The Michigan Prisoner Mental Health Care Improvement Project:

A Blueprint for Transforming Prisoner Mental Health Care

Report and Recommendations of the Interagency Mental Health Care Workgroup

Primary Content Editors: Julia Heany, Michigan Public Health Institute
Marti Kay Sherry, Michigan Department of Corrections

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Executive Summary

In August 2007, the Michigan Department of Corrections (MDOC) and the Michigan Department of Community Health (MDCH) convened an interdepartmental Mental Health Care Workgroup comprised of key stakeholders from MDOC, the Michigan Department of Community Health (MDCH), the private sector, and advocacy organizations to review the delivery of mental health care in the correctional system and to make recommendations for redesign. The Workgroup met through June of 2008 and was guided by the following vision statement from Directors Patricia Caruso and Janet Olszewski:

> Vision
> *The Michigan Department of Corrections will institute a single managed delivery system of care to provide a continuum of comprehensive and integrated mental health services based upon the individual needs of the offender. There will be external oversight responsible for the development and monitoring of standards to ensure that the MDOC system is the benchmark for the nation. Resources will be provided to meet the needs of the customer driven system.*

Following an assessment of the current mental health care delivery system's strengths, weaknesses, opportunities, and threats, the Workgroup formed four committees to develop redesign recommendations. The four committees were co-chaired by a MDOC and MDCH representative.

I. The Pre-Prison committee was formed to recommend changes to mental health care assessment and delivery prior to intake. Operating under the following mission statement, the Pre-prison committee proposed four key recommendations.

> Mission
> *To more appropriately manage the needs of individuals with mental illness and disabilities and substance addiction in the corrections systems, including the local jails, and to reduce the number of people with mental illness and disabilities and substance addiction from entering the corrections system thereby reducing the costs in the corrections system and re-directing the dollars to community based treatment programs.*

A. Primary Recommendations:

Recommendation 1:
Improve mental health services in the community, in the jails, and in the court system.

- Conduct local assessments of mental health services.
- Provide training and implement evidence based practices.
- Amend Kevin's Law.
- Provide training for probate court judges.
- Provide training related to the psychiatric patient advocate designation.
- Change the criterion of "potential harm" in the Mental Health Code.
- Achieve mental health parity.

Recommendation 2:
Institute diversion programs.

- Define responsibility for jail diversion programs.
- Establish models for re-entry from jail to the community.
- Establish mental health courts in Michigan.

Recommendation 3:
Improve the management of individuals in jail.

- Provide continuity of mental health care during incarceration in jail.
- Identify jail inmates with mental illness.
- Train staff to screen for mental illness and to make referrals when needed for comprehensive mental health assessment.
- Survey local jails to determine prevalence of mental illness.

Recommendation 4:
Share information appropriately across the criminal justice system.

- Develop a standard transfer packet.
- Amend forms to allow a judge to order the release of mental health records.
- Distribute complete and accurate information regarding mental health history and treatment to correctional facilities.

II. The Intake committee was formed to recommend changes that would impact the process of receiving a prisoner from jail and into the prison system. Guided by the following mission statement, the committee proposed three key recommendations.

Mission
To ensure that at the time of intake, all *necessary or relevant information related to the mental health care needs of prisoners entering the correctional system is obtained and that prisoners are appropriately assessed so that mental health issues are identified.*

B. Primary Recommendations:

Recommendation 5:
Establish stable and adequate staffing.

- Offer staggered or flexible work schedules.
- Enhance recruitment efforts.
- Offer pay incentives.
- Partner with universities.

Recommendation 6:
Establish a thorough and accurate history of mental illness for MDOC's records at reception.

Recommendation 7:
Establish a system that effectively and efficiently identifies prisoner needs.

III. The Incarceration committee was formed to recommend changes to mental health care delivered in the prison setting. After developing the following mission statement, the Prison committee proposed five key recommendations.

Mission

To create a system that seamlessly delivers and tracks mental health services within the prison setting. The system will be tailored for the individual prisoner needs and addresses both existing and emergent needs.

C. Primary Recommendations:

Recommendation 8:

Minimize the use of segregation for prisoners with mental health needs, and reduce the negative mental health impact of segregation on prisoners with mental illness or those at risk of developing mental illness.

- Reduce the number of prisoners with mental illness in segregation.
- Ensure proper diagnosis of prisoners with mental illness in segregation.
- Train staff to appropriately interact with prisoners that have a mental illness in a segregated setting.
- Address risk reduction and containment.
- Modify conditions of confinement.
- Identify alternative settings for prisoners with mental health needs that address security concerns.
- Ensure that mental health services delivered in segregation are integrated with services offered in other treatment settings.

Recommendation 9:

Identify gaps in access to and delivery of services to prisoners with mental health issues and develop a system to continuously examine and improve the delivery of programs and services, focusing on mental health and health care services.

Recommendation 10:

Provide training for all staff in the effective identification of prisoners with mental health issues to assure that they receive treatment from properly trained staff in a safe and secure prison environment.

- Train non-clinical staff in the identification of signs and symptoms of mental illness, strategies for interacting with prisoners with mental illness, and resources available for mental health issues.
- Train clinical staff in diagnosis, evidence based treatment, and best practices.
- Evaluate the training needs of staff, the effectiveness of trainings provided and the impact of training on the service delivery system.

Recommendation 11:

Develop responsive treatment and mental health services, based on the objective assessment of individual prisoners, delivered by a collaborative system that ensures shared responsibility and continuity of care.

- Implement treatment modalities that prisoners can access that are evidence based practices and coordinated throughout the system.

Recommendation 12:

Establish prisoner mental health treatment settings that ensure an appropriate therapeutic environment.

- Decide which of several models for the delivery of mental health care is most suitable for implementation in MDOC.
- Revise the current continuum of care to include a complete spectrum of services.
- Expand the telemedicine unit to provide psychiatric consultation to other prisons.
- Determine whether MDOC itself, MDOC in collaboration with MDCH, MDOC in collaboration with a for-profit vendor, or MDOC in collaboration with an academic center are best geared to implement the strategies identified in these goals and objectives.
- Ensure that the system of mental health care meets accreditation requirements.
- Provide adequate office and treatment space at all levels of care.
- Define essential characteristics of a therapeutic environment and how they can be achieved at every level of care.

IV. The Preparation for Release committee was formed to recommend changes to the reentry process for prisoners with mental illness. Guided by the mission statement that appears below, the committee developed six key recommendations.

<u>Mission</u>

To ensure that specific strategies and collaborative strategies for continuity of care are developed and implemented that provides services, benefits, and supports in the community for each prisoner released in need of treatment for mental health, medical, and substance abuse disorders.

D. Primary Recommendations:

Recommendation 13:
Ensure that all individuals leaving the prison system are appropriately linked with entitlement benefits prior to release to assist in successful reintegration. Individuals should be screened and linked with all entitlements they may be eligible for including Medicaid, Social Security and Veterans Benefits.

- Screen and assess all prisoners with mental illness to determine appropriate entitlement options.
- For those prisoners screened as likely to be eligible for any form of entitlement, designated staff at the facility will facilitate the completion of applications as appropriate.

Recommendation 14:
Ensure that all discharging prisoners (Max Outs) have transition plans developed and appropriate links to community supports.

- Identify earlier those prisoners who are discharging on their PMX (Parole Max Date).
- Develop transition plans for prisoners who are discharging on their PMX date.

Recommendation 15:
Ensure that all prisoners in need of guardianship have a guardian at the time of release.

Recommendation 16:
Provide cross-system training to prison staff, parole agents, and community members on the appropriate ways to interact with individuals with mental illness who also engage in criminal behavior.

Recommendation 17:
Identify prisoners with special needs and ensure that any unique characteristics are communicated to the community and addressed within his/her transition plan.

- Address the needs of those individuals who have both medical concerns and mental disabilities that will impact transition to the community.
- Address needs of sex offenders as they transition into the community.
- Address needs of elderly prisoners as they transition to the community.
- Address needs of youthful prisoners as they transition into the community.
- Address needs of prisoners with developmental disabilities as they transition into the community.
- Ensure that appropriate information is consistently included in the TAP/Discharge Plan for prisoners with special needs.

Recommendation 18:
*Identify prisoners with less severe mental illnesses, and ensure that these individuals have access to appropriate follow up services upon re*lease.

- Develop strategies to identify prisoners with less severe mental illnesses and a consistent process to assist in transition planning.
- Develop TAP/Discharge Plans to address mental health needs for those individuals with less severe mental illness.

In addition to these key recommendations and action steps, each group proposed activities and/or tasks, identified key players, and noted the resources that would be required to implement the recommendations. These details are described in the full report.

The recommendations and action steps developed by the Mental Health Care Workgroup integrate the perspectives and experiences of a diverse set of stakeholders and establish a vision for mental health care redesign that encompass each stage of prison incarceration. The recommendations provide a blueprint for guiding the system redesign toward better meeting the needs of individuals with mental illness in the prison and in the community.

Chapter I: Introduction to the Prisoner Mental Health Care Improvement Project

I. Project Background

As part of a broad effort to improve the quality of health care in the Michigan prison system, the Michigan Department of Corrections (MDOC) established the prison Health Care Quality Improvement Team (HCQIT). In October 2007, the HCQIT published a strategic plan outlining a process designed to improve health care in the prison system.

As part of the strategic plan, the HCQIT determined that the MDOC should work with the Michigan Department of Community Health (MDCH), its partner in delivering services to mentally ill prisoners, to conduct a broad based and comprehensive review of MDOC's prisoner mental health programs. Historically, MDOC has contracted with private vendors for health care and associated services; however, MDOC has provided mental health care using a bifurcated delivery system through which some services are provided directly through MDOC and other services are provided through a contract with MDCH. This system has been difficult to oversee and manage, and it has lacked coordination and integration. Until 2007, this partnership between MDOC and MDCH was required by statute, but the passage of Public Act 124 provided an opportunity to develop new and creative approaches to the delivery of mental health services to prisoners.

II. The Formation of the Mental Health Care Workgroup

In order to explore opportunities to redesign the MDOC mental health care delivery system, MDOC and MDCH co-convened a multi-disciplinary workgroup including representatives from MDOC, MDCH, the private sector, and advocacy organizations[1] to review the current system and develop recommendations for redesign. This Mental Health Care Workgroup developed a comprehensive set of recommendations to improve the provision of mental health care services in the corrections system, which are described in this Blueprint document. The Mental Health Care Workgroup focused on three critical components of system redesign:

1. The redesign of the prisoner mental health system from the current bifurcated delivery system with undefined reporting requirements into a seamless delivery system;
2. The redesign of components of mental health services within the corrections system; and
3. The redesign of community systems for pre- and post-incarceration delivery of mental health services.

[1] A complete list of Mental Health Care Workgroup participants can be found in Appendix I.

A. Vision and Guiding Principles

The Mental Health Care Workgroup was guided by a vision statement and guiding principles, which were developed and adopted early in the process. The vision statement and guiding principles provided by Directors Patricia Caruso and Janet Olszewski follow:

Vision Statement

The Michigan Department of Corrections will institute a single managed delivery system of care to provide a continuum of comprehensive and integrated mental health services based upon the individual needs of the offender. There will be external oversight responsible for the development and monitoring of standards to ensure that the MDOC system is the benchmark for the nation. Resources will be provided to meet the needs of the customer driven system.

Guiding Principles

- Mental health services are provided under a single administrative structure;
- Access is timely, skilled, and culturally appropriate;
- A comprehensive range of services is available;
- Services are integrated and connected;
- Staff are appropriately trained and their skills are maintained;
- Service delivery is transparent and accountable;
- Service delivery effectively utilizes evidence based practices;
- Care is individualized;
- The treatment environment is appropriate; and
- Determination of detention/release is judicial.

This process was also guided by and incorporated recommendations from a variety of other reports and initiatives that provided assessments and recommendations for change in prisoner health and mental health care delivery systems. A cross-walk between these various studies and the recommendations of the Mental Health Care Workgroup can found in Appendix II.

III. Workgroup Structure and Processes

Once formed in August 2007, the Workgroup met on a monthly basis through June 2008. Meetings were held in downtown Lansing, and involved presentations from key stakeholders, large group facilitated conversation, and small group work. The Workgroup process was led by MDOC and MDCH leadership, with assistance from consultants from Community Health

Ventures (CHV) who provided expertise in core facilitation and mental health care knowledge. CHV's services were provided through a grant from the JEHT Foundation to the Michigan Public Health Institute.

A. SWOT Analysis

The first task of the Mental Health Care Workgroup was to identify the strengths, weaknesses, opportunities, and threats of the existing system using a technique known as SWOT analysis, as well as other issues that required the workgroup's consideration as a result of their impact on the prison mental health system. Weaknesses in the existing system were given a ranking of "major," "intermediate," and "minor." Those issues that were considered a major weakness were prioritized in terms of developing alternative approaches in the provision of services. Issues with the ranking of intermediate were also considered to be key considerations in the system redesign process. Those issues ranked as minor required consideration, but Workgroup members found that, if higher ranked weaknesses were addressed, weaknesses identified as minor would also be resolved. Results of the SWOT Analysis are presented in Table 1.

Table 1: Results of SWOT Analysis

Major	Intermediate	Minor	IDENTIFIED WEAKNESS
ADMINISTRATIVE			
			Communication between the Stakeholders
	X		Interdisciplinary communication is poor
X			Unclear accountability to the Chief Medical Officer
X			Unclear roles
X			No overarching monitoring of the system
	X		Inadequate feedback to the staff
	X		Inconsistency in treatment documentation
	X		Lack of information and data
	X		Failure to recognize relationship between health care and mental health
X			The two sides are not going down the same path
X			Unclear accountability to primary care providers
			Coordination of Services
X			Services are not coordinated
	X		Some services are not multidisciplinary
X			Mental health and physical health services are not integrated
	X		There is a failure to follow through
		X	There is a duplication of services
X			Nursing services are split between physical and mental health
	X		Lack of services for those with co-occurring disorders
X			Difficulty handling complex cases (self-mutilation)

Major	Intermediate	Minor	IDENTIFIED WEAKNESS
			Resource Limitations for the Delivery of Mental Health Services
	X		Security barriers limit therapy and treatment locations
	X		Lack of mental health special needs beds
	X		Inadequate staff allocation
	X		Lack of services for those with a developmental disability
	X		Lack of services for inmates who are mentally ill but not SMI
TRAINING AND HUMAN RESOURCES			
			Administrative Issues
X			Unclear accountability
	X		Interdisciplinary communication issues
	X		Communication barriers limit access to tools – Internet, phone, etc.
	X		Staff resistance to change
	X		Inadequate feedback to staff
X			Mutually agreed upon and understood performance measures & outcomes
			Training
	X		Lack of training for nurses in mental health issues
X			Lack of training for officers in recognizing & handling of mentally ill prisoners
	X		Trust Issues – mentally ill or acting out?
	X		Need for specialized training for staff
	X		Lack of training for field agents
	X		Foreign trained medical providers can lack sensitivity to prison population
	X		Cultural competency
			Appropriate Staffing
X			Difficulty recruiting mental health professionals
	X		Nursing services are split between physical and mental health
X			Civil service rules – hiring, pay scales, new professions, regional differences
			Working Conditions
	X		Poor working conditions
	X		Shifts in population
	X		Unavoidable daily workloads
	X		Staff is overworked
	X		Barriers to treatment because of time limits placed on therapy & location
			Intake

Major	Intermediate	Minor	IDENTIFIED WEAKNESS
X			Lack of information data – bifurcation of the system
	X		Inconsistency in treatment and documentation
	X		No systematic way to identify individuals with serious mental illness
	X		Intake should identify individuals with non-severe mental illness
	X		Lack of adequate pre-incarceration info on mental health populations
X			Programs offered at wrong time in treatment cycle
		X	Diversion of populations
	X		Inability for some correctional facilities to respond to mentally ill prisoners
			Release
	X		Mission narrowing (AOP/SOP)
	X		Lack of parole planning for those with mental illness
	X		Lack of good collaboration with the community at time of discharge
	X		Medication availability upon release
	X		Parolee may not know how to access services
X			Programs offered at wrong time in treatment cycle delays release
	X		Mental health information may not follow all parolees out of the prison
	X		Lack of information, data – bifurcation of system
POLITICAL ENVIRONMENT			
	X		Resources
	X		Services are designed by political mandate
	X		Public policy makers do not understand impact of program closures
	X		Civil Service Rules – hiring, pay scales

B. Identified Subpopulations

One of the points highlighted by the SWOT analysis was that the prison population is not homogeneous and that the mental health needs of prisoners in various subpopulations are very different. The Mental Health Care Workgroup identified several specific subpopulations in the correction system whose mental health care needs should be addressed in recommendations for system redesign. For example, female prisoners have different treatment needs given the higher incidence of depression and post traumatic stress disorder in female prisoners as compared with the male population. The list of subpopulations identified by the Workgroup follows:[2]

- Prisoners with serious and persistent mental illness;
- Prisoners with mental illness that is not considered "serious and persistent;"
- Prisoners with developmental disabilities; and
- Prisoners with special needs, including
    - Sex offenders;
    - Assaultive offenders;
    - Youthful prisoners;
    - Women;
    - Prisoners with a dual diagnosis, including substance abuse;
    - Prisoners with a closed head injury;
    - Prisoners with dementia or Alzheimer's disease; and
    - Prisoners who are transgender.

C. Policy Issues

Based on the SWOT Analysis, the Workgroup also identified several policy issues that have had a significant impact on the prison mental health care system. These are issues that warrant attention in the effort toward providing comprehensive services for individuals with mental illness who are incarcerated.

1. Revise involuntary commitment restrictions;
2. Change confidentiality statutes and regulations to allow for sharing of medical records and data;
3. Request assistance from the Sheriff's Association to ensure that Sheriff's reports to prisons include:
    - Contact with community mental health system;
    - Medications, diagnoses, and other physical health care needs; and
    - Substance use or other behavioral issues;

4. Cultivate advocates/champions in the local communities and on the state level;
5. Develop a funding stream for recovery support specialists to partner with the parolee upon release;
6. Specialty geriatric mental health services are needed both in the prison and in the community including nursing homes that will accept parolees;

[2] The definitions for the specific populations can be found in Appendix III.

7. Revise Pre-Sentence Investigation Report to ensure that information about mental health issues and treatment is included. Require that all of the most recent data be included in the Pre-Sentence Investigation report that is sent to the corrections system;
8. Create mental health courts throughout the State of Michigan;
9. Reduce number of sentencing guidelines;
10. Define target population to be served by mental health providers in the correction systems;
11. Move policy toward universal health care access with mental health parity;
12. Promote anti-stigma campaigns and other educational efforts surrounding mental illness;
14. Identify children with mental illness early;
15. Provide treatment in juvenile detention;
16. Ensure access to all records, including the special education records of the offender;
17. Increase funding to local communities for a uniform array of jail diversion programs, including development of shared definitions of pre- and post-booking for adults and youthful prisoners;
18. Increase mandatory treatment options as part of court orders for the offender;
19. Mandate and finance cross-training between mental health and correction professionals;
20. Provide funding for programs to provide services for the parolees upon release to the community;
21. Eliminate regulatory barriers to ensure that state identification cards as well as entitlements are in place upon release from the prison into the community; and
22. Introduce and pass legislation that would place restrictions on those that "max-out" to ensure compliance with treatment.

D. Committee Work

Based on the results of the SWOT analysis, and with consideration of the needs of these subpopulations, the workgroup broke into four committees. The committees were organized around the various systems that a prisoner interacts with as they move through the system, and included:

- Pre-prison
- Intake
- Incarceration
- Preparation for Release

Committee membership was based on interest and expertise. Committees were asked to analyze existing conditions, guided by the results of the SWOT analysis, and make recommendations for improvement that were consistent with the vision statement and guiding principles. Committees met both during and outside of Workgroup meetings to develop a committee mission statement and identify a series of goals, objectives, and action steps for system redesign. The results of the work of each committee were presented to the larger Workgroup during the final two workgroup meetings for vetting, consolidation, and consensus building.

IV. Organization of this Report

The Mental Health Care Workgroup, including key stakeholders from across the system, underwent a structured process to identify the strengths, weaknesses, opportunities, and threats facing the current system of providing mental health care to prisoners. During this process, the workgroup reviewed recently published reports that have assessed the prison mental health system and incorporated many the ideas and recommendations included in these documents. Having also identified key subpopulations and defined the policy context of the prison mental health care system, the Workgroup committees generated recommendations, which will be presented in this report.[3] The report includes the following chapters:

- Chapter 2 will provide a brief literature review framing the challenges and opportunities facing the prison mental health care system.
- Chapter 3 will review the recommendations developed by the Workgroup in brief.
- Chapter 4 will review the recommendations developed by the Pre-Prison committee.
- Chapter 5 will review the recommendations developed by the Intake committee.
- Chapter 6 will review the recommendations developed by the Incarceration committee.
- Chapter 7 will review the recommendations developed by the Preparation for Release committee.
- Chapter 8 will provide final thoughts and conclusions.

[3] A list of the acronyms used in the report can be found in Appendix IV.

Chapter 2:
Conceptual Background

I. Incidence of Mental Illness among Prisoners

Many incarcerated persons suffer from serious psychiatric disorders. In the last several decades dozens of published studies have documented rates of mental illness, variously defined, in correctional populations throughout the world. At least three dozen research articles and reviews have been published on this topic since 2001.

This literature can be understood only in the context of the conceptual and operational definitions of the term itself. The DSM-IV[4] employs the expression mental *disorder*, and includes under that rubric most psychological deviations that are either distressing to the individual or that impairs functional capacity. The expression *serious* (or *severe) mental illness (SMI)* is ordinarily reserved for conditions that result in severe impairment in functioning—incapacity to work, to think logically, to care for oneself, or to engage in ordinarily family and social roles. SMI includes DSM-IV disorders characterized by psychosis, including schizophrenia, bipolar disorder, schizoaffective disorder, delusional disorder, psychotic disorder NOS, or those associated with suicidality, such as major depression, other non-psychotic disorders of mood, and severe personality disorders such as borderline personality disorder. SMI also embraces "organic" mental disorders, such as dementia, when accompanied by symptoms of psychosis or self-harm. (For more information on definitions of mental illness see Appendix III.)

Operational definitions of mental illness or SMI are equally important when interpreting the academic literature. Definitions using well-validated diagnostic instruments applied by expert interviewers to both interview and file data generally yield more representative rates than, say, paper surveys of inmates. Some diagnoses are inherently more reliable (e.g., psychosis) because defining symptoms do not fall on a continuum of normality as do symptoms such as mood state, sleep disturbance, and inability to concentrate, the presence of which involve subjective judgments of severity.

One approach to bringing sense to a large body of seemingly disparate research is the meta-analysis, in which the results of high-quality studies are statistically weighted by sample size and pooled to yield average rates. This technique was applied to 62 studies comprising 22,790 prisoners in a seminal paper by Fazel and Danesh[5] that, arguably, gives us the best estimates available for the prevalence of mental illness in a wide range of correctional populations. Among male prisoners, this study estimates that 3.7% have a psychotic disorder, 10% have major depressive disorder, 65% have a personality disorder, and 47% have antisocial personality disorder. Among women, 4.0% have a psychotic disorder, 12% have major depressive disorder, 42% have a personality disorder, and 21% have antisocial personality disorder, according to the estimates produced by this study. Generally, studies in the United States revealed higher rates of psychosis (4.5%) and lower rates of antisocial personality (18%) than did studies conducted elsewhere. Psychopathology was somewhat more common in jails than in prison, though the

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[4] American_Psychiatric_Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders, Text Revision: DSM-IV-TR*. Washington, D.C.: American Psychiatric Press.

[5] Fazel, S., Bains, P., & Doll, H. (2006). Substance abuse and dependence in prisoners: a systematic review.[see comment]. *Addiction, 101*(2), 181-191.

differences overall were rather small. Rates of psychosis and major depression from this study were about 2-4 times those expected in the general non-prisoner population corrected for age.

Among the individual studies of prison populations, a British study conducted for the Department of Health stands out as one that was unusually rigorous and thorough.[6] The prison population of the United Kingdom comprises about 50,000 sentenced inmates and about ¼ as many remand inmates. 1,200 male sentenced prisoners, 1,200 male remand prisoners, and 800 women prisoners (over-sampled) were surveyed. Lay interviewers employed a series of questions derived from the Diagnostic Interview Schedule, the ICD-10 diagnostic criteria, the Alcohol Use Disorders Identification Test, and the Clinical Interview Schedule – Revised, and administered a brief intellectual examination, the QUICK test. Clinicians employed the Structured Clinical Interview for DSM-IV – II to diagnose personality disorders and the Schedules for Clinical Assessment in Neurospsychiatry to diagnose psychotic disorders. The results are of interest because they are comprehensive and realistic. They include indices of both diagnosis and prisoner-reported symptoms that demonstrate the wide disparity in findings obtained when clinical methods are contrasted with problem lists.

This study found that 10% of male remand prisoners, 7% of male sentenced prisoners, and 14% of female prisoners evidenced some type of functional psychosis, including schizophrenia or manic depressive disorder. The majority of the sample displayed evidence of a personality disorder, including 78% of male remand prisoners, 64% of male sentenced prisoners, and 50% of female prisoners. High rates of neurotic disorders (e.g., depressive episode, anxiety disorder, phobia, OCD, panic) were identified as well, with 59% of male remand prisoners, 40% of male sentenced prisoners, 76% of female remand prisoners, and 63% of female sentenced prisoners displaying evidence of a neurotic disorder. Few prisoners with no psychological disorder, including substance abuse or dependence, were identified. Only 5% of male remand prisoners, 8% of male sentenced prisoners, 4% of female remand prisoners, and 10% of female sentenced prisoners did not have evidence of a mental disorder.

Some studies identify even higher rates of psychopathology in correctional populations. This can sometimes be attributed to methodology, as in the often cited study of James and Glaze,[7] which used self-report of symptoms of mental illness and treatment history rather than clinical diagnoses. Using this method, authors found that 56.2% of state prison inmates had a mental health problem, and 43.8% had no mental health problem. Moreover, they found that prisoners with a mental health problem were more likely than prisoners without a mental health problem to have a criminal record, a history of substance dependence or abuse, drug use in the month before arrest, homelessness in the year before arrest, a history of physical or sexual abuse, and a parental history of drug or alcohol abuse. Moreover, prisoners with mental illness were more likely to have been charged with violating facility rules and were more likely to have been injured in a fight since admission.

Yet very high rates of psychopathology are also sometimes found using clinical interviewing. For example, in a recent study of 302 admissions to the Iowa state prisons, lifetime rates of disorder among men were 94.3% and among women 92.9%, as ascertained from interviews

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[6] Singleton, N., Meltzer, H., & Gatward, R. (1997). *Psychiatric Morbidity Among Prisoners: Summary Report*: Government Statistical Service.
[7] James, D., & Glaze, L. (2006). *Mental Health Problems of Prison and Jail Inmates. USDOJ BJS Special Report*: United States Department of Justice.

using the Mini-International Neuropsychiatric Interview-Plus (MINI-Plus).[8] Indeed, the *average* prisoner received more than four lifetime diagnoses, among which substance use disorders in 90%, antisocial personality disorder in 35%, and attention deficit hyperactivity disorder in 22% were prominent. While these particular diagnoses generally do not comprise SMI or draw much psychiatric attention in a limited-resource environment, other problems, for which psychiatric treatment would likely be essential, were equally prevalent, including psychoses in 35%, mood disorders in 54%, and "risk for suicide" in 30%. Rates for disorders judged to be present at the time of the interview were also quite high. For instance, 16.7% of men and 14.3% of women had a current diagnosis of major depression, 22.0% of men and 25.0% of women had mania or hypomania, 18.2% of men and 23.2% of women had generalized anxiety disorder, 10.2% of men and 23.2% of women had post-traumatic stress disorder, and 3.0% of men and 7.1% of women had a diagnosis of schizophrenia or psychotic disorder. The very high rate of psychoses reported here reflects inclusion of substance-induced psychoses which, because they tend to reflect external causes rather than intrinsic psychopathology, are often ignored in prisoner assessments.

According to MDOC data sources, the current percentage of mentally ill inmates incarcerated in Michigan's prisons ranges from 16% to 24%. This number encompasses those prisoners that are either mentally ill or have mental disability or functional limitations that could benefit from treatment.

Rates of mental illness are not only high relative to the general population; it is also generally believed that rates of mental illness have risen substantially in correctional settings during the last several decades. Increasing rates of illness in correctional settings have usually been attributed to deinstitutionalization of mental health care, tightening standards for civil commitment under the influence of legislation and case law, inadequate support of community-based care, homelessness, and limited offender access to treatment resources including long-term inpatient care.[9] To these we may add the burgeoning costs of inpatient care and reduced lengths of stay resulting, at least in part, from aggressive "management" of care, and increasing detection of mental illness. Accrediting organizations and courts have mandated improved screening for mental illness; epidemiological methods for diagnosing illness have improved; and the willingness of prisoners to acknowledge symptoms may have changed as improved treatment options and, perhaps, reduced stigma associated with receiving treatment, have encouraged self-disclosure.

II. Diversion from Jails and Prisons

Most advocates would agree that the best way to avoid inappropriate incarceration or "criminalization" of mentally ill persons is to provide aggressive services in the community that avoid engagement with the criminal justice system in the first instance. Suggested remedies include "mental health consultation to police in the field; formal training of police officers; careful screening of incoming jail detainees; diversion to the mental health system of mentally ill persons who have committed minor offenses; assertive case management and various social

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[8] Gunter, T. D., Arndt, S., Wenman, G., Allen, J., Loveless, P., Sieleni, B., et al. (2008). Frequency of mental and addictive disorders among 320 men and women entering the Iowa prison system: use of the MINI-Plus.[see comment]. *Journal of the American Academy of Psychiatry & the Law, 36*(1), 27-34.

[9] Lamb, H. R., & Weinberger, L. E. (1998). Persons with severe mental illness in jails and prisons: a review.[see comment]. *Psychiatric Services, 49*(4), 483-492.

control interventions, such as outpatient commitment, court-ordered treatment, psychiatric conservatorship, and 24-hour structured care; involvement of and support for families; and provision of appropriate mental health treatment."[10]

Diversion may occur at any time in the criminal justice process up to the time of sentencing. It may occur with no sanction imposed (i.e., charges dismissed), with sanctions reduced, or with sentencing deferred and conditional on compliance with interventions. For relatively minor offenses, police officers can refer offenders immediately to treatment, but this presupposes that (1) the police officer has had training in identifying persons with mental illness; (2) there are alternative resources available; (3) access to resources is reasonably convenient not only for the offender, but also for the police officer; (4) the clinical presentation overcomes legal barriers to compulsory treatment; and (5) the responsible mental health clinicians are willing and able to assume responsibility for care of the offender.

Diversion after booking entails identifying the offender's mental health needs, ascertaining an appropriate mental health response, and settling the charges, actions that require cooperation among attorneys, judges, diversion staff, and other criminal justice personnel. Mental health courts, or specialized courts with judges and staff specifically commissioned to developed mixed psychiatric-criminal justice solutions for mentally ill offenders, were introduced a decade ago to fulfill this function.[11] Mental health courts vary considerably in their structures and processes and are still in their infancy with respect to developing best practices and demonstrating favorable outcomes.[12] As might be expected, their benefits may be minimal or transient if needed services and aggressive follow-up are not available and actively implemented.[13]

Recently, the Michigan Probate Judges Association provided a series of recommendations related to reforming Michigan's mental health system that could impact the number of offender's entering the system. Their goal is that the mental health system facilitate the treatment of an individual at the earliest possible time in order to maximize the potential for a successful outcome. In order to accomplish this goal they recommend that the statutory criteria for involuntary treatment be changed, the Michigan Mental Health Code amended to require that the court order for involuntary treatment be 180 days, and require that treatment be directed by an independent psychiatrist who would oversee coordination of outpatient/inpatient care. Additional recommendations include the provision for permanent enhanced access status to persons who meet the statewide criteria for severity, and the hierarchy of choice, as recommended by the Commissions should be fully implemented[14]. These reforms will assist in decreasing the number of individuals entering the criminal justice system with mental illness.

[10] Lamb, H. R., & Weinberger, L. E. (1998). Persons with severe mental illness in jails and prisons: a review.[see comment]. *Psychiatric Services, 49*(4), 483-492.
[11] Griffin, P. A., Steadman, H. J., & Petrila, J. (2002). The use of criminal charges and sanctions in mental health courts. *Psychiatric Services, 53*(10), 1285-1289.
[12] Steadman, H. J., Deane, M. W., Morrissey, J. P., Westcott, M. L., Salasin, S., & Shapiro, S. (1999). A SAMHSA research initiative assessing the effectiveness of jail diversion programs for mentally ill persons. *Psychiatric Services, 50*(12), 1620-1623.
[13] Broner, N., Lattimore, P. K., Cowell, A. J., & Schlenger, W. E. (2004). Effects of diversion on adults with co-occurring mental illness and substance use: outcomes from a national multi-site study. *Behavioral Sciences & the Law, 22*(4), 519-541.
[14] Mack, Jr., M.L. (2008). Involuntary Treatment for the Twenty-First Century. *The Quinnipiac Probate Law Journal*, 21, 290-320.

III. Prison Mental Health Services

Screening and identification of prisoners with mental health needs is widely recognized as the predicate upon which meaningful intervention is possible. Recent years have seen improvements in the methodology of screening, but ultimately the gold standard for ascertaining need is the time-consuming clinical interview. Screening tools are important in identifying offenders needing closer assessment whose initial presentation does not plainly announce their need for intervention. Screening tools for specific populations have been developed, including tools for youth and for the intellectually challenged.

Screening having been accomplished, treatment becomes the principal business of corrections mental health staff. The prevailing model of mental health care in prisons is based on the continuum of care provided in community mental health settings. This model generally includes four components, a clinic-based outpatient treatment system, residential treatment in prison-based units modified for the mentally ill (residential treatment programs, special care units, etc.), crisis stabilization programs for short-term assessment and emergency treatment, and hospital or quasi-hospital inpatient units.[15]

The model assumes that, as in community settings, outpatient services are fundamentally less restrictive and more desirable. Thus, a major objective of such continua is to move suitable inmates to outpatient treatment. The basic assumption, however, is not always correct. Segregation units, for example, may be classed in general population and prisoners confined in them may receive all outpatient services at cell-side. For some prisoners, the more protective environment of a residential unit offers greater latitude for eccentricities of behavior and thus has the effect of being less restrictive. In brief, while community treatment outside of an institution is unquestionably less restrictive and, for most, more desirable, it is not always clear that life within a general population prison environment, which, after all, by any ordinary standard is among the most restrictive settings imaginable, affords greater liberties than that within a dedicated treatment setting.

Recognizing that some relatively stable inmates function poorly in general population, the California Department of Corrections has proposed dedicated prisons within which the full continuum of mental health care can be provided in a relatively protected environment. This proposal is new and untested, but it may set the direction for future correctional mental health care.

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[15] Metzner, J. L., Cohen, F., Grossman, L. S., Wettstein, R. M., & Wettstein, R. M. (1998). Treatment in jails and prisons. In *Treatment of offenders with mental disorders.* (pp. 211-264). New York, NY, US: Guilford Press.

"The other half of the housing and facilities [for about 5000 inmates] will be for mental health services. Approximately seventy percent of this housing will consist of open-space dormitories for an "enhanced outpatient program," eighteen percent will be for high-custody enhanced outpatients, and less than fifteen fourteen percent will be for a mix of mental health crisis beds, acute beds, an intermediate care facility and a high-custody intermediate care facility."[16]

The academic literature offers little guidance on these alternative models for mental health care in corrections. Similarly, there is little discussion about the role or need for a psychiatric hospital, as distinct for an intensively staffed "inpatient" unit or crisis stabilization program, within a system of care, or whether such a hospital is better placed within a department of corrections or located in the community with services contracted as needed. Transfer from prison to hospital for psychiatric care appears to be common in the United Kingdom. In Michigan, of course, psychiatric hospitals are often employed to care for detainees when jail services on-site are inadequate for their care, indicating that security considerations alone do not preclude such transfers.

Standards for use of restraint by mental health personnel in correctional environments have been proposed, essentially following the prescription of the Center from Medicare and Medicaid Services that defines community practice.[17] Whether restraint can be practiced appropriately in a non-hospital custody environment has been persuasively questioned by at least one leading thinker:

In contrast to the position taken in the American Psychiatric Association's "Resource Document on The Use of Restraint and Seclusion in Correctional Mental Health Care," this commentary proposes limiting the use of mental health restraints to the stabilization of unsafe situations during the time it takes to transfer an inmate to a psychiatric hospital. Jails and prisons are inherently nontherapeutic environments and are not adequate settings for managing mental health emergencies, such as those that require the use of restraints. Correctional conditions often contribute to the onset, and impede the resolution, of the underlying mental health crisis. Attempts to contain mental health emergencies in a correctional setting with an expanded use of restraints can compromise clinical care, overlook the root cause of many crises, impair the role of mental health professionals by blurring the distinction between mental health and security staff, and can lead to a deterioration in the standards of care.[18]

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[16] Kelso, J. C. (2008). *Achieving a constitutional level of medical care in California's prisons: the federal Receiver's trunaround plan of action*. Retrieved 7/13/2008, 2008, from http://www.cphcs.ca.gov/docs/court/ReceiverTurnaroundPlan_060608.pdf

[17] Metzner, J. L., Tardiff, K., Lion, J., Reid, W. H., Recupero, P. R., Schetky, D. H., et al. (2007). *Resource document on the use of restraint and seclusion in correctional mental health care.[see comment]*.

[18] Appelbaum, K. L. (2007). Commentary: the use of restraint and seclusion in correctional mental health.[comment]. *Journal of the American Academy of Psychiatry & the Law, 35*(4), 431-435.

IV. ReEntry

The goals of forensic mental health treatment among United States practitioners are decidedly different from those of most clinicians in Canada and the U.K. The focus here has been on identification of mental illness and treatment in the conventional sense, whereas elsewhere one primary objective of mental health treatment has been reduction of recidivism. While treatment of psychiatric disorders may well reduce recidivism, this has rarely been the purpose of treatment in the United States. Successful re-entry, however, requires a different perspective in which primary mental health concerns blend with analysis and mitigation of criminogenic risk factors, that is, the characteristics of the offender that increase the probability of recidivism. From a narrowly psychiatric perspective, the issues and management of community re-entry of prisoners reaching their maximum sentences or who are paroled are substantially similar to the jail diversion issues discussed above. An important difference, however, is that offenders subject to re-entry usually have committed more serious offenses than those targeted for jail diversion. A second important difference is that corrections authorities have as much time as they may need to implement programs and therapies designed to reduce later offending.

A variety of special programs have been developed for probationers and parolees though none have clearly emerged as the "best practices" or as evidence based practices. Effective collaboration between mental health and corrections agencies is obviously critical to success of any re-entry plan,[19] and this can sometimes be achieved by placing both groups of officials under a single agency or a single roof. Criminogenic factors that must be addressed both before and after release include substance abuse, access to mental health services, adherence to mental health recommendations, access to general medical care, reintegration with families, employment and training, and housing. Often the barriers to success, such as the double stigma of mental illness and criminal history, are invisible.[20]

Ultimately, the needs of the re-entering mentally ill offender are not dissimilar from those that might have been identified in the community before the first arrest. Initiation into the criminal justice system is itself a screening tool that identifies those persons in the community with the greatest need for services. If services that enhance mental health and reduce criminal behavior can be offered *after* this "screening," it is not clear why, they could not have been provided before, perhaps at a lesser cost.

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[19] Wilson, A. B., & Draine, J. (2006). Collaborations between criminal justice and mental health systems for prisoner reentry.[see comment]. *Psychiatric Services, 57*(6), 875-878.

[20] Wormith, J. S., Althouse, R., Simpson, M., Reitzel, L. R., Fagan, T. J., & Morgan, R. D. (2007). The Rehabilitation and Reintegration of Offenders: The Current Landscape and Some Future Directions for Correctional Psychology. *Criminal Justice And Behavior, vol, 34*(7), 879-892.

Chapter 3:
Recommendations Overview

The following recommendations represent a brief and high-level overview of the system redesign recommendations prepared by the Mental Health Care Workgroup. Many recommendations include lettered secondary recommendations that, if implemented, would facilitate the goals of the broader recommendation. Detailed descriptions of the Workgroup's full recommendations can be found in Chapters 4-7.

I. Pre-Prison

Recommendation 1:
Improve mental health services in the community, in the jails, and in the court system.

a. Conduct local assessments of mental health services.
b. Provide training and implement evidence based practices.
c. Amend Kevin's Law.
d. Provide training for probate court judges.
e. Provide training related to the psychiatric patient advocate designation.
f. Change the criterion of "potential harm" in the Mental Health Code.
g. Achieve mental health parity.

Recommendation 2:
Institute diversion programs.

a. Define responsibility for jail diversion programs.
b. Establish models for re-entry from jail to the community.
c. Establish mental health courts in Michigan.

Recommendation 3:
Improve the management of individuals in jail.

a. Provide continuity of mental health care during incarceration in jail.
b. Identify jail inmates with mental illness.
c. Train staff to screen for mental illness and to make referrals when needed for comprehensive mental health assessment.
d. Survey local jails to determine prevalence of mental illness.

Recommendation 4:
Share information appropriately across the criminal justice system.

a. Develop a standard transfer packet.
b. Amend forms to allow a judge to order the release of mental health records.
c. Distribute complete and accurate information regarding mental health history and treatment to correctional facilities.

II. Intake

Recommendation 5:
Establish stable and adequate staffing.

a. Offer staggered or flexible work schedules.
b. Enhance recruitment efforts.
c. Offer pay incentives.
d. Partner with universities.

Recommendation 6*:*
Establish a thorough and accurate history of mental illness for MDOC's records at reception.

Recommendation 7*:*
Establish a system that effectively and efficiently identifies prisoner needs.

III. Incarceration

Recommendation 8:
Minimize the use of segregation for prisoners with mental health needs, and reduce the negative mental health impact of segregation on prisoners with mental illness or those at risk of developing mental illness.

a. Reduce the number of prisoners with mental illness in segregation.
b. Ensure proper diagnosis of prisoners with mental illness in segregation.
c. Train staff to appropriately interact with prisoners who have a mental illness in a segregated setting.
d. Address risk reduction and containment.
e. Modify conditions of confinement.
f. Identify alternative settings for prisoners with mental health needs that address security concerns.
g. Ensure that mental health services delivered in segregation are integrated with services offered in other treatment settings.

Recommendation 9:
Identify gaps in access to and delivery of services to prisoners with mental health issues and develop a system to continuously examine and improve the delivery of programs and services, focusing on mental health and health care services.

Recommendation 10:

Provide training for all staff in the effective identification of prisoners with mental health issues to assure that they receive treatment from properly trained staff in a safe and secure prison environment.

a. Train non-clinical staff in the identification of signs and symptoms of mental illness, strategies for interacting with prisoners with mental illness, and resources available for mental health issues.
b. Train clinical staff in diagnosis, evidence based treatment, and best practices.
c. Evaluate the training needs of staff, the effectiveness of trainings provided, and the impact of training on the service delivery system.

Recommendation 11:

Develop responsive treatment and mental health services, based on the objective assessment of individual prisoners, delivered by a collaborative system that ensures shared responsibility and continuity of care.

a. Implement treatment modalities that prisoners can access that are evidence based practices and coordinated throughout the system.

Recommendation 12:

Establish prisoner mental health treatment settings that ensure an appropriate therapeutic environment.

a. Decide which of several models for the delivery of mental health care is most suitable for implementation in MDOC.
b. Revise the current continuum of care to include a complete spectrum of services.
c. Expand the telemedicine unit to provide psychiatric consultation to other prisons.
d. Determine whether MDOC itself, MDOC in collaboration with MDCH, MDOC in collaboration with a for-profit vendor, or MDOC in collaboration with an academic center are best geared to implement the strategies identified in these goals and objectives.
e. Ensure that the system of mental health care meets accreditation requirements.
f. Provide adequate office and treatment space at all levels of care.
g. Define essential characteristics of a therapeutic environment and how they can be achieved at every level of care.

IV. Preparation for Release

Recommendation 13:

Ensure that all individuals leaving the prison system are appropriately linked with entitlement benefits prior to release to assist in successful reintegration. Individuals should be screened and linked with all entitlements they may be eligible for including Medicaid, Social Security and Veterans Benefits.

a. Screen and assess all prisoners with mental illness to determine appropriate entitlement options.
b. For those prisoners screened as likely to be eligible for any form of entitlement, designated staff at the facility will facilitate the completion of applications as appropriate.

Recommendation 14:
Ensure that all discharging prisoners (Max Outs) have transition plans developed and appropriate links to community supports.

a. Identify earlier those prisoners who are discharging on their PMX (Parole Max Date).
b. Develop transition plans for prisoners who are discharging on their PMX date.

Recommendation 15:
Ensure that all prisoners in need of guardianship have a guardian at the time of release.

Recommendation 16:
Provide cross-system training to prison staff, parole agents, and community members on the appropriate ways to interact with individuals with mental illness who also engage in criminal behavior.

Recommendation 17:
Identify prisoners with special needs and ensure that any unique characteristics are communicated to the community and addressed within his/her transition plan.

a. Address the needs of those individuals who have both medical concerns and mental disabilities that will impact transition to the community.
b. Address needs of sex offenders as they transition into the community.
c. Address needs of elderly prisoners as they transition to the community.
d. Address needs of youthful prisoners as they transition into the community.
e. Address needs of prisoners with developmental disabilities as they transition into the community.
f. Ensure that appropriate information is consistently included in the TAP/Discharge Plan for prisoners with special needs.

Recommendation 18:
Identify prisoners with less severe mental illnesses, and ensure that these individuals have access to appropriate follow up services upon release.

a. Develop strategies to identify prisoners with less severe mental illnesses and a consistent process to assist in transition planning.
b. Develop TAP/Discharge Plans to address mental health needs for those individuals with less severe mental illness.

Chapter 4
Recommendations: Pre-Prison

The Pre-Prison committee and the larger Workgroup fully recognized that early and appropriate identification of mental health needs and making essential services readily available to those identified is critical if efforts to prevent incarceration or divert individuals from jails or prisons are to be successful. Identifying mental health needs just prior to sentencing represents a missed opportunity for prevention and is a disservice to both the individual in need and the community.

As such, the Mental Health Care Workgroup recognized the value of engaging with the education system and the Department of Human Services in identifying the mental health needs of children and youth who are at risk. Their knowledge of community-based prevention opportunities would be invaluable in efforts to identify needs and in arranging the necessary supports needed to divert youth from activities that may result in future incarceration.

However, for the purposes of this effort to redesign the prison mental health care system, the Mental Health Care Workgroup faced the challenge of focusing on those issues that could be addressed in the State correctional system. Therefore, although the broader context of finding appropriate avenues to address mental illness within our communities and prevent mental illness from developing are critical to the corrections system, they could not be addressed through this process.

These pre-prison recommendations focus on redesign opportunities at the point of entry into the prison mental health system. The recommendations recognize opportunities for prison diversion that exist at the interface between the corrections system and community-based systems for meeting the needs of individuals with mental illness. They also address the role of jails and courts in ensuring that individuals with mental illness receive necessary treatment when they reach the prison system.

These recommendations were developed under the following mission:

> Mission Statement
>
> *To more appropriately manage the needs of individuals with mental illness and disabilities and substance addiction in the corrections systems, including the local jails, and to reduce the number of people with mental illness and disabilities and substance addiction from entering the corrections system thereby reducing the costs in the corrections system and re-directing the dollars to community based treatment programs.*

Recommendations and action steps follow, with a rationale describing each recommendation and the activities, key players, and resources necessary for each of the specific action steps.

Recommendation 1:
Improve mental health services in the community, in the jails, and in the court system.

Action Step 1a: Conduct local assessments of mental health services.

A community needs assessment related to mental health services and alternatives to incarceration can provide a guide to help determine the current strengths and service gaps in the criminal justice and mental health systems. Such an assessment would identify services needed in local communities to provide mental health services and opportunities for diversion as an alternative to incarceration. In addition, such an assessment provides the opportunity to ensure that all possible sources of funding have been explored for programs that are needed to fill the gaps in service.

Activities	*Key Players*	*Required Resources*
1. Locally assess and identify: - the range of existing services and their accessibility - underserved populations in the community and jail - existing community assessments that identify the populations to be served - barriers that prevent people from receiving mental health services - ability to garner support to fund mental health jail diversion services	Community Corrections Advisory Board, Michigan Association of Counties (MAC), Michigan Sherriff's Association (MSA) & Local Counterpart, Other Criminal Justice Stakeholders	National Consumer Supported Technical Assistance Center Community Needs Assessment (nsctac.org), Local community collaborative bodies, Local coalitions or advisory groups, Local community mental health (CMH) agencies

Action Step 1b: Provide training and implement evidence-based practices.

Criminal justice stakeholders may benefit from training in the ability of individuals with mental illness to live successful lives and contribute to their communities with access to appropriate mental health services. Public education and awareness of mental health issues and existing services is essential to help eliminate the stigma associated with mental illness.

Criminal justice stakeholders and others should be trained in de-escalation, identifying signs and symptoms of mental illness, placing individuals with mental illness in the most appropriate setting, appropriate treatment in jail, and discharge planning into treatment and other community based services from jail.

Action Step 1b continued:

Activities	*Key Players*	*Required Resources*
1. Provide training to criminal justice stakeholders, front-line officers, first responders, jail booking staff, etc., to identify and interact with persons with mental illness in order to develop a common understanding of mental illness and how it can manifest itself during contact with law enforcement.	Michigan State Police (MSP), MAC, MSA, Michigan Association of CMH Boards, Local CMH Agencies, The Prosecuting Attorney's Association of Michigan	Qualified training staff, Curriculum[21]
2. Adopt evidenced-based practice models (e.g., pre-arrest diversion, jail re-entry strategies) using a variety of practices from the Michigan Commission on Law Enforcement Standards, SAMHSA, and other entities.	Same as above	

Action Step 1c: Amend Kevin's Law.[22]

Kevin's Law allows courts to order treatment for individuals with serious mental illness who do not meet the current criteria for involuntary hospitalization but who need outpatient mental health treatment to protect themselves and others. Kevin's Law amends the Michigan Mental Health Code by establishing criteria for Assisted Outpatient Treatment (AOT) under court order. AOT is a comprehensive array of mental health services tailored to the needs of the individual. These services are provided through the individual's local Community Mental Health Services Program (CMHSP). An individual who is ordered to receive AOT must meet the definition of a "person requiring treatment" under a section of the Mental Health Code that expands the definition of a "person requiring treatment" to include those who have mentally illness but are noncompliant with recommended mental health treatment. Noncompliance is reviewed over a four year period and is identified as (a) two placements in a psychiatric hospital, prison, or jail; and/or (b) an act, attempt or threat of serious violent behavior.

Many probate judges either question the constitutionality of Kevin's Law or believe that it fails to provide them with the necessary legal tools to impose involuntary court ordered out-patient treatment on someone who does not voluntarily agree to appear in court to be subjected to such an order. [23]

Activities	*Key Players*	*Required Resources*
1. Develop language that the Legislature can use to amend Kevin's Law or to adopt new legislation to provide probate court judges with the necessary tools to enforce Kevin's law or other appropriate statutes related to involuntary hospitalizations or outpatient mental health treatment.	State Court Administrator's Office (SCAO), Probate Court Judges, Advocates	SCAO, Legislature

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[21] Suggested curriculum: Oakland County Correctional Officers Training Curriculum: Train the Trainers, Training and Public Education: *Life after Lockup: Improving Reentry from Jail to the Community,* http://www.ojp.usdoj.gov/BJA,pdf/Lifeafter Lockup./PDF

[22] Michigan Mental Health Code, PA 258 of 1974 as amended

[23] On the other hand, evidence of some use does exist. The Oakland County Community Mental Health Director has stated in a letter to the Detroit News on July 10, 2008, that this tool has been used to serve approximately 300 individuals in that county since 2005.

Action Step 1d: Provide training for probate court judges.

Kevin's Law and other statutes that relate to tools that can be used for the treatment of individuals with mental illness may be difficult to interpret and apply. Additional training may facilitate the use and enforcement of these statutes throughout the state.

Activities	*Key Players*	*Required Resources*
1. Provide training to probate court judges and Community Mental Health personnel on "court ordered treatment – section 401 (d), "Kevin's Law" or "Assisted Outpatient Treatment."	MDCH, SCAO, Judge's Associations	Qualified trainers, MDCH, SCAO
2. Provide training to Probate Court Judges on Alternative and Combined Alternative Treatment Orders (Section 474, 447A and 475) and court ordered treatment (Sections 401 (b) unable to attend to basic needs and (c) impaired judgment).	MDCH, SCAO, Judge's Associations	Qualified trainers, MDCH, SCAO
3. Provide training on a variety of issues related to involuntary commitments and outpatient treatment.	MDCH, SCAO, Judge's Associations	Qualified trainers, MDCH, SCAO

Action Step 1e: Provide training related to the psychiatric patient advocate designation.

Designation and utilization of a patient advocate under the law can assure that someone experiencing temporary incapacitation from a serious mental illness will receive treatment that meets their desires and circumstances.

Activities	*Key Players*	*Required Resources*
1. Provide training to relevant stakeholders on psychiatric patient designation consistent with MCL Section 700.5506 (designated patient advocate).	SCAO, MDCH, Judge's Associations	Qualified trainers, SCAO, Legislature

Action Step 1f: Change the criterion of "potential harm" in the Mental Health Code.

The courts and the mental health system rely too heavily on immediate harm to self or others as a criterion for the requirement of treatment. House Bill 6083 recognizes two other criteria and incorporates the three traditional criteria into one subsection. The two additional criteria are: a) serious risk of harm by being unable to attend to his/her needs for food, shelter, and clothing; and, b) demonstrated mental illness with a lack of ability to understand the need for treatment, creating significant risk of harm in the near future.

Activities	*Key Players*	*Required Resources*
1. Endorse House Bill 6083.	MDOC, MDCH	
2. Enact House Bill 6083.	Legislature	
3. Sign House Bill 6083 into law.	Governor	

Action Step 1g: Achieve mental health parity.

Michigan is one of eight states that have not enacted some form of private insurance mental health parity legislation. Current Congressional parity efforts, if enacted, would still leave approximately two million privately insured individuals without equal coverage in Michigan. Mental Health Parity legislation is a more realistic approach for the State to ensure significant numbers of people in early stages of mental illness receive treatment.

Activities	*Key Players*	*Required Resources*
1. Endorse mental health parity legislation.	MDOC, MDCH	
2. Enact mental health parity legislation.	Legislature	
3. Sign mental health parity legislation into law.	Governor	

Recommendation 2:
Institute diversion programs.

Action Step 2a: Define responsibility for jail diversion programs.

An Attorney General's opinion and/or legislation are needed due to several conflicting statutes:

- County Jail – MCL, Section 801.41, 66.8, 90.8
- MDOC – MCL Section 791.262 (3) and R791.278-732
- MDCH – MCL Section 330.1208 and 330-2002a

Some jails take the position that providing for the health and welfare of their inmates does not include the provision of mental health treatment services and psychotropic medications. Mental health agencies on the other hand take the position that while jail inmates with mental health needs can request services, the jails have the first obligation to meet those needs unless the inmate's presenting condition is so severe as to make the individual part of the priority population to be served by community mental health agencies.

Activities	*Key Players*	*Required Resources*
1. Define responsibility for jail diversion services pursuant to MCL Section 330.2002a.	MDCH, Legislature	Attorney General Opinion
2. Establish service and treatment standards.	MDCH, Legislature	Attorney General Opinion

Action Step 2b: Establish models for re-entry from jail to the community.

Jails have become a primary institution for people with mental health illness. Jail/prison diversion initiatives are an essential component of the effort to reduce the rate of growth in the number of incarcerated individuals with mental illness. The effectiveness of diversion programs will impact the numbers and nature of the future incarcerated populations in Michigan. Information about the incidence of mental illness among jail inmates can be found in Appendix V.

Activities	*Key Players*	*Required Resources*
1. Ensure prevention processes are in place in all Michigan jails for persons who exhibit a mental health illness.	MSA, MAC, MDOC	MDOC/MSA/MAC Training, *The Jail Administrator's Toolkit for Reentry,*[24] GAINS Re-Entry Checklist

[24] This resource can be located at http://www.ojp.usdoj.gov/ BJA/pdf/ToolkitForReenty/pdf

Action Step 2c: Establish mental health courts in Michigan.

There are about 175 mental health courts in the United States. As of July 2008, Michigan had only one fully operational mental health court program, which was less than a year old. Many mental health courts have shown positive outcomes and cost savings. Mental health courts also open the possibility of moving savings to local community mental health agency services and drawing federal Medicaid assistance matching funds. Instituting mental health courts was also recommended by the Mental Health Commission.

Activities	*Key Players*	*Required Resources*
1. Support the Governor's 2009 Executive Budget recommendation to establish pilot mental health courts with state financial and technical assistance.	MSA, MAC, MDOC, SCAO	Criteria for mental health courts, Jurisdictions willing to develop these courts, Appropriations, Training on court implementation

Recommendation 3:
Improve the management of individuals in jail.

Action Step 3a: Provide continuity of mental health care during incarceration in jail.

Persons with a mental illness and on psychotropic medications may lack treatment during incarceration in jail or during the transition period between booking and the time when the inmate receives his/her first dosage of medication in jail. During this transition period, there may be an increase in the risk for behavioral problems and/or suicide in the jail.

Activities	*Key Players*	*Required Resources*
1. Ensure persons with a mental illness who are prescribed psychotropic medications by a local community mental health agency maintain the continuity of care while in jail and when transferred to another jail or state correctional facilities.	MDOC, MDCH, MSA, MAC, Local CMH agencies	

Action Step 3b: Identify jail inmates with mental illness.

All individuals booked into a jail should be screened for mental illness by a trained staff member designated by the facility administrator as outlined in a facility's policies, procedures and practices.

Activities	*Key Players*	*Required Resources*
1. Ensure jails utilize clear and concise policies and procedures based on evidence based practices for identifying and treating offenders with mental illness.	MDOC, MSA, Jail services	Monitoring by state funding agency, CJS Inspection Report, Administrative Rule R791.731, R791.732

Action Step 3c: Train staff to screen for mental illness and to make referrals when needed for comprehensive mental health assessment.

All individuals in jail should be screened for mental health issues and those who are screened as having challenges should receive a comprehensive mental health assessment. The Bureau of Justice Mental Health Screen (BJMHS) is a reliable screening tool to identify both male and female inmates who are in need of a further mental health assessment. The BJMHS is available at no cost and can be administered in two to three minutes.

Activities	*Key Players*	*Required Resources*
1. Ensure jail staff are appropriately trained to identify persons with a mental illness and how to appropriately respond to their condition. Qualified trainers will use the Michigan Corrections Officers Law Enforcement Standards.	Michigan Corrections Officers Training Council	Qualified trainers, Brief Jail Mental Health Screen, GAINS Center

Action Step 3d: Survey local jails to determine prevalence of mental illness.

Senate Bill 1095, Section 230 states that the Michigan Department of Corrections shall allocate $200,000 for a study of local jails to determine mental illness needs and report on the results of this study by June 1, 2009. S.B. 1095 further states that the Michigan Department of Corrections shall contract with a university for a study of mental illness prevalence, treatment needs and treatment levels in Michigan jails.

Activities	*Key Players*	*Required Resources*
1. Complete a survey of local jails, gathering input on study design from various stakeholders involved with mental health and justice issues.	Counties, Sheriffs, Prosecutors, Judges, Consumers, Families, Advocates, Service Providers	Survey
2. Develop a mutual aid agreement for services to persons with mental illness pursuant to the Mental Health Code.	MSA, MAC, MDCH, Veterans Services	

Recommendation 4:
Share information appropriately across the criminal justice system.

Action Step 4a: Develop a standard transfer packet.

Each time a person with a mental illness is transferred from one facility to another, there is a risk of losing valuable information about his/her condition as well as treatment that was given by the previous care provider. To reduce or avoid such inefficiencies or risk to a person's health, jail and prison staff should create and maintain a thorough summary health record which details the person's condition and treatment for any physical and mental health issues.

Activities	*Key Players*	*Required Resources*
1. Develop a standard transfer packet.[25]	MSA, MAC, MDOC	

Action Step 4b: Amend forms to allow a judge to order the release of mental health records.

Medical records cannot be released without the consent of the prisoner or a court order. A court order releasing the medical records will ensure that the appropriate information related to a person's mental illness will be available to ensure appropriate care for the individual.

Activities	*Key Players*	*Required Resources*
1. Amend the Judgment of Sentence form to allow judges to order the release of any mental health records held by a local community mental health service provider to the MDOC and/or jail upon sentencing.	SCAO, Michigan Association of CMH Boards	
2. Evaluate privacy statutes to permit the prisoner's transfer packet, including physical and mental health records, to be transferred to the MDOC and the jails.	MDOC MDCH Attorney General staff	

[25] Transfer packet should include sheriff's questionnaire, MDOC transfer assignment, medical record (including physical and mental health records), universal release form, birth certificate, other forms of identification, and confirmation receipt form.

Action Step 4c: Distribute complete and accurate information regarding mental health history and treatment to correctional facilities.

Complete and accurate information pertaining to an individual's mental health treatment history including any current health issues and psychotropic medications will assist correctional staff at intake with making a proper assessment of an individual's risk and needs.

Activities	*Key Players*	*Required Resources*
1. Ensure information pertaining to an individual's mental health treatment history and vital statistics are included as part of the pre-sentence investigation report and that the appropriate MDOC policies and procedures are amended as needed.	MDOC	

Chapter 5
Recommendations: Intake/Reception

These recommendations involve redesign of the prison intake process. They are based on the recognition that, when prisoners enter the system through reception, there is an opportunity to gather critical information regarding their mental health history and medication status. In addition, there is an opportunity for screening and setting up psychiatric and psychological services.

These recommendations were developed under the following mission:

> Mission Statement
> *To ensure that at the time of intake, **all** necessary or relevant information related to the mental health care needs of prisoners entering the correctional system is obtained and that prisoners are appropriately assessed so that mental health issues are identified.*

Recommendation 5:
Establish stable and adequate staffing.

Action Step 5a: Offer staggered or flexible work schedules.

In order to provide a more comprehensive assessment of individuals as they enter the corrections system (reception/intake) it may be necessary to alter the current work schedules to ensure staff availability. A new intake screening process and assessment system was recently implemented to determine the mental health status of incoming prisoners. As a result of the implementation of new processes for mental health status screening and for the appraisal of incoming prisoners, there is a potential need to alter work schedules.

Activities	*Key Players*	*Required Resources*
1. Explore flexible scheduling options through a change in work practices and agreements such as 10 or 12 hour shifts and part-time or flex time positions.	MDOC, MDCH	Change in work practices, Agreements with bargaining units
2. Revise current staffing patterns to meet the change in work process as a result of the implementation of the new mental health screening and assessment process.	MDOC, MDCH	Staffing model

Action Step 5b: Enhance recruitment efforts.

There are many issues that impact the recruitment and retention of qualified staff to provide mental health care in the corrections systems. These issues include: parity of wages with the private sector; job classification issues; length of time of the hiring process; inability to utilize retired staff as consultants; and changes in the field as a result of evidence-based practices.

Action Step 5b continued:

Activities	*Key Players*	*Required Resources*
1. Conduct a membership survey about job classifications and descriptions.	MDOC, Unions	Survey
2. Present appropriate changes in the job classifications and position descriptions to the Office of the State Employer, after requesting input from MDOC and MDCH staff.	MDOC, MDCH, Unions	Survey
3. Develop and coordinate strategies to enhance staff recruitment.	MDOC Health Care Administrator, Correctional Mental Health Program Director	Staff time
4. Streamline the process for hiring. For instance, if authorization and funding are available for positions, then the person should be hired on an interim basis. If the LIEN check is not positive, the individual should be terminated from employment.	MDCH, MDOC	Staff time
5. Provide evidence-based training for the identification and screening of individuals for mental illness to clinicians in General Practice (MDs;RNs; MSWs).	MDCH	Trainers
6. Expand the current recruitment and retention bonus to all facilities.	MDOC	Funding
7. Centrally locate the process of identifying, recruiting, and hiring qualified mental health professionals with experience working with prisoners.	MDOC, MDCH	Staff time, Office space
8. Seek legislation to amend new language regarding “double dipping” for exceptions/amendments to the statute.	MDOC	Legislation

Action Step 5c: Offer pay incentives.

There is a disparity between private sector and public sector pay scales that many times prohibits the hiring of qualified staff.

Activities	*Key Players*	*Required Resources*
1. Review comparison wage and benefits with the private sector.	MDCH	Staff time
2. Expand the current recruitment and retention bonus to all facilities.	MDOC	Funding authorization
3. Establish parity with private sector salaries, explore and develop plans for student loan repayments (e.g., Vista, Americorps), and, if the facility is located in a medically under served area, explore the use of individuals in the National Health Corps.	Office of State Employer (OSE), Director of MDOC	

Action Step 5d: Partner with universities.

Universities and colleges can be a source of rotations, clinical placements, and expertise to provide staff support to existing professionals. Students who are in clinical placements or rotations may be more likely to choose state government employment upon graduation as a result of their experience.

Activities	*Key Players*	*Required Resources*
1. Through an intergovernmental agreement, pursue a Memoranda of Understanding with universities for rotations and clinical placements.	MDOC, MDCH	Legislation to provide incentives to universities, Funding to provide stipends to students

Recommendation 6*:*
Establish a thorough and accurate history of mental illness for DOC's records at reception.

The cornerstone of identifying individuals who have mental illness at the time of incarceration is complete and accurate information. Currently, not all information about the individual is available at the time of reception. This lack of information could result in an individual not obtaining the treatment that is needed during his/her stay in the corrections system.

Activities	*Key Players*	*Required Resources*
1. Develop and utilize a standard intake packet to be sent to MDOC.	Appropriate Departments and Agencies, MSA, County Jails, SCA, Courts (to consider release of information)	Complete Sherriff's questionnaire Complete medical transfer record Jail records on physical and mental health and appropriate releases Information from probation and bond cases – Universal release form – Standardized intake packet – Receipt confirmation form – Compatible health care record (Next-Gen)
2. Provide health information (TAS) to jails when prisoner goes out on WRIT.	MDOC, Courts (to consider release of information)	Staff time

Recommendation 7*:*
Establish a system that effectively and efficiently identifies prisoner needs.

In order to better identify individuals with mental health issues there is a need to do a better job screening and assessing the individuals at intake/reception to ensure that appropriate placement and treatment is provided to the prisoner.

Activities	*Key Players*	*Required Resources*
1. Integrate the appraisal tools into the EMR.	MDOC, DIT	Programming, Staff time
2. Develop integrated mental health care teams for service delivery and determine appropriate staffing model and space requirements.	MDOC, DIT	Staff time
3. Complete the COMPAS/TAP on all prisoners upon intake into the system. The mental health treatment needs/unified health care plan should be available on TAP.	MDOC	Staff time
4. Confirm eligibility for everyone entering the system, and assist the prisoner in completing application processes for entitlements if the prisoner is eligible for entitlements.	MDOC	Staff time
5. Obtain vital records and assess the need for a guardian.	MDOC	Staff time
6. Enhance and improve the identification of the level of special needs and improve methods of follow-up when identification is completed.	MDOC	Survey of appropriate level of staffing to accomplish each task

Chapter 6
Recommendations: Incarceration

These recommendations focus on the redesign of mental health care services in the prison setting. They were built around the recognition that the mental health care system must be equipped to appropriately treat a wide range of mental health needs among a diverse population within a safe and secure prison environment, and that the system must be integrated such that transitions between levels and types of service are seamless. It must also be equipped to monitor, on an ongoing basis, the emerging mental health care needs of prisoners, as the signs and symptoms of mental illness can be missed at intake and the prison setting can trigger the emergence of mental illness. These recommendations focus on five issues that emerged from the SWAT analysis: the use of segregation, quality assurance and quality improvement, training, service integration, and the treatment environment.

These recommendations were developed under the following mission:

> Mission Statement
> *To create a system that seamlessly delivers and tracks mental health services within the prison setting. The system will be tailored for the individual prisoner needs and addresses both existing and emergent needs.*

Recommendation 8:
Minimize the use of segregation for prisoners with mental heath needs, and reduce the negative mental health impact of segregation on prisoners with mental illness, or those at risk of developing mental illness.

Action Step 8a: Reduce the number of prisoners with mental illness in segregation.

Segregation of individuals with mental illness can exacerbate existing mental health conditions and cause additional behavioral problems to occur.

Action Step 8a continued:

Activities	*Key Players*	*Required Resources*
1. Evaluate prisoners prior to placement in Administrative Segregation using a pre-screen checklist[26] developed to identify whether emergent, ongoing, or pre-existing mental health conditions are present. Positive screens should be referred for evaluation by mental health staff prior to making the decision to classify to Administrative Segregation.	Facility Security Classification Committee (SCC)	Screening document that can be accurately completed by custodial staff
2. Revise current Facility SCC to be headed by the Deputy Warden.	MDOC	
3. Evaluate placement in Administrative Segregation and consult with the psychiatrist as necessary. If the evaluation results in a positive determination, the prisoner should be placed in temporary segregation pending appropriate placement.	Mental health staff	MDOC policy change, Appropriate staff and staff levels
4. Monitor prisoners in Administrative Segregation by: – Performing daily segregation rounds – Perform 30/60 day segregation evaluations, including out of cell – Holding weekly Risk Management (case management) team meetings – Documenting and following up on any identified concerns – Evaluating referrals from staff – Making referrals to non-segregation levels of care – Consulting with psychiatrist as needed – Coordinating referrals and transfers to appropriate placement – Discussing appropriate treatment plans with prisoners	Mental health staff, Nursing Staff, Other designated staff: - Warden or Deputy Warden - Health Unit Manager - Staff who have interacted with the prisoner on rounds	MDOC policy change, Train staff to accurately identify and report conditions of concern, Appropriate staff and staffing levels

[26] This checklist is currently being developed by a workgroup of mental health professionals.

Action Step 8b: Ensure proper diagnosis of prisoners with mental illness in segregation.

It is important to be able to determine if a prisoner has a mental illness or is exhibiting anti-social behaviors that are not related to a mental illness and may require administrative segregation. Administrative segregation may be counterproductive for individuals exhibiting mental health issues, as it may exacerbate such conditions. It is therefore important to monitor the prisoner in administrative segregation to determine if symptoms of mental illness are triggered by segregation, as intervention may be necessary to remove the prisoner from segregation.

Activities	*Key Players*	*Required Resources*
1. Remover prisoners from their cells for evaluation.	Mental health staff	Appropriate staff and staff levels, Cooperation
2. Provide staff with training on diagnosing mental illness, and particularly symptoms that may be triggered by segregation.	Mental health staff	Qualified trainers, training module, regular training program

Action Step 8c: Train staff to appropriately interact with prisoners that have a mental illness in a segregated setting.

It is often very difficult to determine if behaviors are a result of mental illness or are behaviors that require administrative segregation. Training of staff is key to ensure that staff are able to distinguish the difference and appropriately report and request assistance from a qualified mental health professional.

Activities	*Key Players*	*Required Resources*
1. Deliver appropriate training to all custody segregation staff.	Custody Staff	Qualified trainers, Training modules, Staff time
2. Conduct a literature review or study to determine if rotation of segregation staff out of the unit is advisable due to the stress inherent to working in this environment.	MDOC	Staff time

Action Step 8d: Address risk reduction and containment.

Cross systems (collaborative) case management is required to manage the prisoners in administrative segregation to ensure that evaluations of the prisoner are completed, prisoners are monitored to ensure their safety as well as that of the custody staff, and referrals for treatment or removal from segregation occur when appropriate.

Action Step 8d continued:

Activities	*Key Players*	*Required Resources*
1. Implement collaborative case management (cross systems case management) to ensure continuity of care and provide feedback documentation to other units with direction to refer prisoner again if symptoms persist.	Prison health care personnel	Staff training on case management, Appropriate staff and staff levels
2. Closely monitor prisoners who are on hunger strikes or on observation for potential self-harming behavior, making referrals to health care staff for evaluation.	All staff	Staff training

Action Step 8e: Modify conditions of confinement.

There is a need to create a more suitable environment to ensure treatment is provided that will promote behavior change for prisoners with mental health issues.

Activities	*Key Players*	*Required Resources*
1. Create suitable treatment environment that includes access to greater stimulus to reduce isolation.	Correctional Facility Administration (CFA), Mental health staff	Physical plant change, Policy change
2. Review the use of transition units for reinforcements to promote behavior change.	CFA, Mental health staff	Policy change

Action Step 8f: Identify alternative settings for prisoners with mental health needs that address security concerns.

Alternative treatment settings are needed for prisoners with mental health issues who also pose significant security risks. A sufficient number of beds need to be available to adequately meet the need for secure status outpatient and residential treatment programs.

Activities	*Key Players*	*Required Resources*
1. Develop an alternative setting for higher security residential treatment where all staff are part of the treatment team. There may be a need for separate settings for prisoners with mental illness and developmental disabilities.	Mental health staff, CFA	Trained staff, Health care administrator review, Alternative setting
2. Review criteria for admission to the Social Skills Developmental Unit (SSDU) to determine if adequate resources have been provided or if changes are necessary to encourage admission of an increased number of prisoners who are developmentally disabled.	CFA, Mental health staff	Parameters for transfer, Staff training, Health care administrator review, Reallocation or additional allocation of services

Action Step 8g: Ensure that mental health services delivered in segregation are integrated with services offered in other treatment settings.

In order to ensure that prisoners with mental health issues receive appropriate treatment, care must be coordinated and integrated with physical health care treatment. In addition, case management for prisoners with mental health issues will assist with the coordination of care.

Activities	*Key Players*	*Required Resources*
1. Improve and increase case management services to provide seamless coordination between physical and mental health care.	Qualified case managers	Appropriate staff and staffing levels
2. Participate in case management to provide optimum coordination of care.	Wardens, Deputy Wardens, Nursing Supervisor, Mental health staff, Health Unit Managers	Appropriate staff and staffing levels

Recommendation 9:
Identify gaps in access to and delivery of services to prisoners with mental health issues and develop a system to continuously examine and improve the delivery of programs and services, focusing on mental health and health care services.

In order to provide treatment for prisoners with mental health issues, it is important to determine the gaps in the current treatment system, as well as which treatment modalities (evidence based practices) provide the greatest likelihood of successful treatment. As a result of the identification of gaps in services and what treatment modalities are needed, especially for high risk populations, the corrections system can develop assessment and treatment processes to ensure that prisoners have access to the care that is needed. The development and implementation of a Quality Assurance Plan along with monitoring of the performance measures will provide a road map for the provision of quality mental health care in the corrections system.

Activities	*Key Players*	*Required Resources*
1. Examine existing data collection methods, assessment processes, and data reports to identify gaps in the system and whether further data collection is needed. Include an examination of measures of process and outcome.	MDOC staff, Mental health staff (PSU & CHMP)	Staff time
2. Conduct a review of the literature from other state correctional systems to determine the types of performance measures that were developed and best or promising practices.	MDOC staff	Staff time
3. Examine the needs of high volume and high risk populations.	MDOC, Mental health staff	Staff time
4. Develop a Quality Assurance Plan to ensure that assessment processes adequately identify prisoners in need of services and prisoners have access to needed services. The QA plan will identify service gaps and ensure that program services are developed, managed, and delivered appropriately. Performance monitoring using the QA plan can lead to increased cost efficiencies and cost savings.[27]	Mental health staff, MDOC, MDCH, Community partners	6-8 months of staff time, CMHP Performance Improvement Plan and other resources

[27] The plan will include: (1) goals and measurable, specific, and realistic objectives for improvement in each service area; (2) management and organization; (3) resources (facilities, personnel, QA tools and techniques, risk mgt); (4) measures and monitoring procedures for both processes and outcomes; (5) performance standards, where appropriate, and a schedule for reporting and reviewing data; (6) a monitoring system for the referral and assessment process; (7) training requirements; and (8) QA/CQI activities to be used to plan and test improvements for specific processes or programs.

Recommendation 10:
Provide training for all staff in the effective identification of prisoners with mental health issues to assure that they receive treatment from properly trained staff in a safe and secure prison environment.

Action Step 10a: Train non-clinical staff in the identification of signs and symptoms of mental illness, strategies for interacting with prisoners with mental illness, and resources available for mental health issues.

All prison staff have an important role to play in the identification of prisoners who may benefit from mental health services. All prison staff have the potential to interact positively and effectively with prisoners who have mental health challenges. Moreover, it is consistent with the role of some prison staff, such as Assistant Resident Unit Supervisors, counselors, and chaplains, to play a more hands-on role in addressing the needs of prisoners who have mental health challenges. However, non-clinical prison staff need training in understanding symptoms of mental illness and strategies for interacting with prisoners who have mental health challenges in order to perform these tasks effectively.

Action Step 10a continued:

Activities	*Key Players*	*Required Resources*
1. Develop or modify training modules that will be delivered to all non-clinical staff. Steps include: – Research existing empirically validated training programs – Review and modify existing training modules or research and write new training modules as needed, focusing on symptoms of mental illness.[28] – Pilot test training modules – Determine the most effective training strategy, including the timing and frequency of training	Training department, Michigan Prisoner Re-entry Initiative (MPRI) Phase One Committee, Outside experts and consultants, Mental health and health care staff	Staff time, Consultant costs, Train-the-trainer opportunities, Appropriate staff and staffing levels
2. Develop or modify additional specialized training modules or provide training forums for ARUSs, Counselors, and Chaplains. Steps include: – Research existing empirically validated training programs (such as Moral Reconation Training) – Review and modify existing training modules or research and write new training modules.[29] – Supplement new hire training with material on problem solving, reflective listening, and working with prisoners with mental health issues – Pilot test training modules – Determine the most effective training strategy, including the timing and frequency of training	Training department, Michigan Prisoner Re-entry Initiative (MPRI) Phase One Committee, Outside experts and consultants, Mental health and health care staff	Staff time, Consultant costs, Train-the-trainer opportunities
3. Identify trainers, schedule trainings, and deliver trainings.	Training department, Trainers, Prison Wardens (to ensure participation	Trainers, Staff time, Appropriate staff and staffing levels, Training space, AV equipment

[28] Training topics for non-clinical staff could include: signs, symptoms, and behaviors associated with mental illness; suicide; strategies for working with prisoners with mental health needs, such as skills for de-escalation and effective communications; resources available in the prison for mentally ill prisoners; and substance abuse.

[29] Additional training topics for ARUSs, Counselors, and Chaplains include: Active listening; problem solving; law/policy; overcoming stigma related to mental illness; working with women with mental illness; co-occurrence; assessment

Action Step 10b: Train clinical staff in diagnosis, evidence based treatment, and best practices.

Providing psychological and psychiatric services within the prison context presents unique challenges. Specific types of psychological disorders are more prevalent within the prison population and there are psychological and behavioral issues that occur in the prison setting that are highly uncommon outside of the prison setting. Moreover, clinical professionals working in the prison context face unique challenges related to the prison environment, such as safety and security regulations and practices. In addition, all clinical practitioners require ongoing professional development in order to ensure that their work is in alignment with best practices and emerging research. As such, it is critical that clinical staff have access to comprehensive, coordinated professional development and training opportunities.

Activities	*Key Players*	*Required Resources*
1. Identify the office or individual who should take responsibility for training clinical staff, and – Expedite any necessary service contracts – Gather input from clinical staff on training needs – Identify internal training capacity – Write grants if needed	Bureau of Health Services, Mental Health and Health Care Administrators	Staff time
2. Develop or modify training modules and identify training opportunities. Steps include: – Research existing empirically validated training programs – Review and modify existing training modules or research and write new training modules.[30] – Ensure training opportunities align with training needs – Pilot test training modules – Determine the most effective training strategy, including the timing and frequency of training – Build in opportunities for continuing education credits – Develop train-the-trainer options – Explore opportunities for peer-to-peer training and feedback	To be identified	Staff time, Consultant costs, Train-the-trainer, opportunities, Funds for materials

[30] Training topics for clinical staff could include: evidence based treatment; cognitive behavioral therapy; didactic behavioral therapy; psycho-social rehabilitation; social skills development; approaches with assaultive and sex offenders; treating individuals in segregation, including training on behaviors specific to this setting such as self-injurious behavior and behavioral reinforcement systems; recognition of value of clinical treatment and addressing over-reliance on medication; psychotropic medications including types, side effects and what they address; activity therapies; attitude change among clinical staff; diagnostic training, including what to look for, how to document, longitudinal considerations, looking at symptomatolgy more closely, utilizing a systematic approach; dual diagnosis; substance abuse/addiction; addressing the unique needs of the female prisoner; preparing prisoners for parole; treatment continuity in the community; social/cultural context; 0ther disorders unique to prison; ethics; empathy training; medical symptoms that mimic mental illness; documentation; lesbian/gay/bisexual/transgender/queer (LGBTQ); parenting/family violence; anger management; bereavement therapy.

Action Step 10b continued:

Activities	*Key Players*	*Required Resources*
3. Identify trainers, schedule trainings, and conduct trainings.	To be identified, Trainers	Trainers Staff time Training space AV equipment Travel funds Funds for trainers Funds for materials

Action Step 10c: Evaluate the training needs of staff, the effectiveness of trainings provided and the impact of training on the service delivery system.

Training must be designed to meet the educational needs of all staff, including non-clinical staff, the goals of the system, and the mental health needs of prisoners. It is critical that strategies exist to assess the impact of training and to improve the training system over time.

Activities	*Key Players*	*Required Resources*
1. Conduct a survey to determine staff training needs based on system-wide goals.	Training department, MPRI Phase I Committee, BHCS Planning Manager	Staff time, Cost of method, Analysis resources
2. Evaluate training to determine if it was understood by staff by: – Identifying training objectives – Developing evaluation tool – Implementing the tool and analyzing the data – Making modifications based on evaluation results – Supplementing evaluation results by including an additional assessment in staff performance evaluations related to the content of these training sessions	Training department, Staff supervisors	Staff time, Cost of method, Analysis resources
3. Determine impact on staff performance and system outcomes by: – Developing goals – Developing outcome measures – Developing a method and data collection system – Implementing an evaluation study – Making modifications based on results	CQI or External Evaluator	DIT to develop data collection system, Staff time, Cost of method, Consultant costs

Recommendation 11:
Develop responsive treatment and mental health services, based on the objective assessment of individual prisoners, delivered by a collaborative system that ensures shared responsibility and continuity of care.

Action Step 11a: Implement treatment modalities that prisoners can access that are evidence based practices and coordinated throughout the system.

Effective treatment modalities and systems of mental health care provided in the correctional setting are based on the following principles:

- Modification of existing models of care delivery in order to ensure that care is based on coordination and continuity;
- Access to mental health services is ensured through a variety of pathways;
- Access to the continuum of programs and services is offered in the prison setting;
- An ethic of shared responsibility for prisoner mental health care throughout the system; and
- Coordination of treatment across programs and services

Action Step 11a continued:

Activities	*Key Players*	*Required Resources*
1. Implement collaborative case management, ensuring that staff interact with prisoners to enhance motivation and in a way that is responsive to the risk and needs of individual prisoners.	CFA custody staff, Mental health staff, Health care staff	Staff training, Appropriate staff and staffing levels
2. Implement one, unified case plan (or Transition Accountability Plan) that: – crosses CFA, health care, mental health, and FOA – is used to track needs, goals, tasks, and activities – is designed and implemented through cross-discipline treatment team meetings, which ensure unified case planning and increase staff interaction	CFA custody staff, Mental health staff, Health care staff	Shared electronic records, Case manager positions to coordinate care for particularly high-risk and complex cases, Appropriate staff and staffing levels
3. Reduce barriers associated with prisoner treatment by: – mobilizing around the prisoner, rather than moving the prisoner to the treatment team – Examine the current distribution of mental health resources and seek to maximize those resources by considering the consolidation of treatment sites to provide more opportunities to deliver the full continuum of care in a single location and minimize barriers associated with prisoner movement	Treatment teams, CFA's Committee on Prison Efficiencies	Analysis of current distribution of mental health resources
4. Integrate mental health programming with other CFA-delivered programs by: – Training in and implementation of collaborative case management – Training mental health staff in CFA programs as they are approved so that staff can make referrals appropriately and benefit from the lessons learned through these interventions – Training staff in symptoms of mental illness to increase the likelihood of appropriates referrals and the use of appropriate de-escalation techniques	CFA staff, Mental health staff, FOA staff, CFA staff	Appropriate staff and staffing levels

Recommendation 12:
Establish prisoner mental health treatment settings that ensure an appropriate therapeutic environment.

Action Step 12a: Decide which of several models for the delivery of mental health care is most suitable for implementation in MDOC. The Committee offered three models for consideration.

The environment within which mentally ill prisoners live from day to day may be as important for recovery as the evidence based treatments they receive. Different models emphasize different objectives in recovery, require different levels and emphases in resource distribution, and depart to greater or lesser degrees from traditional correctional approaches to confinement and supervision. Our current approach advocates integration of mentally ill prisoners into general population settings following the community mental health model in which services are provided in the least restrictive setting possible. Temporary respites in more intensive residential settings are available for prisoners who require them. A mental health center model, in contrast, emphasizes the value of a longer-term protected setting, distinct from the ordinary prison environment. An intermediate model employs a hospital as a temporary environmentally distinct respite from ordinary conditions for the treatment of prisoners during periods of acute illness. Each of these approaches has merit and each should be investigated with respect to anticipated treatment, impact, security, practicality, and cost.

Action Step 12a continued:

Activities	*Key Players*	*Required Resources*
1. Evaluate the relative strengths and limitations of the following three models for providing mental health care in prison settings based on a review of these models in other states, possibly including site visits by policymakers and experts: – The existing system with enhancements (an example can be found in Arizona)[31] – The hospital has a "hub" (an example can be found in New York and Ohio)[32] – A single center for everyone who needs mental health treatment (an example can be found in California)[33]	MDOC, MDCH	Staff time, Travel expenses, Costs associated with implementation of the model, Appropriate staff resources
2. Allocate adequate bed space to meet existing and expanded service needs, including a secure alternative to administrative segregation, based on a needs assessment.	CFA, MDCH	Costs associated with space needs for each model
3. Locate treatment units in proximity to available professional resources, such as professional schools and communities where professionals reside.	CFA, MDCH	Resources required for re-assignment of prisoners Possible physical plant changes
4. Employ enhanced case management to achieve continuity of care – Place responsibility for case management with a case manager	MDOC, CMHP	Appropriate staff resources
5. Consolidate services currently provided by PSU and CMHP under one provider. – Determine the employer of record for the mental health professionals – Ensure a smooth transition for employees who are affected by consolidation	MDOC, MDCH, CMHP, PSU, Human Resources, Labor unions	Staff time
6. Adapt characteristics of the setting as needed to facilitate the objectives and values of collaborative case management to foster successful community re-entry of prisoners, and review all proposed innovations with respect to this model.	MDOC, CMHP, MPRI	Staff resources

[31] The existing prison-based model offers outpatient care, residential treatment, crisis stabilization, inpatient-rehabilitation, and inpatient acute care, along with such services as may be required for additional populations to be served.

[32] The hospital based model existed between 1994-2005. The hospital is effectively a freestanding facility within MDOC that is staffed and governed by mental health specialists.

[33] Under this model, high need mentally ill prisoners would be treated in mental health centers that offer a complete continuum of care within a protected environment. Special populations, such as prisoners with dementia and developmental disabilities, would occupy the same or alternative centers.

Action Step 12b: Revise the current continuum of care to include a complete spectrum of services. The new continuum should incorporate services for identified groups (dementia, transgender, medically fragile, developmentally disabled, self-injurious behavior, primary substance abuse[34] and sex offenders[35]) and should consider two levels of RTP (higher and lower functioning).

The various stakeholders of the Mental Health Workgroup initially identified gaps in the current continuum of care. This objective addresses how to conduct a further assessment of the gaps in service and methods for providing such services.

Activities	*Key Players*	*Required Resources*
1. Conduct a needs assessment to ascertain demand for new mental health units, using existing statistics conducting additional studies as needed – Study rates of mental illness, severity and needs for special populations (DD, dementia, medially fragile, youth)	CMHP, PSU	Existing databases Staff time
2. Determine which existing prisons are best suited to accommodate special units by analyzing such factors as existing physical plants, the need for modifications or new construction, the geographic distribution of units as well as security levels and needs.	MDOC (CFA), PSU, MDCH, Health Care	
3. Revise existing policies and procedures to accommodate the expanded continuum of care by developing plans related to the proper mix of mental health, health care, and custody personnel as well a procedure and any variations from existing MDOC policies.	CMHP	Staff time
4. implement plans related to physical plant modifications and construction, recruitment of necessary staff and the reassignment of prisoners and staff.	MDOC (CFA), PSU, MDCH, Health Care	May involve major investment of capital and staff resources

Action Step 12c: Expand the telemedicine unit to provide psychiatric consultation to other prisons.

Telemedicine services are currently being used by health care providers and consultants, including psychiatrists. Available evidence, though limited, suggests that psychiatric services provided by teleconference are qualitatively comparable to services rendered face-to-face. Expanded use of telemedicine by psychiatrists would provide additional support for correctional facilities that lack immediate access to psychiatric services. It would also expand the pool of psychiatrists available for provision of care to prisoners at remote sites.

[34] It is unclear whether persons with primary substance abuse will be handled as part of the mental health spectrum. Persons with dual diagnosis of psychiatric and substance abuse disorders comprise the majority of the mental health problem, and thus are best addressed with a broad dual diagnosis model applied to mental health in general, rather than as a unique subgroup.

[35] This includes the significant number of sex offenders with developmental disabilities or mental illness. It does not include persons with index sex offenses whose only mental health problems are substance abuse or less serious personality disorders.

Action Step 12c continued:

Activities	*Key Players*	*Required Resources*
1. Ascertain the adequacy of the telemedicine equipment and procedures at all affected sites.	CMHP, Health Care, Custody	Unknown
2. Hire at least one full-time psychiatrist whose primary function will be to conduct telemedicine consultations statewide.	CMHP	Will likely replace psychiatric time at other locations and is likely to be budget neutral
3. Develop procedures for collaboration between on-site health care and PSU and the psychiatric telemedicine consultant. Staff should also focus on conveying information through telemedicine consultations and provide follow-up care as a result of such consultations.	CMHP, PSU, Health Care	Staff time

Action Step 12d: Determine whether MDOC itself, MDOC in collaboration with MDCH, MDOC in collaboration with a for-profit vendor or MDOC in collaboration with an academic center are best geared to implement the strategies identified in these goals and objectives.

The National Commission on Correctional Health Care, the American Friends Service Committee, the Partners in Crisis, and this Workgroup have identified weaknesses in the current system. This objective addressing the need to ascertain which collaborators most effectively and efficiently implement the MDOC vision recognizes that the distribution of tasks within and outside MDOC is crucial to the outcome.

Activities	*Key Players*	*Required Resources*
1. Study existing departmental collaborations in other states through a review of the literature, and contact other states with similar collaborations in place to assess benefits and challenges.	MDCH, MDOC	Staff time, Travel costs
2. Study existing correctional collaborations with for-profit vendors in other states through a review of the literature and contact with other states.	MDOC	Staff time, Travel costs
3. Study existing correctional collaborations with academic centers in other states through a review of the literature and contact with other states.	MDCH, MDOC	Staff time, Travel costs
4. Contact Michigan medical school departments of psychiatry (UM, WSU, MSU) to ascertain interest and recommendations, if any.	MDCH	

Action Step 12e: Ensure that the system of mental health care meets accreditation requirements.

Accreditation of mental health services helps ensure that a standard of quality is met while services are provided to the prisoners. There are several types of accreditation. The accrediting entity that is selected is often contingent upon the treatment philosophy and milieu. If there is a change in the accrediting body, then the accrediting standards must be applied in order to determine issues such as physical plant and policies.

Activities	*Key Players*	*Required Resources*
1. Determine which type of accreditation is desired (JCAHO, CARF, NCCHC) based on an assessment of the drawbacks, appropriateness, costs, and benefits of different accreditation approaches.	MDCH, Health Care Unit	Staff time
2. Apply accreditation standards to ensure that goals and objectives in the Mental Health Plan meet accreditation requirements, and identify accreditation criteria governing key decisions about physical plant, staff and policy.	MDCH, Health Care Unit	Staff time

Action Step 12f: Provide adequate office and treatment space at all levels of care.

In order to provide effective treatment there are office and treatment space requirements that need to be met. Treatment space must securely accommodate multiple, simultaneous activities; ensure the privacy of confidential communications; and minimize environmental distractions such as excessive noise. Space must be sufficiently varied in size and quality to facilitate individual and group therapies, activity therapies, and treatments requiring special equipment such as projectors, monitors, computers and materials for teaching specific skills. Clinicians require space for efficient documentation of care and for team meetings.

Action Step 12f continued:

Activities	*Key Players*	*Required Resources*
1. Define characteristics of treatment space required based upon accreditation standards, level of care and anticipated programming. – Define treatment space that is of adequate size and addresses security and confidentially concerns – For inpatient programs, define examination room and common area space requirements	CMHP	
2. Project treatment space requirements at each level of care based on setting, programming, and population served.	CMHP	
3. Decide where to place mental health services and what plant modifications may be required at each location.	CMHP, MDOC	Construction costs, Prisoner relocation costs
4. Design space suitable for the secure management of patient/prisoners who would otherwise be in segregation that minimize social isolation, stimulus deprivation, and stimulus excess.	CMHP, CFA	Cell modifications may be required
5. Design or adapt spaces suitable to the care of special populations, such as those individuals with dementia, self-injurious behaviors or medically fragile based on: – A needs assessment – An identified standard of care with respect to space, staffing, etc – Identification of facilities best suited to accommodate special units – Accreditation standards	MDCH (including CMHP and consultation from other MDCH units with expertise in relevant populations), CFA	Physical plant modifications

Action Step 12g: Define essential characteristics of a therapeutic environment and how they can be achieved at every level of care.

Change in the way treatment is provided requires review of professional staffing, security of treatment areas and processes, and adequacy of the physical plant. Staff attitudes and values should foster a culture of positive living, supporting the creative application of limited resources to emotional, cognitive, physical and spiritual recovery.

Action Step 12g continued:

Activities	*Key Players*	*Required Resources*
1. Determine types and numbers of staff with respect to discipline and training needed to provide services at each level of care. This will require a comprehensive review of existing standards of care as defined in accreditation standards, community practice and other correctional systems.	CMHP	
2. Ensure that any space that is available for treatment provides for confidential communication and for appropriate restrictions on access to mental health records.	CMHP	Physical plant changes
3. Modify treatment and location to meet the security needs of the mental health populations due to unexpected and unusual behaviors, ineffectiveness of ordinary disciplinary measures and changing security needs of individuals at different stages of treatment.	CMHP, MDOC	
4. Expand the role of correctional staff as co-therapists by using the model of resident unit officers in resident treatment programs toward the goal of shifting staff attitudes, values, and culture and creating a more therapeutic environment.	CMHP, MDOC	Training resources, Changes in mix of custody and mental health staff
5. Determine when single-cell bunking is necessary and appropriate because of mental health needs, as well as when dormitory bunking advances mental health purposes and reduces suicide risk. Create space that allows for adequate observation of high-risk prisoners and minimizes risk of self harm.	CMHP, Custody	Results could require additional or reduce cell requirements by substituting dormitory settings, Outfitting of improved observation cells and suicide-proof cells
6. Facilitate spiritual pursuits by improving access to volunteers offering religious and spiritual counseling and programming.	MDOC	
7. Promote activities during free time that promote mental health.	MDOC, CMHP	
8. Identify and promote other ingredients of therapeutic environment by piloting environmental changes and novel interventions that employ emerging therapeutic techniques.	MDOC, MDCH	Variable, on-going

Chapter 7
Recommendations: Preparation for Release

These recommendations provide a foundation for the redesign of the system that prepares prisoners for release. Prisoners with mental illness are likely to need supports in place in order to successfully reintegrate with the community. These recommendations recognize the value of careful planning for the transition from prison to community prior to release by linking prisoners with entitlement benefits, planning for the needs of prisoners who are discharged without parole, establishing guardianships when needed, linking prisoners with community resources, and establishing follow-up services when necessary.

These recommendations were developed under the following mission:

> Mission Statement
> *To ensure that specific strategies and collaborative strategies for continuity of care are developed and implemented that provides services, benefits, and supports in the community for each prisoner released in need of treatment for mental health, medical, and substance abuse disorders.*

Recommendation 13:
Ensure that all individuals leaving the prison system are appropriately linked with entitlement benefits prior to release to assist in successful reintegration. Individuals should be screened and linked with all entitlements they may be eligible for including Medicaid, Social Security and Veterans Benefits.

Action Step 13a: Screen and assess all prisoners with mental illness to determine appropriate entitlement options.

Prisoners with mental illness may be eligible for benefits due to their mental health and veteran status. Not all prisoners will be eligible for these benefits. A screening tool would identify those who are most likely to qualify so that resources can be spent on completing applications for those individuals. Many of the entitlement applications require face-to-face meetings with the individual and first hand knowledge of their current clinical and medical status. Assigning designated staff at the correctional facilities to perform screening and assessment for benefits is critical in determining if they are eligible for benefits.

Action Step 13a continued:

Activities	*Key Players*	*Required Resources*
1. Determine at intake whether the prisoner was a recipient of Medicaid, SSI/SSDI, or Veteran Benefits through an interview with prisoner and data match between MDOC and DCH/DHS. MDOC should suspend benefits rather than terminate benefits to ensure availability at release.	MDOC	Data match between MDOC and MDCH
2. Determine prisoners' mental health status at intake and In-reach through a file review (including a review of the Parole Eligibility Report), interviews with prisoners, and consultation with prisoners' significant others.	MDOC, Intake staff, Health Care, Social Workers, IPA, ARUSs	Record access, Access to pre-prison records regarding entitlements
3. Develop a screening tool that will give an idea of those prisoners that will likely be eligible for entitlements.	DHS, VA, MDOC, Eligibility Examiners	Staff experienced with entitlement benefits criteria
4. Provide specialty training in entitlements for staff that will be assigned the job duties of Entitlement Specialists by requesting that DHS and the VA send its staff to provide the training to ensure a strong knowledge base.	MDOC	Qualified trainers from DHS/VA[36]

Action Step 13b: For those prisoners screened as likely to be eligible for any form of entitlement, designated staff at the facility will facilitate the completion of applications as appropriate.

Prisoners with mental illness may be eligible for benefits due to their mental health and veteran status. Not all prisoners will be eligible for these benefits. A screening tool will identify those that are most likely to qualify so that resources can be spent on completing applications for that population. Many of these applications require face-to-face meetings with the individual and first hand knowledge of their current clinical and medical status. Assigning designated staff at the correctional facilities to ensure completion of applications is critical in ensuring the receipt of benefits. These benefits facilitate faster connections in the community and provide a funding stream for services, medications and housing. Having benefits established prior to release will allow a smoother and efficient transition to the community.

[36] MDOC should also explore the option of merging staff with DHS and the VA through a contractual relationship to perform entitlement application functions. An example of this type of relationship would be the assignment of a DHS staff to work at a MDOC facility to perform this function.

Action Step 13b continued:

Activities	*Key Players*	*Required Resources*
1. Staff facilities with entitlement specialists.	MDOC, CFA	Staff time, Extensive training, Space
2. Enter into agreements concerning process by which MDOC staff will be trained and certified to act on behalf of or in concert with partner agencies to determine eligibility and make application for prisoners' entitlements.[37]	MDOC, DHS, VA	Training through partner agencies, Access to information systems and relevant forms and processes
3. Establish MDOC entitlement specialist positions to: – Assess prisoners' eligibility for entitlements – Assist with application processes – Facilitate completion of entitlement application forms by MDOC, DCH or off-site medical and mental health staff, as needed – Utilize SOAR program for those prisoners eligible for Social Security – Determine need for vital records in pursuit of entitlements – Obtain birth certificates, Social Security cards, state identification card, military records, etc. as needed – Track entitlement applications to the decision point and follow up with appeals as appropriate	Entitlement specialists	Staff time, Access to records and tracking systems, Cooperation from medical and mental health staff, Training

[37] This also would also present an opportunity to merge staff in a contractual relationship.

Recommendation 14:
Ensure that all discharging prisoners (Max Outs) have transition plans developed and appropriate links to community supports.

Action Step 14a: Identify early those prisoners who are discharging on their PMX (Parole Max Date).

Prisoners with mental illness discharging from the prison system have unique and complicated challenges. Without parole supervision, it is very difficult to ensure compliance with mental health treatment upon release. In addition, access to mental health services in the community varies by individual county resources and lacks consistency across the state. Development of transition plans and targeted care coordination through the MPRI-MH Demonstration Project has been found to be a key component of success and should be used to assist those discharging on their parole max out date.

Activities	*Key Players*	*Required Resources*
1. Publish a quarterly report of all cases with a PMX three months or less from the date of the query, no parole in hand, and actively involved in mental health treatment. Flag cases serving flat terms for Felony Firearm	MDOC, Office of Research and Planning	Staff time, Research assistance
2. Provide prisoners who "max-out" the same services and supports as prisoners paroled through the MPRI system	MDOC	Staff time
3. Explore individual CMH resource barriers related to access and eligibility for services, including: – Clarifying definitions for eligibility – Clarifying procedures for handling uninsured that are SPMI – Addressing general fund limitations – Developing strategies to impact barriers in an effort to increase constancy across the state	MDOC, MDCH	Staff time

Action Step 14b: Develop of transition plans for prisoners who are discharging on their PMX date.

Prisoners with mental illness discharging from the prison system have unique and complicated challenges. Changing discharge dates and numerous facility moves prior to release complicate transition planning. Without parole supervision, it is very difficult to ensure compliance with mental health treatment upon release. Development of transition plans and targeted care coordination through the MPRI-MH Demonstration Project have been found to be key components of success.

Activities	*Key Players*	*Required Resources*
1. Utilize the MPRI process for those prisoners that are maxing out. This means that MDOC should develop specific and individualized transition plans that address needs related to housing, physical and mental health, substance abuse and employment, six months prior to release. This plan would also include oversight and coordination post-release through local MPRI or MPRI-MH. Develop a pilot project with a small number of prisoners to determine the best way to provide the services and supports.	MDOC, ARUS, IPA, Transition Teams	Same as MPRI parole cases, Necessary funding, Appropriate language in comprehensive plans
2. Utilize the MPRI process for those prisoners who are maxing out by transitioning them to feeder facilities three to six months prior to release to allow time for in-reach activity. This would include allowing the prisoner who is maxing out to use local MPRI resources for up to six months following release.	MDOC	Same as MPRI parole cases, Necessary funding, Appropriate language in comprehensive plans
3. Refer max-out cases which would technically meet D-47 criteria if paroled, to the MPRI-MH Demonstration Project for case planning and oversight post-release.	MDOC/MPRI-MH Demonstration Project	Enhanced funding
4. Implement a process that ensures that individuals who meet criteria for inpatient or outpatient court orders discharge only once they have an appropriate order in place.	MDOC, CMHP	Consistent policies and procedures, Consistency across probate courts, Staff time

Recommendation 15:
Ensure that all prisoners in need of guardianship have a guardian at the time of release.

The potential need for a guardianship becomes more important as a prisoner with mental illness gets closer to release into the community. Early identification and facilitation of guardianship is important to ensure that the prisoner's needs are adequately addressed. Having this issue assessed early in the prisoner's term is critical to achieving every other recommendation in the plan.

Activities	*Key Players*	*Required Resources*
1. Develop a screening process or instrument for the annual assessment of the need for a guardian for a prisoner with mental health issues who may be incapable of giving informed consent. Ensure that that all prisoners receive regular informed consent hearings as part of this process.	MDOC, MDCH	Research to develop screening tool, Staff training or advocates in facilities
2. Cross-train staff with regular inmate contact concerning issues pertaining to guardianship.	MDOC, ARUS, IPA, Resident Unit Officers, Health Care, Social workers, Entitlement specialist	Training

Recommendation 16:
Provide cross-system training to prison staff, parole agents, and community members on the appropriate ways to interact with individuals with mental illness who also engage in criminal behavior.

Prison staff, parole agents and community members consistently have difficulty identifying and addressing the complicated and multiple needs of prisoners with mental illness. The corrections and mental health systems generally do not speak the same language and have trouble bridging the gap between the two systems. There is also a great deal of stigma across the two systems that impact the successful transition of prisoners into the community.

Activities	*Key Players*	*Required Resources*
1. Develop and implement a cross-systems training module that would be geared toward prison staff and parole agents.[38]	MDOC, MDCH	Staff time, Training resources
2. Develop and implement a cross-systems training module that would be geared toward community members that would target: – Understanding the MDOC system – Parole agent role and expectations – Identifying criminal behavior and how this differs from mental illness – Strategies for working with the ex-offender population	MDOC, CMHs, Community mental health partners	Staff time, Training resources
3. Increase cross-system communication prior to release to increase awareness and understanding of the needs of the ex-offender.	MDOC, CMHs, Community mental health partners	Staff time, Cross-system support

[38] See Chapter 5, Recommendation 3 for more specific information on training recommendations.

Recommendation 17:
Identify prisoners with special needs and ensure that any unique characteristics are communicated to the community and addressed within his/her transition plan.

Action Step 17a: Address the needs of those individuals who have both medical concerns and mental disabilities that will impact transition to the community.

Many prisoners with mental illness have additional unique needs that impact their transition to the community as well as a variety of medical needs. Special attention and consideration need to be made to these added dynamics. Many times consistent and specific communication around these needs does not occur in the community and may not be included in the TAP or discharge plan for the offender. These prisoners may be released without specific attention to ensure that these unique needs are addressed and that all available community resources have been identified.

Activities	*Key Players*	*Required Resources*
1. Coordinate with medical personnel to ensure that all documentation related to medical conditions are included in discharge planning paperwork and that specific and detailed medical issues are consistently described in the TAP which accompanies the PER (Parole Eligibility Report). The prisoner's medical limitations and needs (i.e., dialysis, insulin, mobility restrictions, hearing impairment, etc.) upon release to the community must be clearly explained.	MDOC, ARUS, IPA, Health Care, Social workers	Training/orientation
2. Ensure that a medical trained specialist is part of the Transition Team to ensure that these needs are adequately addressed.	MDOC/MPRI Transition Teams	Medical specialists

Action Step 17b: Address needs of sex offenders as they transition into the community.

Many prisoners with mental illness have additional unique issues that impact their transition to the community including the commission of crimes related to sexual offenses. Special attention and consideration need to be made to these added dynamics. Many times consistent and specific communication around issues related to sex offender status does not occur in the community. These prisoners may be released without specific attention to ensure that these unique needs are addressed in the community and that all available community resources have been identified.

Action Step 17b continued:

Activities	*Key Players*	*Required Resources*
1. Ensure that those prisoners with a history of sexual deviance and sexually motivated crime are identified. Such prisoners should be screened specifically for the risk of sexual re-offending, obligations to register as sex offenders, placement, education and employment restrictions, etc.	MDOC, ARUS, IPA, PSI Writer, Parole Board	Training
2. Train community members on sex offense guidelines, restrictions, and parole expectations.	MDOC, MPRI Transition teams	Training, Public education resources

Action Step 17c: Address needs of elderly prisoners as they transition to the community.

Many prisoners with mental illness have additional geriatric needs that impact their transition to the community. Special attention and consideration need to be made to these added dynamics. Many times, consistent and specific communication around these needs does not occur in the community and may not be included in the TAP or discharge plan for the offender. These prisoners may be released without specific attention to ensure that these unique needs are addressed in the community and that all available community resources have been identified.

Activities	*Key Players*	*Required Resources*
1. Staff involved in case planning must ensure that any needs pertaining to dementia, physical fragility, transportation, medication, etc. are covered in the parole or discharge plan.	MDOC, ARUS, IPA, Health Care, Social workers	Training
2. Ensure that a geriatric trained specialist is part of the Transition Team.	MDOC/MPRI Transition Team	Geriatric health specialists

Action Step 17d: Address needs of youthful prisoners as they transition into the community.

Many prisoners with mental illness have additional unique issues that impact their transition to the community including issues related to their youthful age. Special attention and consideration need to be made to these added dynamics. Many times consistent and specific communication around issues related to a youthful offender does not occur in the community. These prisoners may be released without specific attention to ensure that these unique needs are addressed in the community and that all available community resources have been identified.

Action Step 17d continued:

Activities	*Key Players*	*Required Resources*
1. Identify youthful offenders for transition planning. Staff involved in transition planning must include a specialist familiar with youthful offender issues and local resources available upon reentry.	MDOC, Research staff, Transition Teams	Research, Youth specialist
2. Conduct a focus group session, involving providers of youth services, MDOC and other community partners to address the special needs of the youthful prisoner population to comprehensively evaluate the essential community resources needed to ensure successful transition. If these essential services are not available, develop strategies to broaden services base.	MDOC, Research staff, Transition Teams, Community partners	Research, Staff time, Monetary resources

Action Step 17e: Address needs of prisoners with developmental disabilities as they transition into the community.

Prisoners with developmental disabilities either as a primary or secondary diagnosis have needs that impact their transition to the community. Special attention and consideration need to be made to these added dynamics. Many times consistent and specific communication around these needs does not occur in the community and may not be included in the TAP or discharge plan for the offender. These prisoners may be released without specific attention to ensure that these unique needs are addressed in the community and that all available community resources have been identified.

Activities	*Key Players*	*Required Resources*
1. Incorporate results of specific and detailed psychological and IQ tests into the discharge planning process. If test results are unavailable, administer tests as needed.	MDOC, Education staff, Health Care, Social workers, IPA, ARUS	Training
2. Ensure that a specialist handling developmental disabilities is part of the Transition Team to ensure that these needs are adequately addressed and all available resources are identified.	MDOC/MPRI Transition Teams	Developmental disability specialist

Action Step 17f: Ensure that appropriate information is consistently included in the TAP/Discharge Plan for prisoners with special needs.

Many prisoners with mental illness have additional unique needs that impact their transition to the community. Special attention and consideration need to be made to these added dynamics. Many times consistent and specific communication around these needs does not occur in the community and may not be included in the TAP (Transition Accountability Plan) or discharge plan for the offender. Data systems to track all of the special needs cases will greatly assist in the development and implementation of a successful TAP Plan.

Activities	*Key Players*	*Required Resources*
1. Develop data systems to accurately track all special needs cases to ensure appropriate staff and partners recognize these prisoners at each phase and write TAP/Discharge Plans accordingly.	MDOC, Research staff	Research assistance, Training

Recommendation 18:
Identify prisoners with less severe mental illnesses and ensure that these individuals have access to appropriate follow up services upon release.

Action Step 18a: Develop strategies to identify prisoners with less severe mental illnesses and a consistent process to assist in transition planning.

There are many prisoners within the prison system that have less severe mental illness, but still may require connections to community supports in order to ensure a successful transition. These are cases that fall through the cracks if they are not eligible for entitlements or Community Mental Health services. Many times these prisoners also have substance abuse issues and personality disorders, making them very difficult to effectively treat. If these prisoners are not given the proper support, they are the most likely to commit new crimes and be returned to prison.

Activities	*Key Players*	*Required Resources*
1. Develop a process for identifying prisoners with less severe mental illness. Look at not only those prisoners currently active with CMHP, but also those that have a mental health history or are involved with the PSU (Psychological Services Unit).	MDOC, ARUS, Health Care, IPA, CMHP	Training
2. Evaluate the possible needs of this population upon transition into the community by reviewing records and mental health history.	MDOC, Transition Team, IPA	Training
3. Ensure that all prisoners with any history and potential need for mental health services upon release will be designated MPRI or part of the MPRI-MH Demonstration Project.	MDOC, Parole Board, Steering Teams, Office of Offender Reentry (OOR)	Funding, Parole Board support, Change in criteria for admission to MPRI

Action Step 18b: Develop of TAP/Discharge Plans to address mental health needs for those individuals with less severe mental illness.

There are many prisoners within the prison system that have less severe mental illness, but still may require connections to community supports in order to ensure a successful transition. These are cases that fall through the cracks if they are not eligible for entitlements or Community Mental Health services. Many times these prisoners also have substance abuse issues and personality disorders, making them very difficult to effectively treat. If these prisoners are not given the proper support, they are the most likely to commit new crimes and be returned to prison.

Action Step 18d continued:

Activities	*Key Players*	*Required Resources*
1. Develop a resource manual for prisoners with less severe mental illness that includes information on how to access mental health services in their county of return, as well as additional natural resources for medications and services (i.e., free clinics, sliding scale services). This resource manual would also include relevant substance abuse supports.	MDOC, MDCH	Staff time, Existing resource guides (NAMI, AA/NA)
2. Continue training regarding this population with MPRI Transition Teams.	MDOC, Steering Teams, Transition Teams	Training
3. Encourage Steering Teams to provide adequate funding to fill gaps related to services, medications, transportation, and housing, and expand the provider base for this population through comprehensive planning.	MDOC, Steering Teams, OOR	Funding

Chapter 8
Conclusion

The recommendations of the Mental Health Care Workgroup are intended to provide a blueprint for the redesign of the mental health care system in Michigan's prisons based on the vision:

> *The Michigan Department of Corrections will institute a single managed delivery system of care to provide a continuum of comprehensive and integrated mental health services based upon the individual needs of the offender. There will be external oversight responsible for the development and monitoring of standards to ensure that the MDOC system is the benchmark for the nation. Resources will be provided to meet the needs of the customer driven system.*

The work presented in this document represents a meaningful integration of perspectives and compilation of the experiences of diverse stakeholders. It establishes redesign goals for each stage of prison incarceration, from pre-prison to release, and provides action steps that support each recommendation. The Workgroup believes that, if implemented, this blueprint will provide the foundation for a corrections mental health system that will meet the needs of prisoners with mental illness and improve the system's capacity to meet the needs of individuals with mental illness in community settings.

I. Unresolved Challenges

As mentioned, the Workgroup included a diversity of perspectives and a wealth of experience in each aspect of the prison system's response to the mental health needs of prisoners. The diverse background of participants and the complexity of the topic led the group to discussion topics that could not be resolved in the context of Workgroup meetings, but that are important issues for further consideration by DOC and its partners.

Release of Information

- Although there are procedures in place for the release of information, there was discussion about the release of information to mental health providers and family members.

Medicaid Entitlements

- How can we best assure that prisoners who are eligible for various benefits receive tem and insure that those benefits are suspended and not terminated during incarceration? There is a current planning effort in place that is looking at entitlements and developing a strategy for this process. This initiative started after the Workgroup concluded.

House Bills 6073 and 6084

- The Estates and Protected Individuals Code (EPIC; MCL Section 700-5314c) establishes that the guardian with medical authority may give the consent or approval that is necessary to enable the ward to receive medical or other professional care, counsel, treatment or service. These bills clarify that this would include psychiatric hospitalization or mental health outpatient care and treatment recommended by a mental health professional;

- MCL Section 330.1415 allows a ward to block a voluntary psychiatric hospital admission arranged by a guardian with court-appointed medical authority for the ward. These bills remove this inconsistency with EPIC so that guardians with medical authority can assert on their own to medically recommended mental health treatment or termination of treatment; and,

- Although recommended by the Mental Health Commission, there are concerns by some stakeholders that appropriate safeguards are currently in place for the protection of people with mental illness and should not be revised.

Psychiatric Competency:

- What dispositions are criminal courts giving to defendants already under other court's orders for plenary guardianships?

- What changes, if any, should be made in the dispositions of criminal courts for such defendants?

Re-design of the Juvenile Justice System

- The State of Michigan should consider examining the juvenile justice system to develop meaningful reforms including efforts to address the needs of children and youth with mental illness. There is a study of the juvenile justice system as it relates to Child Welfare Services. There was interest expressed in the possible opportunity for collaboration between that effort and this correctional mental health report.

II. Final Thoughts and Next Steps

This final document will be disseminated back to the workgroup members that contributed considerable time and effort to this endeavor. The report will also be shared with both the MDOC and MDCH Directors, and their feedback will be used in developing an implementation plan. In addition, a crosswalk prioritizing the recommendations will be created. The crosswalk will look at the recommendations, prioritize them by importance, and also identify the effort needed to implement each recommendation. This document will be utilized by the implementation team, which will comprise line staff at both MDOC and MDCH. The implementation team will be pivotal in developing a process for carrying out these recommendations.

The blueprint developed by the Mental Health Care Workgroup integrate the perspectives and experiences of a diverse set of stakeholders and establish a vision for mental health care redesign that encompass each stage of prison incarceration. This report will be a critical component in shaping MDOC’s efforts to improve mental health services.

APPENDIX I

Workgroup Membership

MEMBERS OF THE MENTAL HEALTH CARE WORKGROUP

Dennis Schrantz, Co-Chair
Deputy Director
Planning and Community Development Administration
Michigan Department of Corrections

Ed Dore, Co-Chair
Chief Deputy Director
Michigan Department of Community Health

Don Allen
Director
Office of Drug Control Policy
Michigan Department of Community Health

Cynthia Archer-Gift
Chief Psychiatric Nurse Consultant
Office of Psychiatric Medical Services
Michigan Department of Community Health

Kenneth D. Brzozowski,
Administrator
Office of Community Corrections
Planning and Community Development Administation
Michigan Department of Corrections

Roy Calley
Director
Corrections Mental Health Program
Michigan Department of Community Health

Elmer Cerano
Executive Director
Michigan Protection and Advocacy Service

Julie Chaffee
Community Corrections Manager
Washtenaw County

Nick Ciaramitaro
Director of Legislation and Public Policy
American Federation of State, County, and Municipal Employees (AFSCME)

Risa Coleman
Director of Clinical Services
Detroit-Wayne Community Mental Health

Dr. James Dillion, M.D.,
Chief of Clinical Affairs
Corrections Mental Health Program
Michigan Department of Community Health

Le'Ann Duran, Manager
Office of Offender ReEntry
Planning and Community Development Administration
Michigan Department of Corrections

Scott Dzurka
President and Chief Executive Officer
Partners in Crisis

Diane Gartland
Psychologist Manager
Psychological Services Unit
Michigan Department of Corrections

Michael Glynn
Regional Administrator
Outstate Region Office
Field Operations Administration
Michigan Department of Corrections

Pete Govorchin
Assistant Attorney General
Corrections Division

Betsy Hardwick
Program Administrator
MPHI-MI Program

Michael Head
Deputy Director
Mental Health and Abuse Administration
Michigan Department of Community Health

Julia Heany
Program Director
Michigan Public Health Institute

Barbara Hladki
Regional Health Administrator
Bureau of Health Care Services
Michigan Department of Corrections

Duncan Howard
Administrator of Operations
Bureau of Health Care Services
Michigan Department of Corrections

Jessie Jones
Research Associate
Michigan Public Health Institute

Judy Kell
Consultant
Community Health Ventures

Cynthia Kelly
Director
Hospital and Center Operations
Michigan Department of Community Health

Mark Kielhorn
Director
Program Development
Michigan Department of Community Health

Shannon Laing
Research Associate
Michigan Public Health Institute

Terry Malloy
Regional Health Administrator
Bureau of Health Care Services
Michigan Department of Corrections

Angela Martin
Quality Administrator
Bureau of Health Care Services
Michigan Department of Corrections

Anthony McCloud
Manager of Offender ReEntry for the
Correctional Facilities Administration
Michigan Department of Corrections

Edward Mize
Operations Administrator
Correctional Facilities Administration
Michigan Department of Corrections

Scott Morgan
Medical Social Worker
Duane L. Waters Health Center
Michigan Department of Corrections

Mary Parson
Director, Inpatient Services
Corrections Mental Health Program
Michigan Department of Community Health

Jamie Pennell
Chairperson
Advisory Council on Mental Illness

Penny Ryder
Co-Director
American Friends Service Committee

Mark Reinstein
President
Mental Health Association in Michigan

John Rubitschun
Deputy Director
Field Operations Administration
Michigan Department of Corrections

Michelle Sandborn
Jail Administrator
Macomb County Jail

Barbara Sampson
Chairperson
Parole Board
Michigan Department of Corrections

Darlene Schimmel
Administrator
Office of Parole and Probation Services
Field Operations Administration
Michigan Department of Corrections

Jeri-Ann Sherry
Regional Prison Administrator
Correctional Facilities Administration
Michigan Department of Corrections

Marti Kay Sherry
Planning Manager
Bureau of Health Care Services
Michigan Department of Corrections

Richard Stapleton
Administrator
Office of Legal Affairs
Operations Support Administrator
Michigan Department of Corrections

Cheryl Streberger
Benefits Representative
UAW Local 6000

Dennis Straub
Deputy Director
Correctional Facilities Administration
Michigan Department of Corrections

Harry Trapp
Assistant Deputy Warden
Reception and Guidance Center
Michigan Department of Corrections

James Yarborough
Executive Planning Liaison
Planning and Community Development
Administration
Michigan Department of Corrections

Vondie Woodbury, Facilitator
Executive Director
Muskegon Community Health Project

Lynda Zeller
Health Services Administrator
Bureau of Health Care Services
Michigan Department of Corrections

APPENDIX II

Cross-walk of Mental Health Care Workgroup Recommendations with Other Assessments

CROSSWALK: CORRECTIONS HEALTHCARE AND MENTAL HEALTH REPORT RECOMMENDATIONS

The following table displays the relationships between the recommendations that emerged from the Mental Health Workgroup and the recommendations that were published by the Michigan Mental Health Commission, the American Friends Service Committee, and the National Commission on Correctional Health Care, as they related to mental health care in Michigan's prisons.

Mental Health Workgroup Report Recommendations	Michigan Mental Health Commission Recommendations[39]	American Friends Service Committee Recommendations[40]	NCCHC Report Recommendations[41]
Pre-Prison			
1. *Improve mental health services in the community, in the jails, and in the court system.*	25. The array of mental health services must be available and accessible to eliminate the use of the juvenile and criminal justice systems as "providers of last resort."		
1a. Conduct local assessments of mental health services.			
1b. Provide training and implement evidence-based practices.			
1c. Amend Kevin's Law.			
1d. Provide training for probate court judges.			
1e. Provide training related to the psychiatric patient advocate designation.			

[39] Michigan Department of Community Health. (2005, April). Transforming Mental Health Care in Michigan: A Plan for Implementing Recommendations of the Michigan Mental Health Commission. Download from: http://mich.gov/mentalhealth/.

[40] Tripp, A., Holbrook, N., Walen, R.. & Walsh, R. (2007, December). Tolerating Failure: The State of Health Care and Mental Health Care Delivery in the Michigan Department of Corrections. Download from: http://www.prisoneradvocacy.org/.

[41] National Commission on Correctional Health Care. (2008, January). A Comprehensive Assessment of the Michigan Department of Corrections Health Care System. Download from: http://www.michigan.gov/documents/corrections/Final_MDOC_HCS_Report_222383_7.pdf.

Mental Health Workgroup Report Recommendations	**Michigan Mental Health Commission Recommendations**[39]	**American Friends Service Committee Recommendations**[40]	**NCCHC Report Recommendations**[41]
1f. Change the criterion of "potential harm" in the Mental Health Code.			
1g. Achieve mental health parity.			
2. *Institute diversion programs.*	26. The legislature, the executive branch, the judiciary, and law enforcement should require effective and measurable, evidence-based pre- and post-booking diversion programs, including formalizing the shared legal duty of CMHSPs, law enforcement, and jails for diversion and revising law to include "diversion from the juvenile justice system" and expanding mental health and drug courts through the state.		
2a. Define responsibility for jail diversion programs.	29. The legislature should clarify responsibility for the provision of mental health diversion services where the "county of crime" is not the "county of residence" by directing that the CMHSP of the county in which a crime is committed is responsible for the		

Mental Health Workgroup Report Recommendations	Michigan Mental Health Commission Recommendations[39]	American Friends Service Committee Recommendations[40]	NCCHC Report Recommendations[41]
	provision of diversion services, including arrangements with the county of residence, where appropriate.		
2b. Establish models for re-entry from jail to the community.			
2c. Establish mental health courts in Michigan.			
	27. Joint training should be ensured across CMHSPs, first responders, service providers, law enforcement, defense attorneys, prosecutors, judiciary, and corrections and probation officers on the implementation of established and required pre- and post-booking diversion programs throughout the state.		
3. *Improve the management of individuals in jail.*			
3a. Provide continuity of mental health care during incarceration in jail.			
3b. Identify jail inmates with mental illness.			
3c. Train staff to screen for mental illness and to make referrals when needed for	28. State and local law enforcement, including police, corrections, and judicial authorities,		

Mental Health Workgroup Report Recommendations	Michigan Mental Health Commission Recommendations[39]	American Friends Service Committee Recommendations[40]	NCCHC Report Recommendations[41]
comprehensive mental health assessment.	and the Michigan Department of Corrections should ensure screening and assessment for mental health at their point of entry, booking or reception for children and adults, and at first contact with the juvenile and criminal justice systems.		
3d. Survey local jails to determine prevalence of mental illness.			
4. *Share information appropriately across the criminal justice system.*			
4a. Develop a standard transfer packet.			
4b. Amend forms to allow a judge to order the release of mental health records.			
4c. Distribute complete and accurate information regarding mental health history and treatment to correctional facilities.			
Intake			
5. Establish stable and adequate staffing.		The Department of Management and Budget should incorporate required	

Mental Health Workgroup Report Recommendations	Michigan Mental Health Commission Recommendations[39]	American Friends Service Committee Recommendations[40]	NCCHC Report Recommendations[41]
		staffing levels for medical and mental health contractor into the contracts for health care services. The Department of Management and Budget should require the MDOC to report to the legislature immediately when medical or mental health staffing falls below the required levels. When contractors fail to meet the required staffing levels, the Department of Management and Budget must penalize the contractors, including a reduction in payments, debarment, and charges for costs incurred in hiring temporary staff to fill the service gaps.	
5a. Offer staggered or flexible work schedules.			
5b. Enhance recruitment efforts.			
5c. Offer pay incentives.		The MDOC should work with the contractor/s to establish competitive payment scales for all health care providers. The MDOC should implement an incentive plan; i.e.	

Mental Health Workgroup Report Recommendations	**Michigan Mental Health Commission Recommendations**[39]	**American Friends Service Committee Recommendations**[40]	**NCCHC Report Recommendations**[41]
		sign-on bonuses for new staff working in prisons in rural areas.	
5d. Partner with universities.		Through a joint cooperative effort of the governor and state legislature, special professional correctional health care specialty programs in medicine and in clinical and counseling psychology could be established at all major Michigan tax-supported universities with medical schools, schools of nursing, and schools granting doctoral degrees in psychology. Each of these programs could establish graduate level internship programs placing students under appropriate supervision in correctional facilities, where they will provide timely, competent, direct patient care to prisoners in need.	
6. Establish a thorough and accurate history of mental illness for DOC's records at reception.			

Mental Health Workgroup Report Recommendations	**Michigan Mental Health Commission Recommendations**[39]	**American Friends Service Committee Recommendations**[40]	**NCCHC Report Recommendations**[41]
7. *Establish a system that effectively and efficiently identifies prisoner needs.*	28. State and local law enforcement, including police, corrections, and judicial authorities, and the Michigan Department of Corrections should ensure screening and assessment for mental health at their point of entry, booking or reception for children and adults, and at first contact with the juvenile and criminal justice systems.		
	Incarceration		
8. *Minimize the use 8. Minimize the use of segregation for prisoners with mental health needs, and reduce the negative mental health impact of segregation on prisoners with mental illness or those at risk of developing mental illness.*			
8a. Reduce the number of prisoners with mental illness in segregation.			
8b. Ensure proper diagnosis of prisoners with mental illness in segregation.			

Mental Health Workgroup Report Recommendations	**Michigan Mental Health Commission Recommendations**[39]	**American Friends Service Committee Recommendations**[40]	**NCCHC Report Recommendations**[41]
8c. Train staff to appropriately interact with prisoners who have a mental illness in a segregated setting.			
8d. Address risk reduction and containment.			
8e. Modify conditions of confinement.			
8f. Identify alternative settings for prisoners with mental health needs that address security concerns.			
8g. Ensure that mental health services delivered in segregation are integrated with services offered in other treatment settings.			
9. *Identify gaps in access to and delivery of services to prisoners with mental health issues and develop a system to continuously examine and improve the delivery of programs and services, focusing on mental health and health care services.*			
			Evaluate the AOP/SOP impact on recidivism. Change its

Mental Health Workgroup Report Recommendations	**Michigan Mental Health Commission Recommendations**[39]	**American Friends Service Committee Recommendations**[40]	**NCCHC Report Recommendations**[41]
			[DOCs] criteria for admission into the AOP/SOP programs. Create a state-wide waiting list into the AOP/SOP programs to make the admission process more equitable.
			Identify psychologists who either provide patient care or perform evaluations for the Parole Board, but not both.
10. *Provide training for all staff in the effective identification of prisoners with mental health issues to assure that they receive treatment from properly trained staff in a safe and secure prison environment.*			
10a. Train non-clinical staff in the identification of signs and symptoms of mental illness, strategies for interacting with prisoners with mental illness, and resources available for mental health issues.			
10b. Train clinical staff in diagnosis, evidence based			

Mental Health Workgroup Report Recommendations	Michigan Mental Health Commission Recommendations[39]	American Friends Service Committee Recommendations[40]	NCCHC Report Recommendations[41]
treatment, and best practices.			
10c. Evaluate the training needs of staff, the effectiveness of trainings provided, and the impact of training on the service delivery system.			
11. *Develop responsive treatment and mental health services, based on the objective assessment of individual prisoners, delivered by a collaborative system that ensures shared responsibility and continuity of care.*			
11a. *Implement treatment modalities that prisoners can access that are evidence based practices and coordinated throughout the system.*		The MDOC should mandate consistency in treatment of medical and mental health care ailments (including special accommodations) among all facilities.	
12. *Establish prisoner mental health treatment settings that ensure an appropriate therapeutic environment.*			
12a. Decide which of several models for		The former Huron Valley Center at	

Mental Health Workgroup Report Recommendations	Michigan Mental Health Commission Recommendations[39]	American Friends Service Committee Recommendations[40]	NCCHC Report Recommendations[41]
the delivery of mental health care is most suitable for implementation in MDOC.		Ypsilanti could be re-opened and accredited as an inpatient psychiatric facility, with assistance from university psychiatry and psychology departments, and could offer psychiatric residencies and psychology internships.	
12b. Revise the current continuum of care to include a complete spectrum of services.			
12c. Expand the telemedicine unit to provide psychiatric consultation to other prisons.			
12d. Determine whether MDOC itself, MDOC in collaboration with MDCH, MDOC in collaboration with a for-profit vendor, or MDOC in collaboration with an academic center are best geared to implement the strategies identified in these goals and objectives.		Merge the bifurcated mental health care system into a single, unified whole, under a reorganized and accountable bureau within the MDCH.	Give serious consideration to consolidating all mental health services under a single entity to avoid the inefficiencies inherent in the current organizational structures as well as the potential for compromising the quality of mental health care. Review its [MDOCs] contract with the DCH to ensure that it continues to reflect the MDOC's needs regarding mental

Mental Health Workgroup Report Recommendations	**Michigan Mental Health Commission Recommendations**[39]	**American Friends Service Committee Recommendations**[40]	**NCCHC Report Recommendations**[41]
			health services.
12e. Ensure that the system of mental health care meets accreditation requirements.			
12f. Provide adequate office and treatment space at all levels of care.			
12g. Define essential characteristics of a therapeutic environment and how they can be achieved at every level of care.			
		The Legislature should implement an adequately funded Office of the Legislative Medical Corrections Ombudsman (staff to include medical personnel). This body will report to both CMH and the legislative committee recommended in this report, which will oversee issues including, but not limited to: medical treatment, mental health treatment, health care and mental health care in segregation, and therapeutic programming.	

Mental Health Workgroup Report Recommendations	Michigan Mental Health Commission Recommendations[39]	American Friends Service Committee Recommendations[40]	NCCHC Report Recommendations[41]
		The legislature should create a commission to conduct annual, open, well-advertised hearings concerning medical and mental health care treatment… This commission will hold bimonthly meetings to discuss issues concerning health care and mental health care within the MDOC, and will have a clear mandate and authority to make recommendations as directed by the legislative committee outlined below.	
		A permanent legislative committee should be created to oversee health care and mental health care within the MDOC. The committee should be co-chaired by the chairperson of the Senate and House Appropriations Sub-committee on Corrections.	
			Appoint a contract monitor to oversee this [mental health contract with MDCH] contract. We noted that the psychologist in central office does not have any supervisory

Mental Health Workgroup Report Recommendations	**Michigan Mental Health Commission Recommendations[39]**	**American Friends Service Committee Recommendations[40]**	**NCCHC Report Recommendations[41]**
			responsibilities for regional psychologists, who report to the regional health administrators. Perhaps this person could serve as the contract monitor.
Preparation for Release			
13. *Ensure that all individuals leaving the prison system are appropriately linked with entitlement benefits prior to release to assist in successful reintegration. Individuals should be screened and linked with all entitlements they may be eligible for including Medicaid, Social Security and Veterans Benefits.*			
13a. Screen and assess all prisoners with mental illness to determine appropriate entitlement options.			
13b. For those prisoners screened as likely to be eligible for any form of entitlement, designated staff at the facility will facilitate the completion of applications as			

Mental Health Workgroup Report Recommendations	Michigan Mental Health Commission Recommendations[39]	American Friends Service Committee Recommendations[40]	NCCHC Report Recommendations[41]
appropriate.			
14. *Ensure that all discharging prisoners (Max Outs) have transition plans developed and appropriate links to community supports.*	30. The transition from detention or incarceration to community-based treatment and services should be strengthened by initiating pre-release programming at the point of reception or intake, and training for release supervisors on what to expect from mental health clients. Pre-release planning should address the person's mental health and other needs, and include such areas as collaborative interagency release plans and improved release guidelines; linkages to community resources during supervision or upon release; risk/need reduction; and relapse prevention.		
14a. Identify early those prisoners who are discharging on their PMX (Parole Max Date).			
14b. Develop transition plans for prisoners who are discharging on their PMX date.			
15. *Ensure that all*			

Mental Health Workgroup Report Recommendations	Michigan Mental Health Commission Recommendations[39]	American Friends Service Committee Recommendations[40]	NCCHC Report Recommendations[41]
prisoners in need of guardianship have a guardian at the time of release.			
16. *Provide cross-system training to prison staff, parole agents, and community members on the appropriate ways to interact with individuals with mental illness who also engage in criminal behavior.*	30. The transition from detention or incarceration to community-based treatment and services should be strengthened by initiating pre-release programming at the point of reception or intake, and training for release supervisors on what to expect from mental health clients….		
17. *Identify prisoners with special needs and ensure that any unique characteristics are communicated to the community and addressed within his/her transition plan.*	30. The transition from detention or incarceration to community-based treatment and services should be strengthened by initiating pre-release programming at the point of reception or intake, and training for release supervisors on what to expect from mental health clients. Pre-release planning should address the person's mental health and other needs, and include such areas as collaborative interagency release plans and improved		

Mental Health Workgroup Report Recommendations	Michigan Mental Health Commission Recommendations[39]	American Friends Service Committee Recommendations[40]	NCCHC Report Recommendations[41]
	release guidelines; linkages to community resources during supervision or upon release; risk/need reduction; and relapse prevention.		
17a. Address the needs of those individuals who have both medical concerns and mental disabilities that will impact transition to the community.			
17b. Address needs of sex offenders as they transition into the community.			
17c. Address needs of elderly prisoners as they transition to the community.			
17d. Address needs of youthful prisoners as they transition into the community.			
17e. Address needs of prisoners with developmental disabilities as they transition into the community.			
17f. Ensure that appropriate information is consistently included in the TAP/Discharge Plan for prisoners with special needs.			

Mental Health Workgroup Report Recommendations	Michigan Mental Health Commission Recommendations[39]	American Friends Service Committee Recommendations[40]	NCCHC Report Recommendations[41]
18a. Develop strategies to identify prisoners with less severe mental illnesses and a consistent process to assist in transition planning.			
18b. Develop TAP/Discharge Plans to address mental health needs for those individuals with less severe mental illness.			
	30. The transition from detention or incarceration to community-based treatment and services should be strengthened by ***initiating pre-release programming at the point of reception or intake***, and training for release supervisors on what to expect from mental health clients. Pre-release planning should address the person's mental health and other needs, and include such areas as collaborative interagency release plans and improved release guidelines; linkages to community resources during supervision or upon release; risk/need		

Mental Health Workgroup Report Recommendations	Michigan Mental Health Commission Recommendations[39]	American Friends Service Committee Recommendations[40]	NCCHC Report Recommendations[41]
	reduction; and relapse prevention.		

APPENDIX III

Definitions

DEFINITIONS

1. Developmental Disability:

(A) In general the term "developmental disability" means a severe, chronic disability of an individual that:

(i) is attributable to a mental or physical impairment or combination of mental and physical impairments;

(ii) is manifested before the individual attains age 22;

(iii) is likely to continue indefinitely;

(iv) results in substantial functional limitations in three or more of the following area of major life activity:

(v) self care;

(vi) receptive and expressive language;

(vii) learning;

(viii) mobility;

(ix) self-direction;

(x) capacity for independent living;

(xi) economic self-sufficiency; and

(xii) reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

(B) Infants and Young Children

An individual from birth to age nine, inclusive, who has a substantial developmental delay or specific congenital or acquired condition, may be considered to have a developmental disability without meeting 3 or more of the criteria described in clauses (i) through (v) of subparagraph (A) if the individual, without services and supports, has a high probability of meeting those criteria later in life.

2. Serious Mental Illness:

A diagnosable mental, behavioral, or emotional disorder affecting an adult that exists or has existed within the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association by the Department of Community Health and that has resulted in functional impairment that substantially interferes with or limits one or more major life activities. Serious mental illness includes dementia with delusions, dementia with depressed mood and dementia with behavioral disturbance but does not include any other dementia unless the dementia occurs in conjunction with another diagnosable serious mental illness. The following disorders also are included only if they occur in conjunction with another diagnosable serious mental illness.

(a) A substance abuse disorder;
(b) A developmental disorder; and
(c) A "V" code in the diagnostic and statistical manual of mental disorders

3. Substance Abuse

Taking of alcohol or other drugs at dosages that place an individual's social, economic, psychological, and physical welfare in potential hazard or to the extent that an individual loses the power of self-control as a result of the use of alcohol or drugs, or while habitually under the influence of alcohol or drugs, endangers public health, morals, safety, or welfare, or a combination thereof.

4. Dementia

Significant loss of intellectual abilities such as memory capacity, severe enough to interfere with social or occupational functioning.

5. Alzheimer's Disease

A group of disorders involving the parts of the brain that control thought, memory, and language. It is marked by progressive deterioration, which affects both the memory and reasoning capabilities of an individual.

6. Sex Offender

A generic term for persons convicted of crimes involving sex, including rape, molestation, sexual harassment and pornography production or distribution.

7. Dual Diagnosis

The co-existence of two conditions. Examples are depression and substance abuse, or schizophrenia and developmental disabilities.

8. Transgender

Having personal characteristics (as transsexuality or transvestism) that transcend traditional gender boundaries and corresponding sexual norms.

9. Closed Head Injury/Traumatic Brain Injury

An acquired injury to the brain caused by an external physical force, resulting in total or partial functional disability or psychosocial impairment, or both, that adversely affects a child's educational performance. The term applies to open or closed head injuries resulting in impairments in one or more areas, such as cognition; language; memory; attention; reasoning; abstract thinking; judgment; problem-solving; sensory, perceptual, and motor abilities; psycho-social behavior; physical functions; information processing; and speech. The term does not apply to brain injuries that are congenital or degenerative, or to brain injuries induced by birth trauma." [34 Code of Federal Regulations §300.7(c) (12)]

APPENDIX IV

Acronyms

ACRONYMS

ARUS	Assistant Resident Unit Supervisor
CARF	Commission on the Accreditation of Rehabilitation Facilities
CCAB	Community Corrections Advisory Board
CFA	Correctional Facilities Administration
CJS	County Jail Services
CMHP	Correctional Mental Health Program
CMHSP	Community Mental Health Services Program
CMS	Correctional Medical Services
CQI	Continuous Quality Improvement
COMPAS	Corrections Offender Management Profiling Alternative Sanctions
DHS	Department of Human Services
DIT	Department of Information Technology
EMR	Electronic Medical Record
FOA	Field Operations Administration
HC	Health Care
HR	Human Resources
HUM	Health Unit Manager
IPA	Individual Parole Agent
JCAHO	Joint Commission on the Accreditation of Health Care Organizations
LGBTQ	Lesbian, Gay, Bisexual, Transgender, Queer
MAC	Michigan Association of Counties
MACMHB	Michigan Association of Community Health Board
MCOLES	Michigan Commission on Law Enforcement Standards
MCOTS	Michigan Correctional Officer's Training Council
MDOC	Michigan Department of Corrections
MSA	Michigan Sheriff's Association
MPRI	Michigan Prisoner Reentry Initiative
NCCHC	National Commission on Correctional Healthcare
OOR	Office of Offender Re-entry
OSE	Office of the State Employer
QMHP	Qualified Mental Health Profession
PAAM	Prosecuting Attorney's Association of Michigan
PER	Parole Eligibility Report
PMX	Parole Max-out date
PSU	Psychological Services Unit
PTSD	Post Traumatic Stress Disorder
RPT	Residential Treatment Program
RUO	Resident Unit Officer
SCAO	State Court Administrator's Office
SCC	Security Classification Committee
SSA	Social Security Administration

SOAR	SSI/SSDA Outreach, Access and Recovery
SSDU	Social Skills Development Unit
TAP	Transition Accountability Plan
VA	Veterans Administration

APPENDIX V

Incidence of Mental Illness in Jails

Incidence of Mental Illness in Jail
Overview

Studies of the incidence of mental illness in jails have suggested that 7.2-64% of jail inmates have a mental illness. Studies that focus on Michigan's jails have found incidence rates between 7.5-51%. The variability in these rates is related to several factors. First, the definition of mental illness utilized in the study has an impact on the rates identified. Studies that focus on serious mental illness, such as schizophrenia and manic depression, tend to find rates between 6-16%. Studies with broader definitions of mental illness tend to find higher rates. Second, studies vary by the methodology they utilize to set the rate. Studies that ask jails to report their rates of mental illness tend to identify rates between 7.2%, whereas studies that use clinical interviews tend to identify rates between 51-64%. With respect to the incidence of specific disorders in jail, studies have found rates of schizophrenia between 1.0-8%, bipolar disorder between 1.5-18%, major depressive disorder between 7.9-15.2%, and anxiety disorders between 7-20.0%.

Descriptions of the methods and findings of key studies of the incidence of mental illness in jail are provided below.

Michigan Data

Study 1: Torrey et al. Criminalizing the Seriously Mentally Ill: The Abuse of Jails as Mental Hospitals. National Alliance for the Mentally Ill and Public Citizen's Health Research Group. 1992.

1,391 jails across the country, holding 62% of national jail inmates, responded to a February '92 survey. The instrument had been mailed to 3,353 jails. In Michigan, 47 of 82 jails responded (57%), the 14th-best rate among all states and the District of Columbia.

It was found that 7.2% of inmates nationally had "serious mental illness" (SMI), defined as schizophrenia, bipolar disorder and "related conditions." Respondents were told that symptoms of SMI were: hearing voices; confused or illogical thinking that doesn't make sense; delusions; bizarre or inappropriate behavior; and repeated mood swings from severe depression to mania.

Among other national findings:

~The most common SMI offenses cited by jails were: assault &/or battery (41% of jails); theft (30%); disorderly conduct (29%); and drug- and alcohol-related (29%).

~92.5% of jails said SMI inmates must be watched more closely for suicide.

~87% said SMI inmates require more attention from jail staff.

~86% reported holding SMI inmates on an average day.

~52% said SMI inmates increased potential for outbreaks of violence.

~40% said SMI inmates were abused by other inmates.

~19.5% reported that SMI inmates made up at least 6% of daily census.

Data were provided on three issues allowing comparison of individual states to national averages:

~Michigan's SMI inmate proportion was 7.46%, slightly higher than the national average and 37th (from lowest to highest) among the 50 states and D.C.

~Michigan matched the national average of 35.7% of SMI inmates receiving outpatient treatment post-release. This ranked 26th (from highest to lowest) among the 50 states and D.C.

Michigan was also 26th (from lowest to highest) in percentage of jails holding SMI individuals without criminal charges. The national average was 29%; Michigan's was 25.5%.

In the authors' opinion, major contributing factors to incarceration of persons with mental illness included: the relative ease with which untreated SMI individuals can become involved in "disorderly" conduct and drug offenses; "mercy bookings" by law enforcement to get people with nowhere to turn off the streets; and lack of access to community care and treatment, in part due to "profound failure" of the public mental health system.

Study 2: State Representative Liz Brater. ***Mental Illness in Michigan Jails: The 1997-98 Brater Jail Survey***. **Michigan House of Representatives. April 9, 1998.**

Representative (now Senator) Brater surveyed all Michigan sheriff departments in 1997-98. Sixty of the 83 departments responded. Statewide, 9.6% of inmates were reported to be on psychotropic medications. Respondents were also asked for the current number of inmates with symptoms of a serious mental illness (undefined in the report released 4-9-98). The statewide proportion for this was 8.1%. Only a small number of those making such survey determinations locally reported special expertise in mental health care.

Study 3: Office of Psychiatric Affairs, Michigan Department of Community Health. ***Incidence of Serious Mental Illness of the Jail Population in the State of Michigan.*** **February 1999.**

Clinicians under the direction of a Wayne State University psychologist conducted diagnostic clinical interviews with a random sample of inmates from the county jails in Wayne, Kent and Clinton. Across the three jails combined, 51% of the sample had a primary diagnosis of mental illness (exclusive from substance abuse, which had a 33% prevalence rate as a primary diagnosis). The categories of diagnosis broke down as follows:

~Schizophrenia & Psychotic Disorders – 8%
~Bipolar Disorders – 18%
~Major Depressive Disorders – 8%

~Anxiety Disorders – 7%
~Adjustment Disorders – 6%
~"Other Disorders" – 4%

Each of the three jails had at least a 46% mental illness prevalence rate. For the diagnoses likely to involve greatest severity (the first three on the list above), the respective per-jail rates were:

Kent – 40%
Wayne – 39%
Clinton – 17%

No other mental health-related variables were examined across the combined study population.

National Data

Study 4: Lamb and Weinberger. *Persons with Severe Mental Illness in Jails and Prisons: A Review*. Psychiatric Services. 49:4, April 1998.

The authors searched *MEDLINE, Psychological Abstracts* and the *Index to Legal Periodicals and Books* going back to 1970 for studies of mental illness in jails and prisons. The article's reference section lists 110 sources. The authors concluded, "Clinical studies suggest that 6 to 15 percent of persons in city and county jails…have severe mental illness." Severe mental illness was not formally defined in the article. The authors' narrative descriptions of selected studies focused primarily on the diagnoses of schizophrenia/other psychotic, bipolar disorder, major depression and mania. In the case of one prison study narrative, functional disability and service need appeared to be the operational factor.

Regarding causative factors for justice system incarceration of persons with mental illness, the authors wrote, "The most common factors cited…are deinstitutionalization and the unavailability of long-term hospitalization in state hospitals for persons with chronic and severe mental illness, more formal and rigid criteria for civil commitment, the lack of adequate support systems for mentally ill persons in the community, the difficulty mentally ill persons coming from the justice system have gaining access to mental health treatment in the community, and a belief by law enforcement personnel that they can deal with deviant behavior more quickly and efficiently within the criminal justice system than in the mental health system. A factor less commonly discussed is the public's attitude toward persons with mental disorders who commit crimes."

Study 5: Ditton. *Mental Health and Treatment of Inmates and Probationers.* US Department of Justice, Bureau of Justice Statistics (BJS). Special Report, July 1999.

"Nationally representative" samples of inmates at federal prisons, state prisons and local jails, as well as probationers, were interviewed. For jails, the study estimated that 16% of inmates nationally had mental illness. This determination was based on positive inmate response to one or both of two questions:

~Do you have a mental or emotional condition?

~Because of an emotional or mental problem, have you ever been admitted to a mental hospital, unit or treatment program where you stayed overnight?

The reliability and validity of psychiatric determinations based on those questions can certainly be questioned.

Regarding jail inmates considered to have mental illness, they were more likely than other jail inmates to: be incarcerated for a violent offense; have a previous criminal history; be under the influence of alcohol or other drugs at the time of current offense; have experienced prior negative consequences from alcohol use; have been homeless in the year prior to arrest; have experienced prior physical or sexual abuse; be in fights during their current incarceration; and be charged with breaking jail rules.

41% of jail inmates considered to have mental illness had received some form of mental health services during their current incarceration. The predominant mode of such service was provision of medications.

Study 6: *Prevalence of communicable disease, chronic disease, and mental illness among the mental illness population.* In The Health Status of Soon-to-Be-Released Inmates: A Report to Congress. National Commission on Correctional Health Care (NCCHC). 2002.

Mental illness six-month prevalence data from the National Comorbidity Survey (early '90s) were adjusted for jail populations and weighted for 1995 demographics of those populations. Estimates of the numbers/percentages of U.S. jail inmates with current mental illness were derived for six conditions. These conditions were not mutually exclusive; i.e., a given inmate could cross into two or more conditions. The findings were:

~Schizophrenia/Psychosis – a 6-month prevalence range of 1.0-1.1% (4,955-5,589 inmates).

~Major Depression – 7.9-15.2 percentage range (39,690-76,229 inmates)

~Bipolar Disorder – 1.5-2.6 percentage range (7,755-12,920 inmates)

~Dysthymia – 2.7-4.2 percentage range (13,644-21,040 inmates)

~Post-Traumatic Stress Disorder (PTSD) – 4.0-8.3 percentage range (19,770-41,509 inmates)

~Other (non-PTSD) Anxiety Disorders – 14.1-20.0 percentage range (70,613-100,098 inmates)

This report also gave mental illness estimates for prisons, except that the base for prisons was the lifetime prevalence data from the National Comorbidity Survey.

Study 7: James and Glaze. *Mental Health Problems of Prison and Jail Inmates.* US Department of Justice, Bureau of Justice Statistics (BJS). Special Report, September 2006.

Over 6,000 inmates from more than 400 jails across the country were interviewed. (The study also covered federal and state prisons.) It was estimated that 64% of jail inmates nationally (as well as 56% of state prison inmates and 45% of federal prisoners) had mental health problems.

This study has been harshly criticized by some because: (1) they consider its numbers too high to be believed; and (2) they assume the same methodology as the 1999 BJS study (self-reported answers to a few questions) was utilized. The latter assumption is incorrect. While an inmate could be classified as having a mental health problem by self-reported answers similar to those from '99, the newer study also assessed 12-month symptomatology through a modified version of the Structured Clinical Interview (SCI) for the Diagnostic and Statistical Manual of Mental Disorders, fourth edition. And in this study, only a very small percentage of jail inmates (3.5%) were considered to have a mental health problem based solely on self-reported answers to the 1999-style questions. (43.2% of jail inmates fell in the mental illness category solely through symptoms derived from the SCI. Another 17% of jail inmates qualified for the mental illness category through both variables. In other words, virtually every inmate considered to have mental illness was validated by the SCI.)

Diagnostic clinical interviews are an accepted tool for assessing mental illness among sample populations. What is unknown from the base report on this 2006 BJS study is how the SCI was modified, and the qualifications of the persons administering it.

The mental illnesses of interest to this study through the SCI were Major Depressive Disorder (MDD), Mania and Psychotic Disorder.

30% of jail inmates had symptoms of MDD. To be so classified, and inmate had to show depressed mood or decreased interest/pleasure in activities, along with four other symptoms of depression.

54.5% of jail inmates had symptoms of Mania Disorder. To be so categorized, an inmate had to display three related symptoms or a persistent angry mood.

24% of jail inmates showed symptomatology of Psychotic Disorder, based on either delusional or hallucination symptoms.

The SCI surveys did not assess the duration or severity of symptoms, and no exclusions were made for symptoms due to medical illness, bereavement or substance use. (49% of jail inmates showed evidence of both a mental disorder and substance dependence or abuse.)

Regarding the very high prevalence numbers found, the authors wrote, "The high rate of symptoms of mental health disorder among jail inmates may reflect the role of local jails in the criminal justice system. Jails are locally operated correctional facilities that receive offenders after an arrest and hold them for a short period of time, pending arraignment, trial, conviction, or sentencing. Among other functions, local jails hold mentally ill persons pending their movement to appropriate mental health facilities."

17.4% of jail inmates with mental illness were in some form of treatment during their current incarceration. The modal forms (tied) of such treatment were medications and "professional mental health therapy."

Almost three-fourths of mental illness jail inmates were under incarceration for a non-violent offense. And close to three-fourths of mental illness jail inmates were repeat offenders.

Similarly to the 1999 BJS study, those with mental illness were more likely than other jail inmates to have: committed a violent offense; been previously arrested; been homeless before current arrest; been using drugs before current arrest; a determination of substance dependence or abuse; previous engagement in binge drinking; been injured in a fight since current admission; and been charged with facility rule violations during current admission.

Study 8: Lamb et al. *Treatment prospects for Persons with Severe Mental Illness in an Urban County Jail.* Psychiatric Services. 58:782-86, June 2007.

A random sample of 104 inmates in the Los Angeles County Jail's facility for mental health was reviewed. 75% were diagnosed as having severe mental illness (SMI), defined as schizophrenia, schizoaffective disorder, bipolar disorder or major depression with psychotic features. Of the SMI group, 76% required inpatient care or its equivalent* for part of their time in jail for their current offense; 92% had a history of nonadherence to medications before their current arrest; 95% had prior arrests; 72% had prior arrests for one or more crimes of violence; 41% had a history of incarceration in state prison (and 24% were sent to state prison with respect to their current offense); 76% were known to have a history of substance abuse; and 36% were homeless at the time of their current arrest.

These results show that, for one of the country's largest urban jails, the conditions of persons accepted into the jail's mental health facility were predominantly serious, necessitating significant treatment responses if and when they could be applied. Additionally, recidivism was almost universal, and medication noncompliance, homelessness and substance abuse all appeared to be factors needing remediation to break the incarceration cycle. The authors suggested measures such as assertive community treatment, mental health courts and assisted outpatient treatment were needed.

Applying the lower-range estimates of the 2002 NCCHC report (discussed above) to the year 2004, the authors concluded that the national number of SMI inmates in jails was 71,399.

In one of their "Discussion" paragraphs, the authors wrote, "Our review of the electronic criminal histories proved instructive. We also knew the circumstances of the current offense and often of prior offenses from the inmate's jail psychiatric record. Thus we were able to observe that a series of nonserious offenses committed by many persons with severe mental illness often resulted in a lengthy criminal history with no narrative included in the electronic records as to what really happened. These individuals may have appeared as habitual criminals when they came to the attention of law enforcement and their criminal histories were accessed. In reality, they were persons with serious mental illness who were not receiving adequate treatment, and they acted in an inappropriate and often aggressive manner when stressed." The authors further

wrote, “There must be a very large increase in psychiatric treatment and rehabilitation resources in the mental health system to accommodate persons with severe mental illness who are (to be) diverted.” And it was suggested that there must be better recruitment and retention of mental health professionals who can treat and manage a difficult population in the community.

In a subsequent presentation (“A National State of Denial: Severe Mental Illness Has in Fact Been Criminalized”) to the Mental Health Association in Michigan’s Annual Conference (6-7-07), lead author Dr. H. Richard Lamb reported that available short-term, intermediate and long-term psychiatric inpatient beds have decreased dramatically in the U.S., and that this was an important factor in the criminalization of persons with mental illness.** Other contributing factors he cited were: involuntary treatment being more difficult to obtain; mental health facility reluctance to deal with aggressive persons; and peace officer perceptions of premature community reentry of persons whom law enforcement believe are a danger.

*The equivalent was a lockdown area – “a highly staffed, highly structured area for people whom the mental health staff believe need acute psychiatric hospitalization” but for whom inpatient beds were unavailable. The lockdown area was used for no other purpose, and its admission criteria were the same as those for admission to the jail’s acute inpatient unit.

**On December 4, 1997, The Detroit News published an analysis of state records indicating that the number of Michigan prison inmates who had formerly been in a state psychiatric hospital had increased from 2,208 (5.25%) to 2,706 (5.8%) from 1993-97. This period generally coincided with a timeframe during which Governor Engler closed well over half the state psychiatric hospitals that had been in existence. The then-Director of DCH sharply criticized the quality (or perceived lack thereof) of the story, but the Senate Fiscal Agency wrote in a related 1998 issue paper that the change in the percentage of inmates having a former state hospital stay was statistically significant, though not definitive proof of any causation.

APPENDIX VI

Mental Health Appraisal Process and Documentation

In July 2008, MDOC established a procedure known as the Mental Health Appraisal Process at the Charles Egeler Reception and Guidance Center (RGC). This process was developed to ensure that prisoners entering the MDOC system received a mental health screening and appraisal to identify potential suicide risk prisoners, those experiencing mental health crisis, possible symptoms of serious mental illness/severe mental disorders, significant developmental disabilities, or prisoners with other mental health problems. This process was designed to ensure a timely screening and appraisal and referral for a mental health evaluation by a Qualified Mental Health Processional (QMHP).

The Appraisal/Referral Unit is part of an integrated continuum of mental health care, and is the component of providing identification of potential mental health needs of persons entering the MDOC prison system. The program functions as a main entry point into the Corrections Mental Health Services Program and determines if the individual has mental health needs, and what would be the most appropriate treatment and level of care. The target population includes individuals with severe to mild impairments due to mental illness, developmental disability, emotional disorder, behavior disorder or mental health crisis.

The staffing of the unit consists of unit chiefs/supervisors (who may be a psychiatrist, psychologist, social worker, or clinical nurse specialty), QMHP's, and health care nursing staff. Below is the documentation that is utilized in the screening and appraisal process.

Mental Health Appraisal Documentation

MICHIGAN DEPARTMENT OF CORRECTIONS
MH/MR SERVICES
MENTAL HEALTH APPRAISAL

INSTITUTION:_________________________________
NAME:_______________________________________
ID #:_______________________________________
DOB:____
RACE:______________________ SEX:___________

RECEPTION MENTAL HEALTH APPRAISAL DOCUMENTATION

SUMMARY PAGE

I. Recommendations:

[ ] Emergent Mental Health Evaluation
- [ ] Danger to self
- [ ] Danger to others secondary to mental illness
- [ ] Exhibiting psychotic symptoms

[ ] Psychiatric Evaluation
[ ] Further MH/MR Evaluation/Services
[ ] No Further MH/MR Evaluation
[ ] Other

II. Reason for Referral (if applicable):

____
____
____

III. Special Precautions:

____
____
____

Records Reviewed:

PSI	[ ] Yes	[ ] No
Community mental health records	[ ] Yes	[ ] No
Community medical records	[ ] Yes	[ ] No

____ Screener Signature and Title

_____________________ Date

Prisoner Name:____ **ID #:**_____________________

I. Psychotropic Medications History: [ ] None [ ] See below*

Medication:	Dosage:	Dates Taken:

II. History of self-injury (not suicidal; note frequency and age this type of behavior began): [ ] None [ ] Yes*

Comments:____

III. Serious suicide attempt, plan for or thoughts of in the past: [ ] None [ ] Yes*

Comments:____

IV. Present thoughts or plans of self-injury or of suicide: [ ] None [ ] Yes*

Comments:____

V. Adjustment to incarceration including jail:

Length of time in county jail:________________________

Adjustment during jail confinement:____

Adjustment to current incarceration:

[ ] Good (no adjustment problems)
[ ] Satisfactory (Minor/expectable problems)
[ ] Unsatisfactory (Significant problems which may require intervention)*
[ ] Unclear/Unknown

Adjustment to prior incarceration:

[ ] No prior incarcerations
[ ] Good
[ ] Satisfactory
[ ] Unsatisfactory
[ ] Unclear/Unknown

Comments:____

VI. Mental Health Screening for Men

[ ] Yes [ ] No Have you ever had worries that you just can't get rid of?
[ ] Yes [ ] No Some people find their mood changes frequently – as if they spend every day on an emotional roller coaster. Does this sound like you?
[ ] Yes [ ] No Do you get annoyed when friends or family complain about their problems? Or do people complain that you're not sympathetic to their problems?
[ ] Yes [ ] No Have you ever felt like you didn't have any feelings, or felt distant or cut off from other people or from your surroundings?*
[ ] Yes [ ] No Has there ever been a time when you felt so irritable that you found yourself shouting at people or starting fights or arguments?
[ ] Yes [ ] No Do you often get in trouble at work or with friends because you act excited at first but then lose interest in projects and don't follow through?
[ ] Yes [ ] No Do you tend to hold grudges or give people the silent treatment for days at a time?
[ ] Yes [ ] No Have you ever tried to avoid reminders, or to not think about, something terrible that you experienced or witnessed?
[ ] Yes [ ] No Has there ever been a time when you felt depressed most of the day for at least two weeks?*
[ ] Yes [ ] No Have you ever been troubled by repeated thoughts, feelings, or nightmares about something you experienced or witnessed?*
[ ] Yes [ ] No Have you ever been in a hospital for non-medical reasons such as in a psychiatric hospital? (Do NOT include going to an Emergency Room if you were not hospitalized.)*
[ ] Yes [ ] No Have you ever felt constantly on guard or watchful even when you didn't need to, or felt jumpy and easily startled?*

Prisoner Name:____ **ID #:**_____________________

Comments:____

VII. Mental Health Inpatient Treatment History: [ ] None [ ] See below*

Date/Time Period/Duration	Institution/Facility	Diagnosis	Medication

VIII. Mental Health Outpatient Treatment History: [ ] None [ ] See below*

Date/Time Period/Duration	Institution/Facility	Diagnosis	Medication

IX. History of Mental Health Treatment in Jail/Prison: [ ] None [ ] See below*

Date/Time Period/Duration	Institution/Facility	Diagnosis	Medication

X. History of Alcohol and/or Drug Usage

[ ] None [ ] Alcohol [ ] Amphetamines [ ] Cannabis
[ ] Cocaine [ ] Hallucinogens [ ] Inhalants [ ] Opioids
[ ] Phenocyclidine [ ] Sedatives, hypnotics or anxiolytics [ ] Other:_________________________________

Prisoner Name:____ **ID #:**____________________

History of Alcohol/Drug Abuse or Dependence
[ ] Abuse [ ] Dependence [ ] Experimentation [ ] Social use only

History of treatment
[ ] None [ ] Ongoing [ ] Successful [ ] Unsuccessful

XI. History of head trauma/seizures/stroke

[ ] None
[ ] Seizures [ ] Currently on anticonvulsant medication
[ ] Head trauma/injury without loss of consciousness
[ ] Head trauma/injury with loss of consciousness*
[ ] Stroke
Comments:____
____

XII. History of assaultive/violent behaviors: [ ] No history of assaultive/violent behaviors

[ ] Physical assault without weapon
[ ] Physical assault with weapon
[ ] Homicide, manslaughter or other assault resulting in victim's death
[ ] Sexual assault, adult victim
[ ] Sexual assault, child victim
[ ] Terroristic threats or acts

Comments:____

____

XIII. History of being a victim of abuse: [ ] No history of being a victim of abuse

[ ] Physical abuse as child
[ ] Sexual abuse as child
[ ] Emotional abuse as child
[ ] No abuse as child

Relationship of abuser to victim:
[ ] Parent/guardian [ ] Relative [ ] Friend/associate
[ ] Stranger

[ ] Physical abuse as adult
[ ] Sexual abuse as adult
[ ] Emotional abuse as adult
[ ] No abuse as adult

Relationship of abuser to victim:
[ ] Parent/guardian [ ] Relative [ ] Friend/associate
[ ] Stranger

Comments:____

____

XIV. History of special education and disability benefits

[ ] None
[ ] Enrolled in Special Education classes in school*
[ ] Received High School Diploma or GED
[ ] Received SSI disability benefits
[ ] Received Veteran's disability benefits
[ ] Received other disability benefits
[ ] History of MRIDD services

[ ] Highest grade completed in school:
1 2 3 4 5 6 7 8 9 10 11 12
Vocational 1 2 3 4 – area of study:_________________
College 1 2 3 4 5 6 7 8
Area of study/degree:______________________________

Comments:____

Prisoner Name:____ **ID #:**_____________________

XV. Behavioral observations
(Check all that apply)
[ ] Aggressive [ ] Irrational [ ]Elevated Mood
[ ] Agitated [ ] Labile [ ] Angry/Irritable
[ ] Delusional [ ] Lethargic [ ] Passive*
[ ] Poor eye contact [ ] Disorganized Thinking [ ] Withdrawn
[ ] Hallucinations* [ ] Paranoid* [ ] Terrified/Crying
[ ] Hyperactivity* [ ] Depressed [ ] Other:________________

Comments:____

____

XVI. Does the offender desire mental health treatment?
*[ ] Yes [ ] No

Comments (describe what the offender hopes to gain from treatment:____

____

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*A Yes to this question automatically warrants referral for a Mental Health Evaluation.

Revised: 6/5/08