

Improving Psychiatric Care in the Minnesota Corrections System:

The Minnesota Psychiatric Society and the Minnesota Department of Corrections Engage in Ongoing Dialogue

The Minnesota Psychiatric Society is committed to being an ally to the Minnesota Department of Corrections (DOC), Minnesota Department of Human Services (DHS), county correctional facilities, and all other interested parties, in the effort to ensure quality mental health care and release preparation for the mentally ill individuals who are entrusted to their care by the citizens of Minnesota. As a result of the Minnesota Psychiatric Society's Correctional Psychiatry Caucus' January 2005 paper, *Meeting the Needs of People with Mental Illness in Jails, Prisons, and Other Correctional Settings in Minnesota*, MPS and the Minnesota DOC have established an ongoing dialogue on behalf of incarcerated individuals with mental illness.

OVERVIEW OF THE 2005 REPORT

The delivery of appropriate mental health care in the Minnesota DOC correctional settings is a vital link in the chain of care for mentally ill offenders. The chain starts with local law enforcement and ends with successful community re-entry. Envisioning and implementing this continuity of care is essential if we are to stem the epidemic of mental illness in correctional settings.

Correctional institutions were never intended to be the primary source of mental health and health care. However, with severe mental illness affecting an estimated 15% to 30% of the prison population and a growing number of incarcerations in our state, the reality is that our prisons and jails have become de facto mental health treatment facilities. Stakeholder groups can and must help the Minnesota DOC and counties meet this unexpected burden.

The Minnesota Psychiatric Society offers to participate in or to facilitate discussions among DOC, DHS, academic medical institutions in the State of Minnesota, and other mental health providers. Improved links among all of these entities would raise the standards of care in Minnesota's prisons and jails and smooth the transition of incarcerated mentally ill individuals into the community when they leave the correctional institution.

The MPS is also willing to advocate for the Minnesota DOC and DHS in legislative initiatives aimed at decreasing the number of mentally ill men and women in the criminal justice system. Many people with mental illness find themselves in correctional settings, often for reasons directly related to their illnesses. This situation, sadly, is becoming more frequent, while resources to serve this population are dwindling. The Minnesota Psychiatric Society recognizes that it must advocate for this often unrecognized and invisible constituency. We also recognize that we must work with other groups and agencies concerned with the care of these people.

Our advocacy on behalf of mentally ill inmates is important to Minnesota citizens and to the welfare of society at large. It is important to remember that almost all inmates are released back to the community. Therefore, it is socially imperative that appropriate treatment be rendered during incarceration to prevent further deterioration of inmates' mental illnesses and associated repeat criminal behavior and re-incarceration which compound human, social, legal, and economic costs. The goal of the experts from DOC and MPS is to join together to share expertise in order to improve outcomes for incarcerated individuals, their caregivers, and ultimately the citizenry of Minnesota.

Inmates have constitutionally and legally guaranteed rights to obtain appropriate medical and mental health care. Physicians treating these inmates are bound by professional, licensing, clinical, and ethical guidelines to provide care that is commensurate with prevailing standards of such care in the outside community. The Minnesota Psychiatric Society supports policies and practices designed to ensure that health care and mental health care provided in correctional institutions meet professional and prevailing

community standards of care. In addition, MPS is committed to working with advocates and DOC experts to identify ways we can support each other as we address this unique population and situation.

The Minnesota Psychiatric Society is committed to being an ally of the Minnesota DOC, DHS, counties, mental health advocates such as NAMI-MN and the Forensic Network, and all other interested parties, in the effort to ensure quality mental health care and appropriate release preparation for mentally ill individuals who are entrusted to their care by the citizens of Minnesota. We agree that the dimensions of the problem as outlined in the report paint a complicated problem in need of immediate attention.

Dimensions of the Problem

The Numbers

The past 50 years have seen a dramatic increase in the number of people incarcerated in the United States. Currently, approximately two million people are incarcerated in our country. As the ranks of the incarcerated have increased, the number of mentally ill among them has grown to an alarming number. Mentally ill individuals are over-represented in incarcerated populations. Depending on the study and source, between 15% and 30% of inmates are seriously mentally ill.

Most of the mental illnesses represented in the incarcerated population data are severe and persistent mental illnesses (SPMI). In the greater community, these serious mental illnesses are present in only about 8% of the population; the rate is at least double that in the incarcerated population. Many inmates who do not meet the definition of SPMI have significant emotional and behavioral problems that also require mental health treatment. In addition, approximately 60% to 70% of all inmates have substance-related disorders; 80% to 90% of mentally ill inmates are chemically dependent.

Co-morbid medical problems such as HIV and hepatitis C also are more common in inmates who are mentally ill or addicted. Currently, 20% of all HIV-positive and hepatitis C-positive individuals pass through jails and prisons every year, and 30% of people with

active tuberculosis (TB) pass through correctional settings every year. These are national figures, but they are most probably representative of Minnesota as well.

It must be noted that incarceration itself contributes to mental illness. Suicide rates in jails are up to ten times as high as in the general population, and rates in prisons are typically twice as high as in the community. Mental illness and severe intoxication often contribute to the crime for which the person is arrested, and symptoms continue after the individual goes to jail. Being placed behind locked doors is often a severe stressor in itself, which can precipitate acute episodes of mental illness and decompensation.

Some of the most acute illnesses are seen in jails, when inmates typically are first incarcerated. Indeed, jails have become de facto mental health treatment facilities. In this day of closing state hospitals that have historically treated people with mental illness, it has been said that either the Riker's Island facility serving New York City or the Los Angeles County Jail is the largest inpatient mental health facility in the country; each serves many thousands of mentally ill "patients" daily.

Conditions in jails and prisons often include overcrowding, overstimulation, and victimization by antisocial inmates. The reverse side of these conditions—isolation and even sensory deprivation in segregation, solitary confinement, and the new, so-called “supermax” prisons—can be equally stressful. In fact, researchers have described a “supermax syndrome” in which people with existing stable mental illness decompensate and people with no past history develop new-onset mental illness in response to the stressful conditions of being locked down for days or even months at a time.

A recent article in the *New York Times Magazine* noted that since 1998, about 6 percent of inmates in New York have been housed in “special housing units” (i.e., segregation units), but that 34 percent of suicides have occurred there. Data in New York DOC indicate that one out of six inmates has mental illness, and that nearly 20% of the inmates in disciplinary lockdown, i.e., segregation or “the hole,” are mentally ill. Minnesota likely has similar numbers.

The increasing number of inmates with mental illness has created an unexpected burden for correctional institutions. These facilities were created for the containment (and, sometimes, the rehabilitation) of criminals, and not for the delivery of primary mental health care, yet they have become de facto mental health treatment facilities. This is the difficult position in which all correctional institutions—including those of the Minnesota DOC (DOC), Minnesota's county jails, and other facilities—now find themselves.

The Costs of Incarceration

As the number of people with mental illness behind bars increases, the cost of incarceration continues to escalate. From 1996 to 1998, California saw a 118% increase in incarcerated mentally ill men and women. In the 1980s, Colorado's population of mentally ill inmates jumped from 4% to 16% of the incarcerated population.

Incarceration of mentally ill inmates is much more expensive on a daily and annual basis. For example, in Pennsylvania the average inmate costs the state \$80 a day, but the average mentally ill inmate costs \$140 a day (including treatment costs).

In addition, these inmates generally receive longer sentences and are more likely to serve the maximum term of their sentences. If left untreated, they are prone to recidivism, further escalating their suffering, as well as compounding monetary and social costs to the community.

Prisons and jails have a constitutional and legal mandate to provide medical and mental health care to inmates. Yet, these institutions have many important competing missions and limited resources with which to fulfill them. These resources are diminishing at present as most states, including Minnesota, face budgetary deficits. This has put significant pressure on those who are responsible for delivering mental health services in correctional settings, since those services are not the primary function of correctional facilities.

When mental health treatment in prisons is inadequate, there are serious repercussions for the mentally ill individuals, correctional institutions, and society as a whole. Worsening of mental illness can lead to physical and mental deterioration, aggression, and suicide. Those who are mentally ill are vulnerable to victimization by other inmates.

The cost to correctional institutions of untreated mental illness and chemical dependency is considerable. For example, offenders with behavioral problems due to inadequately treated mental illness often find their way to expensive high-security or segregation units.

Communities expect correctional institutions to protect citizens—not only by containing criminals for the term of their sentences, but also by providing inmates with the rehabilitation, health and mental health care, vocational training, treatment, and discipline necessary to return them safely to the community.

Citizens and communities are stakeholders in the outcomes of the incarceration of people with mental illness. Thus, correctional institutions are subject to legal and public scrutiny of their delivery of mental health care.

Many states have turned to managed-care type organizations (MCOs) to help handle the escalating costs of medical and mental health care in prisons as a way to cut prisons' rising operating costs. These entities, serving as middlemen, often try to impose cost savings that state departments have not been able to make on their own. However, the pressure on MCOs to meet their own business goals can lead to undue cost-cutting measures and to ethical conflicts between clinical responsibilities and MCOs' financial incentives.

Because mentally ill offenders do not tend to have many advocates in the system, their needs often come last. Indeed, some have referred to this population as an invisible constituency.

Cost shifting within the state due to criminalization of the mentally ill. Cost shifting across state departments that deal with mentally ill individuals can increase the state's true cost of treating people with severe and persistent mental illness. Cost cutting in state mental health departments, problems with access to care, and poor reimbursement have all led to diminished community resources. As a result, an increasing number of mentally ill individuals are seen in incarceration settings, where the cost of containing and treating them is considerably increased. This is often a direct consequence of a lack of adequate funding and access to early intervention and intensive treatment in the community.

The criminalization of people with mental illness is not cost effective. Furthermore, cost shifting operates in the reverse direction as well. Failure to meet the mental health needs of incarcerated individuals by leaving their illnesses unrecognized and untreated increases the cost of stabilizing them in the community when they are released, and frequently leads to recidivism and re-incarceration, at further expense to the state.

Cost-saving alternatives to incarceration. Adequate reimbursement and funding for community-based treatment that allows for early recognition, early intervention, and early treatment of mental illness in its most treatable phases has been shown to reverse the costly trend toward criminalization of the mentally ill. Data on early intervention at the outset of mental illness indicate that for every \$1 spent proactively in early intervention, \$16 is saved in costs later.

Alternatives to incarceration once an offense has been committed can be quite cost effective. For example, data from the National Association of the Mentally Ill (NAMI)–Texas indicate that the average non-mentally ill inmate costs the state of Texas \$22,000 annually, while the annual cost for a mentally ill inmate ranges from \$30,000 to \$50,000 annually. Diversion of nonviolent mentally ill offenders into intensive community treatment programs with residential components costs approximately \$10,000 a year.

Texas has more than 100,000 incarcerated individuals. Therefore, diverting these non-violent mentally ill offenders in Texas could result in a cost savings ranging from \$60

million to \$444 million annually. Minnesota has one of the lowest per-capita rates of incarceration of all the states. Only about 8,000 inmates—about 8% of the total in the Texas system—are currently housed by the Minnesota DOC. Yet, applying even the most conservative estimate of potential savings in Texas (\$60 million) to Minnesota's incarcerated populations would yield savings on the order of \$4.8 million per year in Minnesota (i.e., 8% of \$60 million).

In addition, it is well known that duplication of services increases costs. Better integration across DHS and DOC, and between county jails and the community mental health systems, could yield further savings in administrative costs.

The Consequences

Mentally ill offenders eventually return to the community. Upon doing so, they face challenges that include finding housing, employment, health care, and supports for recovery from alcoholism and chemical dependency. They often must struggle with these tasks while suffering pronounced emotional and cognitive deficits. If unprepared for this transition, they risk further deterioration, violence, re-offending, and re-incarceration.

Former inmates often are forced to return not to the place where they lived, or where they have family or other supports, but instead to the county where their crime was committed. This leaves many without the natural support structures that would promote successful integration back into the healthy, law-abiding community.

To make matters more difficult, many important social services and benefits are discontinued during inmates' incarceration. Recently released mentally ill individuals must reapply for benefits, including Medical Assistance, MinnesotaCare and General Assistance. There can be lengthy delays before these benefits are reinstated, resulting in delays in access to housing, jobs, and adequate treatment in the community. Untreated mental illness—whether in the community or in a correctional institution—becomes progressively more complex and more resistant to treatment.

All of these factors play into recidivism among mentally ill offenders, who have the highest recidivism rates of all incarcerated offenders. Recidivism is costly in terms of both economic and social consequences, including the impact on victims of crime. Repeated crime and re-incarceration also necessitate more intensive and more costly programs of care.

The Situation in Minnesota

The number of inmates in Minnesota prisons has risen from about 6,000 four years ago to nearly 8,000 now, and is still in a phase of dramatic upsurge. Based on the estimates noted above, an estimated 1,500 to 2,000 of them are mentally ill. Twenty-six percent of incarcerated individuals in Minnesota prisons are on psychotropic medication. If national figures apply to Minnesota, an estimated 30% to 60% of inmates in Minnesota would benefit from mental health services.

Community juvenile justice systems.

The juvenile justice systems face all the same challenges that exist in the adult correctional system, compounded by the fact that child and adolescent psychiatrists are in even shorter supply than adult psychiatrists. The situation in the juvenile justice system is much worse than in adult correctional facilities. More than 100,000 youth are in jail in the United States at any one time. This group is at high risk for mental health and substance abuse problems.

A survey conducted among 1,829 youths aged 10 to 18 at the Cook County, Illinois, Juvenile Detention Center showed that 10% of males and 14% of females had both substance abuse and a major mental disorder such as psychosis, mania, or major depressive episode. About one-third of the 1,800+ youth had substance abuse plus behavioral disorders such as ADD, conduct disorder, or oppositional disorder. Among the 874 youth identified with substance abuse disorders, the rate of co-morbid major mental health disorders was 30% for females and 21.4% for males. Among youth identified with major mental illness, 50% of females and 75% of males also reported substance abuse disorder.

The Cook County survey concluded that:

- Substance abuse is co-morbid with major mental illness and behavioral disorders in incarcerated youth. The rate of mental illnesses and substance abuse is higher among youth in detention than in the general population of youth.
- The density of mental illness and substance abuse among youth in detention creates a special population of high-need, underserved youth.
- Longstanding neglect of this population, ill-advised policy and funding decisions, and provider shortages together have contributed to an enormous challenge in meeting the mental health needs of this distinct group.
- Increased efforts, resources and integration are warranted to build a system of care that provides access to screening, early identification and evaluation, treatment, and follow up for incarcerated youth.

Minnesota data indicate that there are more than 200 juveniles in correctional settings, including the Red Wing facility, detention centers, and residential treatment facilities. This estimate does not include the number of juveniles in private for-profit correctional facilities. Estimates indicate that 60% to 70% of incarcerated juveniles need mental health services.

Contracted services.

For several years, Minnesota DOC has contracted with a private, for-profit managed care organization, Correctional Medical Services (CMS), to provide physicians, dentists, physician assistants, and physical therapists, and to manage pharmacy costs.

Psychologists, nurses, records staff, and case managers remain as DOC employees. Like other managed care organizations, CMS functions according to business incentives. In Minnesota, CMS is given a fixed amount with which to provide services but still make a profit—regardless of increases in numbers of inmates, costs of medications, etc.

Pressures for cost containment—which may come not just from managed care organizations alone but also from state administration and the legislature—can undermine

the provision of health care commensurate with prevailing community standards. Drastic cuts or service limitations may appear reasonable from a budget and business perspective but can make it difficult, if not impossible, to provide the services needed by the growing population of inmates with mental illness.

Essential Criteria and Accreditation in Corrections

Correctional institutions currently are subject to a number of guidelines and standards set by the regulatory, legal, accrediting, and other institutions that monitor them. They follow these guidelines and standards in designing their mental health services. The essential criteria for mental health care of incarcerated men and women, established in the United States Supreme Court cases of *Estelle v. Gamble* (1976) and *Ruis v. Estelle* (1980), are:

- Mental health screening evaluations;
- Mental health treatment that includes more than just supervision, containment, and segregation;
- Participation of trained and qualified mental health providers in sufficient numbers to provide individualized treatment;
- Prevention of involuntary administration of psychiatric medication without adequate supervision and review; and
- Identification and treatment of individuals with suicidal tendencies.

In addition to legal precedents, the American Correctional Association and the National Commission on Correctional Health Care, the two major accrediting organizations for correctional institutions in our country, have mandatory standards addressing appropriate mental health care. Similarly, many professional associations, including the Public Health Association, the American Psychiatric Association, the American Association of Community Psychiatrists, and the American Psychological Association, have guidelines regarding the care of incarcerated mentally ill men and women. The Joint Commission on the Accreditation of Hospital Organizations (JCAHO) also accredits mental health services in many correctional institutions and defines the standard of care in these institutions. DOC representatives note that DOC facilities are accredited by the JCHA.

Report Noted Psychiatrists' Concerns

The report noted that psychiatrists had concerns related to the following areas:

- ***Restricted formularies.*** DOC and CMS have agreed to a trial in which approval of non-formulary medications is left in the hands of the psychiatrist. This arrangement allows physicians to exercise expert clinical judgment and render quality care to their patients, rather than requiring tiers of oversight. This change in policy may or may not succeed in reaching the twin goals of quality care and managed costs, but it does signal an openness to work together to have means of conflict resolution. In addition, MPS and DOC are planning regular meetings with stakeholders to discuss formulary decision-making issues related to optimal care and safety in the prison environment.
- ***Inmates' access to general mental health services and chemical dependency treatment.*** These services are severely limited because of the shortage of psychologists, mental health professionals, and counselors. Lack of access applies to assessment, group treatment, and individual counseling. Recruiting and retaining personnel is an ongoing challenge for DOC due to mandated budget constraints and workplace issues. DOC and MPS will work together to create new opportunities to address this situation.
- ***Inmates' access to prompt psychiatric care.*** Speed of access varies across institutions. Rapid psychiatric evaluation is particularly important in high-security segregation housing units. The paradox is that segregation is where access to prompt psychiatric care is especially poor. This is due to perceptions (and misperceptions) about the population in segregation, as well as to logistical issues (e.g., separation from the clinic where the psychiatrist sees most other patients, time-intensive security clearance procedures).

Access can also be poor for more subtly psychotic and for depressed or anxious inmates, who can easily fall through the cracks of a system designed to meet only the most obvious needs.

One part of the solution to the problem of prompt access to psychiatric care is provision of an adequate number of psychiatrists. The American Psychiatric Association guidelines recommend one psychiatrist for every 160 mentally ill inmates. MPS and DOC will

partner to address the shortage in resources as they share information and join together to educate decision-makers.

- ***Need for speedy civil commitments.*** Inmates in psychiatric crisis need rapid access to psychiatric medical evaluation and treatment. Mentally ill incarcerated individuals who meet the criteria for civil commitment should be transferred out of the DOC to an appropriate DHS facility, such as the Minnesota Security Hospital in St. Peter.

- ***Overcrowding in prisons.*** Inmates typically spend long periods in large barracks-type rooms when they first arrive in prison; they must earn the right to a smaller room over time. Some of the most toxic interactions with other inmates occur in these large rooms, where the mentally ill inmate has no easy way to escape intimidation or just to find some peace and quiet. The need for adequate resources is central to answering this concern.

Together, stakeholders must educate decision-makers and advocate for effective funding.

- ***Release planning.*** Comprehensive release planning for inmates with mental illness is imperative. Immediate care in the community is not only medically necessary but will also help reduce recidivism. DOC has taken steps to improve release planning. Case managers now work with inmates who have serious and persistent mental illness to set up housing and appointments with primary care and mental health providers. This effort is funded through recently passed legislation that was supported by MPS members and the Minnesota Association of Community Mental Health Programs, among other advocates.

The DOC also has a policy of providing one week of medications to inmates at the time of release, and a one-month prescription. This policy helps to prevent acute relapse and gives released mentally ill and addicted inmates more time to get settled in the community and to schedule appointments with their community providers. Unfortunately, very few inmates have insurance to help them get the prescription filled when they leave a correctional facility.

Continuity of care should also include medication and appointments with the necessary mental health professionals, as well as basic community supports such as housing, employability, and vocational rehabilitation services. Public insurance is needed to ensure access to mental health professionals and other necessary health care. Ideally, community providers will come into the prisons to make contact with mentally ill inmates before their release, and mental health centers will reach out to make this

connection.

More extensive links between the DOC and DHS are essential. Mentally ill offenders move across both systems of care and suffer from the disconnections between those two systems of care. For the same reasons, improved linkages are needed between the county and community mental health system and the population of mentally ill individuals incarcerated in jails. These linkages are building thanks to DOC outreach and coordinated advocacy with interested legislators.

- ***Integration of mental health care with primary care.*** As is true in the community outside of correctional settings, integration of mental health and primary care is clinically effective, results in better quality of care overall, and saves money. Using psychiatric physician assistants and psychiatric clinical nurse specialists, in collaborative agreements with psychiatrists, could expand the capacity of psychiatric physician care, and could also enhance the collaborative relationships between psychiatric practitioners and primary care physicians, physician assistants, and nurses.
- ***Mental health coverage in county jails.*** MPS and DOC are working with Senator Linda Berglin to create legislation that would address this issue as it relates to prescription purchasing. The legislation is a starting point and we applaud Senator Berglin for her leadership and concern for this situation.

Recommendations, Updates and Continuing Dialogue

The Minnesota Psychiatric Society is committed to working with all stakeholders in order to improve the situation outlined previously. DOC representatives welcome input and plan to meet with MPS, the University of Minnesota, Correctional Medical Services staff, Minnesota legislators and advocates to share expertise and discuss ongoing partnerships. MPS will coordinate quarterly discussion meetings in an effort to offer support for improvements and learn from other stakeholders. Together we will work to improve the situation for mentally ill persons in the Minnesota corrections system.

The Minnesota Psychiatric Society is gratified that the DOC has already implemented many of the recommendations included in the January 2005 report. We are encouraged and committed to work with DOC and others to continue to improve conditions for

mentally ill people in the state's criminal justice system. Nationally, Minnesota Corrections is seen as a frontrunner and DOC personnel have worked hard to make progress with limited resources.

1. Broad service needs

- **Diversion alternatives to incarceration** (e.g., mandated chemical dependency and psychiatric treatment, community service, and community monitoring and supervision). Diversion substantially reduces costs and increases the degree and timeframe of accountability for diverted offenders, and likely improves outcomes in the treatment of mentally ill offenders in diversion programs. Effective diversion alternatives require strong coordination across different levels of the law enforcement, justice, and mental health systems. Therefore, our forums for continuing dialogue will include stakeholders in the criminal justice system.

- **Early identification** of mental illness at the onset of an incarceration and assessment throughout an inmate's sentence. For many inmates, the jail or prison is the site of their first episode of mental illness. Early identification may reduce the costs associated with delaying care for more refractory illness that will emerge in the future, both in the community and in correctional settings. It also is necessary to better identify inmates who remain significantly mentally ill and/or dangerous when their prison terms are completed. They must be provided comprehensive psychiatric evaluation and, when necessary, be transferred to appropriate restrictive settings, such as the Minnesota Security Hospital.

- **Coordination across the treatment system**, specifically between the DHS and the DOC, and also between community mental health centers and jails. People with mental illness move across community and correctional systems. The DHS mandate includes mentally ill individuals who are incarcerated in the DOC. Through improved collaboration, DHS and DOC can more effectively treat these people, keep them in the community whenever possible, and help them get back to the community after a period behind bars. In addition, publicly funded community mental health centers and other mental health clinics in the community must become more involved in the spectrum of

care for offenders, including maintaining contact while their clients/patients are in jail or prison and helping with post-release planning and transition back to the community. The linkage and coordination between DHS and the DOC, and between community mental health centers and jails, is pivotal in the successful transition of mentally ill offenders at the completion of their sentences, and will be vital in increasing their chances of success in the community and reducing recidivism. The role of community mental health case managers is critical in forging these important linkages.

- **Coordination across levels of the justice system.** The management of mentally ill offenders requires coordinated efforts by state mental health organizations and the criminal justice system in these important areas:
 - Training of law enforcement officials in recognizing and managing mentally ill individuals engaged in disruptive or illegal behavior.
 - Police-based diversion programs.
 - Mental health court sanctioning of mentally ill offenders to a period of mandated and monitored treatment in the community.
 - Improved coordination and sharing of information among correctional institutions probation officers, mental health case managers, and mental health providers in the community prior to release of mentally ill offenders.

2. Treatment-related needs

- **Optimal, quality treatment.** People with mental illness in correctional settings need to receive treatment at a level of quality commensurate with prevailing community standards of care. Quality treatment of mental illness and addictions in correctional settings can help stabilize illness. This in turn can improve employability, an important ingredient in reducing recidivism.
- **More appropriate use of segregation.** Discipline and investigation are required, but more efforts must be made to move seriously mentally ill inmates to appropriate treatment settings, as rapidly as possible. This includes moving mentally ill inmates to more restrictive mental health units, or perhaps even to DHS facilities, such as a regional treatment center (RTC).

- **Improved access for offenders to addictions treatment and aftercare.** Success in treating addictive behavior has a high likelihood of reducing criminal behavior, thus helping to prevent recidivism. Correctional settings should foster a recovery-based treatment philosophy.
- **Vocational focus** in treatment programs and other services to inmates. Giving mentally ill inmates the opportunity for vocational training and developing job skills will lead to increased employability, which will increase their chances of successful re-integration into the community and reduce recidivism
- **Speedy commitment process** for inmates who meet criteria for civil commitment. These inmates need to have access to rapid assessment, medical treatment, and monitoring. If necessary, they also must receive speedy commitment to an appropriate facility, such as a DHS Regional Treatment Center, or, if the inmate is mentally ill and dangerous, to the Minnesota Security Hospital in St. Peter.
- **Improved general conditions** in prisons and jails. Prison conditions, particularly overcrowding, must be addressed. The housing status of inmates with mental illness should be reviewed and, at times, placement decisions should be made based on this review. Good diet options should be available for mentally ill patient/inmates who face elevated risks of metabolic syndrome, weight gain, and diabetes. MPS and DOC will initiate meetings to discuss these issues and find ways to work together to access resources to improve this situation.
- **Training for correctional officers** to aid them in identifying and managing mentally ill incarcerated individuals.
- **A modern formulary** that includes at least a subset of the medications used in community practice as first-choice treatments for similar conditions. A reasonable formulary consistent with modern psychiatric practice would include at least two second-

generation antipsychotic agents as options for first-line treatment. It would also include at least two SSRI antidepressants for initial treatment. These recommendations are consistent with published treatment algorithms, including the widely accepted Texas Medication Algorithm Project, the Harvard Algorithm Project, and the Correctional Medication Algorithm outline. MPS is meeting with DOC representatives and legislators to discuss the unique environmental aspects impacting formulary decisions in Minnesota prisons. In addition, MPS and DOC are working with Senator Linda Berglin to extend shared purchasing power through legislation allowing county jails to participate in a statewide formulary prisons.

A simple, streamlined procedure should also be in place for accessing non-formulary medication for inmates who fail to respond to formulary medications in prison or in previous episodes of illness. The DOC is using a good process on a trial basis and MPS supports its expansion from a clinical perspective.

- **Routine screening for co-morbid medical problems** such as hepatitis A, B & C, HIV-AIDS, and tuberculosis. Like offenders with mental illness, the chemically dependent population also has high co-morbidity with medical conditions such as HIV-AIDS, hepatitis B and C, and tuberculosis.

3. Staffing needs

- **Adequate staff** (including social workers, case managers, and nurses) to handle the needs of mentally ill inmates.

All correctional sites, including jails, juvenile centers, and prisons, must have adequate mental health staff. Policy should be developed to encourage more access to psychiatric services in jails across Minnesota. Sufficient funding is crucial to maintaining needed staff.

Creative, cost-effective ways to gain and retain highly qualified forensic psychiatrists. Using psychiatric physician assistants and psychiatric clinical nurse specialists, in collaborative agreements with psychiatrists, could expand the capacity of psychiatric physician care, and could also enhance the collaborative relationships between psychiatric practitioners and primary care physicians, physician assistants, and nurses.

- **Contracting arrangements** between DOC and an academic medical center with the aims of increasing the quality and number of psychiatrists and other staff, and providing opportunities for training and research, which would in turn improve the standard of quality care. The Minnesota DOC will work with MPS and others to explore creative and cost-effective options for securing mental health and psychiatric services for mentally ill inmates.

4. Release Planning Needs

- **Emphasis on social services support and case management** to prepare inmates for successfully re-entering the community.
- Improved planning for adequate **housing and employability** post-release.
- **Improved access to and re-initiation of insurance benefits** (especially Medical Assistance) post-release to ensure access to psychiatric and other mental health and general health services in the community. Ideally, inmates should be able to retain their eligibility for Medical Assistance, MinnesotaCare, or other payment sources throughout their incarcerations, so that they do not have to go through the process of re-applying after release. Prescriptions and a small supply of medications should be made available to jail inmates at the time of release, as the DOC now provides for prison inmates being released.
- **Visits by community mental health providers** to prisons and jails, to make contact with mentally ill inmates before they are released to community treatment.
- **Expanded links between the DOC and DHS** to better connect the two systems of care for inmates who move between them. A post-release tracking system should follow up if an inmate fails to show up for planned appointments. In many cases, particularly in larger cities, there would be merit in assigning specialized teams, similar to Assertive Community Treatment Teams, to work with mentally ill inmates through the transition period. At a minimum, case managers could be available to set up and go the first outpatient appointment like they do in the DHS system.
- **Improved linkage between the county mental health system and mental health centers** in the community, and mentally ill individuals in jails and prisons.

5. Administrative and Oversight Needs

- **Improved oversight** of DOC, CMS, and county jail systems, to assure that mental health care is delivered in accordance with prevailing standards of care in the community (e.g., the DOC will hold CMS accountable for providing quality mental health care commensurate with prevailing community standards, and at the level legally guaranteed by the U.S. Supreme Court and other judicial mandates).
- **Establishment of an independent psychiatric review board** with an advisory function to the DOC to help design and implement effective mental health programs in correctional settings.
- **Restoration of the Ombudsman position in the DOC**, to advocate for the needs of inmates independent of the DOC and any agency with which DOC might contract.
- **Psychiatric medical leadership** at all administrative levels within DOC and CMS, in the Mental Health Unit, and at all levels of policymaking in the DOC and CMS. A Medical Director for Psychiatry can perform all of these vital functions.

The Role of the Minnesota Psychiatric Society

The delivery of appropriate mental health care in the Minnesota DOC correctional settings is a vital link in the chain of care for mentally ill offenders. The chain starts with local law enforcement and ends with successful community re-entry. Envisioning and implementing this continuity of care is essential if we are to stem the epidemic of mental illness in correctional settings.

Correctional institutions were never intended to be the primary source of mental health and health care. However, with severe mental illness affecting an estimated 15% to 30% of the prison population and a growing number of incarcerations in our state, the reality is that our prisons and jails have become de facto mental health treatment facilities.

Professional mental health societies can and must help the Minnesota DOC and counties meet this unexpected burden. To this end, the Minnesota Psychiatric Society Correctional Psychiatry Caucus offered its 2005 report.

The Minnesota Psychiatric Society proposes the following to help implement the above recommendations:

- MPS participation in, and facilitation of, discussions among DOC, DHS, academic medical institutions, and other mental health providers.
- MPS advocacy for DOC and DHS through legislative initiatives aimed at decreasing the mentally ill population in the criminal justice system and at ensuring appropriate mental health services for those who are in the system.
- MPS collaboration with the Forensic Network, NAMI-MN, other consumer groups, and other mental health advocates.
- Establishment of an ongoing MPS advisory group to the DOC and CMS, to provide psychiatric clinical expertise and psychiatric medical leadership in review of its mental health care and treatment programs.
- Availability of an MPS member to sit on the current DOC Advisory Committee.

The Minnesota Psychiatric Society is committed to being an ally to the Minnesota DOC, DHS, counties, and all other interested parties, in the effort to ensure good quality mental health care and release preparation for the mentally ill individuals who are entrusted to their care by the citizens of Minnesota.

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