epsd Mixed	1
Delirium Due to Gen. Med. Cond.	1
Total (all primary illnesses)	40
Coal Twp	
Maj. Dep. Disor., Recur. Episodes	65
Depression NOS	32
Schizophrenia, Paranoid Type	31
Schizoaffective Disorder	31
Adjustment Disorder	27
Anxiety Disorder, NOS	17
Bipol I Dis, Mst Recent Epsd Mixed	17
Brief Psychotic Disorder	16
Mood Disorder, NOS	8
Psychotic Disorder, NOS	8
Post Traumatic Stress Disorder	8
Total (all primary illnesses)	332
Cresson	
Schizophrenia, Paranoid Type	77
Anxiety Disorder, NOS	38
Maj. Dep. Disor., Recur. Episodes	28
Depression NOS	25
Schizoaffective Disorder	15
Adjustment Disorder	10
Bipol I Dis, Mst Recent Epsd Mixed	10
Brief Psychotic Disorder	10
Bipol I Dis, Most Recent Epsd Dep	6
Mood Disorder, NOS	6
Cresson (continued)	
Psychotic Disorder, NOS	6
Psycho/Physical	6
Total (all primary illnesses)	296
Dallas	
Depression NOS	46
Maj. Dep. Disor., Recur. Episodes	40
Schizoaffective Disorder	37
Adjustment Disorder	34
Schizophrenia, Paranoid Type	26
Brief Psychotic Disorder	14
Personality Disorder NOS	13
Mood Disorder, NOS	12
Bipol I Dis, Mst Rcnt Epsd Hypomanic	11
Post Traumatic Stress Disorder	11
Total (all primary illnesses)	344
Fayette	
Depression NOS	1
Dysthymic Disorder	1
Total (all primary illnesses)	2
Frackville	
Maj. Dep. Disor., Recur. Episodes	29
Depression NOS	26
Schizophrenia, Paranoid Type	23
Schizoaffective Disorder	22
Adjustment Disorder	13
Schizophrenia	13
Schizophrenia, Undifferent. Type	13
Brief Psychotic Disorder	8
Drug Dependence	8
Psychotic Disorder, NOS	8
Total (all primary illnesses)	228

Table 13 (continued)

Institution/ Primary mental illness diagnosis	Number of inmates
Graterford	
Adjustment Disorder	58
Schizophrenia, Paranoid Type	55
Schizoaffective Disorder	46
Depression NOS	44
Maj. Dep. Disor., Recur. Episodes	38
Antisocial Personality Disorder	27
Dysthymic Disorder	26
Unsp Mtl/Beh Prob	26
Personality Disorder NOS	21
Anxiety Disorder, NOS	19
Total (all primary illnesses)	572
Greene Cnty	
Maj. Dep. Disor., Recur. Episodes	40
Adjustment Disorder	30
Depression NOS	26
Schizoaffective Disorder	24
Psychotic Disorder, NOS	22
Schizophrenia, Paranoid Type	21
Anxiety Disorder, NOS	19
Dysthymic Disorder	17
Maj. Dep. Disor., Single Episode	14
Brief Psychotic Disorder	12
Total (all primary illnesses)	313
Greensburg	
Depression NOS	27
Adjustment Disorder	25
Maj. Dep. Disor., Recur. Episodes	16
Anxiety Disorder, NOS	12
Mood Disorder, NOS	11
Brief Psychotic Disorder	8
Schizoaffective Disorder	6
Bipol I Dis, Mst Recent Epsd Mixed	4
Drug Dependence	4
Bipol I Dis, Mst Rcnt Epsd Hypomanic	3

Institution/ Primary mental illness diagnosis	Number of inmates
Greensburg (continued)	
Dysthymic Disorder	3
Psychotic Disorder, NOS	3
Schizophrenia, Paranoid Type	3
Personality Disorder NOS	3
Post Traumatic Stress Disorder	3
Total (all primary illnesses)	147
Houtzdale	
Depression NOS	95
Maj. Dep. Disor., Recur. Episodes	43
Adjustment Disorder	36
Schizoaffective Disorder	22
Psychotic Disorder, NOS	15
Anxiety Disorder, NOS	13
Mood Disorder, NOS	12
Brief Psychotic Disorder	11
Schizophrenia, Paranoid Type	10
Schizophrenia	10
Total (all primary illnesses)	334
Huntingdon	
Adjustment Disorder	43
Schizophrenia, Paranoid Type	26
Antisocial Personality Disorder	25
Depression NOS	24
Maj. Dep. Disor., Recur. Episodes	20
Brief Psychotic Disorder	17
Psychotic Disorder, NOS	15
Mood Disorder, NOS	14
Not Classified Elsewhere	12
Anxiety Disorder, NOS	11
Dysthymic Disorder	11
Schizoaffective Disorder	11
Total (all primary illnesses)	318

Institution/ Primary mental illness diagnosis	Number of inmates
Laurel Highlands	
Maj. Dep. Disor., Recur. Episodes	4
Brief Psychotic Disorder	3
Schizophrenia, Paranoid Type	3
Schizoaffective Disorder	3
Depression NOS	2
Schizophrenia	2
Antisocial Personality Disorder	1
Anxiety Disorder, NOS	1
Bipolar II Disorder	1
Dementia	1
Schizophrenia, Disorgan. Type	1
Drug Dependence	1
Dysthymic Disorder	1
Nonpsy Org Brain	1
Schizophrenia, Residual Type	1
Sexual Deviations	1
Schizophrenia, Undifferent. Type	1
Total (all primary illnesses)	28
Mahanoy	
Adjustment Disorder	44
Maj. Dep. Disor., Recur. Episodes	33
Schizophrenia, Paranoid Type	16
Depression NOS	14
Personality Disorder NOS	14
Schizoaffective Disorder	12
Non-Dependent Drug Abuse	10
Post Traumatic Stress Disorder	9
Antisocial Personality Disorder	8
Bipol I Dis, Most Recent Epsd Dep	8
Total (all primary illnesses)	252

Table 13 (continued)

Institution/ Primary mental illness diagnosis	Number of inmates
Mercer	
Maj. Dep. Disor., Recur. Episodes	28
Dysthymic Disorder	14
Depression NOS	8
Schizophrenia, Paranoid Type	8
Anxiety Disor/Obs Compul Disor	8
Brief Psychotic Disorder	7
Personality Disorder NOS	6
Mood Disorder, NOS	5
Schizoaffective Disorder	4
Anxiety Disorder, NOS	3
Total (all primary illnesses)	125
Muncy	
Depression NOS	80
Drug Dependence	80
Adjustment Disorder	38
Schizoaffective Disorder	26
Distrb Cndt Ntels	25
Schizophrenia, Paranoid Type	25
Maj. Dep. Disor., Recur. Episodes	23
Anxiety Disorder, NOS	15
Not Classified Elsewhere	13
Schizophrenia	12
Total (all primary illnesses)	414
Other	
Depression NOS	1
Substance Withdrawal	1
Total (all primary illnesses)	2
Pine Grove	
Adjustment Disorder	12
Distrb Cndt Ntels	4
Anxiety Disorder, NOS	3
Delirium Due to Gen. Med. Cond.	3
Pine Grove (continued)	
Mood Disorder, NOS	3
Bipol I Dis, Mst Rcnt Epsd Hypomanic	2
Bipol I Dis, Mst Recent Epsd Mixed	2
Brief Psychotic Disorder	2
Psychotic Disorder, NOS	2
Schizoaffective Disorder	2
Total (all primary illnesses)	42
Pittsburgh	
Schizophrenia, Paranoid Type	45
Maj. Dep. Disor., Recur. Episodes	24
Depression NOS	23
Schizoaffective Disorder	21
Schizophrenia	21
Psychotic Disorder, NOS	17
Adjustment Disorder	14
Schizophrenia, Undifferent. Type	13
Anxiety Disorder, NOS	12
Personality Disorder NOS	12
Total (all primary illnesses)	297
Quehanna	
Brief Psychotic Disorder	1
Mood Disorder, NOS	1
Total (all primary illnesses)	2
Retreat	
Depression NOS	24
Schizoaffective Disorder	20
Adjustment Disorder	16
Maj. Dep. Disor., Recur. Episodes	13
Brief Psychotic Disorder	12
Retreat (continued)	
Maj. Dep. Disor., Single Episode	8
Psychotic Disorder, NOS	8
Mood Disorder, NOS	7
Post Traumatic Stress Disorder	7
Antisocial Personality Disorder	6
Schizophrenia, Paranoid Type	6
Total (all primary illnesses)	170
Rockview	
Maj. Dep. Disor., Recur. Episodes	45
Schizoaffective Disorder	34
Depression NOS	32
Adjustment Disorder	31
Schizophrenia, Paranoid Type	31
Anxiety Disorder, NOS	16
Bipol I Dis, Mst Recent Epsd Mixed	13
Brief Psychotic Disorder	13
Psychotic Disorder, NOS	12
Schizophrenia	12
Total (all primary illnesses)	379
Smithfield	
Adjustment Disorder	15
Depression NOS	15
Personality Disorder NOS	14
Mood Disorder, NOS	13
Brief Psychotic Disorder	12
Not Listed	11
Maj. Dep. Disor., Recur. Episodes	11
Schizoaffective Disorder	9
Conduct Disorder	8
Anxiety Disorder, NOS	7
Not Classified Elsewhere	7
Total (all primary illnesses)	183

Table 13 (continued)

Institution/ Primary mental illness diagnosis	Number of inmates	Institution/ Primary mental illness diagnosis	Number of inmates	Institution/ Primary mental illness diagnosis	Number of inmates
Somerset		Waymart			
Maj. Dep. Disor., Recur. Episodes	57	Depression NOS	37		
Depression NOS	54	Maj. Dep. Disor., Recur. Episodes	35		
Adjustment Disorder	41	Mood Disorder, NOS	18		
Schizoaffective Disorder	30	Schizoaffective Disorder	18		
Brief Psychotic Disorder	26	Dysthymic Disorder	17		
Anxiety Disorder, NOS	22	Anxiety Disorder, NOS	15		
Psychotic Disorder, NOS	21	Brief Psychotic Disorder	14		
Schizophrenia, Paranoid Type	21	Schizophrenia, Paranoid Type	14		
Dysthymic Disorder	20	Adjustment Disorder	13		
Mood Disorder, NOS	13	Maj. Dep. Disor., Single Episode	13		
Total (all primary illnesses)	429	Total (all primary illnesses)	270		
		Grand total (all primary illnesses)	6,979		

Table 14

NUMBER OF MENTALLY ILL INMATES BY MINIMUM PRISON SENTENCE
AND PRIMARY MENTAL ILLNESS DIAGNOSIS IN PENNSYLVANIA

Primary diagnosis	Minimum prison sentence										Total
	<1 yr	1-2 yrs	2-3 yrs	3-5 yrs	5-10 yrs	10-20 yrs	>20 yrs	Life	Execution	Unknown	
Depression NOS	150	201	147	151	95	58	19	63	7	0	891
Major Dep Disorder, Recurrent Episodes	84	122	96	154	136	71	19	75	1	1	759
Adjustment Disorder	74	105	66	103	116	43	17	74	9	1	608
Schizophrenia, Paranoid Type	32	61	56	93	94	53	13	101	2	0	505
Schizoaffective Disorder	53	96	55	82	86	29	13	41	4	0	459
Anxiety Disorder, NOS	50	76	42	57	39	29	12	31	3	0	339
Brief Psychotic Disorder	44	77	38	53	43	13	11	11	1	0	291
Drug Dependence	71	97	35	30	24	10	6	5	1	0	279
Dysthymic Disorder	16	43	21	38	36	27	15	35	0	0	231
Mood Disorder, Not Otherwise Specified	35	45	35	43	28	14	4	16	0	0	220
Psychotic Disorder, NOS	28	37	23	32	35	23	9	28	2	0	217
Antisocial Personality Disorder	11	22	22	38	24	19	11	14	2	0	163
Bipol I Dis, Most Recent Episode Mixed	24	38	23	28	18	7	3	11	0	0	152
Post Traumatic Stress Disorder	14	40	26	28	19	11	1	5	0	0	144
Major Depressive Disorder, Single Episode	10	30	16	20	21	13	5	19	1	1	136
Personality Disorder NOS	10	24	17	22	19	16	5	17	0	0	130
Schizophrenia, Undifferentiated Type	8	19	11	22	32	14	4	16	0	0	126
Conduct Disorder	20	29	19	13	17	6	4	9	0	0	117
Schizophrenia	1	14	15	22	16	9	8	18	0	0	103
Not Classified Elsewhere	12	20	13	15	14	9	6	10	1	0	100
Substance Withdrawal	18	27	18	18	12	0	2	2	0	0	97
Bipol I Dis, Most Recent Episode Hypomanic	9	19	12	11	17	8	0	12	0	0	88
Borderline Personality Disorder	9	14	7	24	12	5	2	4	2	0	79
Bipol I Dis, Most Recent Episode Dep.	14	13	11	13	11	4	2	5	0	0	73
Unsp Mtl/Beh Prob	5	13	10	10	7	6	2	7	0	0	60
Alcohol Dependence	13	12	4	14	10	2	1	1	0	0	57
Delirium Due to General Medical Condition	7	13	8	10	4	6	2	5	0	0	55
Bipolar II Disorder	10	10	11	10	4	3	1	3	0	0	52
Delusional Disorder, NOS	3	3	3	5	10	4	1	12	1	0	42
Attention-Deficit, Hyperactivity	6	7	5	8	3	1	1	0	2	0	33
Mild Mental Retardation	1	6	4	7	7	1	2	0	0	0	28
No Diagnosis Recorded	3	9	4	6	2	1	1	2	0	0	28
Schizophrenia, Residual Type	1	4	1	3	4	4	1	7	0	0	25
Anxiety Disor/Obs Compulsive Disorder	1	3	1	7	7	2	0	3	0	0	24
Dementia Due to Gen. Med. Condition	4	10	2	1	2	2	0	1	0	0	22
Paranoid Personality Disorder	1	2	2	2	5	3	0	7	0	0	22
Social Phobias	3	2	1	2	3	5	0	3	0	0	19
Sexual Deviations	1	0	3	2	7	2	2	2	0	0	19
Non-Dependent Drug Abuse	2	3	4	2	5	1	0	1	0	0	18
Schizophrenia, Disorganized Type	1	1	2	6	2	0	0	4	1	0	17
Bipol I Disor, Recurrent Manic Episodes	2	1	3	5	2	1	0	3	0	0	17
Malingering	0	3	4	1	3	2	2	1	0	0	16
Schizotypal Personality Disorder	0	4	1	2	3	1	0	3	0	0	14
Cyclothymic Disorder	2	2	1	2	1	1	1	2	0	0	12
Psycho/Physical	0	3	0	3	2	1	1	0	0	0	10
Acute Stress Disorder	1	2	2	2	0	1	0	1	0	0	9
Nonpsy Org Brain	0	2	0	2	1	3	0	1	0	0	9
Alcohol Intoxication/Withdrawal Delirium	0	1	3	0	3	0	0	0	0	0	7
Bipolar I Disorder, Single Manic Episode	2	0	0	2	3	0	0	0	0	0	7
Schizoid Personality Disorder	0	0	0	0	2	1	1	3	0	0	7
Schizophrenoform Disorder	0	5	1	0	0	0	0	1	0	0	7

Table 14 (continued)

Primary diagnosis	Minimum prison sentence										Total
	<1 yr	1-2 yrs	2-3 yrs	3-5 yrs	5-10 yrs	10-20 yrs	>20 yrs	Life	Execution	Unknown	
Borderline Intellectual Functioning	1	1	0	2	0	2	0	0	0	0	6
Dementia	0	0	0	0	3	2	0	0	0	0	5
Narcissistic Personality Disorder	0	0	0	0	1	1	1	2	0	0	5
Personality Disord/Obs Compulsive Disor	0	0	1	0	0	1	1	1	0	0	4
Somatization Disorder NOS	0	1	0	1	1	0	0	1	0	0	4
Schizophrenia, Catatonic Type	0	0	1	1	1	0	0	0	0	0	3
Conversion Disorder	0	1	0	1	0	0	0	0	0	0	2
Dependant Personality Disorder	0	1	0	1	0	0	0	0	0	0	2
Moderate Mental Retardation	1	1	0	0	0	0	0	0	0	0	2
Distrb Spec Ch/Adl	1	0	0	0	0	0	0	0	0	0	1
Hypochondriasis	0	0	0	0	0	0	1	0	0	0	1
Learning Disorders	0	0	0	1	0	0	0	0	0	0	1
Grand total	869	1,395	906	1,231	1,072	551	213	699	40	3	6,979

Table 15

NUMBER OF MENTALLY ILL INMATES BY MINIMUM PRISON SENTENCE
AND PRIMARY MENTAL ILLNESS DIAGNOSIS IN PENNSYLVANIA (SORTED BY DIAGNOSIS CATEGORIES)

Primary diagnosis	Minimum prison sentence										
	<1 yr	1-2 yrs	2-3 yrs	3-5 yrs	5-10 yrs	10-20 yrs	>20 yrs	Life	Execution	Unknown	Total
Dementias											
Dementia	0	0	0	0	3	2	0	0	0	0	5
Alcohol Intoxication/Withdrawal Delirium	0	1	3	0	3	0	0	0	0	0	7
Substance Withdrawal	18	27	18	18	12	0	2	2	0	0	97
Delirium Due to General Medical Condition	7	13	8	10	4	6	2	5	0	0	55
Dementia Due to Gen. Med. Condition	4	10	2	1	2	2	0	1	0	0	22
Total	29	51	31	29	24	10	4	8	0	0	186
Schizophrenias and Other Psychotic Disorders											
Schizophrenia	1	14	15	22	16	9	8	18	0	0	103
Schizophrenia, Disorganized Type	1	1	2	6	2	0	0	4	1	0	17
Schizophrenia, Catatonic Type	0	0	1	1	1	0	0	0	0	0	3
Schizophrenia, Paranoid Type	32	61	56	93	94	53	13	101	2	0	505
Schizophrenia, Residual Type	1	4	1	3	4	4	1	7	0	0	25
Schizophrenia, Undifferentiated Type	8	19	11	22	32	14	4	16	0	0	126
Schizophrenoform Disorder	0	5	1	0	0	0	0	1	0	0	7
Schizoaffective Disorder	53	96	55	82	86	29	13	41	4	0	459
Total	96	200	142	229	235	109	39	188	7	0	1,245
Mood Disorders											
Bipolar I Disorder, Single Manic Episode	2	0	0	2	3	0	0	0	0	0	7
Bipolar I Disor, Recurrent Manic Episodes	2	1	3	5	2	1	0	3	0	0	17
Major Depressive Disor, Single Episode	10	30	16	20	21	13	5	19	1	1	136
Major Dep. Disor, Recurrent Episodes	84	122	96	154	136	71	19	75	1	1	759
Bipol I Dis, Most Recent Episode Hypomanic	9	19	12	11	17	8	0	12	0	0	88
Bipol I Dis, Most Recent Episode Dep.	14	13	11	13	11	4	2	5	0	0	73
Bipol I Dis, Most Recent Episode Mixed	24	38	23	28	18	7	3	11	0	0	152
Brief Psychotic Disorder	44	77	38	53	43	13	11	11	1	0	291
Bipolar II Disorder	10	10	11	10	4	3	1	3	0	0	52
Mood Disorder, Not Otherwise Specified	35	45	35	43	28	14	4	16	0	0	220
Delusional Disorder, NOS	3	3	3	5	10	4	1	12	1	0	42
Psychotic Disorder, NOS	28	37	23	32	35	23	9	28	2	0	217
Dysthymic Disorder	16	43	21	38	36	27	15	35	0	0	231
Cyclothymic Disorder	2	2	1	2	1	1	1	2	0	0	12
Depression NOS	150	201	147	151	95	58	19	63	7	0	891
Total	433	641	440	567	460	247	90	295	13	2	3,188
Anxiety Disorders											
Anxiety Disorder, NOS	50	76	42	57	39	29	12	31	3	0	339
Social Phobias	3	2	1	2	3	5	0	3	0	0	19
Anxiety Disor/Obs Compulsive Disor	1	3	1	7	7	2	0	3	0	0	24
Acute Stress Disorder	1	2	2	2	0	1	0	1	0	0	9
Post Traumatic Stress Disorder	14	40	26	28	19	11	1	5	0	0	144
Nonpsy Org Brain	0	2	0	2	1	3	0	1	0	0	9
Total	69	125	72	98	69	51	13	44	3	0	544
Adjustment Disorder											
Adjustment Disorder	74	105	66	103	116	43	17	74	9	1	608
Total	74	105	66	103	116	43	17	74	9	1	608

Table 15 (continued)

Primary diagnosis	Minimum prison sentence										
	<1 yr	1-2 yrs	2-3 yrs	3-5 yrs	5-10 yrs	10-20 yrs	>20 yrs	Life	Execution	Unknown	Total
Dissociative Disorders											
Depersonalization Disorder	0	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	0	0	0	0
Personality Disorder: Odd and Eccentric Personality Types											
Paranoid Personality Disorder	1	2	2	2	5	3	0	7	0	0	22
Schizoid Personality Disorder	0	0	0	0	2	1	1	3	0	0	7
Schizotypal Personality Disorder	0	4	1	2	3	1	0	3	0	0	14
Total	1	6	3	4	10	5	1	13	0	0	43
Personality Disorder: Dramatic, Emotional, and Eccentric Behavior											
Antisocial Personality Disorder	11	22	22	38	24	19	11	14	2	0	163
Borderline Personality Disorder	9	14	7	24	12	5	2	4	2	0	79
Histrionic Personality Disorder	0	0	0	0	0	0	0	0	0	0	0
Narcissistic Personality Disorder	0	0	0	0	1	1	1	2	0	0	5
Total	20	36	29	62	37	25	14	20	4	0	247
Personality Disorder: Anxious and Fearful											
Avoidant Personality Disorder	0	0	0	0	0	0	0	0	0	0	0
Dependant Personality Disorder	0	1	0	1	0	0	0	0	0	0	2
Personality Disord/Obs Compulsive Disor	0	0	1	0	0	1	1	1	0	0	4
Personality Disorder NOS	10	24	17	22	19	16	5	17	0	0	130
Total	10	25	18	23	19	17	6	18	0	0	136
Substance Abuse Disorders											
Alcohol Dependence	13	12	4	14	10	2	1	1	0	0	57
Drug Dependence	71	97	35	30	24	10	6	5	1	0	279
Non-Dependent Drug Abuse	2	3	4	2	5	1	0	1	0	0	18
Psycho/Physical	0	3	0	3	2	1	1	0	0	0	10
Total	86	115	43	49	41	14	8	7	1	0	364
Somatoform Disorders											
Conversion Disorder	0	1	0	1	0	0	0	0	0	0	2
Hypochondriasis	0	0	0	0	0	0	1	0	0	0	1
Somatization Disorder NOS	0	1	0	1	1	0	0	1	0	0	4
Total	0	2	0	2	1	0	1	1	0	0	7
Sexual and Gender Identity Issues											
Sexual Deviations	1	0	3	2	7	2	2	2	0	0	19
Total	1	0	3	2	7	2	2	2	0	0	19
Fictitious Disorders											
Malingering	0	3	4	1	3	2	2	1	0	0	16
Unsp Mtl/Beh Prob	5	13	10	10	7	6	2	7	0	0	60
Total	5	16	14	11	10	8	4	8	0	0	76
Learning Disorders											
Learning Disorders	0	0	0	1	0	0	0	0	0	0	1
Asoc. W/Disb Elsw	0	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	1	0	0	0	0	0	0	1

Table 15 (continued)

Primary diagnosis	Minimum prison sentence										Total
	<1 yr	1-2 yrs	2-3 yrs	3-5 yrs	5-10 yrs	10-20 yrs	>20 yrs	Life	Execution	Unknown	
Attention-Deficit and Disruptive Behavior Disorders											
Attention-Deficit, Hyperactivity	6	7	5	8	3	1	1	0	2	0	33
Conduct Disorder	20	29	19	13	17	6	4	9	0	0	117
Distrb Spec Ch/Adl	1	0	0	0	0	0	0	0	0	0	1
Total	27	36	24	21	20	7	5	9	2	0	151
Mental Retardation											
Borderline Intellectual Functioning	1	1	0	2	0	2	0	0	0	0	6
Mild Mental Retardation	1	6	4	7	7	1	2	0	0	0	28
Moderate Mental Retardation	1	1	0	0	0	0	0	0	0	0	2
Severe Mental Retardation	0	0	0	0	0	0	0	0	0	0	0
Profound Mental Retardation	0	0	0	0	0	0	0	0	0	0	0
Mental Retardation, Severity Unspecified	0	0	0	0	0	0	0	0	0	0	0
Total	3	8	4	9	7	3	2	0	0	0	36
Not Classified Elsewhere											
Not Classified Elsewhere	12	20	13	15	14	9	6	10	1	0	100
No Diagnosis Recorded	3	9	4	6	2	1	1	2	0	0	28
Total	15	29	17	21	16	10	7	12	1	0	128
Grand total	869	1,395	906	1,231	1,072	551	213	699	40	3	6,979

Table 16

NUMBER OF MENTALLY ILL INMATES BY MAXIMUM PRISON SENTENCE
AND PRIMARY MENTAL ILLNESS DIAGNOSIS IN PENNSYLVANIA

Primary diagnosis	Maximum prison sentence										Total
	≤2 yrs	2-5 yrs	5-10 yrs	10-20 yrs	20-30 yrs	30-40 yrs	>40 yrs	Life	Execution	Unknown	
Depression NOS	73	280	257	124	36	26	23	65	7	0	891
Major Dep. Disorder, Recurrent Episodes	34	173	200	161	43	39	30	77	1	1	759
Adjustment Disorder	34	131	154	133	33	19	20	74	9	1	608
Schizophrenia, Paranoid Type	9	74	124	113	41	24	17	101	2	0	505
Schizoaffective Disorder	24	112	116	109	25	12	16	41	4	0	459
Anxiety Disorder, NOS	25	93	83	59	19	12	14	31	3	0	339
Brief Psychotic Disorder	14	100	84	52	11	7	11	11	1	0	291
Drug Dependence	40	133	49	33	7	5	6	5	1	0	279
Dysthymic Disorder	4	49	52	38	22	12	19	35	0	0	231
Mood Disorder, Not Otherwise Specified	16	65	58	39	14	5	7	16	0	0	220
Psychotic Disorder, NOS	14	54	44	37	16	10	12	28	2	0	217
Antisocial Personality Disorder	3	30	46	34	18	5	11	14	2	0	163
Bipol I Dis, Most Recent Episode Mixed	11	49	48	22	3	3	5	11	0	0	152
Post Traumatic Stress Disorder	7	50	44	23	6	7	2	5	0	0	144
Major Depressive Disorder, Single Episode	4	31	37	24	8	4	7	20	1	0	136
Personality Disorder NOS	4	26	30	29	9	8	7	17	0	0	130
Schizophrenia, Undifferentiated Type	5	21	27	34	13	5	5	16	0	0	126
Conduct Disorder	10	34	31	22	8	0	3	9	0	0	117
Schizophrenia	0	18	24	21	10	5	7	18	0	0	103
Not Classified Elsewhere	3	26	25	18	5	6	6	10	1	0	100
Substance Withdrawal	9	42	21	21	0	0	2	2	0	0	97
Bipol I Dis, Most Recent Episode Hypomanic	7	18	25	15	7	3	1	12	0	0	88
Borderline Personality Disorder	4	17	22	23	4	1	2	4	2	0	79
Bipol I Dis, Most Recent Episode Dep.	6	18	24	11	3	4	2	5	0	0	73
Unsp Mtl/Beh Prob	2	16	12	14	4	3	2	7	0	0	60
Alcohol Dependence	5	15	18	15	1	1	1	1	0	0	57
Delirium Due to General Medical Condition	5	18	10	8	4	3	2	5	0	0	55
Bipolar II Disorder	3	17	16	7	4	0	2	3	0	0	52
Delusional Disorder, NOS	1	3	6	12	3	2	2	12	1	0	42
Attention-Deficit, Hyperactivity	5	11	9	4	0	1	1	0	2	0	33
Mild Mental Retardation	0	6	8	10	0	2	2	0	0	0	28
No Diagnosis Recorded	1	11	10	2	1	0	1	2	0	0	28
Schizophrenia, Residual Type	0	3	6	4	4	0	1	7	0	0	25
Anxiety Disor/Obs Compulsive Disorder	0	5	3	7	3	3	0	3	0	0	24
Dementia Due to Gen. Med. Condition	0	13	3	3	2	0	0	1	0	0	22
Paranoid Personality Disorder	0	4	3	5	2	1	0	7	0	0	22
Social Phobias	1	4	3	2	5	1	0	3	0	0	19
Sexual Deviations	0	2	1	8	3	1	2	2	0	0	19
Non-Dependent Drug Abuse	0	4	5	7	0	1	0	1	0	0	18
Schizophrenia, Disorganized Type	0	1	6	4	1	0	0	4	1	0	17
Bipolar I Disor, Recurrent Manic Episodes	1	2	6	2	3	0	0	3	0	0	17
Malingering	0	4	3	4	1	0	3	1	0	0	16
Schizotypal Personality Disorder	0	2	4	4	0	1	0	3	0	0	14
Cyclothymic Disorder	1	4	2	0	1	1	1	2	0	0	12
Psycho/Physical	0	3	2	3	0	1	1	0	0	0	10
Acute Stress Disorder	1	2	4	0	0	1	0	1	0	0	9
Nonpsy Org Brain	0	1	3	1	1	1	1	1	0	0	9

Table 16 (continued)

Primary Diagnosis	Maximum Prison Sentence										
	≤2 Yrs	2-5 Yrs	5-10 Yrs	10-20 Yrs	20-30 Yrs	30-40 Yrs	>40 Yrs	Life	Execution	Unknown	Total
Alcohol Intoxication/Withdrawal Delirium	0	2	2	2	1	0	0	0	0	0	7
Bipolar I Disorder, Single Manic Episode	1	1	2	3	0	0	0	0	0	0	7
Schizoid Personality Disorder	0	0	0	0	3	0	1	3	0	0	7
Schizophrenoform Disorder	0	5	1	0	0	0	0	1	0	0	7
Borderline Intellectual Functioning	0	1	3	0	0	0	2	0	0	0	6
Dementia	0	0	0	2	1	2	0	0	0	0	5
Narcissistic Personality Disorder	0	0	0	1	1	0	1	2	0	0	5
Personality Disord/Obs Compulsive Disor	0	1	0	0	0	1	1	1	0	0	4
Somatization Disorder NOS	0	0	2	1	0	0	0	1	0	0	4
Schizophrenia, Catatonic Type	0	0	1	2	0	0	0	0	0	0	3
Conversion Disorder	0	1	0	1	0	0	0	0	0	0	2
Dependant Personality Disorder	0	1	1	0	0	0	0	0	0	0	2
Moderate Mental Retardation	0	2	0	0	0	0	0	0	0	0	2
Distrb Spec Ch/Adl	1	0	0	0	0	0	0	0	0	0	1
Hypochondriasis	0	0	0	0	0	0	1	0	0	0	1
Learning Disorders	0	0	1	0	0	0	0	0	0	0	1
Grand total	388	1,809	1,781	1,333	410	249	263	704	40	2	6,979

Table 17

NUMBER OF MENTALLY ILL INMATES BY MAXIMUM PRISON SENTENCE
AND PRIMARY MENTAL ILLNESS DIAGNOSIS IN PENNSYLVANIA (SORTED BY DIAGNOSIS CATEGORIES)

Primary diagnosis	Maximum prison sentence										
	≤2 yrs	2-5 yrs	5-10 yrs	10-20 yrs	20-30 yrs	30-40 yrs	>40 yrs	Life	Execution	Unknown	Total
Dementias											
Dementia	0	0	0	2	1	2	0	0	0	0	5
Alcohol Intoxication/Withdrawal Delirium	0	2	2	2	1	0	0	0	0	0	7
Substance Withdrawal	9	42	21	21	0	0	2	2	0	0	97
Delirium Due to General Medical Condition	5	18	10	8	4	3	2	5	0	0	55
Dementia Due to Gen. Med. Condition	0	13	3	3	2	0	0	1	0	0	22
Total	14	75	36	36	8	5	4	8	0	0	186
Schizophrenias and Other Psychotic Disorders											
Schizophrenia	0	18	24	21	10	5	7	18	0	0	103
Schizophrenia, Disorganized Type	0	1	6	4	1	0	0	4	1	0	17
Schizophrenia, Catatonic Type	0	0	1	2	0	0	0	0	0	0	3
Schizophrenia, Paranoid Type	9	74	124	113	41	24	17	101	2	0	505
Schizophrenia, Residual Type	0	3	6	4	4	0	1	7	0	0	25
Schizophrenia, Undifferentiated Type	5	21	27	34	13	5	5	16	0	0	126
Schizophrenoform Disorder	0	5	1	0	0	0	0	1	0	0	7
Schizoaffective Disorder	24	112	116	109	25	12	16	41	4	0	459
Total	38	234	305	287	94	46	46	188	7	0	1,245
Mood Disorders											
Bipolar I Disor, Single Manic Episode	1	1	2	3	0	0	0	0	0	0	7
Bipolar I Disor, Recurrent Manic Episodes	1	2	6	2	3	0	0	3	0	0	17
Major Depressive Disorder, Single Episode	4	31	37	24	8	4	7	20	1	0	136
Major Dep Disor, Recurrent Episodes	34	173	200	161	43	39	30	77	1	1	759
Bipol I Dis, Most Recent Episode Hypomanic	7	18	25	15	7	3	1	12	0	0	88
Bipol I Dis, Most Recent Episode Dep.	6	18	24	11	3	4	2	5	0	0	73
Bipol I Dis, Most Recent Episode Mixed	11	49	48	22	3	3	5	11	0	0	152
Brief Psychotic Disorder	14	100	84	52	11	7	11	11	1	0	291
Bipolar II Disorder	3	17	16	7	4	0	2	3	0	0	52
Mood Disorder, Not Otherwise Specified	16	65	58	39	14	5	7	16	0	0	220
Delusional Disorder, NOS	1	3	6	12	3	2	2	12	1	0	42
Psychotic Disorder, NOS	14	54	44	37	16	10	12	28	2	0	217
Dysthymic Disorder	4	49	52	38	22	12	19	35	0	0	231
Cyclothymic Disorder	1	4	2	0	1	1	1	2	0	0	12
Depression NOS	73	280	257	124	36	26	23	65	7	0	891
Total	190	864	861	547	174	116	122	300	13	1	3,188
Anxiety Disorders											
Anxiety Disorder, NOS	25	93	83	59	19	12	14	31	3	0	339
Social Phobias	1	4	3	2	5	1	0	3	0	0	19
Anxiety Disor/Obs Compulsive Disor	0	5	3	7	3	3	0	3	0	0	24
Acute Stress Disorder	1	2	4	0	0	1	0	1	0	0	9
Post Traumatic Stress Disorder	7	50	44	23	6	7	2	5	0	0	144
Nonpsy Org Brain	0	1	3	1	1	1	1	1	0	0	9
Total	34	155	140	92	34	25	17	44	3	0	544
Adjustment Disorder											
Adjustment Disorder	34	131	154	133	33	19	20	74	9	1	608
Total	34	131	154	133	33	19	20	74	9	1	608
Dissociative Disorders											
Depersonalization Disorder	0	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	0	0	0	0

Table 17 (continued)

Primary diagnosis	Maximum prison sentence										Total
	≤2 yrs	2-5 yrs	5-10 yrs	10-20 yrs	20-30 yrs	30-40 yrs	>40 yrs	Life	Execution	Unknown	
Personality Disorder: Odd and Eccentric Personality Types											
Paranoid Personality Disorder	0	4	3	5	2	1	0	7	0	0	22
Schizoid Personality Disorder	0	0	0	0	3	0	1	3	0	0	7
Schizotypal Personality Disorder	0	2	4	4	0	1	0	3	0	0	14
Total	0	6	7	9	5	2	1	13	0	0	43
Personality Disorder: Dramatic, Emotional, and Eccentric Behavior											
Antisocial Personality Disorder	3	30	46	34	18	5	11	14	2	0	163
Borderline Personality Disorder	4	17	22	23	4	1	2	4	2	0	79
Histrionic Personality Disorder	0	0	0	0	0	0	0	0	0	0	0
Narcissistic Personality Disorder	0	0	0	1	1	0	1	2	0	0	5
Total	7	47	68	58	23	6	14	20	4	0	247
Personality Disorder: Anxious and Fearful											
Avoidant Personality Disorder	0	0	0	0	0	0	0	0	0	0	0
Dependant Personality Disorder	0	1	1	0	0	0	0	0	0	0	2
Personality Disord/Obs Compulsive Disor	0	1	0	0	0	1	1	1	0	0	4
Personality Disorder NOS	4	26	30	29	9	8	7	17	0	0	130
Total	4	28	31	29	9	9	8	18	0	0	136
Substance Abuse Disorders											
Alcohol Dependence	5	15	18	15	1	1	1	1	0	0	57
Drug Dependence	40	133	49	33	7	5	6	5	1	0	279
Non-Dependent Drug Abuse	0	4	5	7	0	1	0	1	0	0	18
Psycho/Physical	0	3	2	3	0	1	1	0	0	0	10
Total	45	155	74	58	8	8	8	7	1	0	364
Somatoform Disorders											
Conversion Disorder	0	1	0	1	0	0	0	0	0	0	2
Hypochondriasis	0	0	0	0	0	0	1	0	0	0	1
Somatization Disorder NOS	0	0	2	1	0	0	0	1	0	0	4
Total	0	1	2	2	0	0	1	1	0	0	7
Sexual and Gender Identity Issues											
Sexual Deviations	0	2	1	8	3	1	2	2	0	0	19
Total	0	2	1	8	3	1	2	2	0	0	19
Fictitious Disorders											
Malingering	0	4	3	4	1	0	3	1	0	0	16
Unsp Mtl/Beh Prob	2	16	12	14	4	3	2	7	0	0	60
Total	2	20	15	18	5	3	5	8	0	0	76
Learning Disorders											
Learning Disorders	0	0	1	0	0	0	0	0	0	0	1
Asoc W/Disp Elsw	0	0	0	0	0	0	0	0	0	0	0
Total	0	0	1	0	0	0	0	0	0	0	1
Attention-Deficit and Disruptive Behavior Disorders											
Attention-Deficit, Hyperactivity	5	11	9	4	0	1	1	0	2	0	33
Conduct Disorder	10	34	31	22	8	0	3	9	0	0	117
Distrb Spec Ch/Adl	1	0	0	0	0	0	0	0	0	0	1
Total	16	45	40	26	8	1	4	9	2	0	151

Table 17 (continued)

Primary diagnosis	Maximum prison sentence										Total
	≤2 yrs	2-5 yrs	5-10 yrs	10-20 yrs	20-30 yrs	30-40 yrs	>40 yrs	Life	Execution	Unknown	
Mental Retardation											
Borderline Intellectual Functioning	0	1	3	0	0	0	2	0	0	0	6
Mild Mental Retardation	0	6	8	10	0	2	2	0	0	0	28
Moderate Mental Retardation	0	2	0	0	0	0	0	0	0	0	2
Severe Mental Retardation	0	0	0	0	0	0	0	0	0	0	0
Profound Mental Retardation	0	0	0	0	0	0	0	0	0	0	0
Mental Retardation, Severity Unspecified	0	0	0	0	0	0	0	0	0	0	0
Total	0	9	11	10	0	2	4	0	0	0	36
Not Classified Elsewhere											
Not Classified Elsewhere	3	26	25	18	5	6	6	10	1	0	100
No Diagnosis Recorded	1	11	10	2	1	0	1	2	0	0	28
Total	4	37	35	20	6	6	7	12	1	0	128
Grand total	388	1,809	1,781	1,333	410	249	263	704	40	2	6,979

Table 18

NUMBER OF MENTALLY ILL INMATES BY AGE GROUP AND PRIMARY MENTAL ILLNESS IN PENNSYLVANIA (FOR EACH ILLNESS, THE PERCENTAGE OF THE TOTAL NUMBER OF MENTALLY ILL INMATES WITHIN EACH AGE GROUP IS LISTED IN PARENTHESIS)

Primary diagnosis	Age 16-39	Age 40-49	Age 50+	Total
Depression NOS	552 (13.7%)	239 (11.6%)	100 (11.0%)	891 (12.8%)
Major Depressive Disorder, Recurrent Episodes	403 (10.0%)	242 (11.8%)	114 (12.6%)	759 (10.9%)
Adjustment Disorder	411 (10.2%)	143 (6.9%)	54 (6.0%)	608 (8.7%)
Schizophrenia, Paranoid Type	209 (5.2%)	201 (9.8%)	95 (10.5%)	505 (7.2%)
Schizoaffective Disorder	238 (5.9%)	161 (7.8%)	60 (6.6%)	459 (6.6%)
Anxiety Disorder, NOS	204 (5.1%)	90 (4.4%)	45 (5.0%)	339 (4.9%)
Brief Psychotic Disorder	209 (5.2%)	51 (2.5%)	31 (3.4%)	291 (4.2%)
Drug Dependence	204 (5.1%)	66 (3.2%)	9 (1.0%)	279 (4.0%)
Dysthymic Disorder	126 (3.1%)	66 (3.2%)	39 (4.3%)	231 (3.3%)
Mood Disorder, Not Otherwise Specified	121 (3.0%)	63 (3.1%)	36 (4.0%)	220 (3.2%)
Psychotic Disorder, NOS	137 (3.4%)	55 (2.7%)	25 (2.8%)	217 (3.1%)
Antisocial Personality Disorder	111 (2.8%)	45 (2.2%)	7 (0.8%)	163 (2.3%)
Bipolar I Disorder, Most Recent Episode Mixed	85 (2.1%)	46 (2.2%)	21 (2.3%)	152 (2.2%)
Post Traumatic Stress Disorder	74 (1.8%)	38 (1.8%)	32 (3.5%)	144 (2.1%)
Major Depressive Disorder, Single Episode	73 (1.8%)	41 (2.0%)	22 (2.4%)	136 (1.9%)
Personality Disorder NOS	80 (2.0%)	33 (1.6%)	17 (1.9%)	130 (1.9%)
Schizophrenia, Undifferentiated Type	47 (1.2%)	52 (2.5%)	27 (3.0%)	126 (1.8%)
Conduct Disorder	93 (2.3%)	19 (0.9%)	5 (0.6%)	117 (1.7%)
Schizophrenia	33 (0.8%)	55 (2.7%)	15 (1.7%)	103 (1.5%)
Not Classified Elsewhere	58 (1.4%)	29 (1.4%)	13 (1.4%)	100 (1.4%)
Substance Withdrawal	59 (1.5%)	37 (1.8%)	1 (0.1%)	97 (1.4%)
Bipol I Disor, Most Recent Episode Hypomanic	38 (0.9%)	26 (1.3%)	24 (2.6%)	88 (1.3%)
Borderline Personality Disorder	64 (1.6%)	14 (0.7%)	1 (0.1%)	79 (1.1%)
Bipol I Disor, Most Recent Episode Depressed	37 (0.9%)	31 (1.5%)	5 (0.6%)	73 (1.0%)
Unsp Mtl/Beh Prob	37 (0.9%)	14 (0.7%)	9 (1.0%)	60 (0.9%)
Grand total (all mental illnesses)	4,015	2,058	906	6,979
Percent of all mentally ill inmates	57.5%	29.5%	13.0%	100.0%

DEPARTMENT OF CORRECTIONS DEFINITIONS AND DSM-IV DIAGNOSES

Definitions

MHR – These are inmates who are mentally ill and are participating in treatment.

PRT – These are inmates on the MH/MR Roster who are seriously mentally ill and require closer monitoring.

Seriously Mentally Ill – Inmates who are seriously mentally ill have a substantial disorder of thought or mood, which significantly impairs judgment, behavior, capacity to recognize reality, or cope with the ordinary demands of life.

DSM-IV Diagnoses

Dementias
Dementia
Alcohol intoxication/withdrawal delirium
Substance (amphetamine/cocaine/nicotine/opioid/ other) withdrawal
Delirium due to general medical condition
Dementia due to general medical condition (e.g., Alzheimer's)

Schizophrenias
Schizophrenia
Schizophrenia, Disorganized type
Schizophrenia, Catatonic type
Schizophrenia, Paranoid type
Schizophrenia, Residual type
Schizophrenia, Undifferentiated type

Other psychotic disorders
Schizophrenoform disorder
Schizoaffective disorder
Delusional disorder
Psychotic Disorder, Not Otherwise Specified

Mood disorders
Bipolar I Disorder, Single Manic Episode
Bipolar I Disorder, Recurrent Manic Episodes

Major Depressive Disorder, Single Episode
Major Depressive Disorder, Recurrent Episodes

Bipolar I Disorder, Most Recent Episode Hypomanic
Bipolar I Disorder, Most Recent Episode Depressed
Bipolar I Disorder, Most Recent Episode Mixed
Brief Psychotic Disorder
Bipolar II Disorder
Mood Disorder, Not Otherwise Specified
Delusional Disorder, NOS
Other Non organic Psychosis

Dysthymic Disorder
Cyclothymic Disorder
Depression NOS

Anxiety Disorders
Anxiety Disorder, NOS
Social Phobias
Obsessive Compulsive Disorder
Acute Stress Disorder
Post Traumatic Stress Disorder

Adjustment Disorder: clinically significant emotional or behavioral symptoms in response to an identifiable psychosocial stressor/s. Symptoms are sub-threshold for other DSM diagnoses (mainly mood and anxiety disorders).

Adjustment Disorder

Dissociative Disorders: disruption in usually integrated functioning of consciousness, memory, identity, or perception. DSMIV Task Force Chairman questioned whether these disorders exist.

Depersonalization Disorder

Personality Disorder: an enduring pattern of inner experience and behavior that differ dramatically from the expectations of the person's culture, i.e., characteristics that bother other people. These patterns are pervasive and inflexible.

Cluster A: odd and eccentric personality types
Paranoid Personality Disorder
Schizoid Personality Disorder
Schizotypal Personality Disorder

Cluster B: dramatic, emotional, and eccentric behavior.
Antisocial Personality Disorder
Borderline Personality Disorder
Histrionic Personality Disorder
Narcissistic Personality Disorder

Cluster C: anxious and fearful.
Avoidant Personality Disorder
Dependent Personality Disorder
Obsessive Compulsive Disorder
Personality Disorder NOS

Substance Abuse Disorders
Alcohol Dependence
Drug Dependence
Non-Dependent Drug Abuse

Somatoform Disorders: presence of physical complaints that suggest a General Medical Condition (GMC), but complaints cannot be completely explained by GMC, substances, or another disorder.

Conversion Disorder
Hypochondriasis
Somatization Disorder NOS

Sexual and Gender Identity Issues
Sexual Deviations

Fictitious Disorders
Malingering

Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence (ICA Disorders)

Learning Disorders
Learning Disorders

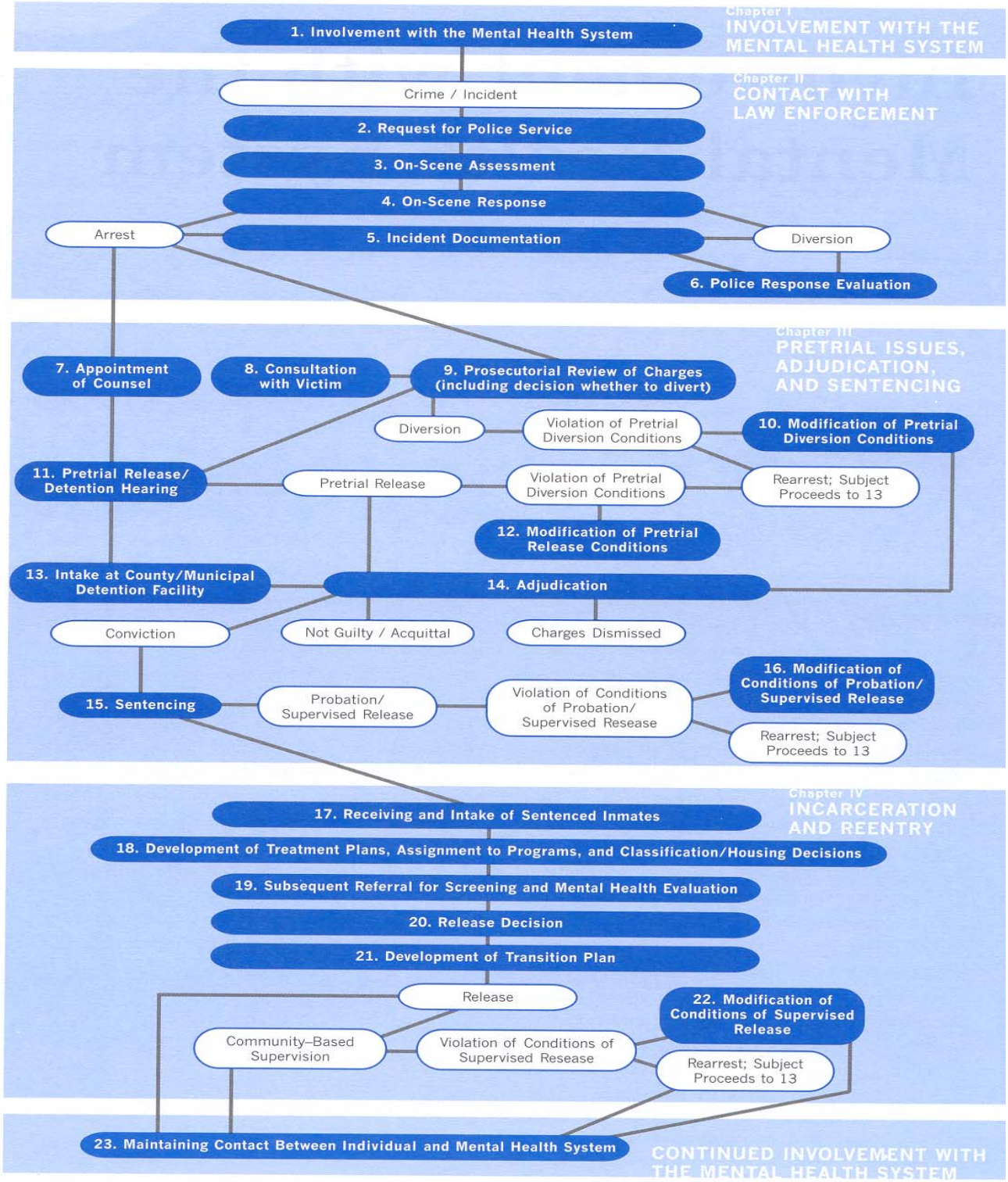
Attention-Deficit and Disruptive Behavior Disorders
Attention-Deficit, Hyperactivity
Conduct Disorder

Mental Retardation
Borderline Intellectual Functioning
Mild Mental Retardation
Moderate Mental Retardation
Severe Mental Retardation
Profound Mental Retardation
Mental Retardation, Severity Unspecified

APPENDIX G

PERSON WITH MENTAL ILLNESS
IN THE CRIMINAL JUSTICE SYSTEM
FLOWCHART

A Person with Mental Illness in the Criminal Justice System: A Flowchart of Select Events



APPENDIX H

MANSFIELD UNIVERSITY STATE SURVEY
2004 RESULTS*

PRESS RELEASE--MARCH 31, 2004:
Pennsylvanians Are Reluctant to Allow Chronically Ill Inmates Early Release from Prison

About 3 out of 4 Pennsylvanians are against the early release to parole of prison inmates who are chronically ill (bedridden). Some 15% of residents favor such a proposal while the remainder says they do not know.

If the inmates who are chronically or terminally ill *pose no threat to society*, then respondents were much more likely to favor such a proposal (45% favor). However, about the same percentage of residents are against it (47%).

The public has a similar view towards those who commit non-violent crime. Some 43% of respondents favor the early release to parole of inmates convicted of non-violent crime. Slightly more (50%) are against it. Thus, about half of Pennsylvanians are opposed to the early release of prisoners whether they are non-violent or non-threatening, seriously ill.

Pennsylvania is one of only a few states to not allow parole for inmates serving a life sentence. When asked if sentencing [provisions] should be changed to allow the possibility of parole for life-sentenced inmate, 3 out of 4 residents said no. Only 18% of those interviewed said yes. These results suggest that Pennsylvanians are very concerned about the threat that prison inmates pose to society and thus are not very willing to take chances with early release.

A few demographic trends were found. Although no clear patterns were found for education, sex of the respondent, and crime victims, there were differences based on age, political party and race. More support for early release to parole for inmates convicted of non-violent crime was found among the following: younger compared to oldest respondents (48 vs. 37%), Democrats compared to Republicans (48 vs. 38%), and blacks compared to whites (55 vs. 42%). A similar pattern existed regarding opinion toward allowing the possibility of parole

for lifers: younger respondents favor it more than older ones (21 vs. 14%), Democrats favor it more than Republicans (21 vs. 13%), and finally blacks favor it more than whites (36 vs. 16%).

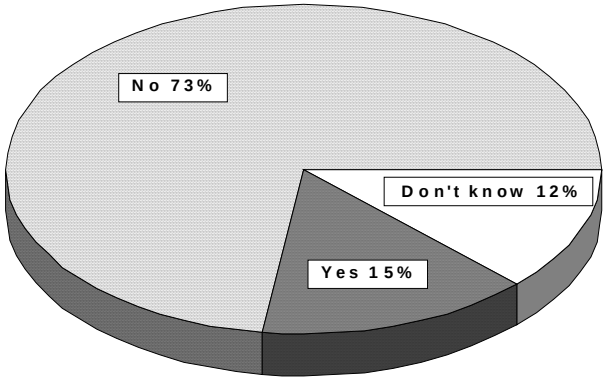
---

*The Mansfield University State Survey (formerly called the Public Mind) is a scientific telephone survey of adults in Pennsylvania co-directed by Drs. Timothy J. Madigan and Richard Feil of Mansfield University. Conducted between February 15th and March 3rd, it contains the opinions of 1,754 respondents. The margin of error on the full sample is approximately 2.4. Data from split-sample questions have a margin of error of 3.1. For more information please contact the co-director Dr. Timothy J. Madigan at (570) 662-4488 or tmadigan@mnsfld.edu.

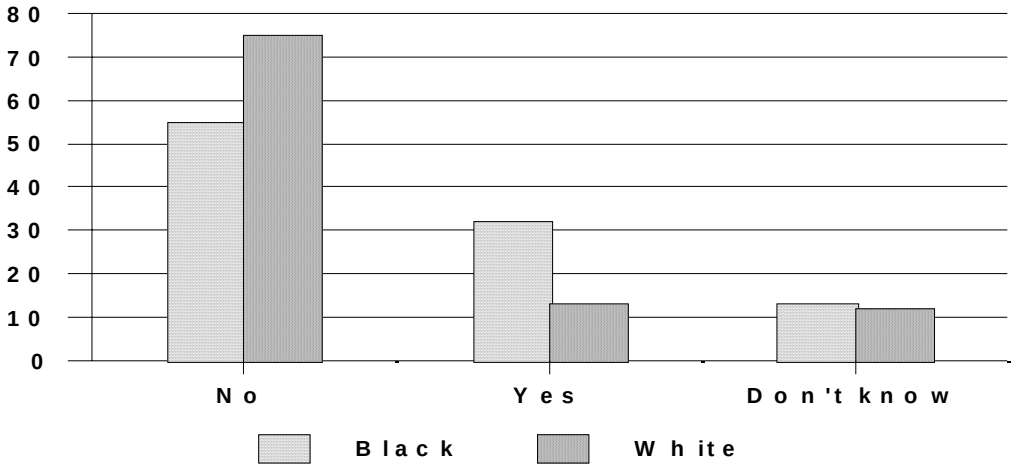
EARLY RELEASE OF INMATES FROM PRISON

☞ **Pennsylvanians are reluctant to allow chronically ill inmates early release from prison.**

"Do you believe that prison inmates who are chronically ill (e.g. bed-ridden) should be eligible for early release on parole?"



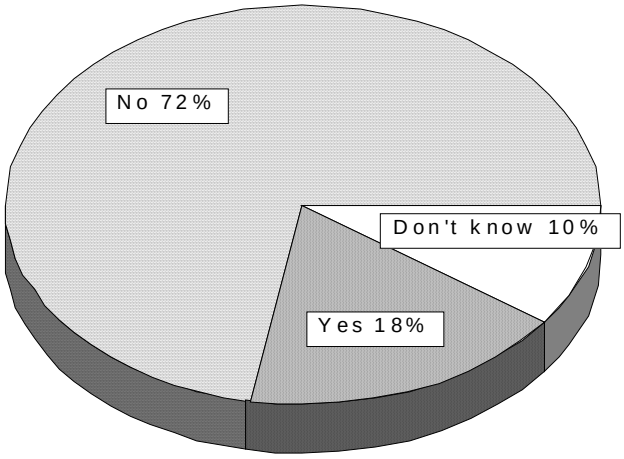
Prison inmates who are chronically ill should be eligible for early release on parole by race:



Analysis: Black respondents are more likely than whites to approve of early release of chronically ill inmates (32 vs. 13%).

☞ **Pennsylvanians are not in favor of allowing the possibility of parole for inmates serving life sentences.**

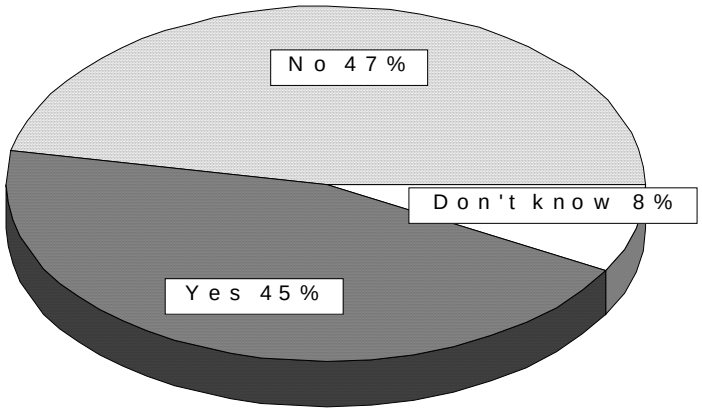
"Should sentencing [provisions] be changed to allow for the possibility of parole for lifers?"



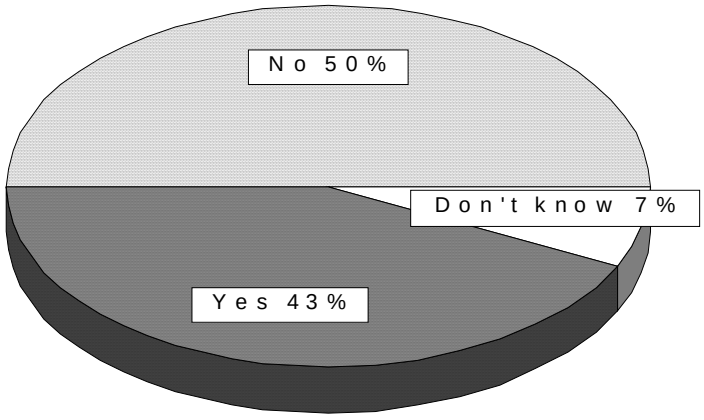
Analysis: Although residents were generally in favor of locking up inmates for life, there was considerable variation in opinion based on demographic factors. For example, Black respondents were twice as likely as whites to favor parole for lifers (36 vs. 16%). Those without a high school education were more likely than those with more education to favor parole (23% vs. 16%). The youngest respondents (21%) were the most likely to favor parole with the oldest the least likely (14%) and those in the middle-aged groups falling between (17%). Republicans were least likely to favor parole (13%) while Democrats were most likely (21%). Residents in urban areas were more in favor of parole for lifers than rural folks (19 vs. 13%). Those who live in Philadelphia County had even higher levels of support for paroling lifers (26%).

☞ **Pennsylvanians are much more likely to favor the early release to parole for chronically or terminally ill inmates who *pose no threat to society.***

"Early release to parole of chronically or terminally ill inmates who pose no threat to society?"



"Early release to parole of inmates convicted of non-violent crime (e.g. Using/selling drugs)?"

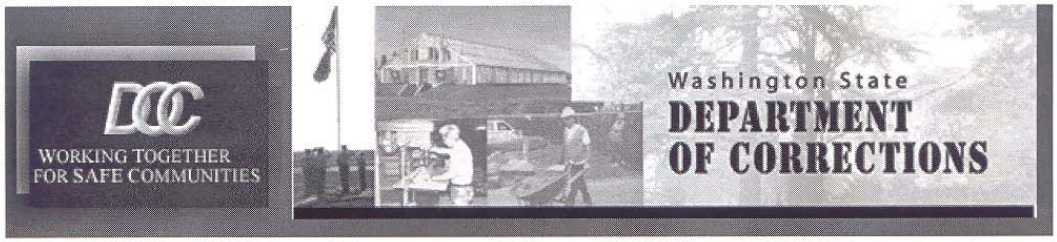


Analysis: The problem with early release for prisoners who pose no threat to society is coming up with a foolproof definition of "no threat."

APPENDIX I

VICTIM WRAP AROUND PROGRAMS

OTHER STATES



The Role of the Victim in Offender Reentry -- Holistic Approach Through Victim Wrap Arounds

I'll hope for the best, but will try to prepare for the worst..."

This statement is from a victim whose offender is preparing to release from prison and reenter the community. The statement reflects and sums up the sentiments of many victims when they learn that their offender is ready for release. The fear, trauma, and harm done from the crime often is resurrected with the final notification of release.

When an offender is preparing for release to the community, victim concerns range from basic safety issues to continued implementation of their rights as victims and availability of community resources and a holistic approach to provide support and protection. Therefore, what should the victim's role be in the reentry process of the offender and how should we, as a system, respond to that role?

In "The Victim Role in Offender Reentry: a Community Response Manual" the American Probation and Parole Association emphasizes the importance of partnerships among professionals in both the justice system and the community.

> "Partnerships that address offender reentry can provide collaborative opportunities to enhance public safety through focusing on offender accountability and successful reintegration into their families and communities; victim assistance; safety for neighborhoods and community; and enhance and strengthen the community supervision of offenders. While the concept of agency and community collaboration when offenders reenter communities is not new, there is significant emphasis on providing resources and maximizing the use of existing resources that strengthen reentry partnerships at the national, state and local levels.
>
> The successful reentry of offenders into the community is neither a linear process nor one that can be accomplished by a single agency. It requires collaboration and commitment from literally anyone concerned about public safety, as well as a commitment to ensuring that victims' rights are consistently enforced and victim services are consistently provided.

> It requires communities--including crime victims and victim service providers to be open to and involved in, partnerships that provide a wide range of opportunities for offenders to return to the community as local members who, given the chance can be held accountable for their actions, and be monitored and provide the supportive services to reduce their chances of recidivism and become productive and responsible members of society."

Providing comprehensive "wrap around" services for victims that identify and respond to their needs is as critical as assisting the offender in reentry into the community. Recently the Department of Corrections developed an initiative that assists in the safety planning for victims as the offender returns to the community, either from prison or county jail confinement. This process involves the victim, multiple partners from corrections, and the community coming together for the purpose of victim support and safety. The process developed is called the "Victim Wrap Around".

Agency staff who participate in the WRAP AROUNDS are staff from the Victim Witness Program, who facilitate the process; Risk Management Specialists; the Classification Counselor (if the offender is still in confinement with the Department); and the Supervision CCO. Local law enforcement from the victim's community, local victim advocates, and the victim and their support are also key to the success of the process. Additionally, based on the circumstances and history of the offender, other team members are also invited to participate, including representatives from the mental health community, domestic violence and sexual assault programs, child and adult protective services, prosecutor-based legal advocates, and representatives from chemical dependency programs.

Safety planning is discussed empowering the victim as an active participant of the team. Through this process the victim has direct input into the release process, including the establishment of conditions. Victims learn firsthand the degree of supervision and monitoring the offender will be under upon release and leave the meeting with a network of "system" folks that are then easily accessible for the victim. The safety plan for the victim that is developed is then incorporated into the overall supervision plan for the offender. The offender does not participate in the Wrap Around meeting. The objective of the Wrap around is to have a clear plan of action that would be put into effect for the victim, in addition to the identification of community resources the vicim can access should the need arise. Victims leave the meeting with the feeling that "the system is really listening to my needs" and "I thought I had to do this on my own (preparing for the release), but I now feel that I'm not alone".

If we do not invite victims to participate and keep them at the center of what we do, we are missing a very important component in our operation.

Managing Offender Risk

Research tells us that...

Crime will be committed when potential offenders are confronted with the opportunity afforded by available targets (victims) in situations of reduced guardianship (Smith and Dickey, 1999). Community safety, i.e., crime prevention, will be achieved when citizens and the system are attending to risks of place, time, and relationships in neighborhoods where the offender is living.

Furthermore,... when "we're faced with a higher-risk offender, we need more intensive and extensive services if we are to hope for a significant reduction in the probability of recidivism. For the higher-risk offender, we need intensive services; for the low-risk offender, minimal or no intervention is sufficient" (Andrews and Bonta, 1998).

To help victims...

Staff developed an initiative to assist them when an offender returns to the community from confinement. This process brings the victim, corrections staff, law enforcement, victim advocates, and the community together to provide support for the victim and to develop a plan to protect them from future harm and harassment. This process is called the "Victim Wrap Around."

Victims have direct input into the release process including the conditions imposed on the offender. A safety plan for the victim is developed and incorporated into the overall supervision plan for the offender. The offender does not participate in the Victim Wrap-Around meeting.

To support offenders...

Staff have formed Risk Management Teams to deal directly with high-risk offenders. These teams focus on individual offenders and can be made up of CCOs, treatment providers, local law enforcement, and community and family members. Teams provide intensive and extensive supervision, monitoring, services, treatment, and support of an offender in a collaborative and interdisciplinary fashion.

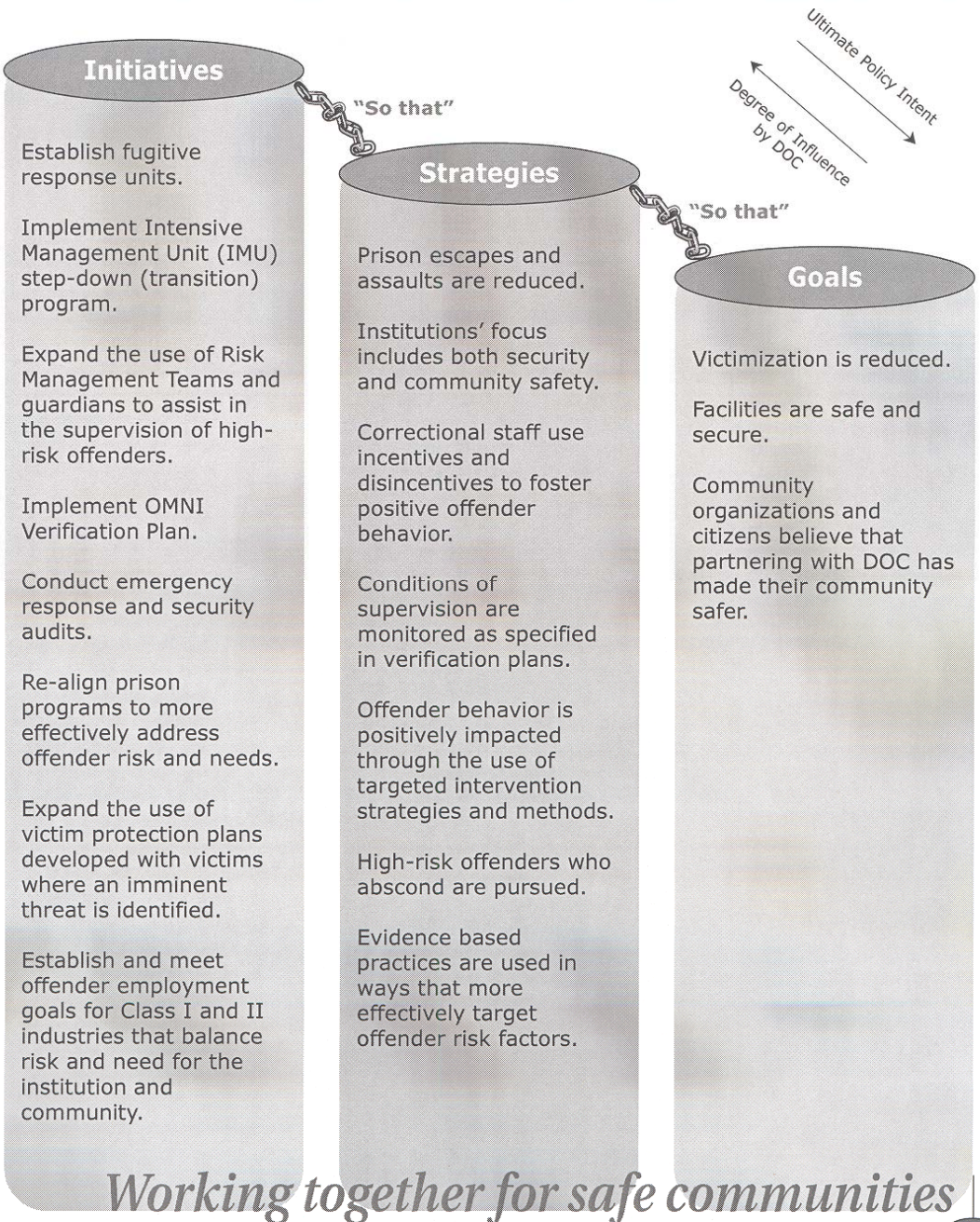
Our experience shows...

That the Victim Wrap-Around program empowers victims, making them active participants of the team. Victims learn firsthand the degree of supervision the offender will be under upon release. They leave the meeting with a network of "system" folks that are easily accessible. They leave the meeting with the feeling that "the system is listening to my needs" and "that I am not alone when the offender is released." The bottom line is, if we do not invite victims to participate and keep them at the center of what we do, justice is left undone.

Risk Management Teams provide increased communication and responsiveness in managing risk and providing services. Offenders monitored by system agents and guardians make for a broader coordinated system of treatment, support, and supervision.

SOURCE: Washington Department of Corrections. *Strategic Plan: Working Together for Safe Communities Fiscal Years 2003-2009*, pp. 28-29. http://www.doc.wa.gov/stratplan/P228StrategicPlan.pdf.

Managing Offender Risk



Working together for safe communities

Promising Practices for Victim Restitution & Compensation

by Luann Smith, 5th Judicial District

I was fortunate to be choosen to attend the 3rd Annual Corrections Based Victim Service Coordinator Training in December 2003.

Here is some information from the workshops I attended. Web sites & phone numbers are provided so that you can make contact, if interested. Feel free to contact me if you have questions or would like additional information. I have a huge notebook & other resource materials from this training.

■ *NIC & OVC Working for You: Resources Available to the Field*

A wide variety of products & services are offered by the NIC, OVC Training & Tech. Ass. Center, Center for Sex Offender Management.

OVC Services: Needs Assessment / Capacity Building / Evaluation & reporting.
(800) 851-3420, (866) 682-8822
www.ojp.usdoj.gov/ovc

TTAC - OVC Training & Technical Assistance Center
(703) 279-4673
ttac@ovcttac.org

National Institute of Corrections
(800) 877-1461
http://www.nicic.org

Center for Sex Offender Management Services: CSOM In-house Reference Library, Telephone Consultation, Training
(301) 589-9383
www.csom.org

OVC has a list of Recommendations regarding restitution in the following publication: New Directions from the Field NCJ #172825. Publication can be accessed through their web site: www.ojp.usdoj.gov/ovc

Workshops attended:

■ *Victim Impact: Listen & Learn, Anne Seymour, Justice Solutions*

New OVC video and discussion guide was introduced—excellent video with 14 vignettes on burglary, assault, robbery, crimes against a person with a disability, child abuse, incest, domestic violence, rape, hate/bias crime, drunk driving, gang violence, arson/homicide, homicide, multiple crimes. Each video segment can be easily incorporated into existing Victim Impact curricula.

■ *Promising Practices: The Victim Wrap Around Program*

Program reps from Vermont & Washington explained their process of safely reintegrating high risk offenders into the community while involving victims in the corrections phase of the criminal justice process.

Main Points:

It's important to protect victims from further harm and enhance safety of victims.

Offenders must be held accountable; reparative sanctions must be imposed.

It's hard to hold offenders accountable until we hear from victims about damage caused.

Risk Management Teams: to monitor, influence, treat and support offender in prison and community. The teams works with offenders on transition issues.

The development of a victim safety plan is as personal as the individual for whom it is developed and is based to a large degree of the personal feelings of the victim.

Wrap around plan provides community resources that join together in support of the victim through the development of a consistent and holistic system.

SOURCE: Iowa Department of Corrections. *The Journey: Victim Advisory Council Newsletter*, Summer 2004, p. 7.

The Ohio Plan for Productive Offender Re-entry

Community Justice is a philosophy that examines how crime affects society as a whole. Historically, the justice system has been focused on simply punishing offenders without looking at the impact of the crime on everyone involved. However, community justice includes four stakeholders- victims, offenders, justice professionals, and community members. They are pieces of a puzzle that must begin working together to hold offenders accountable for their crimes and respect the rights of victims. It recognizes that crime is committed against the community and affects families, neighborhoods, and general peace of mind.

As part of the Ohio Department of Rehabilitation and Corrections' (ODRC) continued commitment to community justice, the next step was to initiate Re-Entry. The *Ohio Plan for Productive Offender Reentry* was introduced to address the return of offenders under supervision back to the community after their sentence is served. It prepares offenders for release beginning at reception and continues throughout their stay at their parent institution.

Reentry also addresses the effects of offender release on their victim(s), a key component that has often been excluded in the past.

As part of the *Ohio Plan*'s Community Justice Partnerships, three recommendations were included to address the issue of offender re-entry and victims' concerns. They are as follows:

Recommendation #42: The Office of Victim Services (OVS) shall contact victims involved in identified higher risk cases to address victims' safety planning needs.

Shannon Hunt and Heather Smith, OVS Advocates, are collaborating with institution staff, the Adult Parole Authority and community resources in Lima County to initiate "Victim Wrap-Around"- a process that will include prior notification to victims of certain identified offenders- offenders who have committed sex offenses, domestic violence offenses or have been assessed by ODRC as high-risk. Once notified, the victim will be offered a "Wrap-Around", which will provide her (or him) with assistance from community and Department resources. This might include safety planning, crisis counseling, sex offender information and whatever else they might need in order to feel safe and supported once the offender is released.

Once this pilot program in Lima is up and running, the Wrap-Arounds will be expanded to Cuyahoga and Franklin Counties.

Recommendation #43: OVS shall coordinate the development of a research instrument and the completion of research on victim awareness program currently offered by the Department of Rehabilitation & Correction.

In partnership with OVS, the ODRC offers training to increase victim awareness among offenders. The program examines various crimes, examining the dynamics of each crime and the effect the crime has on the victim. This program uses written exercises and victim impact panels to bring the offender face to face with not just a crime, but also a person directly affect by it, providing an opportunity for an offender to step outside their world to see crime from a different perspective. For many, this class is an eye-opening experience and it gives offenders the opportunity to take personal responsibility for their actions.

Lori King, another OVS advocate, is currently working on the creation and implementation of a Victim Awareness Program Measurement Tool. Its purpose is to find out how the program is working. Before now there was nothing in place to prove the validity of the program. The long-term and short-term expectation of this project is to show proof it is making a difference.

The method of data collection is done through information gathered on each offender who enrolls in the program. The facilitator of each program submits the reports upon completion of each victim awareness program.

Recommendation #44: OVS shall develop a standardized curriculum for domestic violence programs within the institutions.

Recently, domestic violence programming was approved to be a core re-entry program in the prisons. Shelly Nichols, our Administrative Assistant, has been working on the implementation of the programming recommendation along with Karin Ho, our Administrator, and an advisory committee. They will use a nationally recognized Batterer's Intervention program called EMERGE, which is cutting edge and focuses on offender accountability and victim sensitivity. Shelly and Karin hope to travel to Massachusetts in June to receive training in the EMERGE program.

Once trained, Shelly will begin to select and interview appropriate volunteers who will conduct the EMERGE program in the prisons. Shelly will also be educating prison re-entry committees about the EMERGE program.

SOURCE: Ohio Department of Rehabilitation and Correction. *The Bridge: From Community to Corrections for Crime Victims*, May 2004, p.2. http://www.drc.state.oh.us/web/Victim%20Newsletter%202004.pdf

Offender Reentry

The State of Vermont Department of Corrections and the Burlington Community Justice Center are working together to develop an Offender Reentry Program that will:

- Provide information to the Burlington residents about the offenders returning to their neighborhoods
- Have community members hold offenders accountable to restoration
- Build relationships between offenders and community members
- Support offenders in their efforts to become productive members of the community
- Provide parallel support to victims whose offenders are returning to the community
- Ensure that offenders recognize the impact of their actions on the victims of their crimes

Executive Summary:

In response to the federal “A Job And A Place To Live” Offender Reentry Grant, the City of Burlington Community Justice Center is developing an Offender Reentry Project that will seek to increase safety by activating community resources to assure that offenders returning from prison have a sound plan for success and are held accountable to their commitments.

An Offender Reentry Community Advisory Panel comprised of Law Enforcement Personnel, a Victim Advocate and community volunteers will be created to oversee Offender Reentry in the City. The Panel will have two main functions: 1) to review individual offender's reentry plans and 2) review information on general offender activity in Burlington and make recommendations for program and policy changes. When appropriate, a team of two community volunteers will be assigned to an offender to provide feedback on the offender's impact on the community, to connect him or her to resources and positive relationships. Three to six months prior to release, a series of meetings (conferences) will be held to bring together the people who will be involved in the Offender's release process. At the same time, a separate Victim Wrap Around

process will bring together the victim's support persons and DOC staff to discuss her or his desires and needs relating to the release of the offender. Information shared and agreements made during these meetings will be reflected in the Reentry component of the Offender Responsibility Plan and the Community and Victim Safety Plans.

Through the collaboration of State and local government and internal Department of Corrections systems shifts, the program will seek to close the gaps that create barriers to successful offender reentry. Community agencies (housing, employment, social support, etc.) will be brought into the offender reentry planning process to create a network of accountability and resources.

The release policies of the DOC and the individual release plans of offenders will become more transparent and accessible to both service agencies and community members. In addition, offenders will learn about the impact of their actions, and hear expectations for their future behavior directly from citizens.

In summary, the Burlington Offender Reentry Project will be a collaboration of the City of Burlington, the State of Vermont Department of Corrections, the Citizens of Burlington, Local Service Providers, Victim Advocates, Crime Victims, Offenders and their support persons. Each will play an integral part in meeting the goal of the over all project which is to improve community and victim safety through implementation of an offender reentry program.

CJC Offender Reentry Staff Person:

The Community Justice Center will hire a full time Offender Reentry Staff Person (with experience working with serious and violent offenders) who will oversee all Offender Reentry Program activities.

Reentry Staff Person Authority & Responsibilities:

- Maintain updated data on all active offenders in the Offender Reentry Program

- Meet with Offenders and DOC staff throughout the incarceration and community phases of their sentence
- Support the work of Community Volunteers
- Support and participate in Victim Wrap-Around Meetings when appropriate
- Recruit service providers to participate in Case Conference or Advisory Committee Meetings when appropriate
- Support and participate in Case Conferences
- Organize Family Conferences
- Staff Community Advisory Committee
- Maintain relationships & contracts with local service providers
- Work to improve service delivery and collaboration

Victim Wrap-Around Meetings:

Victims of reentering offenders in the CJC reentry program will be offered a Victim Wrap Around meeting. This model, created in Washington State, brings together correctional staff, victim service providers, law enforcement officials with the crime victim and his or her chosen supporters to focus exclusively on comprehensively addressing the complex needs they face when preparing for an offender's return to the community. Department of Corrections Victim Advocates will organize Victim-Wrap Around meetings to be held during the three to six months prior to an offender's release, when appropriate. The CJC Offender Reentry Staff person will aid in the organization of these meetings when appropriate. Conditions established during the Victim Wrap-Around meeting will be included in the reentry component of the Offender Responsibility Plan when appropriate. DOC will commit to supporting the decisions made during the Victim Wrap-around meeting.

Responsibilities of the Department of Corrections:

The City of Burlington Community Justice Center's participation in an Offender Reentry Project will rely upon an on going positive relationship with the State of Vermont Department of Corrections and is contingent upon DOC fulfilling the following responsibilities:

Facility CSS:

The Facility CSS is primarily responsible for the creation of and the offender's adherence to the Offender Responsibility Plan. In addition, he or she is responsible for:

- The initial assessment of the Offender including (criminogenic needs, substance abuse & mental health assessment and treatment, life skill level and makes preliminary determination about what community the offender will reside in when he or she leaves prison)
- Sending a comprehensive report to the CJC Reentry Staff Person for all offenders who will return to Burlington within their first three months in prison.
- Collaborating with the CJC Offender Reentry Staff person
- Assuring that DOC follows through on its responsibilities in the Offender Responsibility Plan
- Supervising the offender's adherence to the Offender Responsibly Plan
- Organizing the Case Conference with the assistance of the CJC Reentry Staff
- Participating in the Victim Wrap Around, when requested
- Participating in the Group Conference, when requested
- General case management
- Transferring all pertinent information to the Field CSS § Fill out the immediate need checklist

SOURCE: Community & Economic Development Office, City of Burlington, Vermont. http://www.cedoburlington.org/cjc/offender_reentry.htm

APPENDIX J-1

SUMMARY OF CORRESPONDENCE FROM THE PUBLIC
DECEMBER 1, 2004

As of December 1, 2004, letters or phone calls have been received from 201 individuals. Several individuals have written or called more than one time but are counted only once. This summary is organized as follows:

I. Addressing both the release of geriatric and seriously ill inmates and parole eligibility for lifers
   A. Supporting
   B. Opposing

II. Geriatric and seriously ill inmates

III. Parole eligibility for lifers
   A. Supporting
   B. Opposing
   C. Supporting for lifers sentenced for second degree murder

IV. Mental health

V. Mandatory minimum sentencing

VI. Miscellaneous

I. Addressing both the release of geriatric and seriously ill inmates and parole eligibility for lifers

A. Supporting

Two individuals wrote to support the conditional release of geriatric and terminally or chronically ill inmates and parole eligibility for lifers.

Nine individuals wrote in support of parole eligibility for lifers and those with serious health problems and for help in obtaining the release of a loved one (most of whom had serious health problems)

SafeNet: Domestic Violence Safety Network, Erie – The executive director wrote to support parole eligibility for lifers and geriatric and seriously ill inmates who are no longer a danger to society and to say that the release of these individuals may be far from compassionate, as they may have no family or support system to sustain them.

B. Opposing

Center for Victims of Violence and Crime, Pittsburgh – The advocacy supervisor wrote and called to say that 35 clients and advocates were surveyed. All were opposed to parole eligibility for lifers and the early release of geriatric and seriously ill inmates, although several said that if an offender is dying before sentencing, he or she should be allowed to die in a nursing home or at home. Several of those surveyed are quoted here:

> Under no circumstance should old age or illness give an inmate the right to compassionate release. The deceased's rights were terminated when they were murdered. The perpetrator did not give them the opportunity to die a natural death. Why should the inmate get special treatment?
>
> I know that it is expensive to keep an inmate in prison for the rest of his or her natural life. However, has the advisory committee considered what the homicide has cost my family? We lost our beloved son. . . . We raised a productive and contributing member of the workforce who paid his taxes, went to church and coached baseball. . . . Do you really think that we would feel compassion for the inmate who killed our son if he became terminally ill? He came very close to destroying our entire family!
>
> My child didn't have the opportunity to die in a hospital bed surrounded by friends and family.
> The [victim] did not have the opportunity for death with dignity.
>
> Inmates are lucky that they have the medical care that they do in prison. There are plenty of hardworking people in this country with substandard medical care.
>
> The size of a cell is nothing compared to the size of a coffin. Life should mean life!

> If "life" no longer means "life," the victims' rights movement in Pennsylvania will take a gigantic step backward.

Crime Victims Council of the Lehigh Valley, Allentown – The executive director wrote to say the following:

> A life sentence is a life sentence, and it can be assumed that an offender serving a life sentence will grow old and may become ill.
>
> It would be a grave injustice to victims to change what a life sentence means in Pennsylvania.
>
> The existing mechanism for release when the Department of Corrections cannot provide care for an inmate (found in Purdon's Pennsylvania Statutes at 61 P.S. § 81) is enough.

Crime Victims' Center of Chester County, Inc. – The executive director and the projects supervisor both wrote that, under current law, defendants are able to present evidence to mitigate the degree of crime and that mechanisms are available to each inmate to have his or her sentence commuted and to be released when the Department of Corrections is unable to provide proper medical treatment. They also advised that victims need to feel some degree of closure and that repeated involvement with the criminal justice system impedes the victim's healing process.

Cumberland County Office of the District Attorney, Victim Services Division – The executive director provided a summary of some comments made by clients.

> Clients whose family members were murdered said life without parole is appropriate. They also opposed the early release of murderers due to illness. Many also expressed opposition to the reduction of penalties for murder.
>
> A few clients said that early release for illness might be alright for crimes other than murder and sexual assault.

Dauphin County Victim/Witness Assistance Program – The executive director wrote in opposition to the reduction of penalties for murder, saying that it would amount to a direct offense to the loved ones of murder victims seeking justice.

Delaware County Women Against Rape, Crime Victim Services Program – The director of victim services wrote in opposition to reduced penalties for murder, parole eligibility for lifers and the early release of seriously ill inmates. She suggested that, if early release of seriously ill inmates is allowed, lifers should be excluded. She also suggested that prisons should be more accommodating to terminally ill prisoners by, for example, providing a more comfortable environment and allowing more family visits.

Schuylkill County District Attorney's Office Victim – The witness coordinator/project director shared the story of a family whose loved one was murdered and who found a small sense of justice in the fact that, although the murderer was not sentenced to death, he would never again be outside of a prison. Lifers should not be released for any reason; they should stay in prison where the jurors who convicted them believed they would stay.

Victims of Irreparable Crime Experience (Allentown) – The co-chair expressed opposition to reduced penalties for murder and the early release of murderers for medical treatment.

Women's Center (Bloomsburg) – The executive director said that reduced sentences for murder would erode justice for victims of serious crime. A minimum sentence of 25 years with the possibility of parole or early release for serious illness for first degree murder does not provide the victim's family with justice that values the life of their loved one.

Victim Outreach Intervention Center (Evans City) – The executive director expressed opposition to parole eligibility for lifers and the early release of geriatric and seriously ill inmates. She added that current law allowing for the conditional medical release of inmates is sufficient. To assume that old or ill inmates are unable or unwilling to commit additional crimes is faulty.

Victims' Intervention Program (Honesdale) – The executive director expressed opposition to parole eligibility for lifers and the early release of geriatric and seriously ill inmates. "A homicide victim doesn't get his/her life back. The family who lost a child due to homicide doesn't get their child back. Life is life." She added that an elderly inmate might lack the skills to live in society, increasing the chance of recidivism, and that a terminally ill person has nothing to lose by committing another crime.

Victim Services Incorporated (Johnstown) – The executive director expressed opposition to reduced penalties for murder and the early release of geriatric and seriously ill inmates. She added that the lives of crime victims are forever changed because of the impact of the crime. Reducing sentences would re-victimize crime victims.

PA Victim Assistance Academy (Lansdale) – The project coordinator wrote in opposition to reduced penalties for murder and the early release of geriatric and seriously ill inmates as not meeting the concerns of victims.

Anti-Violence Partnership of Philadelphia – The executive director expressed opposition to the early release of seriously ill lifers and stated that a great number of co-victims of homicide feel that justice is served only by the imposition of a sentence of death or life without parole. She noted that victims take great comfort in knowing the murderer of their loved one will never return to their community.

Women Organized Against Rape (Philadelphia) – The executive director and ten others expressed opposition to reduced penalties for murder and the early release of geriatric and seriously ill inmates. However, if such changes are made to the law, provisions should be made for victim input statements before seriously ill inmates or lifers are released.

Crisis Center North (Pittsburgh) – The executive director said that the reduction of penalties for violent crimes would significantly compromise the safety of the citizens of Pennsylvania.

A victims' rights advocate and survivor of child sexual abuse wrote in opposition to reduced penalties for murder and the early release of geriatric and seriously ill inmates. She added that such release would not save the government money, as it would just be a different branch of the government paying for the offender.

An individual who helps victims of crime wrote in opposition to parole eligibility for lifers and stated that the current mechanism for the medical release of inmates is sufficient. Some victims do not support the death penalty, but feel that life without parole reflects the heinous nature of the crime. Moving to life with parole would abrogate the rights of victims and communities to safety and security.

A woman whose daughter was murdered wrote in opposition to parole eligibility for lifers and to the early release of geriatric and seriously ill inmates who had committed murder. She noted that such release would not save the Commonwealth money, as the taxpayers would also have to support these individuals outside of prison.

A man whose sister was murdered wrote in opposition to parole eligibility for lifers and the early release of geriatric and seriously ill inmates.

A woman with two friends who were victims of violent crime said inmates incarcerated for killing someone should not get a second chance in society for any reason. The families of murder victims suffer for life, and so should the murderers.

A woman whose daughter and grandson were killed when a high-speed chase occurred while they were taking a walk said that inmates who killed someone should serve the entire sentence they were given and not be released early for any reason, including poor health.

A woman whose ex-husband killed her only child and then himself said she does not have to worry about her child's killer suddenly appearing some day, since he killed himself. However, she has met many individuals in a support group who do worry about the release of their loved one's killer, and they do not want the person released for any reason – including old age or being seriously ill.

A woman whose best friend's son was killed at age 13 by his father (who then killed himself) said that a life sentence should mean life.

A woman whose brother was murdered wrote in opposition to parole eligibility for lifers and the early release of geriatric and seriously ill inmates.

Eight individuals wrote to say they have seen the pain and torment a co-worker/friend went through after the murder of her brother and that murderers should serve their full sentence and not be released for any reason.

Both parents of a 32-year-old woman who was brutally murdered in her workplace in 2002 said that a murderer should be sentenced to death when there is no doubt the person is guilty of murder, but if the murderer gets a life sentence, he should not be released from prison for any reason.

Two individuals wrote about the murder of their 32-year-old granddaughter and how terrified the victim's son is that the murderer will come get him. They prefer the death penalty when there is no doubt the person is guilty of murder, but if the murderer gets a life sentence, he should not be released from prison for any reason.

A woman whose granddaughter was murdered, leaving behind a young son, said the family wanted the killer sentenced to death, but since he was sentenced to life, he should never be released.

A close friend of the parents and grandparents of a woman murdered at her work place said that it would be an injustice if her murderer were ever released from prison for any reason, including age or sickness. She added that, if released, he would have to rely on welfare, which would not save the taxpayers money.

A teenager whose cousin was killed by his father said that killers should be put to death, but if they are instead given life, they should never be released.

A woman whose husband killed her two sons and then himself in 1988 said that a murderer sentenced to life should never be released from prison for any reason.

A woman whose two grandsons were killed by their father said that a murderer sentenced to life should never be released from prison for any reason.

A woman whose two nephews were killed by their father said that a murderer sentenced to life should never be released from prison for any reason. She added that future murderers should be sentenced to death or life without the possibility of parole.

A man whose two nephews were killed by their father said that a murderer sentenced to life should never be released from prison for any reason.

A woman whose best friend's two sons were killed by their father said that a murderer sentenced to life should never be released from prison for any reason.

A woman who knows two women whose children were killed by their father said that a murderer sentenced to life should never be released from prison for any reason.

Two individuals who lost a cousin and a friend to murder said that murderers should not be released from prison for any reason.

Three individuals whose mother and sister (grandmother and mother, mother-in-law and sister-in-law) were murdered eight years ago said that murderers should not be released from prison for any reason. They added that the release of the murderer would be a tremendous injustice and betrayal to the family.

A relative of a woman and her daughter who were murdered wrote in opposition to reduced penalties for murder and parole eligibility for lifers and the early release of geriatric and seriously ill inmates.

One individual wrote in opposition to parole eligibility for lifers, the release of geriatric and seriously ill inmates and reducing penalties for murder. She said that "families of murder victims suffer a life sentence of grief which is not relieved by the passage of time or illness."

A woman whose teen-aged son was murdered wrote in opposition to parole eligibility for lifers and the release of geriatric and seriously ill inmates.

A teenager whose brother was murdered wrote in opposition to parole eligibility for lifers and the release of geriatric and seriously ill inmates.

A grandmother of a murdered teenager wrote in opposition to parole eligibility for lifers and the release of geriatric and seriously ill inmates.

An aunt and two cousins of a teenager who was murdered wrote in opposition to parole eligibility for lifers and the release of geriatric and seriously ill inmates.

Two individuals whose teen-aged friend was murdered wrote in opposition to parole eligibility for lifers and the release of geriatric and seriously ill inmates.

An individual wrote in opposition to parole eligibility for lifers and the early release of geriatric and seriously ill inmates.

II. Geriatric and seriously ill inmates

Crime Victim Center of Erie County, Inc. – The director of advocacy provided survey results, which tally as follows:

Support early release of an inmate who is geriatric, mentally ill or seriously ill?

8 – No
1 – Yes for geriatric and seriously ill inmates who have not killed anyone
1 – Yes, but there should be a special place for them to be placed when released from prison

Support early release of lifers who are geriatric, mentally ill or seriously ill?

8 – No
1 – Possibly, depending on the amount of time served
1 – Possibly, on a case by case basis if the lifer has not killed anyone

Support change in sentencing that would reduce time served for life-sentenced inmates?

8 – No
1 – Not for murder but possibly for other offenses
1 – Possibly, under very extenuating circumstances

A woman wrote to support reasonable policies for the release of geriatric and seriously ill inmates. She explained the many medical problems (including cancer which had drastically metastasized) her father (not a lifer) had and the long time it took to obtain his release from prison to die at home.

One individual, who is the wife of an inmate who is over 50, called in support of the release of geriatric and seriously ill inmates.

One individual, who was released from SCI Graterford in 1995 after serving 15 years, wrote to emphasize the importance of proper nutrition and supplements, including fruits, vegetables, vitamins, minerals and herbs. He also suggested that some health problems, including cancer, in inmates at Graterford may have been caused by bad water and by food grown at Graterford's farm when banned chemicals were used during the 1970s and 1980s.

III. Parole eligibility for lifers

A. Supporting

One individual wrote in support of parole eligibility for lifers and suggested a separate panel be established to review parole applications for female inmates because they have different needs than males.

Thirty-one individuals sent virtually the same form letter supporting parole eligibility for lifers and pointing out that after serving many years in prison individuals transform their lives in a positive way, that lifers play positive roles in our prisons – such as adding stability to the institutions, helping staff deal with problematic inmates and heading programs which help other inmates – and that lifers can also be assets to their communities when released.

Note that three of the letters appeared to be from the same individual and that responses to two of the individuals were returned to the Commission unopened.

Ten individuals sent a form letter calling for a constructive commutation plan to give deserving lifers a second chance and to relieve the tax burden Pennsylvanians bear for corrections. These letters were accompanied by petitions bearing the following numbers of signatures:

48 (however, at least 40 of these appear to have been written by the person who signed the letter)
0 (the petition was signed only by the person who signed the letter and who is counted in the ten above)
23 (the 24th signature was that of the person who signed the letter)
23 (the 24th signature was that of the person who signed the letter)
27 (however, eight appear to be written by the same person)

Four individuals who volunteer with lifers or toured an SCI wrote in support of parole eligibility for lifers, with one of them specifying parole eligibility after 25 years in prison.

One individual who volunteers with lifers called and visited to express support for parole eligibility for lifers.

Three individuals (a cousin and a friend of one lifer and a friend of another lifer) called in support of parole eligibility for lifers.

Ten individuals who have friends or loved ones who are lifers wrote in support of parole eligibility for lifers. (Twenty-two additional family members and one friend of the lifer also signed or were listed at the end of one of these letters.)

One individual, who has a brother and several cousins serving life sentences, wrote in support of parole eligibility for lifers who are at least 50 years old and have served at least 30 years in prison.

One individual wrote to support parole eligibility for lifers who have spent at least 25 or 30 years in prison and have changed for the better.

Three individuals sent virtually the same letter to support parole eligibility for lifers who have spent at least 27 years in prison and are at least 50 years old, based on the merit of their behavior.

One individual wrote supporting parole eligibility for lifers who have served at least 25 years and are found worthy. She specified her brother, a Vietnam Veteran who has suffered from post traumatic stress disorder and has served 28 years on a life sentence, as a worthy candidate.

> She noted that she is somewhat torn in this, because she is also a victim: her husband was killed while their store was being robbed.

One individual wrote to propose the compulsory commutation of life sentence for inmates who committed their crimes as juveniles and were certified as adults after serving 20 years and abiding by certain rules.

One individual, the wife of a lifer who committed his crime at 16 and has been incarcerated for over 30 years, called in support of parole eligibility for lifers.

Two individuals wrote and one individual called in general support of parole eligibility for lifers.

19 individuals sent virtually identical form letters supporting retroactive parole eligibility for lifers.

B. Opposing

Blackburn Center, Greensburg – The executive director and the advocacy program manager wrote to say that because a life sentence is an alternative to a death sentence, a life sentence should never include a mechanism for release other than that in existing law for the medical release of an inmate (found in Purdon's Pennsylvania Statutes at 61 P.S. § 81).

Office of the District Attorney, City and County of Philadelphia – The District Attorney wrote to say the following:

> She is strongly opposed to expanding the release of geriatric and seriously ill inmates who committed serious violent crimes.

Such release would undermine the integrity of the judicial system and place law-abiding citizens in danger, as in the case of the release of Raymond Webb, who was released from a life sentence for a double murder after serving 17 years in Missouri, served six years on a sentence of five to 15 years in Pennsylvania for rape and was recently convicted of rape and attempted murder at the age of 60.

The legal mechanism already exists for the release of an elderly life-sentenced inmate who is truly deserving and is no longer a threat to public safety: the Governor's power to commute sentences and pardon individuals who are recommended by the Board of Pardons.

How can "geriatric" be appropriately defined, considering that some 80-year-olds run marathons and hike the Appalachian Trail while some much younger individuals are incapacitated?

Parole eligibility for lifers would be a misguided and dangerous attempt to balance the budget on the backs of the victims of crime.

Three individuals wrote to oppose reduced penalties for murder and parole eligibility for lifers.

C. Supporting for lifers sentenced for second degree murder

Twelve individuals sent virtually the same form letter supporting parole eligibility for lifers sentenced for second degree murder. All but three of the letters also stated that President Bush has said that, except where an inmate is sentenced to death, a person who has been confined for 25 years should be considered for release from prison.

One letter with the President Bush statement was signed by 29 individuals.

IV. Mental health

PA Community Providers Association – The executive director explained that the Association represents about 150 community-based mental health, mental retardation and substance abuse service providers across the Commonwealth. He offered the following recommendations regarding mental health, mental retardation and substance abuse services for inmates being released into the community:

> In many areas of the Commonwealth, services are already available to inmates released from prison, so a goal could be to use those services as effectively and efficiently as possible, rather than developing a duplicate system.
>
> These inmates would benefit from parole supervision or case management upon release, so that they have support in making the transition back into the community.
>
> Housing, employment and social integration skills must be addressed.

> A major cost shift to local communities must be avoided. Medicare and Medicaid benefits need to be obtained for the inmate, but basic mental health and substance abuse benefits are limited under them. Additional funding will be needed to provide appropriate services.

A psychiatric nurse, who is the father of an inmate with autism, called to recommend the following:

> Diversion from prison is necessary.
>
> Offenders with serious mental health issues should never be put in prison, but if they are, they should never be put in solitary confinement.
>
> No matter where the offender is held, the Behavior Model should be used. Basically, a behavioral psychologist will begin his work with an individual by observing and charting the person's behavior. After a period of time, a pattern (similar to a bell curve) will emerge which shows when the person is likely to have good days (and be receptive to help in changing behaviors) and bad days (when any sort of treatment attempt would be wasted – or even make matters worse). The Behavior Model is not a punitive system and requires a move to non-security mode.

The mother of an inmate with mental health problems called to recommend the following:

> Inmates should be carefully assimilated into prison, especially if there is mental illness present. It is difficult to get used to confinement in the best of circumstances.
>
> An inmate with mental illness should never be held in solitary confinement.

V. Mandatory minimum sentencing

One individual wrote to express concern regarding both mandatory minimum sentencing laws and the disparate sentences individuals receive for committing what appear to be the same crimes. She noted that her husband is serving a sentence of 125 to 250 years on convictions for non-violent drug crimes and that many non-violent offenders receive longer sentences than violent offenders because of mandatory minimum sentencing. She also identified the organization Families Against Mandatory Minimums as an information resource.

VI. Miscellaneous

One individual wrote in "support of the resolution."

APPENDIX J-2

SUMMARY OF CORRESPONDENCE FROM INMATES
DECEMBER 1, 2004

As of December 1, 2004, letters have been received from 92 inmates. Several inmates have written more than one letter but are counted only once. This summary is organized as follows:

I. Addressing both geriatric and seriously ill issues and parole eligibility for lifers

II. Geriatric and seriously ill

III. Parole eligibility for lifers

IV. Mental health

V. Miscellaneous

I. Addressing both geriatric and seriously ill issues and parole eligibility for lifers

Graterford — Parole eligibility for lifers and those serving very long terms of years ("life without the letters"). Halfway-back houses with extensive supervision should be established for lifers and very ill inmates to go to upon showing that they are no longer a threat to society.

Greensburg — Serving life plus 5 – 10 years; Hep C; high blood pressure; has a loving family but cannot get out of prison even though he has serious health problems. Hopelessness in lifers leads to suicide.

Pittsburgh	Many lifers are not interested in parole, as it would only be a way for the state to push seriously ill and geriatric inmates onto county or Federal government. While there might be some healthy men or women who would welcome a chance to get out at age 50 or 60, a sick individual could not realistically attempt life on the outside. The 1997 amendment to the Pennsylvania Constitution (which requires a unanimous recommendation from the Board of Pardons to grant a pardon or commute a sentence when the individual applying is serving a life sentence) stands in the way of possible relief for lifers.
Rockview	Help needed in appealing life sentence; 50 years old; has various health problems.

II. Geriatric and seriously ill

Graterford	Needs a kidney transplant and a proper eye exam because of diabetic nephropathy. Is deprived of needed medication and wants an investigation of his situation.
Graterford	Hep C; 49 years old; not a lifer; wants out of prison.
Laurel Highlands	57 years old; severe stroke in 1997; paralyzed on one side; uses a wheelchair. Was paroled to a Community Corrections Center in Pittsburgh in 1999 but was turned down by the center because it was not wheelchair accessible. Wants help to get out of prison.
Laurel Highlands	Diagnosed with ALS; wants to be paroled to be near his family.
Laurel Highlands	Drinking water not available; an inmate was physically forced to take medication and later beaten. Acting Supt. Hunsberger responded to the inmate's claims.
Muncy	Seen as an inmate crying wolf when seeks medical care; Hep C; diabetes; liver failure; not getting needed regular blood tests or physical therapy.

Muncy	Breast cancer diagnosis was delayed six months resulting in spread to lymph nodes. DOC should offer preventive treatment such as calcium supplements, proper eye prescriptions, follow-up care and better nutrition.
Muncy	Glaucoma; Hep C; needs consistency in care; fears younger inmates.
Muncy	Geriatrics need motivation; only the PA Prison Society provides programs for seniors.
Muncy	Hospice volunteer. Patients need proper medication and sustenance.
Muncy	Uses a wheelchair; lifer; wants help to get out of prison.
Muncy	Better medical care and nutrition are needed.
*Muncy	Lifer wants help securing a medical release from prison.
Somerset	Serving his fourth year of a 5 to 10 year sentence; 53 years old; Hepatitis C; wants help to get an early release from prison.

III. Parole eligibility for lifers

Albion	Parole eligibility for lifers
Coal Twp	Parole eligibility for lifers
Coal Twp	Parole eligibility for lifers. President of Triumph, a service organization at Coal Township which performs charity work. Listed the positive qualities of lifers, long-timers and geriatric inmates. Taxpayers' money which is currently spent to meet the high costs of housing these inmates could be better spent to prevent today's youth from becoming tomorrow's lifers.
Coal Twp	Parole eligibility for lifers
Dallas	Parole eligibility for lifers
	Lifers with terminal illnesses who are not a threat to society should be released to spend their final moments with their families.

Those convicted prior to the change in the Constitution which resulted in lifers being unable to obtain commutation, should be reviewed under the former clemency guidelines.

While a common argument against parole for lifers is that killers will be released into society to kill again, the fact is that offenders who have killed are released back into society every day. These include individuals in Pennsylvania who have served their sentences of years for voluntary manslaughter and third degree murder and individuals in other states who have been paroled from life sentences and go on to lead law-abiding lives.

Most individuals convicted of homicide should be sentenced to life with parole with a specified minimum length of time to be served (i.e., there would be a range of sentences from "five years to life" to "25 years to life").

The sentence of life without parole should be retained for certain offenders, including snipers, serial killers, contract killers and those who commit homicide in order to collect insurance money.

The Board of Pardons should seek the input of the original prosecutor, rather than the current district attorney (who is often unfamiliar with the case and predisposed not to recommend a pardon for fear of a negative media response) when considering an application for clemency.

Because of post traumatic stress disorder and a veteran's willingness to risk his life for his country, the fact that a crime was committed within three years of discharge from active wartime military duty should work in an offender's favor with the Board of Pardons.

When the Board of Pardons recommends clemency, the Governor should be required to sign the recommendation and the offender should be released (immediately if a pardon is granted or, if the sentence is reduced, after the new sentence is served) without the involvement of the Board of Probation and Parole.

Dallas — Parole eligibility for lifers; has served 21 years and hopes his life sentence is not, in reality, a death sentence.

Dallas — Recommends a slow incremental reduction in custody for lifers utilizing "Lifer Houses."

Fayette	Parole for lifers after 25 years served and reaching age 50. Many lifers change over many years of incarceration. Was incarcerated as an adolescent and did not understand the depth of his actions at the time. Is now 54 and has taught many inmates and facilitated many programs, has seven years of college education and a great appreciation of life.
Fayette	Parole eligibility for lifers
Fayette	Parole eligibility for lifers. Fayette is so new that there are no organizations yet for inmates. Requested copies of SR 149 to distribute and status of the study.
*Fayette	Parole eligibility for lifers; 2d degree murder conviction; served 28 years on life sentence; about to give up; danger of suicide for hopeless lifers.
Gaudenzia	Parole eligibility for lifers 25/50
Graterford	Parole eligibility for lifers especially 2d degree; in prison since the age of 17; brother since the age of 18.
Graterford	Detailed "Economic Proposal" regarding parole eligibility for lifers.[59]
Graterford	Parole eligibility for lifers. Some victims also favor parole for lifers because today's technology makes incarceration unnecessary. Wrongly incarcerated due to a coerced confession.
Graterford	A Community Parole Commission for Lifers should be established to review files, interview inmates and other witnesses and make parole determinations for lifers. The Commission would review a lifer when he or she enters the prison system, set a plan for the lifer to complete and review the lifer's progress every three years. When a jury decides on a life sentence, it should also be required to set the number of years the offender would be required to serve on the life sentence before he or she would be eligible for parole. Such a system could also be used for inmates who are serving terms of years. Virginia and Texas statutes are good resources regarding sentencing and parole issues.

[59] See "S.P." in Appendix K, p. 256, for details.

Graterford	Parole eligibility for lifers. Prior studies resulted in numerous recommendations, but no action was taken on them.
Graterford	Lifer for 2d degree murder. Life without the possibility of parole is cruel.
Graterford	Parole eligibility for lifers as long as the victim's family approves.
Graterford	Provided a history of life without parole and a chart "Life Sentences by State."
Graterford	Parole eligibility for lifers
Graterford	Less than 1/3 of 1% of paroled lifers are re-incarcerated on new offenses
Graterford	Parole eligibility for lifers. Veterans cannot get veterans' benefits while incarcerated; made film "Prisoner's Dialogue" to keep youth from prison
Graterford	Parole eligibility for lifers
Graterford	Parole eligibility for lifers. Member of Lifers, Inc. performs many charity works and programs, including selling Girl Scout cookies and holding benefits of various kinds for Big Brothers/Big Sisters, Philadelphia Youth at Risk and many other groups. Rehabilitated, committed lifers have transformed their lives in very positive ways; they have given much from the inside and can give more on the outside.
*Graterford	Parole eligibility for lifers; allow juries to choose between life with the possibility of parole after 20 or 25 years served and life without the possibility of parole. Reinstate a natural progression from incarceration to living in the community by allowing lifers to live and work outside the fence under custody level 2 (provided a copy of revised DOC Policy DC-ADM 805).
Graterford	Parole eligibility for lifers; lifer asking that we speak on his behalf in court.

Greene — Parole eligibility for lifers. At 51 – and after serving 27 years in prison – he does not want to go home and be a burden on his family, although they would not hesitate to take him in. He is at peace and appreciates the structure prison affords. However, he is concerned about his cousin who accompanied him on his crime. His cousin was only 15 or 16 at the time and went with him because he was afraid of him. He feels that he is responsible for destroying his cousin's life and that of his cousin's half brother and regrets he cannot rectify it.

Younger people in prison are more aggressive. They take advantage of the timid, elderly and mentally ill, who make easy targets. Putting an elderly inmate and a young inmate in the same cell is a serious problem. A prison should be set up for inmates who have long sentences and are over 40; it could pay for itself. The prison would be full of inmates who are respectful and responsible and would not have a tension-filled atmosphere. Inmates slightly younger than 40 would begin to conduct themselves in a proper manner in the hopes of being assigned to that prison in the future.

Punishment does not impress inmates doing less than 10 years and they become incorrigibles who believe they are tougher than the system. A prison should be set up for them with a large library, voluntary programs, a high level of security staff and no television.

Greensburg — Juvenile homicide conviction; lifer; accomplished much in prison; innocent

Houtzdale — 1st degree murder at 18; should be able to earn redemption. Parole after 20 years served; age should not be a determining factor in parole for lifers.

Huntingdon — Parole eligibility for lifers 50 and older after serving 25 years. Provided a history of sentencing, parole and pardons in Pennsylvania.

Laurel Highlands — Lifer who committed his crime as a teenager returning from a horrific experience serving in Vietnam. Interested in the idea of parole eligibility for lifers, but thinks there are some Constitutional questions and also noted that it might not actually save the taxpayers money, but just involve cost-shifting to another area of government.

Mahanoy	Parole eligibility for lifers; especially for a crime committed as a teenager. Eligibility at 25/50 if earned a positive confinement record, developed job skills and improved education level.
Mahanoy	Parole eligibility for lifers; 45 years old; sentenced at the age of 17; aberrations such as Reginald McFadden and Mudman Simon should not close the door on those who deserve another chance.
Mahanoy	Retroactive parole eligibility for lifers after serving 25 years
Mahanoy	Retroactive parole eligibility for lifers after serving 25 years job skills; improved education.
Muncy	Parole eligibility for lifers; lifer seeking pro bono representation
Pittsburgh	External vice president of the PA Association of Lifers at SCI Pittsburgh supporting parole eligibility for lifers
Pittsburgh	Parole eligibility for lifers
Pittsburgh	Parole eligibility for lifers; 58 years old; served 38 years
Pittsburgh	Parole eligibility for lifers. It is unfair to be sentenced to life for 2d degree murder if did not actually kill anyone.
Pittsburgh	Parole eligibility for lifers; 57 years old; served 33 years
Pittsburgh	Parole eligibility for lifers; sentenced to life at the age of 16; served 23 years
Pittsburgh	Parole eligibility for lifers. Help needed for commutation request – legal representation; lifer for 25-½ yrs since the age of 16
Pittsburgh	Parole eligibility for lifers. Help needed in commutation request; lifer who has served 31 years.
Rockview	Serving a 6-year sentence, but supports parole eligibility for lifers. His cellmate (now 30) was convicted and sentenced to life for a crime committed at the age of 14 in which he acted as look-out. Society should not incarcerate young people for life without parole.
Rockview	Parole eligibility for lifers; VP of Life Assoc.; status of study

Rockview	Parole eligibility for lifers
Rockview	Parole eligibility for lifers; 43 years old and incarcerated since 1977; has a home plan and a job waiting for him; has been turned down for commutation by the Board of Pardons three times.
Rockview	Parole eligibility for lifers who take responsibility for their actions, accept punishment as a tool to becoming productive in society, show willingness to grow spiritually and emotionally, are 50 years of age or older and have served 25 years or more in prison.
Rockview	Non-lifer supporting parole eligibility for lifers and specifying one lifer in particular who is worthy of parole
Rockview	Parole eligibility for lifers
Rockview	Parole eligibility for lifers; 47 years old; committed murder at the age of 17.
Rockview	Parole eligibility for lifers. The 25/50 proposal is alright if the offense was committed at a young age, but this inmate committed his crime at the age of 50.
Rockview	Parole eligibility for lifers; 35 years old; served one year on a life sentence
Rockview	Parole eligibility for lifers; 53 years old; incarcerated for 33 years
Rockview	How much real consideration is being given to parole eligibility for lifers?
Somerset	Parole eligibility for lifers; committed his crime at the age of 17. Recommends new legislation with exhaustive measures geared toward the rehabilitation of lifers and others. Standards should differentiate between committing a single offense and multiple offenses and should include educational, therapeutic and risk assessment needs. Consideration should be given for youthful offenders and mentally ill offenders.

IV. Mental health

Fayette	Help needed; investigate or represent in MH case at Fayette.
Rockview	Schizophrenia? His psychosis was caused by Dilantin, Naprosyn and polluted water. His alcoholic parents also used various medications. Received sleep medication laced with sex stimulants.

V. Miscellaneous

Albion	Information about the study.
Camp Hill	Convictions of the innocent need to be investigated.
Camp Hill	Concerns regarding how inmates are treated at SCI Camp Hill.
Chester	Status of study.
Dallas	Post Conviction Relief Act – 42 Pa.C.S. § 9545(b) should be repealed or amended to allow a petition later than one year after the date judgment becomes final if "there is a compelling need to address the claim because of a fundamentally unfair trial, illegal sentence or some other manifest injustice."
Dallas	The Department of Corrections and the Board of Probation and Parole exist to keep individuals employed. Programs do not prepare inmates to provide for themselves upon release. Inmates are released without money or help in securing a job.
Dallas	Wants a retirement system for elderly inmates. The system is currently "no work, no pay," no matter how old the inmate is.
Fayette	Help needed; website printouts asking for legal, investigative or advocacy aid.
*Graterford	Para-Professional Law Clinic should remain open
*Graterford	Status of study.
Greene	Help needed; lifer; chronic illness; functional illiterate; terrible injustices in case.

Greene	Wants transcripts of hearings. (No hearings were held.)
Laurel Highlands	Status of study.
Mahanoy	Help needed; serving a life sentence for crime did not commit.
Mahanoy	Copy of resolution.
Pittsburgh	Status of study
Pittsburgh	Heard a rumor that a study regarding parole for lifers is being presented to the General Assembly soon.
Pittsburgh	50-year-old lifer; innocent but cannot be proven innocent by DNA evidence
Rockview	Innocent and asking for assistance

* Not counted, as this individual was counted previously.

Totals by SCI:

2 from SCI Albion
2 from SCI Camp Hill
1 from SCI Chester
3 from SCI Coal Township
6 from SCI Dallas
5 from SCI Fayette
1 from Gaudenzia CCC
17 from SCI Graterford
3 from SCI Greene
2 from SCI Greensburg
1 from SCI Houtzdale
1 from SCI Huntingdon
5 from SCI Laurel Highlands
6 from SCI Mahanoy
8 from SCI Muncy
12 from SCI Pittsburgh
15 from SCI Rockview
2 from SCI Somerset

APPENDIX K

SUMMARY OF SCI SITE VISITS

The Advisory Committee on Geriatric and Seriously Ill Inmates held its organizational meeting on May 30, 2003. At that meeting, the members decided to visit several State correctional institutions (SCIs) to see how they are run and to talk with willing inmates. Because Senate Resolution 149 of 2002 specifies that health, mental health and aging issues must be addressed in the study, visits to the following three SCIs were arranged:

SCI Laurel Highlands (houses many seriously ill male inmates)

SCI Muncy (houses female inmates, including lifers and those who are aging and/or have health problems)

SCI Graterford (houses many aging male inmates and lifers)

Comments made by inmates and SCI staff during the visits are summarized in the remainder of this appendix.

SCI Laurel Highlands Tour
July 14, 2003

Overview

SCI Laurel Highlands has 57 acres and 14 buildings inside the fence. It had been Somerset State Mental Hospital under the Department of Public Welfare and was renovated and re-opened in 1996 as SCI Laurel Highlands. A $32 million renovation was undertaken so that the facility would meet fire safety and Americans with Disabilities Act (ADA) requirements. On June 19, 2003 Laurel Highlands was accredited by the American Correctional Association. During the three-day process, Laurel Highlands proved to be 100% compliant on 45 mandatory standards and 99.8% compliant on about 500 non-mandatory standards.

Laurel Highlands houses geriatric, acute long term care, physically challenged, personal care and general population inmates. It is a flexible institution in many ways. Extensive education, vocational training, recreational and religious programs are available, and ADA issues are addressed in all settings. There is no restricted housing unit (RHU – what inmates refer to as "the hole"), as Laurel Highlands opted to build a gymnasium instead of an RHU. Flexible visiting hours are available for families, especially if an inmate is terminally ill. Families have visited until 11:00 PM, and sometimes through to the next morning.

There have been 120 natural deaths at Laurel Highlands since it opened, and only 18 bodies were claimed by family members.

Statistics as of July 14, 2003

Total population	894
Acute long term care	111
Personal care	179
General population	about 600
Inmates in wheelchairs	134
Average age of all inmates	45
Race:	
Black	34%
Caucasian	53%
Hispanic	11%
Percentage population:	
Pennsylvania residents	70%
From another state	25%
From another country	4%

PA population comes from all counties.
Largest percentages of total population:

From the Philadelphia/Montgomery County region	34%
From Allegheny County	11%

Budget	$36 million
Average annual cost per inmate	$46,000

Employees	146

Many of the security staff are RNs and LPNs who worked at the facility when it was Somerset State Mental Hospital. So, they have a combined security, medical and psychiatric awareness.

Volunteers from Somerset and Cambria Counties in religious and drug and alcohol areas, as well as others	80

Long Term Care Unit A-A

Every bed in the unit is a hospital bed. Medical and security staff work closely with each other. Advisory committee members spoke individually with inmates, L.A., K.K. and D.F.

L.A.

L.A. is 58 years old and entered Corrections in 1994 on a 16 to 36 year sentence. When he was sent to Laurel Highlands in 1997, he was expected to die. But his condition improved. He has a rare lung disease and weighed 180 pounds (much of it water accumulation) when he arrived and now weighs 139. He was on 29 prescription medications and his lips and skin were red and purple when he arrived. The medications have been greatly reduced, his skin is no longer purple and he is on a therapeutic diet.[60] He is very happy with the care he receives. He can go outside every day from 12:30 p.m. to 2:30 p.m., and inmates can socialize in the Day Room. Laurel Highlands has a Buddy System comprised of general population inmates who volunteer and go through a training program to be buddies to inmates who need help. A Buddy will come into the ward and help whoever needs it by doing such things as writing letters, reading mail and straightening up an inmate's area.

Laurel Highlands has a Life Skills program to keep inmates involved and aware of what's happening in the world. Inmates may do such things as watch CNN and discuss world events.

[60] All SCIs offer therapeutic diets and monitor commissary lists for inmate compliance. Therapeutic diets may address issues related to dialysis, cardiac care, diabetes and other disorders.

K.K.

K.K. will be 76 years old in October. He has been at Laurel Highlands since the week after it opened. He has great-grandchildren in New Hampshire who want him to come there, but his parole has been refused. He has not applied for a commutation because he cannot read or write. He never had one day of schooling and grew up in foster homes and prison.

D.F.

D.F. is 43 years old and has served over half his sentence of 10 to 20 years. He was at Graterford, Smithfield, Camp Hill and South Mountain[61] before going to Laurel Highlands. D.F. has been turned down for parole twice because he has not completed the required programs. He has ALS and is bed-ridden. His mother, brothers and sisters are all very supportive. His sister in Iowa would like him to come live with her and has planned that he could go to the University of Iowa for examinations and treatment. Because his parole has been refused, he has not gotten to the point of asking the State of Iowa or the University of Iowa to accept the transfer of his case.

Pre-Release Facilities Needed for Long-Term Care and Personal Care Inmates

If released on parole, L.A. would have no place to go. He is trying to get a transfer to South Mountain Restoration Center (South Mountain), which is operated by the Department of Public Welfare (DPW) and licensed by the Department of Health. The transfer would be a pre-release.[62] It is difficult to find pre-release placements for inmates. There is some success in placing inmates like L.A. who meet the medical criteria to enter a facility such as South Mountain on parole or post-release, but no pre-release inmates have been accepted at South Mountain. It is also difficult to find placements for personal care inmates (as opposed to long-term care inmates such as L.A.), who can care for themselves to a degree. There is a critical need for a State personal care facility. Many inmates who could leave an SCI have families who want nothing to do with them – or do not have families or anybody else who could take them in – so a facility is needed.

[61] Prior to the opening of Laurel Highlands, SCI Camp Hill sent officers to South Mountain and a unit was set up just for inmates the SCI could not care for medically. That unit was considered a Department of Corrections facility. When SCI Laurel Highlands opened, the DOC unit at South Mountain was closed.

[62] An inmate is eligible for pre-release if, among other things, he or she is eligible for parole and has served half the minimum sentence, has been in an SCI for nine months, has been free of misconducts for nine months and has the recommendation of institutional staff. The sentencing judge, prosecuting attorney and victims participate in the decision-making process.

Misconducts

Laurel Highlands quite often uses an informal grievance process. Many of the inmates do not even know where they are, let alone that they have done something wrong. An inmate will often lose television privileges for a while rather than being locked up for a misconduct. Laurel Highlands has had only a few very rare instances of serious misconducts and has never had an employee hurt by an inmate or physical force used against an inmate. This is partly explained by the greater interaction between staff and inmates at Laurel Highlands and the fact that inmates are with their peers and so feel more comfortable than they would in other settings.

Dialysis Unit

The dialysis unit operates six days a week from 6:00 a.m. to 5:00 p.m. and has nine dialysis machines. Twenty-eight inmates receive three or four dialysis treatments every week, and each treatment lasts 3-½ to 5 hours. Each treatment would cost a minimum of $400 - $500 outside of prison. Many of the inmates receiving dialysis qualify for Medicare. Each dialysis machine costs about $16,000.

C.W.

Advisory committee members spoke with C.W., who will be 53 years old in January and has been incarcerated for 31 years. He has hypertension. Inmates used to be taken outside the prison for dialysis. He had been at SCI Pittsburgh/Western and was taken from there to St. Francis General Hospital for his first dialysis treatments. Dialysis was first offered inside at SCI Graterford and then at Laurel Highlands. C.W. is satisfied with his treatment at Laurel Highlands.

Personal Care Unit D

Inmates in Unit D are there because they need some help taking care of themselves or need medical assistance. For example, the unit has 38 inmates using oxygen concentrators. Personal care inmates are assigned to lower bunks, and general population inmates are assigned to upper bunks.

Not all inmates with medical conditions are in Unit A or Unit D. General population inmates may also have problems, such as cardiac issues or HIV.

W.F.

Advisory committee members spoke with W.F., who was in a wheelchair being pushed by a general population inmate. Both of W.F.'s legs are amputated, and he was in that condition when he was sentenced to 1-½ to 3 years in prison. He was incarcerated for 14 months, and since the committee's visit he has gone home to live with his mother.

Exit Interview

Parole

The Department of Corrections (DOC) may not appeal a decision by the Board of Probation and Parole denying parole for an inmate. Inmates who have been paroled from Laurel Highlands have been paroled because staff fills out forms and goes through the process with them. The Board of Probation and Parole issues a parole sheet ("green sheet") explaining what must be done to have parole granted, and even after all that is accomplished, parole may still be refused.

Also, certain facilities will not accept certain inmates on parole. For example, South Mountain will not accept sex offenders who are fixated pedophiles because young children visit family members at South Mountain. South Mountain also refuses dialysis patients because it does not have a dialysis facility and it is 30 miles from the nearest dialysis facility. Some facilities do not accept inmates with progressive diseases, and others do not accept inmates in wheelchairs. So, even if parole is granted, placing the inmate may be problematic.

Finding placements for personal care inmates is more difficult than finding placements for long term care inmates. A State personal care facility would be very helpful. Skilled reimbursement is higher than personal care reimbursement, so funding might be the reason why facilities refuse to accept personal care inmates. DOC's understanding is that the State can opt to use Federal TANF (Temporary Assistance for Needy Families) funds for inmates, but this has not yet been done.

A joint committee between DOC and the Board of Probation and Parole has been looking at parole issues since the beginning of 2003 and is making progress. Laurel Highlands has seen more inmates released on parole in the last few months than usual.

Compassionate Release

No inmate at Laurel Highlands has ever been released under the Compassionate Release Act.[63] An inmate must be in a terminal condition or need medical care that is unavailable at an SCI to be granted compassionate release.

SCI Muncy Tour
July 25, 2003

Overview

The Muncy Industrial Home, a training school for female offenders which was administered by DPW, became SCI Muncy in 1953. It is DOC's only Diagnostic and Classification Center for female offenders. There are a variety of programs at SCI Muncy. The DAILE Program operates under a grant from the Pennsylvania Commission on Crime and Delinquency and is designed to teach life skills to low-functioning inmates and inmates with behavioral problems. Twenty inmates currently participate in the program 8 hours a day, 5 days a week. The House of Hope addresses the dynamics and effects of sexual, emotional and physical abuse, which have been experienced by about 90% of the inmates at Muncy. In the Prison Pup Program, inmates raise service dogs for Canine Partners for Life. Four service dogs are currently being trained by Muncy inmates.

Statistics

Capacity	843 cells
Average population	861
Lifers	128
Capital case inmates	5
Average age	36.5
Age range	17 – 78
65 or older	10
Special Needs Unit capacity	75
Currently holds	
48 SNU inmates	

[63] The Compassionate Release Act is reproduced in Appendix D.

DOC inmate wages range	19 to 42 cents per hour
Highest amount earned by a Muncy inmate in June 2003	$85.68

Several inmates earned no money

Annual budget	$35 million
Employees	459
Volunteers	158

Health

SCI Muncy has acute and chronic care for inmates and currently has one inmate who is terminally ill and is in a volunteer hospice program.[64] Two inmates are taken to Williamsport for dialysis treatments. One inmate in a wheelchair is a younger inmate who had a stroke. Disabilities keep 8 inmates out of the general population and in the infirmary. The puppies in the Prison Pup Program are often brought to the infirmary to help the patients.

The inmates at Muncy tend to have a "health age" about 15 years older than their biological age.

Health Statistics

Number and percentage taking a prescribed medication	551 (65% of total population)
Percentage of total population taking one or more psychotropic drugs	About 41%
Number and percentage of mental health (MH) inmates	378 (43 % of population)
Schizophrenic	45
Bi-polar	25
Non-organic psychosis; may or may not be schizophrenic	11
Mental retardation (MR) inmates	41 (5% of population)

[64] This inmate died several months after the advisory committee's visit.

Sex offenders (23 with MH diagnosis, 5 with MR)	38

8 Inmate residents in the infirmary and their sentences:

Murder 2	life
Murder 2	life
Murder	life
Aggravated assault	7 to 15 years
Aggravated assault	2 to 5 years
Retail theft	3 years, 4 months to 7 years, 11 months, 15 days
Criminal conspiracy	3 to 10 years
Criminal conspiracy	2 to 5 years

Inmate Interviews

The advisory committee members spoke individually with several inmates at SCI Muncy.

J.G.

J.G. will be 63 years old in January 2004, is a lifer and has been in prison since 1991. She has arthritis in both knees and, as a result, has difficulty walking and uses a cane.[65] She had two operations on her shoulder at a hospital in Williamsport and received good care there. She has experienced adequate care at SCI Muncy, but would like to receive physical therapy for her ambulatory problems and wants "real medicine," rather than generics.

J.G. is not able to work, so she receives $15 per month as disability pay. She is taking GED classes five days a week. She said there is not much incentive any more. Inmates used to be able to wear their own clothes and receive food from the outside, but those things are no longer allowed. Also, the increase in the inmate population from about 300 when she arrived at Muncy to almost 900 has made things worse.

[65] In a letter dated August 13, 2003, J.G. said that SCI Muncy is getting her a wheelchair.

L.F.

L.F. is 78 years old, has been in prison for 30 years and is a lifer. She was a practicing psychiatrist when she committed her crime. She said that lifers and geriatrics need motivation and that the counselors are overwhelmed.[66] Muncy has a Services to Elderly Prisoners (STEP) program for seniors 55 and older, which is sponsored by the PA Prison Society, but only about half of the seniors attend on a regular basis. Muncy has changed over the years. For example, when L.F. arrived, the population was about 140 and the inmates were taken outside the prison to go swimming three times a week and were often taken outside to go roller-skating.

Seniors and lifers want a chance to get out of prison. If an inmate is at least 50 years old and has served 25 years, he or she should have the opportunity to be released.[67] L.F. has friends who want her to live with them if she were released from Muncy.

L.F. is the oldest functioning lifer at Muncy. She has stayed active and involved. For example, she has been the chapel musician (playing piano and organ) at Muncy since she arrived. For exercise, she walks outside and does aerobics once a week. The activity department is good, but motivation is lacking. Muncy used to have a Lifers organization, but it was "taken away" two or three years ago.

Separate housing might help some seniors. Muncy used to have separate housing for inmates 40 and older, but no longer does. A geriatric clinic, to monitor geriatric inmates for health problems on a bi-monthly basis, would also be helpful.

N.D.

N.D. is 52 years old and has been paroled from a 2 to 4 year sentence. She was incarcerated at Muncy in 2000 and was diagnosed with breast cancer while in prison. In 2001, she had a mastectomy, chemotherapy and radiation and is now on a 5-year regimen of Tamoxifen. She is happy with the care she received at Divine Providence Cancer Center in Williamsport. She is also thankful that a psychiatrist visited her every day after her mastectomy.

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[66] In a letter dated August 10, 2003, L.F. said that many geriatric inmates do not feel welcome in inmate programs such as art classes, aerobics, drama, etc. She feels that that is really not the case, that it is only a perception many have, but that the geriatric inmates need help to see that they can continue to participate in life.

[67] L.F. mentioned M.S. as an example of an inmate who has done a lot of work and could be safely released into society.

N.D. wants a bone scan because she has pain in her legs which started after her cancer diagnosis, so it is quite a concern for her. However, she has not yet had a scan.

N.D. said that the House of Hope program for domestic violence victims is helpful, as is the STEP Program.

N.D.'s biggest fear is that she will make a technical parole violation and end up in prison again – and not be able to have custody of her children (ages 14 and 10).

M.R.

M.R. is 56 years old. She is a lifer in the general population and has been in prison for 13 years.

M.R. had throat cancer and received chemotherapy and radiation while at Muncy. She now has a bone disease – growing tumors on her bones – and she is concerned about it, but cannot get it checked.

M.R. makes about $14 a month (72 cents a day, five days a week) since she is on medical leave from working. She does not have the money to apply for a commutation.

The STEP Program does a lot for seniors. M.R. participates in knitting and a little exercise. Putting activities for seniors in one building would be helpful, as would separate housing for inmates 50 or older.

J.S.

J.S. is 52 years old and is a lifer. She arrived at Muncy in 2000 in perfect health and a month later could barely walk because the boots issued to all inmates destroyed the nerves in her feet.

J.S. received good, prompt care in October of 2002 when she felt a tear in her abdomen and was operated on within a few hours. However, she said that most inmates' medical concerns are not addressed.

J.S. completed the required 32 hours of training and is now a hospice volunteer. The patient she works with is 34 years old, has AIDS and cancer and has been told she has six to twelve months to live.[68] J.S. is concerned that the

[68] J.S. notified staff that the patient died several months after the advisory committee's visit.

hospice patient does not receive adequate nourishment that she can swallow. She also suggested that dying inmates are denied medication to the point that nurses break rules to give them pain medication. The Health Care Administrator at Muncy replied that the hospice patient receives foods she can digest such as applesauce, grits, cereals, puddings and Jello. A hot-water fountain was also installed so that the patient could make foods she wanted. The patient is very private, does not like to have others in her room and refuses to allow the inmate detail in to clean her room.

SCI Graterford Tour
August 21, 2003

Overview

SCI Graterford is a maximum security prison and is the largest SCI in the Commonwealth. It houses many lifers and about 20% of the State's capital case inmates. It is also the reception center for the Eastern Region and receives parole violators. Graterford receives about 151 new inmates per week, and all of them must be given medical checks and clearances.

Statistics as of August 21, 2003

Population	3,090
Lifers	725
Capital case inmates	48
Capacity	2,554
Average age	38

Health

It was noted that Prisoners Health Systems is assuming the contracted health care role in the prison system on Labor Day 2003.

Graterford used to take inmates outside the prison for dialysis treatment, but started its own program about 10 years ago. A legal opinion determined that the dialysis treatment received at Graterford is adequate.

When assigning an incoming inmate to a prison, his or her medical condition is the most important factor considered by DOC.

There are 2,110 inmates listed on a chronic care list for disorders including diabetes, hypertension and hepatitis C, among others, with some overlap. Graterford has isolation rooms for use when necessary, such as in the case where an inmate has tuberculosis.

Mental Health

Graterford's is one of four male Mental Health Units (MHUs) in the State corrections system. It is licensed only for involuntary inpatient care, meaning that the inmate's commitment is adjudicated – generally on an emergency basis. It receives inmates from other Eastern Region SCIs. The average stay in the MHU is 30 days, and then the inmate returns to general population or is transferred to SCI Waymart – DOC's Forensic Treatment Center for male inmates who require inpatient psychiatric care and treatment.

There are currently nine inmates in the MHU. One has bi-polar disorder, and three are schizophrenic.

Most MH inmates are not paroled from prison, but are only released upon serving their maximum sentence. The few who are paroled often end up back in prison because they receive little or no services. A psychologist at Graterford contacts an inmate with MH problems 12 months before he reaches his maximum sentence to determine what he wants to do and what his needs are. The psychologist then contacts many offices and agencies in an attempt to find a placement for the inmate and arrange his release. For the recent release of a 33-year-old inmate this included, among other things, contacting the county MH office and the county assistance office, taking the inmate for a physical examination to determine Supplemental Security Income eligibility, finding a placement a few blocks away from the county MH caseworker's office, taking the inmate to his new home and introducing him to the landlord, and providing clothes and food to get the inmate started on his own.

Advocacy on behalf of inmates with MH issues involves trying to get good diagnoses and proper medications when receiving the inmates into the system and establishing special Community Corrections Centers (CCCs) for inmates with MH issues upon release from an SCI. For example, a CCC has been established in Philadelphia for MH inmates with a dual diagnosis.

Program Arranged by the Graterford Chapter of the Gray Panthers and Lifers Inc.

The Graterford Committee for Seniors, comprised of members from both the Graterford Chapter of the Gray Panthers and Lifers Inc., organized a program for the members of the advisory committee. Six members of the Gray Panthers and Lifers Inc. made statements and then opened the proceedings to questions from the members.

S.P. – Chair, Graterford Committee for Seniors

The Commonwealth should establish pre-release centers for inmates who have served at least 20 years in prison, are at the age considered geriatric[69] and have shown that they have been rehabilitated. One wing of each center would be for seriously ill inmates who cannot take care of themselves. The other wing would be for inmates who are not ill and would be required to support themselves and give back to society and be paid minimum wage for their services. The centers could be supported by funds diverted from State Lottery proceeds, the interest on the Inmates' Welfare Fund and the profits from the Correctional Industries shops.

Inmates with health problems that require costly treatments and staff, such as hepatitis and kidney failure, could be moved to a housing and support system in which the inmates share in the costs of their care. S.P. said a similar program has been implemented in Monroe County.

S.P. also recognized the importance of funding considerations and the safety of the community.

T.W. – President, Lifers Inc.

An average of 100 new lifers are added to the system in Pennsylvania each year, creating a substantial tax burden on the citizens of the Commonwealth. At this rate, there will be well over 5,000 lifers in the State by 2010. About 600 lifers have been reintegrated into Pennsylvania society since 1941 and have proven to be productive and to pose no threat to society. Pennsylvania is the only State with a mandatory life sentence for first and second degree murder.

[69] During the question and answer period, S.P. said that the focus should be on the number of years served, rather than on age.

Lifers feel sympathy for victims, as most grew up in the same areas that make some individuals criminals and others victims. Also, nobody knows more about the preciousness of life than those who have taken it and are truly repentant. Society should not be ashamed of the concept of mercy.

It has been demonstrated that participation in crime decreases dramatically after age 50. When an inmate reaches 50 years of age and has served 25 years, his or her case should be reviewed to determine if continued incarceration is necessary. The family of the victim should be allowed to participate in the process. On release to a facility as described previously by S.P., the former lifer would be required to pay into the Victims Compensation Fund for five years.

R.C. – Chair, Lifers Judiciary Committee

It can take 10 years for an inmate with a life sentence to realize that life means life in Pennsylvania. At that point he or she becomes introspective and wants to learn and understand and grow.

Risk is a big issue for society. The question is, "Why should anyone ever trust a lifer again?" So, ensuring public safety upon the release of lifers is very important. That an inmate poses no threat while still in prison is demonstrated to corrections staff as he or she earns trust and is moved from one security level to the next lower one.

Lifers go through programs for 25 or 30 years or more. What they learn becomes part of them. An inmate who has changed over 20 or 30 years in prison will continue to behave that way after release. If safety has been proven in prison, it will continue outside. Also, there are 600 ex-lifers in Pennsylvania communities. Less than one percent of released lifers succumb to recidivism. Lifers have proven that they are outstanding workers both inside prison and in society after release. Lifers work well past the age of 50 when in prison, and will maintain jobs after release, as well. Some have family members who will help upon release.

C.G. – President, Graterford Chapter of Vietnam Veterans of America

There are many military veterans in the system, and many of them entered the system at a very young age. Many veterans in prison suffer from post-traumatic stress disorder and other problems related to their military service. Veterans often end up in prison not even knowing why they are there.

If released, rehabilitated veterans could help others avoid the things that lead them into crime. Veterans want to be a positive, productive part of society and are needed on the outside.

J.M. – Founding Member, Para-Professional Law Clinic (PPLC)

Education is key to rehabilitation. When he was put in prison, J.M. was told for the first time in his life that he had to graduate from high school. His desire to learn grew, and he earned three college degrees while at Graterford. Many programs to help inmates were devised by inmates, particularly lifers. Lifers are a great resource for society.

Inmates practice living crime-free while in prison. After release, that practice leads to living crime-free in society. Wrap-around services (such as vocational rehabilitation) are needed after release.

The culture that leads to criminality must be addressed. Keeping individuals from falling into crime and into prison keeps costs down. Rehabilitated lifers who understand why individuals end up committing crimes make excellent teachers and role models in the community.

H.W. – President, PPLC

Lifers need hope that they may someday be released. As bad as South Africa was, they still let Nelson Mandela out of prison after 27 years. Our society should be able to do the same.

Lifers pose much less of a problem on the outside than others who are released from prison. Comparing lifer "recalls" with Ford or GM recalls looks very good.

Question and Answer Period

The panelists were asked to provide recommendations for their stay in prison as well as suggestions regarding release.

Safety of Older Inmates

When told that older inmates at SCI Muncy said they were afraid of younger inmates and recommended separate housing for seniors, the panelists replied that they do not fear younger inmates and that integrated housing allows

lifers to positively influence younger inmates.[70] However, one inmate in the audience who is 55 said that some men develop a sort of paranoia as they age and they might feel that they no longer fit into the society of the prison. Some older inmates don't even know what's going on. So for some, separate housing could be helpful.

Lifers Who Were Convicted as Juveniles

Several inmates in the audience who are not yet 50 were convicted at the age of 15 or 16 and have been in prison for over 30 years. To account for lifers convicted as juveniles, S.P. suggested that the focus be more on the number of years served than on age.

Pre-Release Centers

The panelists advised that there is a divergence of opinion as to whether the recommended pre-release centers should be administered by DOC. R.M. – President of the Graterford Chapter of the Gray Panthers – said that he prefers DOC rather than a private contractor, especially when considering the cost-benefit analysis.

Sentencing; Senior Parole Act

T.W. noted that changes in sentencing are needed. There are plenty of individuals in society who have killed others. Many of them committed the same crimes that earn others a life sentence. Some individuals are able to plea bargain to 3d degree murder, while others who did the same crime end up in prison for life on 2d degree murder convictions. A lifer in prison who has completed years and years of programs and learned to understand his crime and its seriousness and matured and changed so that he will never again take another life is *not* more dangerous than the person on the street who killed somebody but spent few years in prison and never reached the point in prison of maturing and changing.

The panelists clarified that they are recommending a sentencing system that includes life with parole and life without parole. T.W. noted that juries

[70] By e-mail dated August 25, 2003, advisory committee member Dr. Julia Hall provided the following: "In response to [our] question about separating seniors for safety reasons, you must consider that we were talking to a very healthy, active and activist group of seniors/lifers. They are leaders and respected in the prison. Additionally, none could be described as frail.

"I did a needs assessment of seniors and found the response to separate units for seniors to be about 50-50. There were issues of physical status, age, etc. that factor into this decision. Yes, some seniors have been harassed and continue to be vulnerable. Some injuries are accidental, e.g., running younger inmates knocking down frail seniors or pushing ahead of them in lines, etc."

should still do sentencing, but recognized that there are differences, like politics, that can cause two different juries to pass two different sentences on individuals who committed the same crime. The recommended Senior Parole Act would give those sentenced without parole a chance to get out and be productive. There are lifers who were involved in gang warfare during the 1960s and were convicted at 15 or 16, while others who also killed in the gang wars have been in society for decades and have families. The lifers want the chance to be productive in society.

Advisory committee member Judge Anthony said that he was a parole agent at the time Governor Milton Shapp commuted more than 250 lifers. He and his fellow parole agents agreed that lifers made the best charges, as they were mature and settled. Deputy Secretary for the Eastern Region Donald T. Vaughn said that in his 36 years experience as a superintendent, many lifers were released, and very few came back – and most who returned to prison returned on lesser crimes.

S.P. said that the average amount of time served on life sentences in other states is 20 years. So, where some have suggested lifer eligibility for parole after serving 25 years and reaching age 50, the Senior Parole Act could be written using 20 years served instead of 25. While in prison, a lifer would prove that he can safely be moved to a pre-release center. While in the center, he would prove that he can be safely reintegrated into society.

When asked how the Board of Pardons or the Governor or anybody making a parole decision can tell if an inmate has been decriminalized, J.T. responded that the determination must be made on a case-by-case basis. He said that DOC employs lots of professionals who are best able to judge if an individual has been decriminalized. There are doctors, lawyers, criminologists and many others who are in the best spot to judge. However, the Board of Pardons ignores the recommendations of the professionals the State has hired. J.T. asked how they can be allowed to ignore the professionals. He concluded, “How can they ignore my transformation?”