Good morning, Mr. Chairman, my name is Marilyn Rogan. I am a captain of the South Tower Bureau of the Clark County Detention Center. I have over 21 years of experience in corrections. One of my responsibilities is to monitor the medical contract with EMSA/Prison Health Services, the agency responsible for providing mental health services to jail inmates.

Our latest census indicated that there were 474 inmates identified as seriously mentally ill in custody currently receiving psychotropic medications. These inmates, out of a total of ~~2612~~ 3469, represent 19% of the population housed. This figure is 3% over the national estimate by DOJ of mentally ill inmates in corrections facilities. We recognize that there are others in the jail population at any given time that are not part the 474 because they have not been in custody long enough to have been identified and diagnosed or, if identified, have been in custody long enough to have started receiving medication. The number also does not include the average of 9 inmates on suicide watch who are not determined to have a chronic mental illness but are nonetheless in crisis and require specialized attention. Thus, we are confident that our actual population of mentally ill inmates on a typical day exceeds 19% and approaches at least 500. Clark County Detention Center has become a de facto mental hospital, and in fact, is the largest mental hospital in Southern Nevada, with more than 5 times the bed capacity at Southern Nevada Adult Mental Health.

You have perhaps already here the staggering statistic of 25 individuals who had accumulated 8,113 arrests just between 1985 and 2002. While that group may represent an extreme sample of chronic recidivists, untreated mental illness makes a prime candidate for re-offending. Many untreated mentally ill self-medicate, have co-occurring disorders, leading to drug-related crimes along with other charges. Here are typical arrest charges involving the mentally ill: Possession of drugs, assault and battery, petty larceny, misuse of a bus bench, defrauding an innkeeper, public urination, and obstructing traffic.

The problem with the large mentally ill population in CCDC is that a jail is not designed or staffed to be a mental health facility since or mission is primarily to provide safety and security to those inside the jail and the community at large.

We know from studies conducted in other corrections systems, that mentally ill inmates do not fare well in jail settings. For example, studies in some parts of the country indicate that an incarcerated mentally ill inmate may stay in

jail as much as twice as long as a non-mentally ill inmate charged with the same offense. In addition, it is generally believed that mentally ill inmates deteriorate in jails because of the additional trauma of being locked up.

Mentally ill inmates require monitoring as frequently as every 4 minutes but no less than every 15 minutes. This population also requires special housing: for example, to prevent them from being hurt or hurting others. Some are kept in isolation, others are kept in housing close to medical and psychiatric staff. Some are housed in larger groups, but have officers with specialized training assigned to watch them. The monthly bill just for psychotropic medications alone for this group is over $34,000. Currently CCDC uses a formulary less costly than the State formulary, which CCDC is attempting to migrate to, ultimately resulting in a higher monthly bill, but we believe more effective medication.

Our medical contractor provides the following staffing: A medical director, full-time psychiatrist, and ten social workers. We are working to increase our psychiatrist ratio to 1:150 mentally ill inmates, requiring the addition of 2 more full-time psychiatrists.

Despite the fact that jails are inherently ill suited to house the mentally ill, CCDC has undertaken some innovative programs to enhance our ability to serve this vulnerable population. We believe that we have instituted the first program in the nation to provide Crisis Intervention Team (CIT) officers to work with this special population. We have approximately 25 officers in the jail with an additional 40 hours of CIT training. The officers become familiar with different behaviors associated with mental illness and learn techniques for interacting with people and defusing volatile situations. We have started with 25 officers, but the goal is to continue training and dramatically increase the numbers of officers trained throughout the entire jail.

We have also implemented our first CIT unit, which allows mentally ill inmates, who have been stabilized, the advantages of a less restrictive environment, but with the close supervision of specially trained CIT officers. We believe this environment will help prevent deterioration by establishing a routine, including group therapy, development of coping skills for use in controlling their symptoms and their lives, especially upon release from jail.

CCDC has also implemented a jail-aftercare program to help mentally ill homeless inmates transition back into the community, providing shelter, medications and job skills training. Salvation Army, State Mental and Prison Health Services are partners with CCDC in this program. CCDC provides a full-time social worker dedicated to the program, who also provides aftercare services for mentally ill inmates released from jail who are not homeless. For those with homes to return to, the services provided include establishing continued services through Mojave Mental Health or the State, with appointments, prescriptions and case management service. We are hopeful that these aftercare programs which provide for continuity of care will diminish the recidivism among the participants.

Of course, last and certainly not least, is CCDC's partnership with the State and the District Court in the establishment of a Mental Health Court in Southern Nevada. The initial candidates selected for participation will be drawn from CCDC.

From my experience working with mentally ill inmates in Southern Nevada, I have identified the following needs and recommendations:

The first and overwhelming need is for more facilities to ensure mentally ill persons have access to treatment on a regular basis or when in crisis. The planned construction of a new State hospital in the next several years will help substantially with in-patient treatment; however, a desperate need exists for emergency triage for individuals in crisis. Because of the demand on the system, many individuals held on Legal 2000s are released from emergency rooms without receiving treatment. In addition, and very important to corrections, is the need for a drop off center for individuals experiencing a mental health crisis where they can be taken by police rather than to jail. In too many instances, jail is the only alternative available to ensure the safety of the individual or the community, despite the fact that the offense committed is minor. Police and other responders need an alternative to jail for these individuals. Without adequate access to mental health services, it is unlikely that any of the other improvements to the system will make much impact.

Second, individuals who are incarcerated often lose eligibility for Social Security benefits, including Medicaid, due to their incarceration. The process of re-qualifying can be lengthy and frustrating, often disrupting the ability

for released individuals to receive medical and psychiatric care. A streamlined process needs to be implemented to facilitate the transition from jail to community, with no interruption in mental health services.

Finally, a consistent medication formulary used by all local governments for inmates that matches the State would ensure that the same medications are provided to inmates in jail that they have received in the community. This would prevent disruption in medication management and also encourage the newer, more effective medications to be used when appropriate. There is a substantial price tag attached to the newer generation pharmaceuticals, but when appropriately prescribed, can lead to better patient compliance, and therefore, less likelihood of re-offending.

By implementing the above recommendations, we would be providing the mentally ill population of our community with appropriate mental health care. In addition, these recommendations should reduce recidivism and lessen the cost to the community of crimes that are directly related to untreated mental illness. These recommendations represent a fiscally responsible approach to the impact of mental illness on the criminal justice system and the community. Finally, implementing these recommendations will save lives.

That concludes my prepared remarks. I'd be happy to answer any questions.