

REPORT TO THE LEGISLATURE
Pursuant to P.A. 114 of 2009
Section 302
Mental Health Independent Study

Sec. 302. (1) From the funds appropriated in part 1 for the mental health study, the department shall allocate not more than \$400,000.00 for the purpose of contracting for an independent study prescribed under this section.

(2) In consultation with the MDCH, the department shall contract for an independent study on the prevalence of prisoners in need of mental health treatment, substance abuse services, or both, and on the provision of services to prisoners in need of mental health treatment, substance abuse services, or both. The study must be completed or supervised by a psychiatrist as defined in section 100c of the mental health code, 1974 PA 258, MCL 330.1100c. The lead psychiatrist shall not be a current or former employee or contractual agent of the department or the department of community health. At a minimum, the study shall collect and evaluate data on all of the following, to the extent possible under the health insurance portability and accountability act (HIPAA), 42 USC 1320d-6 and 45 CFR parts 160 and 164:

(a) The number of prisoners receiving substance abuse services, including a description and breakdown of the type of substance abuse services provided to prisoners, by major offense type.

(b) The number of prisoners with a primary diagnosis of mental illness, the number of prisoners considered to currently require mental health services, and the number of prisoners receiving mental health services, including a description and breakdown, encompassing, at a minimum, the categories of inpatient, residential, and outpatient care, and the type of mental health services provided to those prisoners, by major offense type.

(c) The number of prisoners with a primary diagnosis of mental illness and receiving substance abuse services, including a description and breakdown, encompassing, at a minimum, the categories of inpatient, residential, and outpatient care, of the type of treatment provided to those prisoners, by major offense type.

(d) Data indicating whether prisoners receiving mental health services for a primary diagnosis of mental illness were previously hospitalized in a state psychiatric hospital for persons with mental illness, by major offense type.

(e) Data indicating whether prisoners with a primary diagnosis of mental illness and receiving substance abuse services were previously hospitalized in a state psychiatric hospital for persons with mental illness.

(f) The cost of psychotropic pharmaceuticals for prisoners with a primary diagnosis of mental illness itemized by type, specific diagnosis, identification as a brand name or a generically equivalent pharmaceutical, and the name of the manufacturer or distributor.

(g) Quarterly and fiscal year-to-date expenditures itemized by vendor, status of payments from contractors to vendors, and projected year-end expenditures from accounts for substance abuse treatment and mental health care.

(h) The number of prisoners that have had their primary diagnosis of mental illness changed while in prison by a mental health clinician from an earlier diagnosis received in prison or while hospitalized in a state psychiatric hospital for persons with mental illness, itemized by current and previous diagnosis.

(i) The number of prisoners with a primary diagnosis of mental illness that previously had received substance abuse services, including a description and breakdown, encompassing, at a minimum, the categories of inpatient, residential, and outpatient care, of the type of treatment provided to those prisoners.

(j) All department policies and procedures relating to prisoners and parolees with mental illness, substance abuse disorders, or both, including, but not limited to, those related to prisoners with discharge status.

(3) A report on the study, together with any recommendations contained in the study and response from the department, shall be provided to the members of the senate and house appropriations subcommittees on corrections and community health, the senate and house fiscal agencies, MDCH, and the state budget director no later than 30 days following the receipt of the completed study. The report shall include all of the information required under subsection(2) and any recommendations. The report also shall include a plan by the department to implement those recommendations with which it agrees and an explanation of any disagreements with recommendations.

Section (a-e), (h) and (i):

**Independent Study of Mental Health and Substance Abuse
Final Report**

**Brant E. Fries, Ph.D., Principal Investigator
University of Michigan¹**

February 16, 2010

I. EXECUTIVE SUMMARY

This study provides an independent survey of the prevalence of psychiatric illness among prisoners in Michigan correctional facilities and the delivery of mental health services for these individuals. The project was performed by the University of Michigan (UM), with assistance from the Michigan Public Health Institute (MPHI) and Nipissing University.

Teams of two assessors visited 24 correctional facilities and conducted interviews on 618 incarcerated subjects. Subjects were randomly sampled based on four strata: males in the general population, males in administrative segregation, males in special units, and females. Approximately one-quarter of the sample was collected from each stratum. Sampling weights were computed to estimate an accurate picture of the full Michigan prison population. This study used a comprehensive mental health assessment tool, the interRAI for Mental Health (interRAI MH) to gather information on signs and symptoms of severe mental illness in the prison population. Assessors collected information from all available sources, including subjects themselves, custody staff, and prison mental health staff.

The assessments were merged with secondary data provided by the Michigan Department Of Corrections (MDOC) containing information on mental health diagnoses or services that the subjects were receiving within the facilities, as well as on demographics and sentencing.

The methodology did not rely on assigning specific DSM-IV Axis I or Axis II diagnoses to subjects, but rather detected whether or not individuals had symptoms indicative of a severe mental illness. Several outcome measures based on the interRAI MH were used to make this determination. Five outcome scales measured cognitive ability, depression, positive and negative psychotic symptoms, and mania symptoms. Any prisoner with severe symptoms on any of the five scales was deemed to have a mental health problem.

According to these measures, 20.1% of men and 24.8% of women in Michigan prisons have mental health symptoms and 16.5% and 28.9%, respectively, are receiving mental health services. However, when compared with the MDOC's mental health records,

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65.0% of prisoners who are experiencing mental health symptoms are not currently receiving any psychiatric services. This percentage is relatively insensitive to different methods or higher severity thresholds for determining mental health services. We also found that 40% of those we determined to be in current need of substance abuse treatment – those with prior use of illegal substances, misuse of prescription medications, and/or prior alcohol abuse, and scheduled to be released within six months – were not receiving these services.

These mismatches between symptoms and service delivery suggests the need for improved procedures for identifying and measuring psychiatric problems within Michigan correctional facilities to ensure that appropriate individuals receive needed care. The study team recommends that MDOC implement a standardized assessment process to be conducted at regular intervals for targeting and improving psychiatric care in the prison system.

II. PROJECT HISTORY

II.A. PA 124 of 2007

Section 302 of the FY2008 Corrections Appropriations Act (PA 124) required an independent study on “the prevalence of prisoners in need of mental health treatment, substance abuse services, or both, and on the provision of services to prisoners in need of mental health treatment, substance abuse services, or both” (See Appendix A for full text). The Michigan Department of Corrections (MDOC) contracted with the University of Michigan to undertake this research study between May 1, 2008 and September 30, 2009.

II.B. Project team

This project was led by researchers at the University of Michigan (UM) Institute of Gerontology and Department of Psychiatry. Michigan Public Health Institute (MPHI) and Nipissing University in North Bay, Ontario served as subcontractors to the project. MPHI led the field effort and data collection, while Nipissing University provided assessor training and consultant services to the UM and MPHI teams.

II.B.1. University of Michigan Key Personnel

Brant E. Fries, Ph.D., Principal Investigator
Philip Margolis, M.D., Lead Psychiatrist
Angela Schmorrow, M.S.W., Project Manager
Sylvia Lang, Ph.D., Project Statistician

II.B.2. MPHI

Julia Heany Ph.D., Program Director
Beth Ann Whitaker, M.A., M.B.A., Program Coordinator
Tristen Anthony, B.A., Research Associate

II.B.3. Consultants (Nipissing University Subcontract)

Greg Brown, Ph.D. - Associate Professor and Chair, Department of Criminal Justice,
Nipissing University

Howard Barbaree, Ph.D. - Professor and Head, Law and Mental Health Program,
Department of Psychiatry, University of Toronto, and Clinical Director, Law and
Mental Health Program Centre for Addiction and Mental Health

John Hirdes, Ph.D. – Professor, Department of Health Studies and Gerontology,
University of Waterloo

Nancy Curtin-Telegdi, RN, MA – Department of Health Studies and Gerontology,
University of Waterloo

III. DATA COLLECTION

This project combined primary data collection by interview of a stratified random sample of Michigan prisoners and use of data compiled by the Michigan Department of Corrections describing mental health services and descriptors of the prisoners' sentences.

III.A. Instrument

This study used the interRAI Mental Health (interRAI MH) assessment system as the primary data collection instrument. The interRAI MH was developed in Canada by the Ontario Joint Policy and Planning Committee (JPPC), a partnership of the Ontario Hospital Association and Ontario Ministry of Health, in collaboration with interRAI. The interRAI MH is designed to support care planning, outcome measurement, quality improvement and case mix based funding applications. Its target population is all adults aged 18 and over in in-patient psychiatric settings, including acute, chronic, forensic and geriatric psychiatry.

The interRAI MH has been in use in Ontario, Canada since 1999, initially as a research instrument, but increasingly as part of normal clinical practice. In 2005, the Ontario Ministry of Health and Long-Term Care (MOHLTC) mandated the use of the interRAI MH, as the basis for the Ontario Mental Health Reporting System (OMHRS), for all patients in Ontario hospitals with designated adult inpatient mental health beds. Besides use in Ontario and elsewhere in Canada, the interRAI MH instrument has been implemented Galicia, Spain since 2000, and used in eight hospital districts in Finland for inpatient care since 2007.

The interRAI MH has been tested for inter-rater reliability with psychiatric patients in acute, long-term, geriatric, and forensic mental health care settings. The majority of items on the instrument demonstrated acceptable or higher average levels of reliability based on kappa coefficients. Kappa is a measure ranging essentially from 0 to 1.0. Scores of above 0.4 are generally considered acceptable while scores above 0.6 are very good. The average reliability of the interRAI MH items has a kappa of .72. Domain areas focusing on mental health service history, diagnoses, physician services,

alcohol/tobacco use, and medication use all had average kappa values of 0.7 or more. Items on violence scored between 0.50 and 0.63².

The interRAI MH, along with its Forensic Supplement, was used in a study of incarcerated populations in Ontario, Canada. This same version was used in this study, with only minor wording and order changes made³. These changes were reviewed and agreed upon by UM, MDOC, and the project consultants prior to data collection. This version has been named the interRAI Mental Health for Correctional Facilities (interRAI CF), and is attached as Appendix B.

This assessment instrument is designed to be collected using all available sources of information, including the prisoners themselves, others who interact with or take care of the prisoner, and any available medical or treatment records. Subjects in our study were informed that we would be speaking to facility staff about them, and that we would be reviewing their mental health records kept by MDOC. However, we would not disclose any information the subjects shared with the assessors to any of these third parties.

The trained assessors were fully capable of obtaining information about all domains of the instruments. However, the items describing substance use proved complicated to complete. Rather than ask for any history of substance use, the interRAI CF collects information only from those within the first two years of their sentence. This choice was made as information about substance use, perhaps decades ago by a long-incarcerated offender, does not have substantial value. In the field, prisoners questioned why we were not collecting information about substance use history and current use, so we experimented with using the relevant items from the interRAI MH. We have reported on lifetime use of substances as reported to us. However, given that reported current substance use within a prison, if it occurred, is a crime, yet also some prisoners may claim use to raise their perceived image, we do not believe the information collected on current use is credible. To do a truly reliable assessment of current drug use would require actual biological drug testing, which was not feasible within the scope of this project. Thus, we do not report on these items. As described later in Section V.A.7, we base our reports about substance abuse on the lifetime presence of substance abuse in prisoners close to release.

We also included on the assessment form a section for the assessors to add any comments they had regarding the interviews. The comments were reviewed by the project team, but were not felt to contain any reportable information.

² Hirdes JP, Smith TF, Rabinowitz T *et al.* The resident assessment instrument-mental health (RAI-MH): inter-rater reliability and convergent validity. *J Behav Health Serv Res* 2002; 29: 419–32.

³ The main changes made to the instrument involved grouping items about history prior to incarceration (substance abuse, gambling, etc.) into a separate section which was only to be completed if the subject had been incarcerated for less than two years. The project team decided that these items were rarely relevant if a subject had already been in prison for a long period of time. The few other changes were minor wording alterations.

III.B. Assessors

A team of assessors were hired by MPHI to complete the interviews. Assessors were required to have a strong background in mental health, assessment, and interviewing techniques. In addition, a couple of the assessors hired also had past experience working within the corrections system.

Assessors attended an intensive two-day training given by the contractors and MDOC which covered security issues, review of the protocols, discussion of interviewing techniques, and a detailed review of the instrument. Assessors were also provided with a comprehensive manual on the use of the instrument. At several points during data collection, assessors also had the opportunity to discuss clinical questions with Dr. Margolis and others on the project team.

III.C. Sampling

III.C.1. Facilities

With the exception of Robert Scott Correctional Facility (SCF), which at the time housed the majority of women prisoners, the facilities to be visited were selected randomly from all of Michigan's correctional facilities. Two camps (one male and one female) were also included. As several camps were undergoing closures at the time, we selected the sampled camps based on availability and geographic convenience. We initially selected 25 facilities; however, due to the closure of Huron Valley Men (HVM), the final facility sample was 24. Additional assessments were collected at Macomb Correctional Facility in order to compensate for the Huron Valley closure. The list of sampled facilities is found in Table 1. It provided a broad geographic representation of the state as well as prisons with varying programs and security levels.

Table 1. Facility Sample

Alger Maximum CF, Munising
Baraga Maximum CF, Baraga
Bellamy Creek CF, Ionia
Camp Lehman, Grayling
Camp Valley, Ypsilanti
Chippewa CF, Kincheloe
Cooper Street CF, Jackson
Earnest C. Brooks CF, Muskegon Heights
G. Robert Cotton CF (pilot), Jackson
Gus Harrison CF, Adrian
Ionia Maximum CF, Ionia

Lakeland CF, Coldwater
Macomb CF, New Haven
Marquette Branch Prison, Marquette
Muskegon CF, Marquette
Newberry CF, Newberry
Oaks CF, Manistee
Parnall CF, Jackson
Pine River CF, St. Louis
Richard A. Handlon CF, Ionia
Robert Scott CF, Plymouth
St. Louis CF, St. Louis
Standish Maximum CF, Standish
Thumb CF, Lapeer

III.C.2. Sampling Strata

Stratification is used in a study to assure that sufficient numbers of individuals with particular characteristics are included in the sample, especially when it is deemed a possibility that random selection may not provide sufficient sample sizes. After discussion with MDOC staff, it was deemed appropriate to stratify only upon sex, the provision of services in special units, and placement in administrative segregation. The Special Units population would include prisoners housed in any of the following types of units:

- Acute care
- Crisis stabilization units
- Detention/punitive segregation
- Hospital
- Protective custody
- Residential treatment programs
- Residential substance abuse treatment
- Social skills development units.

We thus formed four strata for the sampling:

- Male – General Population
- Male – Administrative Segregation
- Male – Special Units
- Females (all)

Since small samples produce estimates with wide margins of error, we used "power analysis" to determine how large a sample was needed to achieve acceptably precise estimates. In power analysis, the analyst specifies three of four inputs--sample size, the approximate value of the estimate (proportion) of interest, an acceptable margin of error,

and a confidence level (probability of a false positive)--and the fourth is completely determined by the statistical relations between these quantities. For the approximate value of the estimate, we used information from past research that approximately 15% of male prisoners and 23% of female prisoners would have mental health problems. With these input estimates and the conventional assumption of a 95% confidence level, a sample size of 150 in each of the four strata would achieve a margin of error of approximately 5% in each stratum and overall, i.e., the estimates we would derive would be accurate to +/-5%.

As a result, the strata targets for this study were set at a total of 600 prisoners, divided evenly with 150 targeted in each of the four strata.

The project team determined which strata would be collected at each facility based on reports provided by MDOC detailing the number of prisoners in each stratum at each site. The original population numbers were provided by MDOC on August 1, 2008. Due to facility closures and programs being moved or discontinued, the strata were reevaluated and modified slightly based on population numbers drawn on April 9, 2009. As it was assumed that the strata represented the only characteristics important to be included in the sampling, we were able to select prisoners from any of the sampled correction facilities.

III.D. Field effort protocols

After the facility sample and strata were determined, MPHI developed a schedule for visiting the facilities. MDOC provided contact information at each facility for a key custody staff member who would help coordinate the visit. Contact information was also provided for a key member of healthcare staff, who would identify members of the healthcare team familiar with each inmate and coordinate interviews with those identified.

Approximately two weeks prior to each facility visit, MDOC produced an ordered list of prisoners to be approached at that facility. The list was developed by randomly selecting from all prisoners in the facility in each of the strata (three for male prisons, one for female prisons). Specific strata goals for each facility were developed in the previous step, and the list provided for an over-sample of names to allow for refusals. MPHI entered this ordered list onto a tracking form, and e-mailed it to the facility contact person. Facilities were instructed that prisoners appearing on the list were not to be transferred until after the study visit unless there was an acute health problem requiring hospitalization or treatment at another location.

Prior to the study visit, correctional staff made the first contact with potential subjects, in the order of the strata lists, to ask if they were interested in meeting with the assessors during their visit. We provided a script to use in these interactions, which briefly explained the study and asked whether the prisoner was willing to be called out to discuss participation in the study. If a prisoner declined to meet with the assessors, the staff member approached the next prisoner on that stratum list. MPHI staff kept a record of

those participating, refusing, or who were unavailable, and confirmed that the each list was being followed in order.

In some situations, a subject appearing on the list for a particular stratum (for example, Administrative Segregation) had moved to a new stratum since the drawing of the list. In this case the individual was no longer considered eligible for the study, and proceeded to the next individual on that strata list.

When assessors arrived in the facility, the subjects who had agreed to meet with them were placed on “call out.” Assessors met with subjects in teams of two, with one performing the interview and the other primarily recording, although the recorder would at times ask for clarifications and help in the interview. With four assessors, the assessor pairs alternated in composition and in who would be the primary interviewer. Rarely, one of two substitute assessors acted as the recorders when one regular assessor was unable to attend. Interviews took place in private rooms in the prison, usually with custody staff within view but always with staff unable to hear the discussions. Assessors prepared for the interview by explaining the study to the potential subject and reviewing the informed consent document with him or her. If the individual consented to participate, he or she signed the document and began the interview. Interviews took approximately one hour on average to conduct.

Following a prisoner interview, the assessors attempted to contact staff members who had been identified by the facility as having particular knowledge or familiarity with the subject. Assessors attempted to conduct staff interviews within the same day as the subject interview. At times the staff interviews were done over the phone and were brief – approximately 5-15 minutes in length. One primary piece of information sought was whether the staff member believed that information provided by the prisoner in an interview should be deemed credible. Assessors did not share prisoner responses with any staff members. If staff responses differed from the subject’s self-report, assessors were instructed to use their best judgment as to which was the most accurate information. Otherwise, staff information was used to supplement any areas that the subject may not have been able to answer fully. We did not ask assessors to identify the source of information for each item; however, the assessors reported that the majority of the information in the study is based directly on subjects’ self-reports.

Once all data had been collected, the pair of assessors reviewed the form together to be sure they were in agreement regarding the coding of the items.

These procedures were tested in a pilot at the Cotton Correctional Facility. Assessor interviews were overseen by the project’s principal investigator, psychiatrist, and UM and MPHI project managers. After the completion of two days of data collection, all these individuals met with the assessors to determine if any changes were needed in the assessments, instructions, or protocols. With no major changes needed, the project launched the full data collection.

In the majority of facilities, data were entered directly onto laptops during the interviews and uploaded at the end of each week at the MPHI offices. To protect against loss of data, information was saved onto both an encrypted jump drive and the laptop's encrypted hard drive. Once the data were uploaded, these backup versions were deleted. In some instances we were unable to get clearance to bring computers into the facility, in which case the forms were completed by hand and the data were entered later at the MPHI offices. In these cases, to ensure accuracy, the data were keyed into the electronic interview form by one of the assessors and then printed and verified against the original hardcopy form by a different assessor. Any necessary corrections were then made to the electronic file.

III.E. Secondary Data Sources

In addition to the primary data collected during the interviews, we also gathered information from existing data sources to aid in the analysis.

III.E.1. Demographics

Demographic records were provided by MDOC, containing information on sex, race, marital status, age, and education level of those subjects participating in the study. The data were generated by MDOC from the Corrections Management Information System (CMIS).

General population statistics were also provided by MDOC with the statewide census numbers in each stratum. These data were developed from CMIS and based on the MDOC census for April 9, 2009. They allowed us to develop sample weights used in the analysis (see Section V.E).

III.E.2. Sentencing

Sentencing information for each subject was provided by MDOC, including information on the crimes associated with the sentence, the date incarcerated, the length of sentence(s), and the earliest possible release date. These data also were developed by MDOC from CMIS.

III.E.3. Health Management Information System (HMIS) Mental Health records

Mental health (MH) records were provided by MDOC using its Health Management Information System (HMIS) database. MDOC provided full history of all HMIS records for each subject that participated in the study. For the purposes of the current project, we limited records to those within one year of the date of each prisoner's assessment.

The HMIS database contains information for prisoners who have been given a psychiatric diagnosis by prison MH staff and/or who are receiving MH services within the facility through the Corrections Mental Health Program (CMHP). CMHP services are provided

to prisoners through MDOC contract with the Michigan Department of Community Health, and are focused on acute care for seriously mentally ill prisoners with acute symptoms of psychosis or high suicide risk and on rehabilitative (sub-acute) care. As of July 2009, 20.8% of the total prisoner population was on active treatment status. The HMIS database includes information on the type of unit (inpatient, outpatient, etc.), type of services (individual and group therapy, and medication management), the general class of medication prescribed, and DSM-IV diagnoses. We do not have information on whether subjects may have been offered but refused services.

Mental health services that are provided by Psychological Services Units (PSUs) within the facilities would not be recorded in the HMIS database, and are not included in our services counts in this report. PSUs are operated by MDOC’s Bureau of Health Care Services, and are responsible primarily for responding to emergencies, providing referrals to treatment, and delivering assaultive offender and sex offender programming.

The omission of the PSU services from the HMIS database only became evident to the study team late in the analysis phase of the project. Collecting PSU service information would have involved a lengthy medical chart review for all of the 618 subjects in the study, and was not deemed feasible within the project’s budget or timeline. CMHP provides the majority of services to the most seriously, acutely mentally ill prisoners – the population of most interest in this study – so we deemed the HMIS data satisfactory for our purposes at this time.

III.F. Psychiatrist review

Both to validate our approach and in response to the requirements of PA 124 of 2007 to have a psychiatrist review a subsample of subjects, Project Psychiatrist Dr. Margolis attended 19 interviews along with the MPHI assessors at five correctional facilities. The list of facilities that Dr. Margolis attended, with the number of interviews in each, is provided in Table 2. Immediately following the assessors’ interview, Dr. Margolis had the opportunity to ask additional questions of the subject. He then used this information to determine independently his provisional diagnoses – if any – of these 19 subjects. Assessors were instructed not to change their answers based on any information gathered during Dr. Margolis’ interview; they could record any insights gained in the comment sections, although none did.

Table 2. Psychiatrist Interviews, by Correctional Facility

Facility	Number of Interviews
G. Robert Cotton CF	2
Robert Scott CF	5
Gus Harrison CF	5
Macomb CF	2
Bellamy Creek CF	5
Total Interviews	19

The sample of subjects interviewed by Dr. Margolis was not intended to be representative of the larger prison population, as representativeness is not critical in correlational research such as this. The visited facilities were chosen by geographic location and, in some cases, by presence of psychiatric service programs within the prison. Given the small number of interviews he was able to conduct, it was our goal that Dr. Margolis see a larger proportion of subjects who were likely to have mental health problems.

As part of the analysis, we compared the information gathered by the assessors to the provision psychiatric diagnoses assigned by Dr. Margolis. We discuss these analyses in Section VI.A.

III.G. Human Subjects Review

All sampling, data collection and analysis procedures, including the wording of the informed consent document used in this study were approved by the Institutional Review Boards of the University of Michigan, Michigan Public Health Institute, and Michigan Department of Community Health.

IV. MISSING SUBJECTS

As part of its data collection protocol, MPHI tracked all subjects who, although included on the sample list, either refused to participate or were unavailable to be interviewed when the assessors arrived at the facility. In this section we examine the magnitude of any bias caused by these missing subjects.

IV.A. Refusals

A total of 262 of the individuals approached declined to participate in the study. Prisoners could refuse to participate when first contacted by facility staff, or could also refuse at any point after meeting with the assessors. Interviews could also be stopped at any time, either by the subject or by the assessors (due to safety concerns or concerns that the subject was not fully competent to give consent). Only two interviews were stopped mid-way.

In addition to the above refusals, one prisoner wrote to the study just before the issuance of this report and requested that his/her data be omitted; we have complied. Due to human subjects' protections, we are not permitted to analyze any data describing these individuals other than the facility where they were imprisoned. Refusals by facility are shown in Table 3.

Table 3. Refusals by Facility

Facility	Number of Refusals
Alger Maximum CF	7
Baraga Maximum CF	4
Bellamy Creek CF	35
Camp Lehman	9
Camp Valley	2
Chippewa CF	8
Cooper Street CF	0
Earnest C. Brooks CF	10
G. Robert Cotton CF (pilot)	4
Gus Harrison CF	21
Ionia Maximum CF	7
Lakeland CF	7
Macomb CF	10
Marquette Branch Prison	27
Muskegon CF	3
Newberry CF	10
Oaks CF	4
Parnall CF	11
Pine River CF	7
Richard A. Handlon CF	8
Robert Scott CF	49
St. Louis CF	9
Standish Maximum CF	10
Thumb CF	0
TOTAL	262

IV.B. Unavailable Individuals

In addition to the refusals discussed in the prior section, there were 125 instances where individuals who appeared on the sample list were unavailable when the assessors arrived at the facility. The reasons given were that the subject was: 1) transferred to another facility, 2) paroled, 3) now in a new strata, or 4) unable to be interviewed due to illness or hospitalization, or because he or she was working. The breakdown by reason recorded is shown in Table 4.

Table 4. Number of Unavailable Subjects, by Reason Unavailable

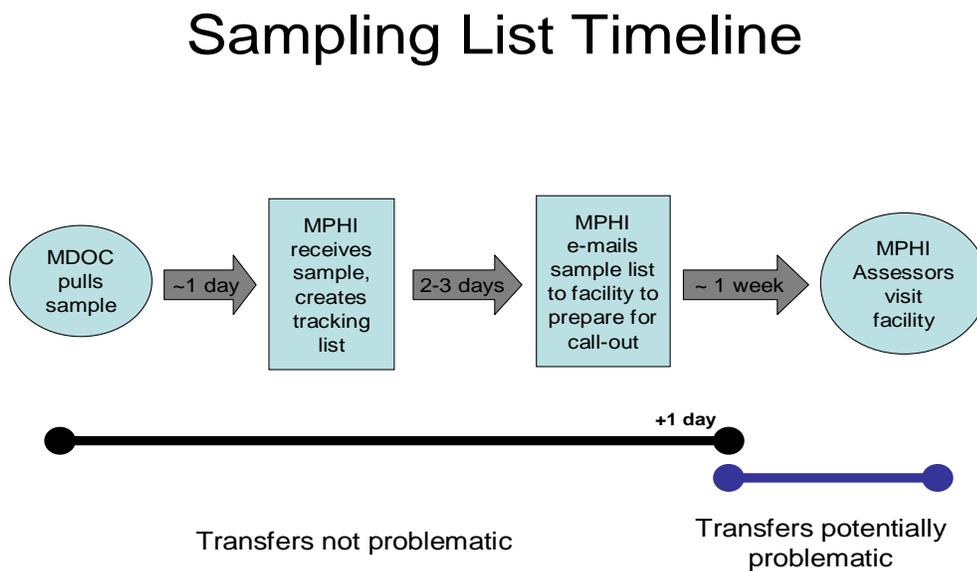
Reason	Number
Transferred to Another Facility	67
Changed Strata	42
Paroled	4
Sickness/Working	12
Total Unavailable Subjects	125

MDOC provided the residential history for each of these unavailable prisoners. We reviewed these data to determine if there was any pattern that would suggest that certain subjects were intentionally moved or made unavailable so as to avoid their participating in our study, and thereby potentially biasing our results.

IV.B.1. Transfers to Other Facilities

There were 67 prisoners who had been on the sample list, but were transferred to another facility before assessors could interview them. While the facilities were instructed by MDOC not to transfer any subjects on the sample list, there was a time delay of several days between the sample being drawn by MDOC and it being received by the facility from MPHI. When the sample was drawn by MDOC, it was first sent to MPHI, who entered the information on the tracking list. MPHI then sent the sample list to the facility, usually within 2-3 days of receiving it from MDOC. Clearly, transfers made by the facility during this time are not intentional. We also assume a transfer up to one day following the receipt of the sample list is also not problematic, as the transfer was probably arranged prior to receipt of the list. Figure 1 shows a timeline of this process.

Figure 1. Sampling List Timeline



Of the 67 transfers, 23 involved Scott Correctional Facility (SCF) prisoners being re-located to Huron Valley Complex for Women (WHV). This was part of a planned moving process and unlikely to be related to our study.

Of the 44 remaining transfers, 17 were transferred either before the facility received sample list, or within 1 day of receipt, and were therefore deemed to be unproblematic. An additional 16 seemed explainable by hospitalizations, school, paroles, transfers to receive special services, or a long delay between draw and visit⁴, so were also deemed unproblematic. Therefore, only 11 of the transfers were even potentially questionable. Table 5 provides additional detail.

Table 5. Transfers to Other Facility, by Reason for Transfer

Reason for Transfer	Number Transferred
Total Transfers	67
Transfers from Scott Correctional Facility	23
Other Transfers	44
Transferred before the facility received sample list, or within 1 day of receipt	17
Hospitalized	3
In school	1
Transferred to new facility to receive new services (RTPs)	5
Paroled	3
Long delay before visit (facility revisited late in study)	4
Potential Problems	11

IV.B.2. Strata Changes

A total of 42 people were coded as being in the target facility, but transferred to a different sampling stratum when the assessors visited. The study protocol for these situations was to replace those subjects with the next person on the list for that same stratum, in order to assure appropriate numbers of subjects in each stratum. The issue, of course, is whether the replacement will be "just like" the original person on the sample list. As before, if the stratum change occurred before the facility received the list (i.e., between the time the list was generated and when the facility got the list and could have achieved a transfer), or even one day longer, then there is no problem (see Figure 1). But if facilities purposefully move prisoners out of Administrative Segregation (Ad Seg), for example, to avoid them from being part of our sample, then there is a risk that the random replacement will not be "just like" the original. In general, we did not expect that this would happen for several reasons. First, we would still be getting another Ad Seg person as a replacement, and he/she would likely be fairly similar, so it is unlikely that

⁴ Two early facilities were visited for a second time late in the field effort in order to collect more subjects within the Special Units strata. Rather than regenerate a new sample list, MPHI assessors continued on the original sample list.

tampering would be worthwhile. Second, facilities were not aware of the project’s protocol to replace a person after a stratum change rather than retain them in the study. Third, we do not expect that a facility would have taken a prisoner off of, say, Ad Seg and create a potentially serious security risk, solely to avoid this person being in our sample. However, if this were done, we would expect that the prisoner would be returned to Ad Seg soon after the study for the safety of the prisoner, other prisoners, and correctional staff.

We thus reviewed the residential history to examine the permanence of these 42 transfers (Table 6). In all cases when strata change actually occurred, the move appeared to be fairly permanent (lasting at least two months or longer). However, we identified nine potentially problematic subjects within the “strata change” category: two subjects were actually facility transfers, occurring after sample list received, and seven subjects appeared in MDOC records actually to be in the facility and in the appropriate strata at the time of visit.

Table 6. Strata Changes

Reason for Strata Change	Number of Strata Changes
Total dropped due to changed strata	42
Transferred to new strata and remained 2+ months	28
Sampling/Coding Error	5
Transferred to new facility after sample list received	2
In facility and in appropriate strata during visit	7

IV.B.3. Paroles and “Other” Unavailable Subjects

The remaining 16 unavailable subjects include four individuals that had been paroled prior to our arrival in the facility. These releases were confirmed by MDOC records and were deemed unproblematic.

Finally, twelve individuals were coded with a disposition of “other” by the assessors. The assessors used this code if a prisoner was sick, hospitalized, in school, or working at the time of the visit. MDOC records were able to confirm the hospitalizations. As facilities had agreed to excuse subjects from school or work to participate in the study if they chose, the remaining “other” cases are more accurately described as refusals. All twelve of these cases were therefore deemed unproblematic.

IV.B.4. Questionable Cases

In summary, only 20 of the unavailable individuals appear to be even potentially questionable (Table 7). This represents only 2% of prisoners actually approached for the study. We have no indication that any activities by prison staff or administration were performed to bias the study.

Table 7. Questionable Cases, by Reason and Whether a Potential Problem

Reason	Number	Potential Problem
Refused	262	0
Unavailable	125	20
Transferred to other facility	67	11
Dropped because changed strata	42	9
Paroled	4	0
Other (In Hospital, Working)	12	0

V. METHODOLOGY

V.A. Measures of Mental Health Symptoms

The interRAI CF assessment can be used to produce scales measuring the presence and severity of MH problems. Five of these scales were used in the project to indicate the presence of symptoms of mental illness:

- Cognitive Performance Scale (CPS)
- Depression Rating Scale (DRS)
- Positive Symptoms Scale (PSS)
- Negative Symptoms Scale (NSS)
- Mania Scale

The scales, as the symptoms themselves, are overlapping. Nevertheless, the research performed on these scales demonstrates that together they can provide an accurate “provisional mental health diagnosis.” In the following, we describe each scale, the original validation work that was performed when the scale was developed, how it is scored, and what threshold was used as an indicator of a severe problem. Finally, we provide information on how the scales were summarized to a single measure of the presence of a MH problem.

V.A.1. Cognitive Performance Scale (CPS)

The CPS describes cognitive status (dementia and other), and is based on the items for short-term memory, decision making, and ability to express self.⁵ It has been validated against the Folstein Mini-Mental Status Exam in nursing facilities and inpatient psychiatry settings. The possible score ranges from 0-7 (intact to very severe impairment), with a score of 2 or more indicating severe symptoms.

⁵ Item numbers from the interRAI CF for each scale are provided here as footnotes. For the CPS, items used are G1, G2a, and I1. The interRAI CF instrument is attached as Appendix B. .

V.A.2. Depression Rating Scale (DRS)

The DRS describes symptoms of depression, and is based on the items for negative statements, persistent anger, expressions of unrealistic fears, repetitive health complaints, repetitive anxious complaints, facial expressions, and tearfulness.⁶ It has been validated in nursing homes and inpatient psychiatry against the Hamilton and Calgary depression scales. Scores range from 0-14. A score of 6 or more indicates severe depression, and is associated with increased suicidality, command hallucinations, and concern about risk of harm to self. Scores greater than 3 indicate a more moderate depression.

V.A.3. Positive Symptoms Scale (PSS)

The PSS is an indicator of positive psychotic symptoms, defined as symptoms and behaviors present beyond normal experience of persons without severe mental illness. The scale is based on the items for hallucinations, command hallucinations, delusions, and abnormal thought process/form⁷. It has been validated in inpatient psychiatry against the PANSS Positive Symptoms subscale. Scores range from 0-12, with the threshold for severe symptoms being 3 or more.

V.A.4. Negative Symptoms Scale (NSS)

The NSS is an indicator of negative psychotic symptoms, defined as a loss of involvement or engagement beyond the normal experience of persons without severe mental illness. It is based on items for anhedonia, withdrawal from activities, lack of motivation, and reduced social interaction⁸. It has been validated against the PANSS Negative Symptoms Scale. Scores range from 0-12. The threshold for severe symptoms is 6 or more, and the threshold for mild symptoms is 3 or more.

V.A.5. Mania Scale

The Mania Scale is based on items of inflated self worth, hyperarousal, irritability, increased sociability, pressured speech, labile affect, and sleep problems⁹. It has been validated on psychiatric staff ratings of risk of harm to others and inability to care for self. Scores range from 0-20, with the threshold for severe symptoms being 5 or more.

V.A.6. Mental Health Symptom Summary Measure

Based on the above MH scales, we developed a MH symptom summary measure which indicates whether a person appears to have a potential psychiatric illness. The Summary Measure counts the presence of any of the five indicators at the severe level:

CPS ≥ 2
DRS ≥ 6
PSS ≥ 3
NSS ≥ 6
Mania ≥ 5

We deemed the presence of any of the five dimensions at this severe level to constitute a mental health problem, i.e., a summary symptom score of 1 or more.

⁶ Items used: D1a, D1b, D1d, D1o, D1p, D1cc, D1ee.

⁷ Items used: D1u, D1v, D1w, D1x.

⁸ Items used: D1y, D1z, D1aa, D1bb.

⁹ Items used: D1h, D1i, D1j, D1k, D1l, D1m, D2.

V.A.7. Substance Abuse

As mentioned previously in Section III.A, measuring substance use in this project was challenging. It also was difficult to determine what level of substance use treatment would be expected in a prison-setting, assuming that prisoners would ideally be not using in that setting and any substance abuse problems would be in remission.

After discussions with MDOC, we deemed that substance abuse treatment would be most important for prisoners who both: 1) had a history of prior substance use problems, and 2) were approaching release into the community within the next six months. We suggest that MDOC utilize the six months prior to discharge to prepare the prisoner for entering (or re-entering) a treatment program for substance abuse. This may be accomplished, in part at least, by reintroducing them to Alcoholics Anonymous and establishing therapy groups as well as individual treatment. If they already are obtaining substance abuse treatment, continuing this treatment until discharge should be quite helpful, and would give them a headstart as they re-enter the “outside world.” Thus, in preparing the prisoner for a return to society, we would hope to facilitate further treatment and to prevent relapse.

From our subject list, we identified a subset of individuals who met the above two criteria. For this subsample, MDOC provided us with information on substance abuse treatments or programs received within the past year prior to assessment.

V.B. Clinical measures

Our clinical measures are derived from the HMIS data provided by MDOC. Of the 618 subjects in our sample, 265 had received MH services within the correctional facilities at some point during their incarceration. The presence of a HMIS records was deemed by MDOC to be the proper identification of any formal MH service, either treatment or medication. We determined that “current service” would consist of treatments or medications provided in the year prior to the assessment of the individual prisoner, as identified by the “review date” of the HMIS record. Using this criterion, 215 (34.8%) of these 265 subjects were currently receiving services; the remaining 50 had not received services for over one year (note, however, that this percentage does not adjust for the targeted stratified sampling).

V.B.1. Diagnoses

Full DSM-IV diagnoses, as assigned by MDOC Qualified Mental Health Professionals (QMHPs)¹⁰, were provided from the HMIS data. The diagnosis fields included:

Axis I: Clinical Disorders (Primary and Secondary)

Axis II: Developmental and Personality Disorders (Primary and Secondary)

¹⁰ A physician, psychiatrist, psychologist, social worker, registered nurse or other health professional who is trained and experienced in the areas of mental illness or mental retardation and is licensed or certified by the State of Michigan to practice within the scope of their professional training.

Axis III: General Medical Conditions (Primary and Secondary)
Axis IV: Psychosocial and Environmental Problems
Axis V: Global Assessment of Functioning

For our purposes, we have focused primarily on Axis I diagnoses, representing the psychiatric problem driving the provision of care. Axis II diagnoses are typically for personality disorders and these disorders may be highly prevalent in prison populations (for example, anti-social personality disorders). The presence of an Axis II diagnosis was not felt to be a high enough criterion for severe, persistent mental illness in this population, as it would not necessarily be either treatable or acute.

V.B.2. Therapies (including substance abuse)

The HMIS database contained information on MH services being provided within the prisons. HMIS codes differentiate between seven types of individual therapies¹¹ and seven types of group therapies¹². From these, we created three measures for services:

- Individual Services Indicator of whether the subject received any individual services with a review date in the year prior to the assessment
- Group Services Indicator of whether the subject received any group services with a review date within the year prior to the assessment
- Therapy Service Indicator of whether the subject had received any individual and/or group service with a review date within the year prior to the assessment.

Substance abuse services were defined using the therapy code variable in HMIS, which includes a category (“GD”) for dual diagnosis/substance abuse services. MDOC has advised us that this is the appropriate variable for determining formal substance abuse treatment within the prisons.

Earlier, in Section V.A.7, we describe the individuals that we felt would appropriately be provided substance abuse treatment. We provided the list of these individuals to MDOC which returned information on the provision of substance abuse therapies by prisons within the year prior to the project’s in-person assessment.

V.C. Medication measures

The HMIS database contains data on the categories of psychiatric medication(s) prescribed, again along with the review date at which they were prescribed (or renewed). The classifications used in HMIS are:

- Antianxiety
- Antidepressants
- Antihistaminic
- Antiparkinsonian

¹¹ Supportive (IS), Cognitive/behavioral (IC), Brief therapy/crisis intervention (IB), Brief therapy/dynamic-insight oriented (ID), Longer term insight oriented (IL), Case management (IM), Medication management (MM).

¹² Psychosocial rehabilitation modules (GP), Dual diagnosis (MI/Substance abuse-dependency) (GD), Cognitive/behavioral (GC), Support (GS), Transactional (GT), Psychodrama (GY), Family therapy (GF).

- Antipsychotic
- Beta adrenergic receptor antagonists
- Hormonal
- Mood stabilizers
- Stimulants
- Other psychotropic medications

In addition, HMIS data indicates whether or not the prisoner has been compliant with these medications.

We used the medication data to create yes/no variables indicating whether a subject had received each class of medications within the last year. We also created a medication count variable which counts how many classes of medications were prescribed. Finally, we indicated whether a subject was ever non-compliant with a class of medication within the last year. Of these multiple measures, we only report here on whether the subject used any medications.

Unfortunately, the HMIS database does not record when a prescription is stopped; therefore, we are not able to determine with certainty whether or not a subject, having been prescribed a medication in the past year, was actually on the medications at the time of the interview. Therefore, our medication measures are based only upon whether the subject had been on the medications at any point in the last year and are likely to overstate the prevalence of medication use at the time of the interview.

V.D. Sentencing measures

MDOC provided information on incarcerations and sentences for all of the subjects, including the date the crime was committed, the date the prisoner was incarcerated, the minimum and maximum release dates, and the crime(s) of which the prisoner was convicted. While the database did contain information on all lifetime incarcerations for each subject, we selected only the offenses related to the incarceration at the time of the interview. We calculated the length of the subjects' incarceration, and the minimum and maximum time left remaining on their sentence, but do not report here on these measures.

Using an algorithm provided by MDOC and applied to the Michigan Compiled Law (MCL) Codes in the CMIS database, crimes were categorized into 17 major offense types:

- Arson
- Assault
- Other assaultive behavior
- Burglary
- Criminal sexual conduct
- Drugs
- Forgery/embezzlement
- Fraud
- Homicide

- Larceny
- Malicious destruction of property
- Motor vehicle
- Operating Under the Influence of Liquor (OUIL) 3rd Offense
- Other non-assaultive offense
- Other sex offense
- Robbery
- Weapons possession.

Since prisoners often are convicted of multiple charges at a single time, it is also often that a subject will have multiple offense types related to his/her current incarceration. Some of the analyses we describe in Section VI are based on the number of offenses rather than the number of prisoners.

V.E. Analytic approaches, weighting

Because we focused on different strata, our sample is not directly representative of the overall Michigan prison population. For example, women constitute 25% of our study sample, but only about 4% of prison population. Therefore, in order to provide results that are directly applicable to the entire population, one needs to weight each observation. For example, each female in our study has been weighted by 12.4% to reduce its impact upon statistics for the full Michigan population. With the exception of the Section VI.B (Sample Fulfillment), the results presented below have all been weighted to provide the results representative to the overall population of the Michigan correctional facilities. To remind the reader that our sample results are projected to the full statewide population, we report these “numbers” with a single decimal digit, such as “33,461.0” in Table 10. The case weights were calculated using total census information provided to us by MDOC as of April 9, 2009 which was 47,888 prisoners¹³.

V.F. Merging databases, analysis using SAS

MDOC and MPHI provided databases to UM in Microsoft Excel format. These files were imported into files analyzable by the SAS statistical language, merged using the subjects’ unique MDOC number. The database development and all analyses were performed using SAS V9.1.3¹⁴. For privacy reasons, identifiers were removed from the final analytic file.

¹³ Due to rounding, some of the tables will deviate slightly from this statewide total number.

¹⁴ SAS Institute, Cary North Carolina, 2005.

VI. FINDINGS

VI.A. Psychiatrist review

As discussed in Section III.F, our project psychiatrist, Dr. Margolis, attended 19 interviews along with the MPHI assessors. Following the interviews, Dr. Margolis wrote brief diagnostic summaries and, when appropriate, assigned provisional diagnoses to each subject based on his assessment.

Of the 19 subjects, Dr. Margolis assigned Axis I diagnoses to 13 and an Axis II diagnosis to an additional one. For the case where Dr. Margolis indicated only an Axis II diagnosis, he did concur that the prisoner had mental health problems. The remaining five individuals did not have a MH problem by his assessment.

We compared his findings to our MH Summary Measure for each individual. We found that in all but one case, Dr. Margolis and the assessors were in agreement as to whether or not a subject had an MH problem. In addition, we compared the symptoms that he had described in his case notes to symptoms detected by the instrument (for example, presence of hallucinations, anxiety, etc.), and also found a high degree of agreement.

In one case the assessment's MH Symptom Summary Measure identified an individual as having a potential MH problem, but Dr. Margolis did not feel the individual had a diagnosis. In reviewing the case notes and the assessment scoring, we noted that the assessors had indicated a particular MH symptom as being active. Dr. Margolis noted that this symptom had occurred in the past, but felt it was no longer an issue for this individual. Therefore, this discrepancy seems likely due to slightly different interpretations as to whether the symptom was ongoing, but the assessors and Dr. Margolis were in agreement regarding the presence of this symptom at some point in time.

Thus, of the 19 prisoners with an in-depth psychiatrist's interview, there was agreement on the presence or absence of psychiatric problems on 18, with only a disagreement on whether the diagnosis was still active on the remaining one. Thus the agreement rate was between 95% and 100%, validating in part the project's approach of using psychiatric scales to indicate psychiatric diagnoses.

Of these 19 subjects, one individual had cognition problems, seven had depression, six had positive psychotic symptoms, three had negative psychotic symptoms, and two had mania, as determined by our MH scales. Overall, a total of 11 subjects triggered as having mental health symptoms according to our summary measure - five of the eleven triggered on multiple domains.

VI.B. Sample fulfillment

A total of 618 subjects were recruited and interviewed for the study. The distribution by strata is shown in Table 8.

Table 8. Study Sample Fulfillment, by Strata

Strata	Goal Sample	Actual Sample
Male – General Population	150	170
Male – Administrative Segregation	150	149
Male – Special Populations	150	150
Female	150	149
Total	600	618

Overall, we exceeded the goal sample size for the total population. Additionally, we achieved the strata goals as well, except for the loss of one observation in each of two strata.

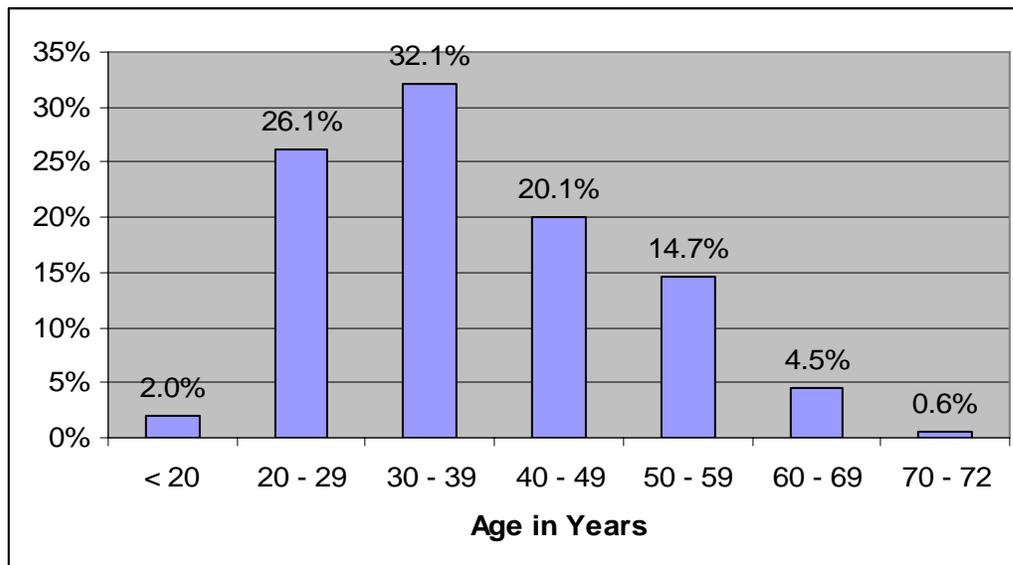
Note: All results reported after this point, unless otherwise noted, were performed using case weights, as discussed previously in Section V.E.

VI.C. Basic demographics of sample

VI.C.1. Age

Age distributions of the subjects are shown in Figure 2, after sample weighting to represent the full Michigan prison population. Of all prisoners, 78.3% are between the ages of 20 and 50 years, with only 5.1% of the prisoners above age 60 years

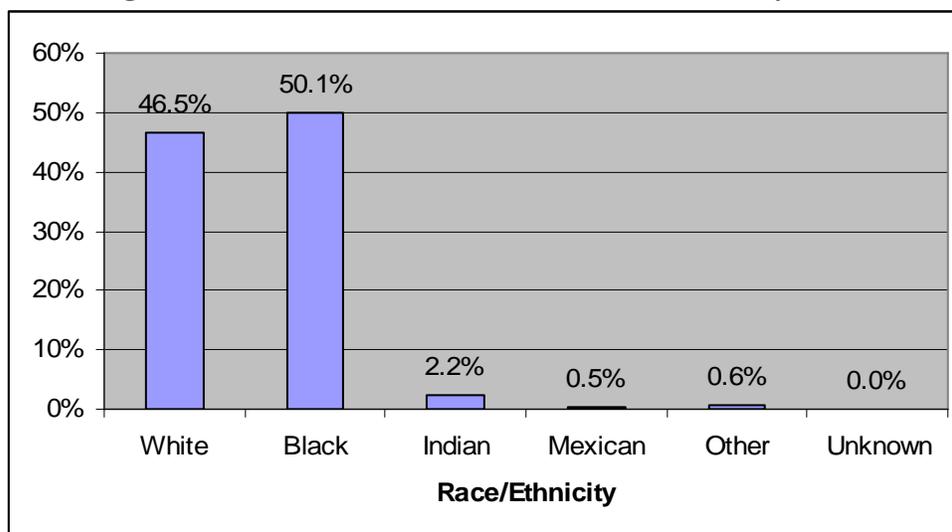
Figure 2. Distribution of Prisoners' Age



VI.C.2. Race/ethnicity

Race/ethnicity was abstracted from the CMIS records, After sample weighting, half of the prisoners in Michigan are black and only a slightly lower percentage (46.5%) are white; of the remaining 3.4%, the majority are Indian (2.2% of all prisoners (see Figure 3).

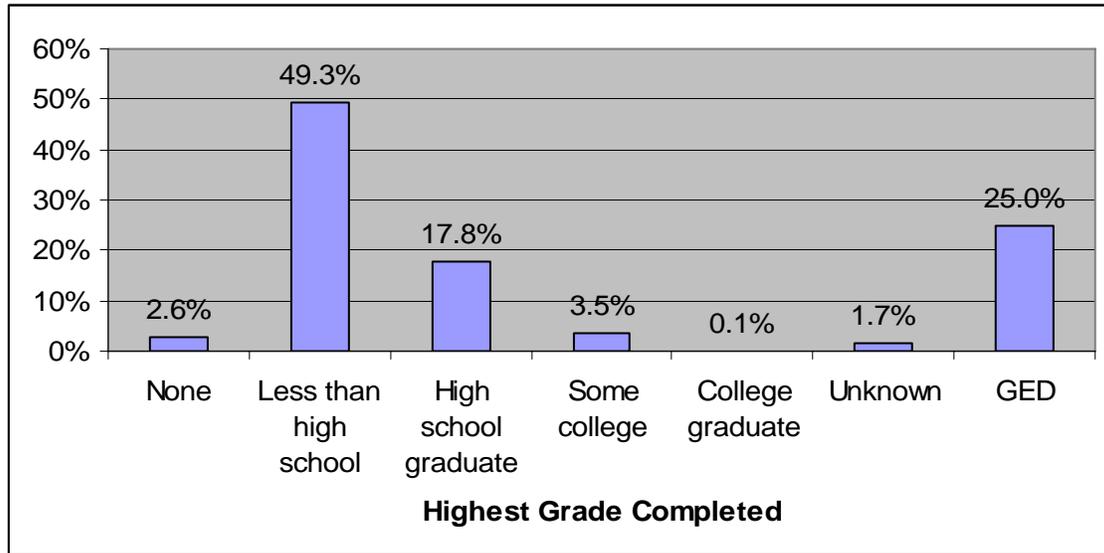
Figure 3. Distribution of Prisoners' Race/Ethnicity



VI.C.3. Education

The highest grade completed is reported in Figure 4. Over half of the sample (51.9%) had less than a high school level education, while on 3.6% had received any college education.

Figure 4. Distribution of Highest Grade Completed by Prisoners



VI.D. Mental Health Symptoms

The psychiatric outcome measures derived from the interRAI CF are discussed previously in Section V.A. Distributions on the five scales and the overall summary score (after weighting to represent the full Michigan prison population) are displayed below in Figures 5-10. Results have been broken out by male and female prisoners. On all scales, higher scores indicate higher severity. The thresholds for each scale, described in Section V.A.6, are indicated by the bold vertical lines on the graphs.

VI.D.1. Cognitive Performance Scale (CPS)¹⁵

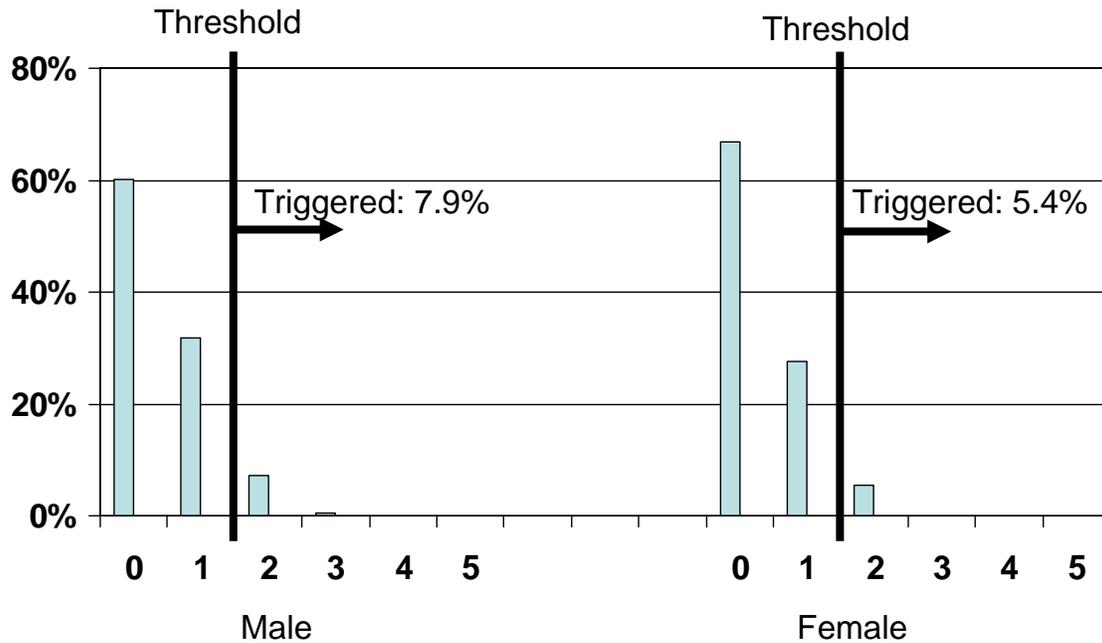
Eight percent of the males and 5.4% of the females had substantial cognitive impairment, as indicated by a CPS scale score of 2 or more. No prisoner in the sample scored at the highest end of the CPS; this is to be expected given the study design. Due to human subjects' requirements, we were not allowed to recruit any subjects who were not cognitively intact enough to give fully informed consent.¹⁶ While reviewing the informed consent document with the prisoners, our assessors would determine whether the individuals understood the study and their rights as a participant. If assessors were

¹⁵ See Section V.A for details on the specific items used in each of the scales displayed here.

¹⁶ We did not record the number of individuals whom assessors determined could not give consent. Assessors did stop two interviews mid-way, as during the conversation they began to feel these subjects were not fully competent to participate.

not certain of this, they ended the interview and did not record any data other than log the refusal (see Section IV.A).

Figure 5. Frequency of Cognitive Performance Scale (CPS), by Sex



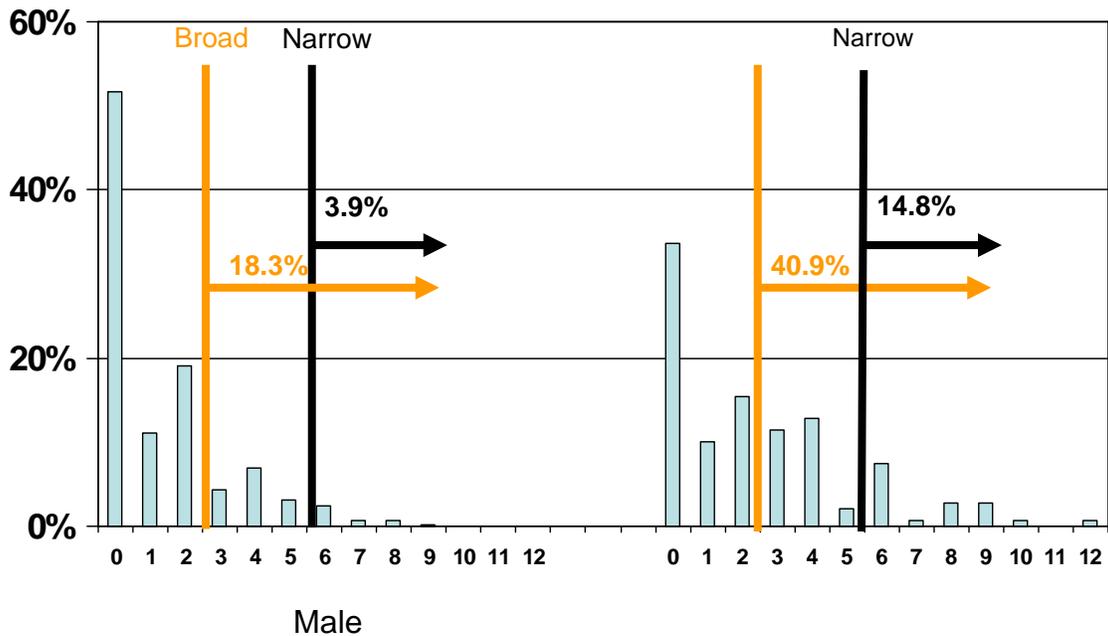
VI.D.2. Depression Rating Scale (DRS)

Using the threshold for severe symptoms (a score of 6 or more on the DRS), 3.9% of the males and 14.8% of females were depressed. This threshold is strongly correlated with increased suicidality, command hallucinations, and concern about risk of harm to self. This higher percentage in women is expected, having been often reported in the general population¹⁷.

Reducing to a threshold of 3 and above would additionally identify prisoners with more moderate levels of depression, similar to what might be treated within a community setting. Including this moderate depression in our estimates, the prevalence of depression in males rises to 18.3% and in females to 40.9%. For our purposes in this report, we have only used the threshold for severe depression.

¹⁷ Kessler, R.C. (2003). Epidemiology of women and depression. *Journal of Affective Disorders*, 74(1), 5.

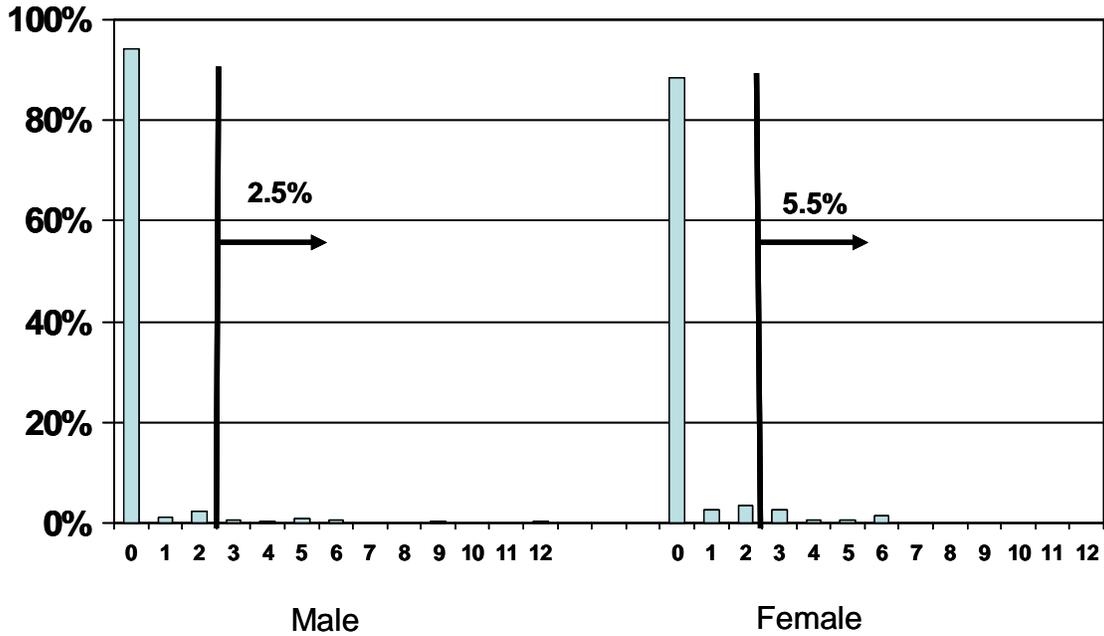
Figure 6. Frequency of Depression Rating Scale (DRS), by Sex



VI.D.3. Positive Symptoms Scale (PSS)

Among the male population, 2.5% trigger as having severe positive psychotic symptoms, as indicated by the PSS values of three or more; this statistic rises to 5.5% among females. As with the CPS, our findings could be skewed more towards mild symptoms, as an individual who was experiencing acute psychotic symptoms (delusions, command hallucinations, etc.) may have been deemed by the assessors or correctional staff as not able to fully consent.

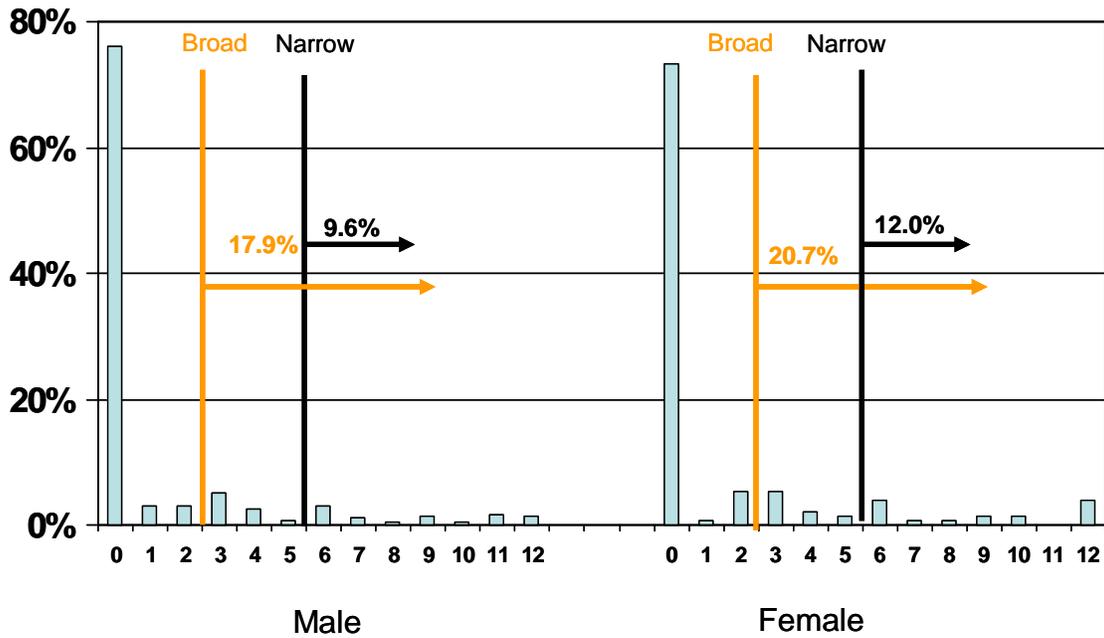
Figure 7. Frequency of Positive Symptoms Scale (PSS), by Sex



VI.D.4. Negative Symptoms Scale (NSS)

At the same time, 9.6% of males and 12% of females triggered as having severe negative psychotic symptoms, as indicated by the NSS scale . Using the threshold for mild symptoms, the numbers increase to 17.9% of males and 20.7% of females. As with depression, we use the severe threshold in our determination of mental illness.

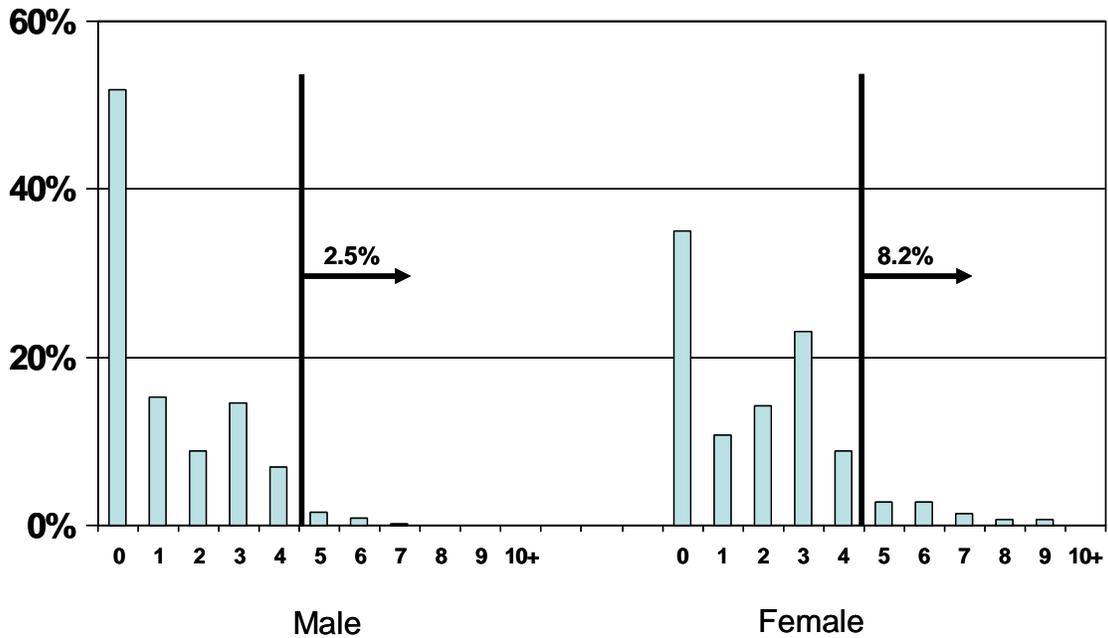
Figure 8. Frequency of the Negative Symptoms Scale (NSS), by Sex



VI.D.5. Mania Scale

Finally, we evaluated the Mania Scale. After weighting to the statewide prison population, 2.5% of males and 8.2% of females reported symptoms related to severe mania, as indicated by scale values of 5 or more.

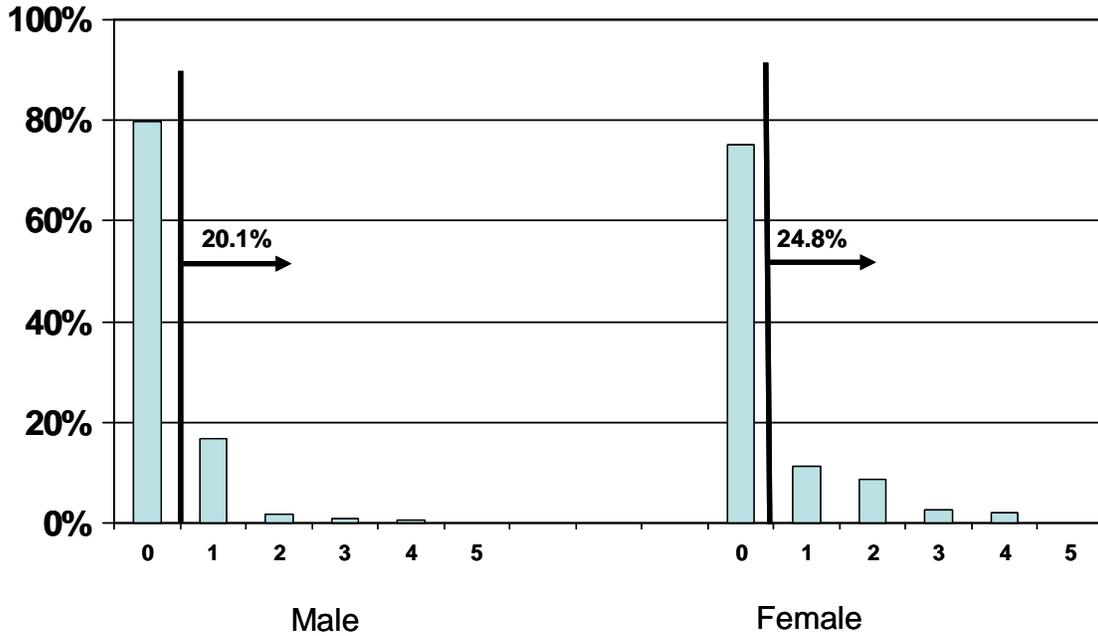
Figure 9. Frequency of Mania Scale, by Sex



VI.D.6. Mental Health Summary Measure

In this study, we have defined a MH problem as the presence of any of the above five outcome scale measures at the severe level. Our summary measure detects how many of the above scales have “triggered” for an individual. The presence of any of the five dimensions (scales) (i.e., a count of 1 or more of the Summary Measure) is deemed to indicate the presence of a substantive psychiatric problem. According to this measure, 20.1% of males and 24.8% of females in the Michigan correctional facilities have symptoms of severe mental illness.

Figure 10. Frequency of MH Symptom Summary Measure, by Sex



For prisoners who only trigger as having a single of the mental health symptom indicators, the distribution by scale is shown below (Table 9). Males with a single trigger most often have negative psychotic symptoms, while females have severe depression.

Table 9. Scale Domain Triggered in Prisoners with a Single MH Trigger, by Sex

	Male (Percent)	Female (Percent)
Total	16.7%	11.4%
CPS Only	5.4%	0.0%
DRS Only	2.8%	5.4%
PSS Only	0.5%	0.0%
NSS Only	7.2%	3.4%
Mania Only	0.9%	2.7%

VI.E MDOC Mental Health Diagnoses and Services

Information on diagnoses, MH services, and medications provided within the facilities was derived from the MDOC HMIS database. Of the 618 subjects in the study, 265 had clinical data recorded; alternately stated, 265 had any MH diagnosis, service, or psychiatric-related medication in the database. Of these, 215 had HMIS records within one year prior to the assessment date, including DSM-IV Axis I and Axis II primary diagnoses.

Of these 215 with records within the last year, all but ten subjects were currently receiving treatments at the time of their assessment. Examining these ten prisoners more closely, we found that seven began treatments shortly after the assessment date, and two had discharge dates within the prior year, and thus did not appear currently to be receiving any treatment. The remaining one prisoner had only a diagnosis on record but no subsequent treatments – it is possible this person had been diagnosed but then refused services, but this is not clear from the data provided. In all of these ten cases, we deemed that the person was not receiving services, thus potentially slightly undercounting the number of prisoners getting MH services. Therefore, we considered 205 subjects as “currently” receiving psychiatric treatment for the purposes of our analyses. Weighted up to the full population, this equates to 17.7% of prisoners.

Weighting to the statewide population, of all of the subjects who were currently receiving *any* treatment, all were receiving individual therapy, 94.5% were receiving medications, and somewhat fewer (52.5%) were receiving group therapy. Of prisoners who received any services, the majority received all three types of therapies. Thus, we have decided to report on whether or not subjects are receiving MH services rather than to report separately on types of services.

Substance abuse services (therapy code GD) reflect only 5.6% of the total MH services provided by MDOC, according to the HMIS database. It is possible that prisoners may be receiving informal help with substance abuse issues, perhaps through Alcoholic Anonymous groups offered within the facility. These are not necessarily professional services, however, and are not being coordinated or provided by MDOC, and therefore not measured in our study.

VI.F. Response to PA 124 of 2007

As discussed earlier, our approach to addressing the PA 124 requests for information on the prevalence of psychiatric diagnoses was to describe the prevalence of psychiatric symptoms indicative of diagnoses. Thus, in the following discussion the term “diagnosis” refers to a diagnosis provided by a MDOC mental health care provider while “mental health symptoms,” indicates that they have triggered on our assessment’s Mental Health Summary Measure.

VI.F.1. Prisoners with mental health symptoms and MDOC mental health diagnoses and Services

The primary question posed by PA 124 of 2007 was the degree to which MH services provided in correctional facilities meet the need based on the prevalence of mental illness in the prison population. Table 10 shows the relationship between whether the individual was determined to have mental health symptoms (the presence of any of the scales at or above their threshold level) and whether he or she received MH services (individual or group therapy, or medication) Again, the numbers displayed reflected weighted population estimates.

Table 10. Prevalence of MDOC Mental Health (MH) Services by the Presence of MH Symptoms (with Row Percentages)

MH Symptoms	MDOC MH Services		Total (with Column Percentage)
	No	Yes	
No	33,461.0	4,715.5	39,773.0 (79.7%)
	87.7%	12.4%	
Yes	6,311.5	3,399.8	9,711.2 (20.3%)
	65.0%	35.0%	
Total	39,773.0	8,115.3	47,887.8 (100.0%)
	83.1%	17.0%	

Our assessment and HMIS records agree that 69.9% (33,461 out of 47,888) of the population both does not have psychiatric symptoms and does not have a MH diagnosis recorded by MDOC. For another 7.1% (3,400 out of 47,888) of the entire population there is also agreement: that prisoners both have MH symptoms indicative of MH diagnoses and a MDOC MH diagnosis receiving services. However, there is substantial mismatch between the 20.3% of individuals with MH symptoms and the 17.0% of those with MDOC MH services. A group representing 9.8% (4,716 out of 47,888) of the population has a MDOC MH diagnosis not detected by our assessment. While there is the chance for some false negatives on our assessment, we do not necessarily consider this discrepancy to be problematic. We are assuming in these cases that MDOC services are adequately managing the MH problem that MDOC detected, and therefore symptoms were not present at the time of our study’s interview.

The sub-population of most concern, however, is the 13.2% of prisoners (6,312 statewide out of 47,888) who have mental health symptoms based on our assessment yet are not receiving MDOC MH services. These prisoners represent fully 65.0% of the 9,711 prisoners statewide whom our assessment indicates to have a serious MH diagnosis. Based on the size and design of our data collection, the 65.0% is accurate with 95% certainly to within +/- 5%.

Alternately computed, if we make the broad assumption that all of the 8,115 prisoners who have a MDOC MH diagnosis would have been detected by our assessment if their symptoms were not controlled, then MDOC is not serving 6,312 out of 14,427 prisoners (all prisoners except the 33,461 without either a study or MDOC MH diagnosis), or 43.7% of the prisoners statewide.

The percentage of potentially mentally ill subjects not receiving services, divided by strata, is presented in Table 11. Overall, as just reported, 65.0% of prisoners with MH symptoms are not being provided MH services. Not surprisingly, this percentage is substantially lowest for the (Male) Special Units strata, as many of the Special Units are MH treatment programs. The Male General Population stratum had the highest percentage of untreated mentally ill. Although female prisoners had a higher prevalence of detected MH symptoms, these symptoms were more often treated; alternately stated, for females, the undertreatment is 54.1%.

Table 11. Untreated Mental Health Symptoms, by Study Strata

	Male – General Population	Male – Administrative Segregation	Male – Special Units	Male	Female	Total
MH Symptoms and No Services	76.7%	57.1%	11.76%	65.5%	54.1%	65.0%

Some of these individuals may have received MH treatment in the past, but have not had any services within the last year. In addition, we do not know whether services may have been offered but refused by the prisoner. A small number of prisoners had a MH diagnosis but services had not begun prior to the assessment, thus increasing these numbers slightly, as we discussed earlier. During the interviews, assessors often heard concerns that prisoners believed having MH services would adversely affect their chances for parole, so it is likely that at least some prisoners are reluctant to seek out or accept treatment. A final explanation might be that the database used may not contain full MH treatment records. Our project team was advised by MDOC to refer to HMIS records as the most complete and readily available database, but it may be that certain types of services are not recorded on this system, for example, if there are informal support groups provided by organizations outside of MDOC.

Table 12 shows the receipt of MH services by each level of our five scales. Care needs to be taken in this table – and several following – interpreting values when the estimated statewide number of prisoners is small. As can be seen, overall, the higher each scale value is, the higher the percentage of prisoners receiving services. These results in part

validate that the five scales we employ in this analysis represent characteristics of prisoners used by MDOC to indicate the need for psychiatric services.

Table 12. Receipt of Services, by Scale Scores

Scale	Number	Percent Receiving MH Services
CPS		
0	28,151.3	11.3%
1	14,802.4	20.3%
2	3,377.7	29.0%
3+	250.8	93.5%
DRS		
0	24,107.4	7.2%
1	5,221.6	14.5%
2	8,968.9	26.8%
3	2,181.9	46.6%
4	3,405.7	33.7%
5	1,430.2	26.9%
6	1,212.4	31.9%
7	332.5	21.5%
8	348.4	20.3%
9+	95.7	48.2%
PSS		
0	44,888.5	13.7%
1	652.2	89.8%
2	1100.0	49.1%
3	264.1	72.1%
4	87.7	81.4%
5	380.2	33.4%
6	241.1	88.1%
7+	203.2	96.0%
NSS		
0	35,877.3	13.1%
1	1,346.5	41.1%
2	1,503.5	24.4%
3	2,383.7	10.0%
4	1,208.5	34.4%
5	353.1	14.4%
6	1,496.9	13.0%
7	510.3	52.0%
8+	2608.6	48.5%
Mania		

0	24,498.6	15.2%
1	7,239.7	20.8%
2	4,308.0	18.6%
3	7,138.1	11.5%
4	3,379.0	28.5%
5	770.1	17.5%
6	404.2	14.6%
7+	87.2	67.1%

We also performed sensitivity analysis, to determine how our estimates might change if we considered fewer scales or different thresholds. First, we increased the thresholds of each scale, one by one, by one and two scale points. The results are shown in Table 13. Increasing the threshold by 2 scale points for all scales left only a few individuals triggered. However, to assure that no one scale was driving these results, we also evaluated the effect of dropping each scale. In all cases, the percentage of individuals with psychiatric symptoms not receiving services, 65.0% by our estimate (Table 10), dropped at the most to 60.2%, but at times also increasing to 67.9%. Thus, our estimate of the percentage of individuals with detected severe psychiatric symptoms is not sensitive to our choice either of psychiatric symptoms or scale thresholds.

Table 13: Effect of Changing Scale Thresholds on Estimate of Underservice and Percent of Prisoners with MH Symptoms

Scale	Percent Underserved after Increase Scale Threshold by 1	Percent Underserved after Increase Scale Threshold by 2	Percent Underserved after Eliminate Scale	Percent with MH Symptoms after Eliminate Scale
CPS	61.2%	61.5%	61.9%	15.1%
DRS	63.8%	63.1%	63.2%	17.4%
PSS	65.5%	65.6%	66.2%	19.8%
NSS	60.2%	60.8%	67.9%	13.2%
Mania	65.1%	63.9%	63.9%	19.3%

As some individuals with cognitive impairment may require services other than psychiatric care (for example, elderly prisoners with dementia), we particularly noted the effect of dropping the CPS scale from the MH symptom calculation. With CPS removed from the summary measure definition, the percentages do not differ greatly: 15.1% of the total population would still trigger for severe MH symptoms, and the underserved population would be 61.9%. Finally, we tested our definition of potential severe mental illness as having both CPS and NSS, so that the only scales items used in the MH symptom calculation were Positive Symptoms, Depression, and Mania. Even with these omissions, the underserved population was still 62.5% (results not shown).

VI.F.2. Prisoners receiving substance abuse and MH treatments, by major offense type

Table 14 displays the number of prisoners receiving substance abuse services (having a therapy code “GD”) by each of the seventeen major offense types. For each offense type, we identify only crimes related to the subjects’ current incarceration and not prior offenses. Note that many prisoners are convicted of multiple offenses, so may appear in multiple offense categories in the table below; on the average, prisoners have 1.6 current offenses.

It is also important to note with this, and other analyses regarding substance abuse treatment, that CMHP does not specifically provide substance abuse services, but only treatment for dual MH/Substance abuse diagnoses. Most substance abuse services provided in the facilities is through PSUs, and consist primarily of educational programming; therefore this information is not collected in the HMIS database. Consequently, the amount of programming being provided for substance abuse is higher than what is shown here. As mentioned earlier in Section V.A.7, we did separately look at substance treatment records for a smaller subset of prisoners who were approaching parole within six months. These results are reported separately in Section VI.F.9, but those services are not included in the tables to follow as they were obtained only on a small subset of prisoners.

Table 14. Prisoners Receiving Mental Health and Substance Abuse Services, by Type of Major Offense

Major Offense Type	Total	Mental Health Services		Substance Abuse Services	
		Number	%	Number	%
Arson	171.4	109.8	64.0	21.3	12.4
Assault	11,735.6	1,787.8	15.2	97.7	0.8
Assaultive Other	5,449.2	1,503.3	27.6	85.3	1.6
Burglary	4,589.6	655.0	14.3	75.6	1.7
CSC	11,507.4	2,485.4	21.6	119.0	1.0
Drugs	6,458.2	463.4	7.2	79.8	1.2
Forgery/Embezzle	897.8	416.6	46.4	33.7	3.8
Fraud	1,030.2	65.9	6.4	32.9	3.2
Homicide	9,400.4	848.4	9.0	53.5	0.6
Larceny	4,011.7	1,034.2	25.8	66.6	1.7
Malicious Destruction	298.8	29.5	9.9	0.0	0.0
Motor Vehicle	917.6	87.2	9.5	12.4	1.4
OUIL 3rd Offense	810.2	21.3	2.6	0.0	0.0
Other Non-Assaultive	2,060.7	417.3	20.3	12.4	0.6
Other Sex Offenses	316.2	278.6	88.1	12.4	3.9
Robbery	8,003.0	1,513.7	18.9	29.5	0.4
Weapons Possession	10,508.0	1,494.4	14.2	105.8	1.0
TOTAL	78,166.0	13,211.9	16.9	837.9	1.1

Using the given indicator, for only 1.0% of current crimes was substance abuse treatment provided, and this percentage was substantially larger only for the relative rare offense of arson (12.4%), where the estimate is relatively unstable due to the small sample size.

Table 14 also displays the number of prisoners receiving MH services by type of major offense. Overall 16.9% of all offense types had mental health services. Services were most likely provided for prisoners with Other Sex Offenses, such as distribution of child pornography, indecent exposure, and prostitution, (88.1% of all those with this offense) and to two thirds (64.0%) with an arson conviction, although, again, both estimates are based on a small sample sizes.

VI.F.3. Prisoners requiring mental health services, by major offense type

In Table 15 we also provide the relationship between major offense type, the presence of MH symptoms, as determined by our assessment, and whether the symptoms were not addressed with services. Using these measures, 20.4% of crimes were committed by

individuals with MH symptoms, and 62.5% of those crimes were committed by prisoners who were not receiving any services for their symptoms (data not shown).

Table 15. Prisoners with Mental Health Symptoms and Not Receiving Mental Health Services, by Major Offense Type

Major Offense Type	Total	Mental Health Symptoms		Mental Health Symptoms, but No Services	
		Number	%	Number	%
Arson	171.4	70.6	41.2	41.1	58.2
Assault	11,735.6	2,148.0	18.3	1,401.6	65.3
Assaultive Other	5,449.2	1,391.7	25.5	551.1	39.6
Burglary	4,589.6	526.8	11.5	340.7	64.7
CSC	11,507.4	2,635.8	22.9	1,560.8	59.2
Drugs	6,458.2	1,607.2	24.9	1,261.2	78.5
Forgery/Embezzle	897.8	154.3	17.2	16.3	10.6
Fraud	1,030.2	53.5	5.2	24.8	46.3
Homicide	9,400.4	654.6	7.0	356.1	54.4
Larceny	4,011.7	986.3	24.6	340.7	34.5
Malicious Destruction	298.8	16.3	5.5	8.2	50.0
Motor Vehicle	917.6	315.4	34.4	274.4	87.0
OUIL 3rd Offense	810.2	21.3	2.6	0.0	0.0
Other Non-Assaultive	2,060.7	164.0	8.0	58.2	35.5
Other Sex Offenses	316.2	8.2	2.6	8.2	100.0
Robbery	8,003.0	2,704.1	33.8	1,834.4	67.8
Weapons Possession	10,508.0	2,458.1	23.4	1,870.5	76.1
TOTAL	78,166.0	15,916.3	20.4	9,948.1	12.7

VI.F.4. Prisoners with mental health symptoms and receiving substance abuse services, by major offense type.

Prisoners who were assessed with MH symptoms, and who are also receiving MDOC substance abuse services, by major offense type are shown in Table 16. It is unwise to evaluate the percentages in this table as some of the numbers are based on very small numbers of individuals; for example, that substance abuse treatment was most prevalent in those with convicted of fraud and getting MH services (38.4) is based only upon an estimated total of 53 individuals statewide who get mental health services. Among the six offense types where there are substantial numbers of prisoners getting MH services – assault, other assault, criminal sexual conduct, drugs, robbery, and weapons possession – the percent getting substance abuse (SA) services ranged from 1% to 3%.

Table 16. Prisoners with MH symptoms receiving SA treatment, by major offense type

Major Offense Type	Total	Mental Health Symptoms		Mental Health Symptoms and Receiving Substance Abuse Services	
		Number	%	Number	%
Arson	171.4	70.6	41.2	0.0	0.0
Assault	11,735.6	2,148.0	18.3	21.3	1.0
Assaultive Other	5,449.2	1,391.7	25.5	42.6	3.1
Burglary	4,589.6	526.8	11.5	29.5	5.6
CSC	11,507.4	2,635.8	22.9	85.3	3.2
Drugs	6,458.2	1,607.2	24.9	33.7	2.1
Forgery/Embezzle	897.8	154.3	17.2	12.4	8.0
Fraud	1,030.2	53.5	5.2	20.5	38.4
Homicide	9,400.4	654.6	7.0	8.2	1.3
Larceny	4,011.7	986.3	24.6	20.5	2.1
Malicious Destruction	298.8	16.3	5.5	0.0	0.0
Motor Vehicle	917.6	315.4	34.4	0.0	0.0
OUIL 3rd Offense	810.2	21.3	2.6	0.0	0.0
Other Non-Assaultive	2,060.7	164.0	8.0	0.0	0.0
Other Sex Offenses	316.2	8.2	2.6	0.0	0.0
Robbery	8,003.0	2,704.1	33.8	21.3	0.8
Weapons Possession	10,508.0	2,458.1	23.4	42.6	1.7
TOTAL	78,166.0	15,916.3	20.4	338.0	2.1

VI.F.5. Prisoners with previous psychiatric hospitalizations

Of the 8,115.3 prisoners who receive MH services, 3,304.3 (40.7%) had a psychiatric hospitalization in their lifetime. Table 17 displays the number of prisoners receiving MH services who have previously been admitted to a psychiatric hospital by major offense type, and thus the percentages is slightly different: 35.5% of all offenses had a prior psychiatric hospitalization. As we did not have formal records related to prior hospitalizations outside of the correctional system, we have based our estimates on prisoners' self-report of any previous lifetime psychiatric admissions. Among the six offense types with substantial numbers of individuals getting MH services (as above), prior hospitalizations were most frequent in those with larceny (64.0%) and criminal sexual contact (50.9%).

Table 17. Previous psychiatric hospitalizations for prisoners receiving MH services, by major offense type.

Major Offense Type	Total	Mental Health Services		Any Lifetime MH Hospital Admissions	
		Number	%	Number	%
Arson	171.4	109.8	64.0	93.4	85.1
Assault	11,735.6	1,787.8	15.2	531.0	29.7
Assaultive Other	5,449.2	1,503.3	27.6	488.4	32.5
Burglary	4,589.6	655.0	14.3	177.2	27.0
CSC	11,507.4	2,485.4	21.6	1,264.0	50.9
Drugs	6,458.2	463.4	7.2	139.5	30.1
Forgery/Embezzle	897.8	416.6	46.4	129.8	31.2
Fraud	1,030.2	65.9	6.4	53.5	81.2
Homicide	9,400.4	848.4	9.0	208.6	24.6
Larceny	4,011.7	1,034.2	25.8	661.5	64.0
Malicious Destruction	298.8	29.5	9.9	8.2	27.7
Motor Vehicle	917.6	87.2	9.5	66.6	76.4
OUIL 3rd Offense	810.2	21.3	2.6	21.3	100.0
Other Non-Assaultive	2,060.7	417.3	20.3	71.3	17.1
Other Sex Offenses	316.2	278.6	88.1	0.0	0.0
Robbery	8,003.0	1,513.7	18.9	333.0	22.0
Weapons Possession	10,508.0	1,494.4	14.2	439.1	29.4
TOTAL	78,166.0	13,211.9	16.9	4,686.6	35.5

VI.F.6. Prisoners with prior psychiatric hospitalizations and substance abuse treatment

Of the 459.7 of prisoners receiving substance abuse services, 172.5 (37.5%) do not have prior psychiatric hospitalization (lifetime) and 287.2 (62.5%) do have a prior psychiatric hospitalization (lifetime). Table 18 shows this distribution by major offense type. Given the very low numbers of prisoners getting substance abuse service, great care should be taken in comparing statistics across offense types.

Table 18. Previous psychiatric hospitalizations for prisoners receiving substance abuse services, by major offense type.

Major Offense Type	Total	Substance Abuse Services		Any Lifetime MH Hospital Admissions	
		Number	%	Number	%
Arson	171.4	21.3	12.4	21.3	100.0
Assault	11,735.6	97.7	0.8	64.0	65.5
Assaultive Other	5,449.2	85.3	1.6	21.3	25.0
Burglary	4,589.6	75.6	1.7	33.7	44.6
CSC	11,507.4	119.0	1.0	64.0	53.8
Drugs	6,458.2	79.8	1.2	33.7	42.2
Forgery/Embezzle	897.8	33.7	3.8	12.4	36.8
Fraud	1,030.2	32.9	3.2	32.9	100.0
Homicide	9,400.4	53.5	0.6	28.7	53.7
Larceny	4,011.7	66.6	1.7	45.3	68.0
Malicious Destruction	298.8	0.0	0.0	0.0	0.0
Motor Vehicle	917.6	12.4	1.4	12.4	100.0
OUIL 3rd Offense	810.2	0.0	0.0	0.0	0.0
Other Non-Assaultive	2,060.7	12.4	0.6	0.0	0.0
Other Sex Offenses	316.2	12.4	3.9	0.0	0.0
Robbery	8,003.0	29.5	0.4	21.3	72.3
Weapons Possession	10,508.0	105.8	1.0	29.5	27.9
TOTAL	78,166.0	837.9	1.1	420.5	50.1

VI.F.7. Prisoners with mental health symptoms and substance abuse services

The comparison of prisoners receiving SA services by prisoners assessed with MH symptoms is shown in Table 19. Only 0.4% of those with MH symptoms are receiving formal services for substance abuse, and only 1.0% of the population overall are receiving these services.

Table 19. MH Symptoms and SA Services, with overall percentages

MH Symptoms	Substance Abuse Services		Total (with Column Percentage)
	No	Yes	
No	37,924.0	252.3	38,177.0 (79.7%)
	79.2%	0.5%	
Yes	9,503.8	2,07.4	9,711.2 (20.3%)
	19.9%	0.4%	
Total	47,428.1	459.7	47,887.8 (100.0%)
	99.0%	1.0%	

VI.F.8. Prisoners who changed mental health diagnoses within the last year

Prisoners could only be assigned one primary diagnosis at a time, so sequentially prisoners could alternate between diagnoses while not actually having any clinical change. As a result, we computed the number of different primary Axis I diagnosis within the past year. Diagnoses were deemed unique at the level of the major diagnosis category – the first three numbers in the DSM-IV diagnosis code. A change in numbers after the decimal point in the code generally reflects a change in severity of the illness and not deemed substantive. Over two-thirds (76.4%) of prisoners with a MH diagnosis had only a single diagnosis assigned during the past year, and 98% had at most two (Table 20).

Table 20. Number of Unique Primary Axis I Diagnoses

# of Axis I Diagnoses	Frequency	Percent
1	6,466.6	76.4
2	1,807.5	21.3
3	164.8	2.0
4	29.5	0.4

VI.F.9. Co-Morbid Substance Abuse and Mental Illness

As discussed previously in Section III.A, we initially only asked questions related to substance use if the subject had been incarcerated less than two years. Mid-way through the study, we added items relating to lifetime substance use for all subjects. We consequently have information on lifetime substance use on 305 subjects and information on substance use immediately prior to incarceration for 164 subjects.

To identify individuals with co-morbid substance abuse and mental illness, we considered anyone who indicated they had previously used substances (drugs, alcohol, or misuse of prescription medications) prior to incarceration or at any point in their lifetime. The joint prevalence of subjects with a substance abuse history who also had mental health symptoms is shown in Table 21.

Table 21. Co-Morbid Substance Abuse and MH Symptoms

Substance Abuse History	MH Symptoms		Total (with Column Percentage)
	No	Yes	
No	3,822.7	508.1	4,330.8 (14.1%)
	12.4%	1.7%	
Yes	20,699.0	5,750.4	26,449.0 (85.9%)
	67.3%	18.7%	
Total	24,521.5	6,258.5	30,780.0
	79.7%	20.3%	100.0%

An overwhelming majority of the prisoners (85.9%) have had a history of substance use at some point. The percentage increases even more among those prisoners with mental health symptoms present; 91.9% (5,750.4/6,258.5) of this group have a history of substance abuse issues, in contrast to 84.4% of those without mental health symptoms.

VI.F.10. Substance Abuse Treatment

To measure the provision of substance abuse (SA) treatments, we focused on subjects with a reported history of substance use, and who were expecting release to the community within six months from the date of our assessment. To determine past SA, we included any lifetime history of illegal drug use or misuse of prescription medication. For prisoners who had been incarcerated less than two years (based on self-report by the prisoner), we also included problem drinking (as measured by the CAGE scale) during the time immediately prior to incarceration.

Table 22 shows the (unweighted) breakdown of subjects based on whether they were approaching release and whether they had a history of substance use.

Table 22. Substance Use History and Expected Release

Substance Abuse History	Expected Release* within Six Months		Total
	No	Yes	
No	242	19	261
Yes	321	25	346
Total	563	44	607

* Information on expected release was missing for 11 prisoners.

As described earlier, we focused on the 25 individuals who both had a history of substance use and were expecting release to the community within six months, as these were the most important target population to receive substance abuse treatment services while still incarcerated. As described earlier in Section V.A.7, MDOC provided us with information from their records on whether each of these individuals was receiving substance abuse treatment.

According to MDOC, each newly committed offender is assessed for substance abuse at a reception facility. In addition, any offender returning to incarceration is also assessed. Diagnostic instruments, including the Substance Abuse Subtle Screening Inventory (SASSI) is administered to determine the level of chemical dependency. The results of this testing are used in conjunction with other information obtained from the interview, from the Pre-sentence Investigation Report and from other sources to determine level of dependency. Due to the independence of this study, however, we did not use the SASSI data in our analyses.

For Table 23, MDOC reported the SA services received by these 25 subjects. Overall, services were received by 15 prisoners; alternately stated, 40% of these individuals needed but did not received SA services.

Table 23. Receipt of Substance Abuse (SA) Services Among those With SA Problems and Expecting to be Released Within Six Months

	Number	Percent
Received SA services within 12 months prior to assessment	12	48.0%
Received SA services only over 12 months prior to assessment	3	12.0%
No SA services	10	40.0%
Total	25	100%

Of the twelve prisoners who had received services within a year prior to our assessment, four were also currently enrolled in services through the parole office. Of the 15 in total who had ever received services, the vast majority were receiving Outpatient Substance Abuse Therapy (see Table 24).

Table 24. Types of Substance Abuse Services

Type of Service	Number	Percent
Outpatient Substance Abuse Therapy	13	86.7%
Residential Substance Abuse Treatment	1	6.3%
Educational	1	6.3%
Total	15	100%

Offenders are prioritized for substance abuse programming based on the available slots for treatment and education at their facility. Offenders who receive major misconduct for substance abuse, test positive for drugs, are within two years of their Earliest Release Date (ERD) are expected to remain at the facility for a duration long enough to complete programming should be given priority for treatment. Offenders with a low priority for treatment or education include those unwilling to participate and those who were unsuccessfully discharged from prior treatment.

Based on this sample, 48% (i.e., 12 out of 25) had received substance abuse services within the year prior to the assessment; this percentage increases to 60% (i.e., 15 out of 25) if we count *all* substance abuse services provided.. We did not know, however, whether services may have been offered and refused to the untreated subjects.

VII. LIMITATIONS OF STUDY

A major limitation of this study is potential gaps in the information on all current mental health services being provided by the correctional facilities. Rather than rely on subjects' reports of services, we felt that department records would provide more accurate information. During analysis, it became clear that the HMIS database was missing some types of services – specifically substance abuse treatment and treatment provided by facility Psychological Services Units (PSUs). The services reported here are only those being provided by the Corrections Mental Health Programs (CMHPs). As discussed earlier, CMHPs deliver the majority of the psychiatric care for acute mental health problems in the correctional facilities; however, we will be missing the crisis intervention, referral, and offender group programs provided through the PSUs in our data. We also do not know how many prisoners refused offered treatment, and thus are counted as “underserved.”

Another major limitation results from the use of prisoner self-reported data, especially in a population in which such reporting can be particularly complicated. There may have been perceived incentives to under- or over- report particular conditions, or to chose

whether or not to participate in the study. Also, as it was not possible in this environment for project staff to be the first point of contact with potential subjects, we are not able to guarantee that recruitment protocols and scripts were followed exactly as directed.

Basing this study on the symptoms identified by the interRAI MH will produce both false positives and false negatives in the results; alternate study designs, such as having a physician assign a diagnosis, would face a similar challenge. However, as the assessment instrument used in this study has been extensively tested and demonstrates good reliability and validity, we anticipate that these errors will be rare and unlikely numerous enough to affect substantially the results reported here.

Finally, as mentioned earlier in this report, we could only interview subjects who were competent to give informed consent. Consequently, individuals who were highly impaired due to their mental illness would be excluded from the study. In a similar vein, we also are unable to look at data for anyone who refused to participate, so do not know if there is any refusal bias.

VIII. RECOMMENDATIONS IN RESPONDING TO PA 124 OF 2007

This study interviewed 618 prisoners incarcerated in Michigan correctional facilities in order to assess the level of psychiatric problems and the provision of services within the prisons. Based on our measures of mental health symptoms, we found that 20.1% of males and 24.8% of females have psychiatric symptoms at the severe level.

MDOC currently provides psychiatric services to 17.0% of their population; however, of those prisoners experiencing MH symptoms, 65.0% did not receive any psychiatric services within the last year. Further study is needed and strongly recommended to determine whether unmet treatment needs warrant substance abuse, psychiatric, or other mental health service delivery. Nevertheless, there is evidence that the scales used to indicate mental health symptoms do measure psychiatric needs recognized by MDOC: across the range of each of five scales used in this study, the percentage served did increase, although there remained a considerable gap between the indicated need and those served.

The under-served percentage of subjects requiring substance abuse services prior to release was somewhat better - 40% of the subsample did not receive any substance abuse services. This number increases to 52%, however, if we only include services within the prior year. As with the mental health services, we would also recommend improved targeting to ensure that those most in need do receive services.

As stated earlier, our information on services did not include any treatment provided by PSUs. PSU services tend to be focused on crisis intervention and referral, and providing programs for assaultive offenders and sexual offenders.

We would recommend that the Department improve methods for screening for and identifying psychiatric illness within their population, and evaluate the services that they are providing. While we have not conducted a thorough evaluation of MDOC's screening and assessment methods, the discrepancy between our indication of mental health symptoms and MDOC services points to an overall weakness in MDOC's assessment process throughout the course of the offender's stay in prison. We do note, however, that MDOC's new intake screening procedure was only implemented in June 2008; therefore, only a relatively small portion of our sample were likely to have been screened on intake with that instrument. When we estimated the percentage of prisoners with unserved psychiatric symptoms, however, we did not notice a significant difference by varying lengths of incarceration (results not shown). Therefore, a standardized, tested assessment system such as the interRAI MH could greatly improve the targeting of services and provision of care. This is especially important in times when department financial resources may be limited, as it becomes even more critical that any services available are targeted to those most in need.

Finally, our study only measured whether or not services were provided – we did not determine whether the services were appropriate or effective. We would recommend a future study to evaluate this issue.

We believe that the adoption of a standardized mental health assessment tool, such as the interRAI for Correctional Facilities instrument used in this study, would help the Department to identify the prisoners in need of services and to monitor their outcomes. Regular assessment performed at fixed intervals would likely help in ensuring that the appropriate population receives services.

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APPENDIX A. PA 124 OF 2007, SECTION 302.

PA 124 of 2007
Fiscal Year 2008 Appropriation Law

Sec. 302. (1) From the funds appropriated in part 1 for the mental health study, the department shall allocate not more than \$400,000.00 for the purpose of contracting for an independent study prescribed under this section.

(2) In consultation with the MDCH, the department shall contract for an independent study on the prevalence of prisoners in need of mental health treatment, substance abuse services, or both, and on the provision of services to prisoners in need of mental health treatment, substance abuse services, or both. The study must be completed or supervised by a psychiatrist as defined in section 100c of the mental health code, 1974 PA 258, MCL 330.1100c. The lead psychiatrist shall not be a current or former employee or contractual agent of the department or the department of community health. At a minimum, the study shall collect and evaluate data on all of the following, to the extent possible under the health insurance portability and accountability act (HIPAA), 42 USC 1320d-6 and 45 CFR parts 160 and 164:

(a) The number of prisoners receiving substance abuse services, including a description and breakdown of the type of substance abuse services provided to prisoners, by major offense type.

(b) The number of prisoners with a primary diagnosis of mental illness, the number of prisoners considered to currently require mental health services, and the number of prisoners receiving mental health services, including a description and breakdown, encompassing, at a minimum, the categories of inpatient, residential, and outpatient care, and the type of mental health services provided to those prisoners, by major offense type.

(c) The number of prisoners with a primary diagnosis of mental illness and receiving substance abuse services, including a description and breakdown, encompassing, at a minimum, the categories of inpatient, residential, and outpatient care, of the type of treatment provided to those prisoners, by major offense type.

(d) Data indicating whether prisoners receiving mental health services for a primary diagnosis of mental illness were previously hospitalized in a state psychiatric hospital for persons with mental illness, by major offense type.

(e) Data indicating whether prisoners with a primary diagnosis of mental illness and receiving substance abuse services were previously hospitalized in a state psychiatric hospital for persons with mental illness.

(f) The cost of psychotropic pharmaceuticals for prisoners with a primary diagnosis of mental illness itemized by type, specific diagnosis, identification as a brand name or a generically equivalent pharmaceutical, and the name of the manufacturer or distributor.

(g) Quarterly and fiscal year-to-date expenditures itemized by vendor, status of payments from contractors to vendors, and projected year-end expenditures from accounts for substance abuse treatment and mental health care.

(h) The number of prisoners that have had their primary diagnosis of mental illness changed while in prison by a mental health clinician from an earlier diagnosis received in prison or while hospitalized in a state psychiatric hospital for persons with mental illness, itemized by current and previous diagnosis.

(i) The number of prisoners with a primary diagnosis of mental illness that previously had received substance abuse services, including a description and breakdown, encompassing, at a minimum, the categories of inpatient, residential, and outpatient care, of the type of treatment provided to those prisoners.

(j) All department policies and procedures relating to prisoners and parolees with mental illness, substance abuse disorders, or both, including, but not limited to, those related to prisoners with discharge status.

(3) A report on the study, together with any recommendations contained in the study and response from the department, shall be provided to the members of the senate and house appropriations subcommittees on corrections and community health, the senate and house fiscal agencies, MDCH, and the state budget director no later than 30 days following the receipt of the completed study. The report shall include all of the information required under subsection (2) and any recommendations. The report also shall include a plan by the department to implement those recommendations with which it agrees and an explanation of any disagreements with recommendations.

APPENDIX B.
interRAI FOR CORRECTIONAL FACILITIES ASSESSMENT TOOL

SECTION C. PRIOR MENTAL HEALTH HISTORY

NOTE: THE ITEMS IN THIS SECTION WILL REFER TO THE PERIOD PRIOR TO THE SUBJECT'S INCARCERATION. IF THE SUBJECT HAS BEEN IN PRISON FOR OVER TWO YEARS, FILL IN C1 BUT OTHERWISE DO NOT COMPLETE THIS SECTION.

1. HAS INDIVIDUAL CURRENTLY BEEN INCARCERATED FOR LONGER THAN TWO YEARS?

0. No (*Continue to C2*)

1. Yes (*Skip to Section D*)

FOR FOLLOWING ITEMS IN SECTION C, ANSWER BASED ON PERIOD JUST PRIOR TO CURRENT INCARCERATION:

2. RESIDENTIAL INSTABILITY

Residential instability over LAST 2 YEARS—e.g., 3 or more moves, no permanent address, homeless, living in shelter

0. No

1. Yes

3. MENTAL HEALTH SERVICES

a. Time since last contact with community mental health agency or professional in PAST YEAR—e.g., psychiatrist, social worker

0. No contact in past year

1. 31 days or more

2. 30 days or less

b. Amount of time in psychiatric hospital or unit in LAST 2 YEARS (*Exclude this admission*)

0. 0 days (i.e., no other admissions in last 2 years)

1. 30 days or less

2. 31 days – 1 year

3. More than 1 year

c. Number of psychiatric admissions in LAST 2 YEARS (*Exclude this admission*)

0. None

1. 1 – 2

2. 3 or more

d. Number of lifetime psychiatric admissions (*Exclude this admission*)

0. None

2. 4 – 5

1. 1 – 3

3. 6 or more

e. Age in years at first overnight stay in a psychiatric hospital or unit

0. Never 2. 15 – 24 4. 45 – 64

1. 1 – 14 3. 25 – 44 5. 65+

4. ALCOHOL

Highest number of drinks in any "single sitting" in LAST 14 DAYS

0. None

1. 1

2. 2 – 4

3. 5 or more

5. NUMBER OF DAYS IN LAST 30 DAYS CONSUMED ALCOHOL TO POINT OF INTOXICATION

0. None 2. 2 – 8 days

1. 1 day

3. 9 or more days, but not daily

4. Daily

6. TIME SINCE USE OF THE FOLLOWING SUBSTANCES

0. Never

3. 8 – 30 days ago

1. More than 1 year ago

4. 4 – 7 days ago

2. 31 days – 1 year ago

5. In last 3 days

a. **Inhalants**—e.g., glue, gasoline, paint thinners, solvents

b. **Hallucinogens**—e.g., phencyclidine or "angel dust", LSD or "acid", "magic mushrooms", "ecstasy"

c. **Cocaine or crack**

d. **Stimulants**—e.g., amphetamines, "uppers", "speed", methamphetamines

e. **Opiates (including synthetics)**—e.g., heroin, methadone

f. **Cannabis**

7. INJECTION DRUG USE—EXCLUDE PRESCRIPTION MEDICATIONS

0. Never used injection drugs

1. Used injection drugs more than 30 days ago

2. Used injection drugs in last 30 days; did not share needles

3. Used injection drugs in last 30 days; did share needles

8. PATTERNS OF DRINKING OR OTHER SUBSTANCE USE IN LAST 90 DAYS

Presence of behavioral indicators of potential substance-related addiction in LAST 90 DAYS

0. No

1. Yes

a. Person felt the need or was told by others to cut down on drinking or drug use, or others were concerned about person's substance use

b. Person has been bothered by criticism from others about drinking or drug use

c. Person has reported feelings of guilt about drinking or drug use

d. Person had to have a drink or use drugs first thing in the morning to steady nerves—e.g., an "eye opener"

e. Person feels social environment encourages or facilitates abuse of drugs or alcohol

9. SMOKES TOBACCO DAILY

0. No

1. Not in last 3 days, but is usually a daily smoker

2. Yes

10. INTENTIONAL MISUSE OF PRESCRIPTION OR OVER-THE-COUNTER MEDICATION IN LAST 90 DAYS—e.g., used medication such as benzodiazepines or analgesics for purpose other than intended

0. No

1. Yes

11. **GAMBLED EXCESSIVELY OR UNCONTROLLABLY IN LAST 90 DAYS**

- 0. No 1. Yes

12. **FINANCES PRIOR TO INCARCERATION**

Because of limited funds, during the last 30 days made trade-offs among purchasing any of the following: adequate food, shelter, clothing; prescribed medications; sufficient home heat or cooling; necessary health care

- 0. No 1. Yes

SECTION D. MENTAL STATE INDICATORS

1. Code for indicators observed in last 3 days, irrespective of the assumed cause [Note: Whenever possible, ask person]

- 0. Not present
1. Present but not exhibited in last 3 days
2. Exhibited on 1-2 of last 3 days
3. Exhibited daily in last 3 days

MOOD DISTURBANCE

- a. Sad, pained, or worried facial expressions
b. Crying, tearfulness
c. Decreased energy
d. Made negative statements
e. Self-deprecation
f. Expressions of guilt or shame
g. Expressions of hopelessness
h. Inflated self-worth
i. Hyper-arousal
j. Irritability
k. Increased sociability or hypersexuality
l. Pressured speech or racing thoughts
m. Labile affect
n. Flat or blunted affect

ANXIETY

- o. Repetitive anxious complaints/concerns (non-health-related)
p. Expressions, including non-verbal, of what appear to be unrealistic fears
q. Obsessive thoughts
r. Compulsive behavior
s. Intrusive thoughts or flashbacks
t. Episodes of panic

PSYCHOSIS

- u. Hallucinations

- v. Command hallucinations
w. Delusions
x. Abnormal thought process

NEGATIVE SYMPTOMS

- y. Expressions, including non-verbal, of a lack of pleasure in life (anhedonia)
z. Withdrawal from activities of interest
aa. Lack of motivation
bb. Reduced social interactions

OTHER INDICATORS

- cc. Repetitive health complaints
dd. Recurrent statements that something terrible is about to happen
ee. Persistent anger with self or others
ff. Unusual or abnormal physical movements
gg. Hygiene
hh. Difficulty falling asleep or staying asleep; waking up too early; restlessness; non-restful sleep
ii. Too much sleep

2. **SLEEP PROBLEMS RELATED TO HYPOMANIA OR MANIA**

Person had 24-hour period with less than 2 hours of sleep caused by increased energy level (Code for most recent instance)

- 0. Never 3. 8-30 days ago
1. More than 1 year ago 4. 4-7 days ago
2. 31 days-1 year ago 5. In last 3 days

3. **DEGREE OF INSIGHT INTO MENTAL HEALTH PROBLEM**

- 0. Full 1. Limited 2. None

4. **SELF-REPORTED MOOD**

- 0. Not in last 3 days 2. In 1-2 of last 3 days
1. Not in last 3 days, but often feels that way 3. Daily in last 3 days
8. Could not (would not) respond

Ask: "In the last 3 days, how often have you felt..."

- a. Little interest or pleasure in things you normally enjoy?
b. Anxious, restless, or uneasy?
c. Sad, depressed, or hopeless?

5. **MENTAL STATE INDICATORS**

Code for indicators observed in last 3 days, irrespective of the assumed cause

- 0. Not present
1. Present but not exhibited in last 3 days
2. Exhibited on 1-2 of last 3 days
3. Exhibited daily in last 3 days
a. Remorseless
b. Impulsive
c. Inappropriately blames others for problems
d. Denies or minimizes harm done to others
e. Expressions supportive of criminal activity

6. **CHANGE IN SEVERITY OR FREQUENCY OF PSYCHIATRIC SYMPTOMS COMPARED TO 30 DAYS AGO, OR SINCE LAST ASSESSMENT IF LESS THAN 30 DAYS AGO**

- 1. Deterioration
- 2. No change
- 3. Improvement
- 4. Marked improvement

- h. **Pica**—Ingestion of non-food items (e.g., soap, dirt, feces)
- i. **Polydipsia**—Inappropriate or excessive fluid consumption (e.g., drinks fluids many times during the day, drinks a huge amount at a time, refuses to stop drinking, drinks secretly from unusual sources)

SECTION E. HARM TO SELF AND OTHERS

1. **SELF-INJURIOUS IDEATION OR ATTEMPT**
Code for most recent instance
 - 0. Never
 - 1. More than 1 year ago
 - 2. 31 days – 1 year ago
 - 3. 8 – 30 days ago
 - 4. 4 – 7 days ago
 - 5. In last 3 days
 - a. **Considered performing a self-injurious act**
 - b. **Most recent self-injurious attempt**
2. **INTENT OF ANY SELF-INJURIOUS ATTEMPT WAS TO KILL HIM/HERSELF**
 - 0. No
 - 1. Yes
 - 8. No attempt
3. **OTHER INDICATORS OF SELF-INJURIOUS BEHAVIOR**
 - 0. No
 - 1. Yes
 - a. **Family, caregiver, friend, or staff expresses concern that person is at risk for self-injury**
 - b. **Suicide plan**—In LAST 30 DAYS, formulated a scheme to end own life
4. **VIOLENCE**
Code for most recent instance
 - 0. Never
 - 1. More than 1 year ago
 - 2. 31 days – 1 year ago
 - 3. 8 – 30 days ago
 - 4. 4 – 7 days ago
 - 5. In last 3 days
 - a. **Violent ideation**—e.g., reports of premeditated thoughts, statements, plans to commit violence
 - b. **Intimidation of others or threatened violence**—e.g., threatening gestures or stance with no physical contact, shouting angrily, throwing furniture, explicit threats of violence
 - c. **Violence to others**—Acts with **purposeful, malicious, or vicious** intent, resulting in physical harm to another (e.g., stabbing, choking, beating)
5. **EXTREME BEHAVIOR DISTURBANCE**
History of extreme behavior(s) that suggests serious risk of harm to self (e.g., severe self-mutilation) or others (e.g., fire setting, homicide)
 - 0. No
 - 1. Yes, but not exhibited in last 7 days
 - 2. Yes, exhibited in last 7 days

2. **BEHAVIOR PROBLEM THAT WAS PERSISTENT BEFORE AGE 12**—e.g., fire-setting, school suspension, bullying, running away from home, cruelty to animals, carrying weapon
 - 0. No
 - 1. Yes
3. **ALCOHOL**
Highest number of drinks in any “single sitting” in LAST 14 DAYS
 - 0. None
 - 1. 1
 - 2. 2 – 4
 - 3. 5 or more
4. **NUMBER OF DAYS IN LAST 30 DAYS CONSUMED ALCOHOL TO POINT OF INTOXICATION**
 - 0. None
 - 1. 1 day
 - 2. 2 – 8 days
 - 3. 9 or more days, but not daily
 - 4. Daily
5. **TIME SINCE USE OF THE FOLLOWING SUBSTANCES**
 - 0. Never
 - 1. More than 1 year ago
 - 2. 31 days – 1 year ago
 - 3. 8 – 30 days ago
 - 4. 4 – 7 days ago
 - 5. In last 3 days
 - a. **Inhalants**—e.g., glue, gasoline, paint thinners, solvents
 - b. **Hallucinogens**—e.g., phencyclidine or “angel dust”, LSD or “acid”, “magic mushrooms”, “ecstasy”
 - c. **Cocaine or crack**
 - d. **Stimulants**—e.g., amphetamines, “uppers”, “speed”, methamphetamines
 - e. **Opiates (including synthetics)**—e.g., heroin, methadone
 - f. **Cannabis**

SECTION F. BEHAVIOR

1. **BEHAVIOR SYMPTOMS**
Code for indicators observed, irrespective of the assumed cause
 - 0. Not present
 - 1. Present but not exhibited in last 3 days
 - 2. Exhibited on 1–2 of last 3 days
 - 3. Exhibited daily in last 3 days
 - a. **Wandering**—Moved with no rational purpose, seemingly oblivious to needs or safety
 - b. **Verbal abuse**—e.g., others were threatened, screamed at, cursed at
 - c. **Physical abuse**—e.g., others were hit, shoved, scratched, sexually abused
 - d. **Socially inappropriate or disruptive behavior**—e.g., made disruptive sounds or noises, screamed out, smeared or threw food or feces, hoarded, rummaged through other’s belongings
 - e. **Inappropriate public sexual behavior or public disrobing**
 - f. **Resists care**—e.g., taking medications / injections, ADL assistance, eating
 - g. **Elopement attempts or threats**

6. **INJECTION DRUG USE—EXCLUDE PRESCRIPTION MEDICATIONS**
 - 0. Never used injection drugs
 - 1. Used injection drugs more than 30 days ago
 - 2. Used injection drugs in last 30 days; did not share needles
 - 3. Used injection drugs in last 30 days; did share needles
7. **PATTERNS OF DRINKING OR OTHER SUBSTANCE USE IN LAST 90 DAYS**
Presence of behavioral indicators of potential substance-related addiction in LAST 90 DAYS
 - 0. No
 - 1. Yes
 - a. Person felt the need or was told by others to cut down on drinking or drug use, or others were concerned about person’s substance use
 - b. Person has been bothered by criticism from others about drinking or drug use
 - c. Person has reported feelings of guilt about drinking or drug use
 - d. Person had to have a drink or use drugs first thing in the morning to steady nerves—e.g., an “eye opener”
 - e. Person feels social environment encourages or facilitates abuse of drugs or alcohol

8. **SMOKES TOBACCO DAILY**
0. No
1. Not in last 3 days, but is usually a daily smoker
2. Yes
9. **INTENTIONAL MISUSE OF PRESCRIPTION OR OVER-THE-COUNTER MEDICATION IN LAST 90 DAYS—e.g., used medication such as benzodiazepines or analgesics for purpose other than intended**
0. No
1. Yes
10. **GAMBLED EXCESSIVELY OR UNCONTROLLABLY IN LAST 90 DAYS**
0. No
1. Yes

SECTION G. COGNITION

1. **COGNITIVE SKILLS FOR DAILY DECISION-MAKING**
Making decisions regarding tasks of daily life—e.g., when to get up or have meals, which clothes to wear or activities to do
0. **Independent**—Decisions consistent, reasonable, and safe
1. **Modified independence**—Some difficulty in new situations only
2. **Minimally impaired**—In specific recurring situations, decisions become poor or unsafe; cues/supervision necessary at those times
3. **Moderately impaired**—Decisions consistently poor or unsafe; cues/supervision required at all times
4. **Severely impaired**—Never or rarely makes decisions
5. **No discernible consciousness, coma**
2. **MEMORY / RECALL ABILITY**
Code for recall of what was learned or known
0. Yes, memory OK
1. Memory problem
- a. **Short-term memory OK**—Seems/appears to recall after 5 minutes
- b. **Procedural memory OK**—Can perform all or almost all steps in a multitask sequence without cues
3. **PERIODIC DISORDERED THINKING OR AWARENESS**
[Note: Accurate assessment requires conversations with staff, family or others who have direct knowledge of the person's behavior over this time]
0. Behavior not present
1. Behavior present, consistent with usual functioning
2. Behavior present, appears different from usual functioning (e.g., new onset or worsening; different from a few weeks ago)
- a. **Easily distracted**—e.g., episodes of difficulty paying attention; gets sidetracked
- b. **Episodes of disorganized speech**—e.g., speech is nonsensical, irrelevant, or rambling from subject to subject; loses train of thought
- c. **Mental function varies over the course of the day**—e.g., sometimes better, sometimes worse
4. **ACUTE CHANGE IN MENTAL STATUS FROM PERSON'S USUAL FUNCTIONING**—e.g., *restlessness, lethargy, difficult to arouse, altered environmental perception*
0. No
1. Yes
5. **CHANGE IN DECISION-MAKING AS COMPARED TO 90 DAYS AGO (OR SINCE LAST ASSESSMENT)**
0. Improved
1. No change
2. Declined
8. Uncertain

SECTION H. FUNCTIONAL STATUS

1. **INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL) CAPACITY**
Code for CAPACITY based on presumed ability to carry out activity as independently as possible. This will require "speculation" by the assessor.
0. **Independent**—No help, set-up, or supervision
1. **Set-up help only**
2. **Supervision**—Oversight/cueing

3. **Limited assistance**—Help on some occasions
4. **Extensive assistance**—Help throughout task, but performs 50% or more of task on own
5. **Maximal assistance**—Help throughout task, but performs less than 50% of task on own
6. **Total dependence**—Full performance by others during entire period
- a. **Meal preparation**—How meals are prepared (e.g., planning meals, assembling ingredients, cooking, setting out food and utensils)
- b. **Ordinary housework**—How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry)
- c. **Managing finances**—How bills are paid, chequebook is balanced, household expenses are budgeted, credit card account is monitored
- d. **Managing medications**—How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments)
2. **ACTIVITIES OF DAILY LIVING (ADL) SELF-PERFORMANCE**
 Consider all episodes over 3-day period.
- If **all** episodes are performed at the same level, score ADL at that level. If **any** episodes at level 6, and others less dependent, score ADL as a 5. Otherwise, focus on the three most dependent episodes [or all episodes if performed fewer than 3 times].
- If most dependent episode is 1, score ADL as 1. If not, score ADL as least dependent of those episodes in range 2-5.
0. **Independent**—No physical assistance, set-up, or supervision in any episode
1. **Independent, set-up help only**—Article or device provided or placed within reach, no physical assistance or supervision in any episode
2. **Supervision**—Oversight/cueing
3. **Limited assistance**—Guided manoeuvring of limbs, physical guidance without taking weight
4. **Extensive assistance**—Weight-bearing support (including lifting limbs) by 1 helper where person still performs 50% or more of subtasks
5. **Maximal assistance**—Weight-bearing support (including lifting limbs) by 2+ helpers –OR– Weight-bearing support for more than 50% of subtasks
6. **Total dependence**—Full performance by others during all episodes
8. **Activity did not occur during entire period**
- a. **Personal hygiene**—How manages personal hygiene, including combing hair, brushing teeth, shaving, applying make-up, washing and drying face and hands - EXCLUDE BATHS AND SHOWERS
- b. **Locomotion**—How moves between locations on same floor (walking or wheeling). If in wheelchair, self-sufficiency once in chair
- c. **Transfer toilet**—How moves on and off toilet or commode
- d. **Toilet use**—How uses the toilet room (or commode, bedpan, urinal), cleanses self after toilet use or incontinent episode(s), changes bed pad, manages ostomy or catheter, adjusts clothes - EXCLUDE TRANSFER ON AND OFF TOILET
3. **TOTAL HOURS OF EXERCISE OR PHYSICAL ACTIVITY IN LAST 3 DAYS**—e.g., *walking*
0. None
1. Less than 1 hour
2. 1 – 2 hours
3. 3 – 4 hours
4. More than 4 hours
4. **CHANGE IN ACTIVITIES OF DAILY LIVING STATUS AS COMPARED TO 90 DAYS AGO, OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS AGO**
0. Improved
1. No change
2. Declined
8. Uncertain

SECTION I. COMMUNICATION AND VISION

1. **MAKING SELF UNDERSTOOD (Expression)**
Expressing information content—both verbal and non-verbal
 0. **Understood**—Expresses ideas without difficulty
 1. **Usually understood**—Difficulty finding words or finishing thoughts BUT if given time, little or no prompting required
 2. **Often understood**—Difficulty finding words or finishing thoughts AND prompting usually required
 3. **Sometimes understood**—Ability is limited to making concrete requests
 4. **Rarely or never understood**
2. **ABILITY TO UNDERSTAND OTHERS (Comprehension)**
Understanding verbal information content (however able; with hearing appliance normally used)
 0. **Understands**—Clear comprehension
 1. **Usually understands**—Misses some part/intent of message BUT comprehends most conversation
 2. **Often understands**—Misses some part/intent of message BUT with repetition or explanation can often comprehend conversation
 3. **Sometimes understands**—Responds adequately to simple, direct communication only
 4. **Rarely or never understands**
3. **HEARING**
Ability to hear (with hearing appliance normally used)
 0. **Adequate**—No difficulty in normal conversation, social interaction, listening to TV
 1. **Minimal difficulty**—Difficulty in some environments (e.g., when person speaks softly or is more than 2 metres [6 feet] away)
 2. **Moderate difficulty**—Problem hearing normal conversation, requires quiet setting to hear well
 3. **Severe difficulty**—Difficulty in all situations (e.g., speaker has to talk loudly or speak very slowly; or person reports that all speech is mumbled)
 4. No hearing
4. **VISION**
Ability to see in adequate light (with glasses or with other visual appliance normally used)
 0. **Adequate**—Sees fine detail, including regular print in newspapers/books
 1. **Minimal difficulty**—Sees large print, but not regular print in newspapers/books
 2. **Moderate difficulty**—Limited vision; not able to see newspaper headlines, but can identify objects
 3. **Severe difficulty**—Object identification in question, but eyes appear to follow objects; sees only light, colours, shapes
 4. **No vision**

- e. **Constipation**—No bowel movement in 3 days or difficult passage of hard stool
- f. **Diarrhea**
- g. **Dry mouth**
- h. **Hypersalivation or drooling**
- i. **Increase or decrease in normal appetite**
- j. **Nausea**
- k. **Vomiting**
- OTHER**
- l. **Blurred vision**
- m. **Daytime drowsiness or sedation**
- n. **Difficulty urinating, urinating 3 or more times a night or polyuria**
- o. **Emergent conditions**—e.g., itching, fever, rash, bleeding
- p. **Headache**
- q. **Peripheral edema**
- r. **Seizures**
3. **DYSPNEA (Shortness of breath)**
 0. Absence of symptom
 1. Absent at rest, but present when performed moderate activities
 2. Absent at rest, but present when performed normal day-to-day activities
 3. Present at rest
4. **FATIGUE**
Inability to complete normal daily activities—e.g., ADLs, IADLs
 0. **None**
 1. **Minimal**—Diminished energy but completes normal day-to-day activities
 2. **Moderate**—Due to diminished energy, UNABLE TO FINISH normal day-to-day activities
 3. **Severe**—Due to diminished energy, UNABLE TO START SOME normal day-to-day activities
 4. **Unable to commence any normal day-to-day activities**—Due to diminished energy
5. **EXTRAPYRAMIDAL SYMPTOMS DURING LAST 3 DAYS**

0. No	1. Yes
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 - a. **Akathisia**—Subjective feeling of restlessness or need for movement
 - b. **Dyskinesia**—e.g., Chewing, puckering movements of mouth; abnormal irregular movements of lips; rocking or writhing of trunk
 - c. **Tremor**—Involuntary rhythmic movements of the fingers, limbs, head, mouth, tongue
 - d. **Bradykinesia**—Decrease in spontaneous movements (e.g., reduced body movement, or poverty of facial expression, gestures, speech)
 - e. **Rigidity**—Resistance to flexion and extension of muscles (e.g., continuous or cogwheeling rigidity)
 - f. **Dystonia**—Muscle hypertonicity (e.g., muscle spasms or stiffness, protruding tongue, upward deviation of the eyes)
 - g. **Slow shuffling gait**—Reduction in speed and stride length, usually with a decrease in pendular arm movement
6. **SKIN PROBLEMS**
 - a. **Major skin problems**—e.g., lesions, 2nd or 3rd degree burns, healing surgical wounds

0. No	1. Yes
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 - b. **Other skin conditions or changes in skin condition**—e.g., bruises, rashes, itching, mottling, herpes zoster, intertrigo, eczema

0. No	1. Yes
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SECTION J. HEALTH CONDITIONS

1. **SELF-REPORTED HEALTH**
Ask: "In general, how would you rate your health?"

0. Excellent	3. Poor
1. Good	8. Could not (would not) respond
2. Fair	
2. **PROBLEM FREQUENCY**
Code for presence in last 3 days

0. Not present	2. Exhibited on 1 of last 3 days
1. Present but not exhibited in last 3 days	3. Exhibited on 2 of last 3 days
	4. Exhibited daily in last 3 days
- BALANCE**
- a. **Dizziness**
- b. **Unsteady gait**
- CARDIAC**
- c. **Chest pain**
- GI STATUS**
- d. **Acid reflux**—Regurgitation of acid from stomach to throat

7. **FOOT PROBLEMS**—e.g., bunions, hammer toes, overlapping toes, structural problems, infections, ulcers
- 0. No foot problems
 - 1. Foot problems, no limitation in walking
 - 2. Foot problems limit walking
 - 3. Foot problems prevent walking
 - 4. Foot problems, does not walk for other reasons
8. **FALLS**
- 0. No fall in last 90 days
 - 1. No fall in last 30 days, but fell 31–90 days ago
 - 2. One fall in last 30 days
 - 3. Two or more falls in last 30 days
9. **RECENT FALLS**
[Skip if last assessment more than 30 days ago or if this is first assessment]
- 0. No
 - 1. Yes
- [blank] Not applicable (first assessment, or more than 30 days since last assessment)
10. **PAIN SYMPTOMS**
[Note: Always ask the person about pain frequency, intensity, and control. Observe person and ask others who are in contact with the person.]
- a. **Frequency with which person complains or shows evidence of pain (including grimacing, teeth clenching, moaning, withdrawal when touched, or other non-verbal signs suggesting pain)**
- 0. No pain
 - 1. Present but not exhibited in last 3 days
 - 2. Exhibited on 1–2 of last 3 days
 - 3. Exhibited daily in last 3 days
- b. **Intensity of highest level of pain present**
- 0. No pain
 - 1. Mild
 - 2. Moderate
 - 3. Severe
 - 4. Times when pain is horrible or excruciating
- c. **Consistency of pain**
- 0. No pain
 - 1. Single episode during last 3 days
 - 2. Intermittent
 - 3. Constant
- d. **Pain control**—Adequacy of current therapeutic regimen to control pain (from person's point of view)
- 0. No issue of pain
 - 1. Pain intensity acceptable to person; no treatment regimen or change in regimen required
 - 2. Controlled adequately by therapeutic regimen
 - 3. Controlled when therapeutic regimen followed, but not always followed as ordered
 - 4. Therapeutic regimen followed, but pain control not adequate
 - 5. No therapeutic regimen being followed for pain; pain not adequately controlled

11. **BLADDER CONTINENCE**
- 0. **Continent**—Complete control; DOES NOT USE any type of catheter or other urinary collection device
 - 1. **Control with any catheter or ostomy over last 3 days**
 - 2. **Infrequently incontinent**—Not incontinent over last 3 days, but does have incontinent episodes
 - 3. **Occasionally incontinent**—Less than daily
 - 4. **Frequently incontinent**—Daily, but some control present
 - 5. **Incontinent**—No control present
 - 8. **Did not occur**—No urine output from bladder in last 3 days

12. **BOWEL CONTINENCE**
- 0. **Continent**—Complete control; DOES NOT USE any type of ostomy device
 - 1. **Control with ostomy**—Control with ostomy device over last 3 days
 - 2. **Infrequently incontinent**—Not incontinent over last 3 days, but does have incontinent episodes
 - 3. **Occasionally incontinent**—Less than daily
 - 4. **Frequently incontinent**—Daily, but some control present
 - 5. **Incontinent**—No control present
 - 8. **Did not occur**—No bowel movement in last 3 days

SECTION K. STRESS AND TRAUMA

1. **LIFE EVENTS**
Code for most recent time of event
- 0. Never
 - 1. More than 1 year ago
 - 2. 31 days – 1 year ago
 - 3. 8 – 30 days ago
 - 4. 4 – 7 days ago
 - 5. In last 3 days
- a. **Serious accident or physical impairment**
 - b. **Distressed about health of another person**
 - c. **Death of close family member or friend**
 - d. **Child custody issues; birth or adoption of child**
 - e. **Conflict-laden or severed relationship, including divorce**
 - f. **Failed or dropped out of education program**
 - g. **Major loss of income or serious economic hardship due to poverty**
 - h. **Review hearing**—e.g., forensic, certification, capacity hearing
 - i. **Immigration, including refugee status**
 - j. **Lived in war zone or area of violent conflict (combatant or civilian)**
 - k. **Witnessed severe accident, disaster, terrorism, violence, or abuse**
 - l. **Victim of crime**—e.g., robbery (exclude assault)
 - m. **Victim of sexual assault or abuse**
 - n. **Victim of physical assault or abuse**
 - o. **Victim of emotional abuse**
 - p. **Parental abuse of alcohol or drugs**

2. **DESCRIBES ONE OR MORE OF THESE LIFE EVENTS (K1) AS INVOKING A SENSE OF HORROR OR INTENSE FEAR**
- 0. No or not applicable
 - 1. Yes
 - 8. Could not (would not) respond
3. **RESILIENCE IN THE FACE OF STRESS**—e.g., identifies and understands sources of stress and enacts strategies to minimize their effect; "I can get through this."
- 0. No
 - 1. Yes

4. **FEARFUL OF A FAMILY MEMBER OR CLOSE ACQUAINTANCE**
0. No 1. Yes
5. **FAMILY MEMBER(S) HAS BEEN VICTIM(S) OF PHYSICAL, EMOTIONAL, OR SEXUAL ABUSE OR ASSAULT**
0. No 1. Yes

SECTION L. MEDICATIONS

1. **LIST OF ALL MEDICATIONS**
Document medications on last page in space provided
2. **REFUSED TO TAKE SOME OR ALL OF PRESCRIBED MEDICATION IN LAST 3 DAYS**
0. No, or no medications 1. Yes
3. **STOPPED TAKING PSYCHOTROPIC MEDICATION IN LAST 90 DAYS BECAUSE OF SIDE EFFECTS**
0. No, or no psychotropic medications 1. Yes
4. **ACUTE CONTROL MEDICATIONS**
- Number of times psychotropic medication used as an immediate response to prevent harm to self or others in last 3 days. Code actual number; if more than 9, code "9".*

SECTION M. SERVICE UTILIZATION AND TREATMENTS

1. **FORMAL CARE**
Contact with formal care provider in last 30 days (or since incarceration if LESS THAN 30 DAYS)
0. No contact in last 30 days
1. No contact in last 7 days, but contact 8 – 30 days ago
2. Contact in last 7 days but not daily
3. Daily contact in last 7 days
- a. **Psychiatrist**
- b. **Nurse-practitioner or MD (non-psychiatrist)**
- c. **Social Worker**
- d. **Psychologist or Psychometrist**
- e. **Occupational Therapist**
- f. **Recreation Therapist**
- g. **Nurse**
- h. **Personal Support Worker/Health Care Aid**
- i. **Other mental health staff**
2. **NURSING INTERVENTIONS**
Record the number of days each of the following was provided for 15 minutes or more per day in the LAST 7 DAYS OR SINCE INCARCERATION if less than 7 days ago. Record "0" if none or less than 15 minutes per day.
- a. **Medical interventions**
- b. **One-to-one counselling, or teaching**
- c. **Crisis intervention**
- d. **Family support or consultation**
3. **TREATMENT MODALITIES (PSYCHOTHERAPIES)**
Code for treatment modalities used in LAST 30 DAYS (or since incarceration if LESS THAN 30 DAYS)
0. Not offered and not received
1. Offered, but refused
2. Not received, but scheduled to start within next 30 days
3. Received 8 – 30 days ago
4. Received in last 7 days
- a. **Individual**
- b. **Group**
- c. **Family or couple**
- d. **Self-help/consumer group—e.g., Alcoholic Anonymous**

- e. **Complementary therapy or treatment**
- f. **Day hospital/Out-patient program**

4. **FOCUS OF INTERVENTION**
Code for types of issues that were a major focus of interventions in LAST 30 DAYS (or since incarceration if LESS THAN 30 DAYS)
0. No intervention of this type
1. Offered, but refused
2. Not received, but scheduled to start within next 30 days
3. Received 8 – 30 days ago
4. Received in last 7 days
- a. **Life skills training**
- b. **Social or family functioning**
- c. **Detoxification or post-detox stabilization**
- d. **Alcohol or drug treatment, including methadone management**
- e. **Vocational rehabilitation**
- f. **Anger management**
- g. **Behavioural management**
- h. **Pain management**
- i. **Crisis intervention**

5. **ELECTROCONVULSIVE THERAPY**
0. Never received and not scheduled to begin within next 7 days
1. Received more than 30 days ago
2. Received 8 – 30 days ago
3. Received in last 7 days
4. Scheduled to begin within 7 days

SECTION N. CONTROL PROCEDURES AND OBSERVATION

1. **CONTROL INTERVENTIONS**
Code for use of each device in LAST 3 DAYS
0. Not used
1. Used less than daily
2. Used daily—Nights only
3. Used daily—Days only
4. Used night and days, but not constant
5. Constant use for full 24 hours (may include periodic release)
- a. **Mechanical restraint**
- b. **Physical or manual restraint by staff**
- c. **Confinement to unit**
- d. **Confinement to cell/temporary segregation**
- e. **Observation Cell**
2. **CLOSE OR CONSTANT OBSERVATION**
Number of days of supervision of the following type in LAST 3 DAYS. If none, record "0".
- a. **Checked at 15-minute intervals**
- b. **Checked at 5-minute intervals**
- c. **Constant observation for less than 1 hour**
- d. **Constant observation for 1+ hour**
3. **PSYCHIATRIC INTENSIVE CARE UNIT**
- Number of days in psychiatric intensive care unit during the LAST 3 DAYS. If none, record "0".*

SECTION O. NUTRITIONAL STATUS

1. **HEIGHT AND WEIGHT**
Record (a.) height in inches and (b.) weight in pounds. Base weight on most recent measure in LAST 30 DAYS.
 a. HT (in.) b. WT (lbs.)
2. **NUTRITIONAL ISSUES**
 0. No 1. Yes
 a. **Weight loss of 5% or more in LAST 30 DAYS, or 10% or more in LAST 180 DAYS**
 b. **Weight gain of 5% or more IN LAST 30 DAYS, or 10% or more in LAST 180 DAYS**
 c. **Fluid intake less than 1,000 cc per day (less than four 8-oz cups/day)**
 d. **Decrease in amount of food or fluid usually consumed**
 e. **Ate one or fewer meals on AT LEAST 2 of LAST 3 DAYS**
3. **PRESENCE OF POTENTIAL SIGNS OF EATING DISORDERS IN LAST 30 DAYS**
 0. No 1. Yes
 a. **Any instances of binge eating, purging, or bulimia**
 b. **Unrealistic fear of weight gain; statements that suggest a distorted body image**
 c. **Fasting or major restriction of diet—EXCLUDE RELIGIOUS PRACTICES**

SECTION P. SOCIAL RELATIONS

1. **BELIEF THAT RELATIONSHIP(S) WITH IMMEDIATE FAMILY MEMBER(S) IS DISTURBED OR DYSFUNCTIONAL**
 0. Belief not present
 1. Only person believes
 2. Family, friends, or others believe
 3. Both person AND others believe
2. **UNSETTLED RELATIONSHIPS**
 0. No 1. Yes
 a. **Conflict with or repeated criticism of family or friends**
 b. **Conflict with or repeated criticism of other prisoners**
 c. **Staff report persistent frustration in dealing with person**
3. **STRENGTHS**
 0. No 1. Yes
 a. **Reports having a confidant**
 b. **Consistent positive outlook**
 c. **Strong and supportive relationship with family**
4. **SOCIAL RELATIONSHIPS**
[Note: Ask person, direct care staff, and family, if available]
 0. Never 3. 4 to 7 days ago
 1. More than 30 days ago 4. In last 3 days
 2. 8 to 30 days ago 8. Unable to determine
 a. **Participation in social activities**
 b. **Visit with a long-standing social relation or family member**
 c. **Other interaction with long-standing social relation or family member—e.g., telephone,**
5. **PEER GROUP INCLUDES INDIVIDUALS WITH PERSISTENT ANTISOCIAL BEHAVIOR** e.g.-deceitfulness, irresponsible work behavior, victim blaming, repetitive lying
 0. No 1. Yes

6. **UNSETTLED RELATIONSHIPS**
 0. No 1. Yes
 a. **Manipulative**—e.g., attempts to control conversation topics, feigns sincerity, incomplete disclosure of goals at the expense of others
 b. **Lacks empathy**—e.g., general indifference to the feelings of others, persistent insincerity in expressing concern for others
 c. **Exploits others**—e.g., abuses others' good will, takes advantage of others' vulnerability

SECTION Q. EMPLOYMENT, EDUCATION, AND FINANCES

1. **ENROLLED IN VOCATIONAL ACTIVITIES WITHIN PRISON**
 0. No 1. Yes
2. **ENROLLED IN FORMAL EDUCATION PROGRAM**
 0. No 1. Yes

SECTION R. RESOURCES FOR DISCHARGE

1. **IS THE PERSON EXPECTED TO BE RELEASED WITHIN THE NEXT 6 MONTHS?**
 0. No (*Skip to R4*)
 1. Yes (*Continue to R2*)
2. **AVAILABLE SOCIAL SUPPORTS (FAMILY/CLOSE FRIEND)**
Presence of one or more family members or close friends who are willing and able to provide the following types of support after discharge from formal care program or setting
 0. Not needed
 1. Regular
 2. Occasional
 3. No
 a. **Help with child care or other dependants**
 b. **Supervision for personal safety**
 c. **Crisis support**
 d. **Support with Activities of Daily Living or Instrumental Activities of Daily Living**
3. **RESOURCES KNOWN TO BE AVAILABLE UPON RELEASE:**
 Code:
 0. No
 1. Yes
 a. **Has a support person who is positive towards discharge or maintaining residence in community**
 b. **Job(s) available on release**
 c. **Housing available on release**
4. **PERSON HAS UNREALISTIC PLANS FOR DISCHARGE, RELEASE, OR TRANSFER TO LOWER SECURITY LEVEL**
 0. No 1. Yes 8. Not applicable

SECTION L. MEDICATIONS (continued from page 7)

1. LIST OF ALL MEDICATIONS

List all active prescriptions, and any non-prescribed (over-the-counter) medications taken in the LAST 3 DAYS
 [NOTE: Use computerized records if possible, hand enter only when absolutely necessary]

For each drug, record:

a. Name

b. Dose—A positive number such as 0.5, 5, 150, 300. [Note: Never write a zero by itself after a decimal point (X mg). Always use a zero before a decimal point (0.X mg)]

c. Unit—Code using the following list:

gtts (Drops)	mcg (Microgram)	ml (Millilitre)	% (Percent)
gm (Gram)	mEq (Milli-equivalent)	oz (Ounce)	Units
L (Litres)	mg (Milligram)	Puffs	OTH

d. Route of administration—Code using the following list:

PO (By mouth/oral)	Sub-Q (Subcutaneous)	IH (Inhalation)	TD (Transdermal)
SL (Sublingual)	REC (Rectal)	NAS (Nasal)	EYE (Eye)
IM (Intramuscular)	TOP (Topical)	ET (Enteral tube)	OTH
IV (Intravenous)			

e. Frequency—Code the number of times per day, week, or month the medication is administered using the following list:

Q1H (Every hour)	Daily	5D (5 times daily)	4W (4 times weekly)
Q2H (Every 2 hours)	BED (At bedtime)	Q2D (Every other day)	5W (5 times weekly)
Q3H (Every 3 hours)	BID (2 times daily)	Q3D (Every 3 days)	6W (6 times weekly)
Q4H (Every 4 hours)	(includes every 12 hours)	Weekly	1M (Monthly)
Q6H (Every 6 hours)	TID (3 times daily)	2W (2 times weekly)	2M (Twice every month)
Q8H (Every 8 hours)	QID (4 times daily)	3W (3 times weekly)	OTH

f. PRN 0. No 1. Yes

g. Computer-entered drug code [Example Canada—DIN]

a. Name	b. Dose	c. Unit	d. Route	e. Freq.	f. PRN	g. Computer-entered drug code															
1.																					
2.																					
3.																					
4.																					
5.																					
6.																					
7.																					
8.																					
9.																					
10.																					
11.																					
12.																					

[Note: Add additional lines as necessary, for other drugs taken]

[Abbreviations are Country Specific for Unit, Route, Frequency]

SECTION T. ASSESSMENT INFORMATION

SIGNATURE OF PERSON COORDINATING/COMPLETING THE ASSESSMENT

- 1. Signature (sign on above line)
- 2. Date assessment signed as complete

2	0			—			—		
Year					Month			Day	

ADDITIONAL ASSESSOR COMMENTS:

Section (f) and (g):

(f) The cost of psychotropic pharmaceuticals for prisoners with a primary diagnosis of mental illness itemized by type, specific diagnosis, identification as a brand name or a generically equivalent pharmaceutical, and the name of the manufacturer or distributor.

Due to University IRB restrictions, MDOC is unable to provide data related to specific diagnosis, and therefore cannot provide a breakdown of brand-specific pharmaceuticals. The total cost of psychotropic medications for the 620 subjects in the study for the period October 1, 2007 through September 30, 2008 was \$105,948.88.

(g) Quarterly and fiscal year-to-date expenditures itemized by vendor, status of payments from contractors to vendors, and projected year-end expenditures from accounts for substance abuse treatment and mental health care.

The following comprises statewide data:

OSAS FY 2009 CFA Treatment Contracts

Outpatient Contracts

APEX -

Huron Valley, Mound, Parr, Gus Harrison,
Cass Lk SAI

Contract Amt.	\$	375,000.00
Proj. w/o max	\$	363,493.77
3 month max	\$	90,000.00
AVERAGE	\$	30,291.15
Total Spent	\$	363,493.77
Balance	\$	11,506.23

MARQUETTE GENERAL - MBP, AMF, CKT

Contract Amt.	\$	90,000.00
Proj. w/o max	\$	30,507.50
3 month max	\$	22,500.00
AVERAGE	\$	2,542.29
Total Spent	\$	30,507.50
Balance	\$	59,492.50

ELMHURST HOME - CFA

Contract Amt.	\$	60,000.00
Proj. w/o max	\$	58,000.00
3 month max	\$	15,000.00
AVERAGE	\$	4,833.33
Total Spent	\$	58,000.00
Balance	\$	2,000.00

NAT BEHAV CONSULT - Pugsley/Leman

Contract Amt.	\$	130,000.00
Proj. w/o max	\$	129,837.50
3 month max	\$	39,000.00
AVERAGE	\$	10,819.79
Total Spent	\$	129,837.50
Balance	\$	162.50

FAMILY SERV & CHILDS AID - Cotton/Egeler Parnall

Contract Amt.	\$	90,000.00
Proj. w/o max	\$	90,000.00
3 month max	\$	24,000.00
AVERAGE	\$	7,500.00
Total Spent	\$	90,000.00
Balance	\$	-

PARTNERS IN CHANGE - Mid Michigan Saginaw Corr

Contract Amt.	\$	300,000.00
Proj. w/o max	\$	211,511.29
3 month max	\$	90,000.00
AVERAGE	\$	17,625.94
Total Spent	\$	211,511.29
Balance	\$	88,488.71

GREAT LAKES REC. - CFA

Contract Amt.	\$	112,000.00
Proj. w/o max	\$	86,760.00
3 month max	\$	28,000.00
AVERAGE	\$	7,230.00
Total Spent	\$	86,760.00
Balance	\$	25,240.00

SAGINAW PSYCH - CFA Deerfield, Sag Reg

Contract Amt.	\$	150,000.00
Proj. w/o max	\$	73,575.00
3 month max	\$	40,000.00
AVERAGE	\$	6,131.25
Total Spent	\$	73,575.00
Balance	\$	76,425.00

LIST PSYCHOLOGICAL - CFA

Contract Amt.	\$	80,000.00
Proj. w/o max	\$	22,992.50
3 month max	\$	22,000.00
AVERAGE	\$	1,916.04
Total Spent	\$	22,992.50
Balance	\$	57,007.50

SELF HELP ADDICTIONS - Cooper, Huron Valley

Contract Amt.	\$	186,000.00
Proj. w/o max	\$	114,335.77
3 month max	\$	48,000.00
AVERAGE	\$	9,527.98
Total Spent	\$	114,335.77
Balance	\$	71,664.23

LMAS DISTRICT HEALTH DEPT. - CFA

Contract Amt.	\$	104,000.00
Proj. w/o max	\$	104,172.60
3 month max	\$	31,200.00
AVERAGE	\$	8,681.05
Total Spent	\$	86,810.50
Balance	\$	17,189.50

WEST MICHIGAN THERAPY CFA - Muskegon Corr, W. Shoreline

Contract Amt.	\$	90,000.00
Proj. w/o max	\$	83,745.00
3 month max	\$	27,000.00
AVERAGE	\$	6,978.75
Total Spent	\$	83,745.00
Balance	\$	6,255.00

WESTERN MICHIGAN UNIV - CFA

Contract Amt.	\$	325,000.00
Proj. w/o max	\$	271,864.26
3 month max	\$	90,000.00
AVERAGE	\$	22,655.36
Total Spent	\$	271,864.26
Balance	\$	53,135.74

SHAR-RSAT at JCS & WHV

WHV - Cooper Street/BPO 7200236-16029	
Site-Residential	
Contractor	SHAR
Contract Amount	\$ 1,500,000.00
TOTAL SPENT	\$ 1,400,466.10
AVERAGE	\$ 116,705.51

Outpatient Totals

Contract Amt.	\$	2,092,000.00
AVERAGE	\$	136,732.93
Total Spent	\$	1,623,433.09
Balance	\$	468,566.91

Section (j):

**A Report to the Michigan Department of Corrections
on Section 302(j) of Public Act 124 of 2007**

Submitted February 2010 by the Mental Health Association in Michigan
A United Way-Supported Agency, Affiliated with Mental Health America

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Acronym Explanations

- ~*BHCS*: Bureau of Health Care Services (in the Michigan Department of Corrections)
- ~*BMU*: Behavior Management Unit
- ~*BPRS*: Brief Psychiatric Rating Scale
- ~*BSI*: Brief Symptom Inventory
- ~*CITP*: Comprehensive Individual Treatment Plan
- ~*CMHS*: Correctional Mental Health Screen
- ~*CMHP*: Corrections Mental Health Program (operated by the Michigan Department of Community Health, under contract with the Michigan Department of Corrections)
- ~*CMS*: Correctional Medical Services (former contractor to the Michigan Department of Corrections for non-behavioral health care)
- ~*DCH*: Michigan Department of Community Health
- ~*DHS*: Michigan Department of Human Services
- ~*DOC*: Michigan Department of Corrections
- ~*HVCC*: Huron Valley Correctional Complex
- ~*ICF*: Ionia Correctional Facility
- ~*MHAM*: Mental Health Association in Michigan
- ~*MMPI*: Minnesota Multiphasic Personality Inventory
- ~*MPRI*: Michigan Prisoner Reentry Initiative
- ~*OPMHT*: Outpatient Mental Health Treatment
- ~*PHS*: Prison Health Services (current contractor to the Michigan Department of Corrections for non-behavioral health care)
- ~*PSU*: Psychological Services Unit (in the Michigan Department of Corrections)
- ~*RTP*: Residential Treatment Program
- ~*SSOTP*: Secure Status Outpatient Treatment Program
- ~*SSRTP*: Secure Status Residential Treatment Program
- ~*QMHP*: Qualified Mental Health Professional
- ~*WCC*: Woodland Center Correctional

Listing of All Recommendations

Recommendation 1: All state prisoners with a known history or current existence of major behavioral disorders should be housed in separate facilities that do not include any other types of inmates. All health care (behavioral and other) in these facilities should be completely managed and operated by one entity.

Recommendation 2: Until and unless the state was to undertake the recommendation above, behavioral health services should be completely managed and operated by one entity.

Recommendation 3: Until and unless the state was to undertake either of the recommendations above, DOC and DCH should take steps to fully integrate correctional mental health and substance abuse services.

Recommendation 4: In 2010, all DOC and DCH documents related to mental health should be cleaned up for dated references; consistency of definitions and timetables; elimination of inter-document contradictions; and grammatical correctness.

Recommendation 5: DOC and DCH should work toward simplification and numerical reduction of their respective departmental documents, and should explore the degree to which the two departments are able to issue joint pieces.

Recommendation 6: Corrections behavioral health documents should be formally revised annually to incorporate any changes in law; new DOC or DCH memoranda; or other significant actions that affect policies/procedures.

Recommendation 7: If DOC is going to continue to allow its facilities to amplify statewide policies/procedures (a questionable practice in what is a statewide – not a local – system), these should truly be add-on amplifications only, and not substantive modifications. Individual facility operating procedures must be regularly checked by DOC administration for consistency with statewide requirements, and individual facility operating procedures should be required to state how the procedures vary from statewide material.

Recommendation 8: DOC and DCH should create a joint document providing a glossary of key definitions that appear frequently in policy documents, as well as an explanation of acronyms often used. Individual documents should continue using the involved definitions (with assurance they are uniformly consistent), and individual documents should specify and re-explain whatever acronyms appear in a given document.

Recommendation 9: DOC should recruit, maintain and have written roles and responsibilities for a departmental position of Chief Psychiatrist. To assist the work of this office (including but not limited to medication matters), the department should maintain, and have ascribed roles and responsibilities for, a psychiatric advisory committee recruited by the Chief Psychiatrist.

Recommendation 10: There should be written documentation of roles and responsibilities for DOC's Medical Services Advisory Committee.

Recommendation 11: DOC, DCH, the Michigan Civil Service Commission and legislative leadership should collaboratively explore steps to increase the effectiveness and efficiency of permanent staff recruitment and hiring for the Corrections Mental Health Program.

Recommendation 12: DOC's medication formulary document (MDOC, BHCS, Clinical Formulary, 6-23-09) should be revised so that it:

- ~Is understandable to persons outside the department;*
- ~Assures access to medications for attention deficit disorders, post-traumatic stress disorder and substance abuse/dependence (presently missing in total);*
- ~Gives better attention to long-acting psychotropic injectables and to hypnotic medications;*
- ~Is consistent throughout in its terminology, definitions and references;*
- ~Includes among its "criteria of choice" the elements of Community Viability and Abuse Potential;*
- ~Corrects the current misstatement that "preferred" and "non-preferred" products will be "typically,...therapeutically equivalent";*
- ~Clearly provides allowance for someone with a history of clinical benefit from a medication used to treat mental illness to remain on or resume use of that product (including injectable medications), irrespective of how "difficult to manage" the consumer had ever been.*

Recommendation 13: Better clarity is needed regarding procedures for a prescriber to request a medication that requires some manner of administrative approval, and the appeal process for an administrative denial of the prescriber's desired medication should be simplified.

Recommendation 14: DOC and DCH need to describe in policy directive and/or operating procedure what the departments will at least attempt to do toward facilitating psychotropic medication continuity for persons on such medication at the time they leave the Michigan prison system.

Recommendation 15: All prisoners with mental illness who are not in DCH's Corrections Mental Health Program should have access to psychiatric medication as clinically warranted.

Recommendation 16: In general, across the entirety of DOC and DCH documents we encountered regarding mental health medication, the materials would benefit from more references to guidelines for psychiatric consultation and monitoring of medication management.

Recommendation 17: Numerous DOC and DCH policy directives and procedures must be revised to comply with a legislative directive against administrative and punitive segregation of prisoners with mental illness that has existed since October 2008.

Recommendation 18: The most segregation-heavy documents in the correctional behavioral health program must not only be revised for compliance with law, but should be distributed in revised draft form in 2010 for a public review and comment period.

Recommendation 19: While the correctional behavioral health program is not legally prohibited from all instances of what is called “temporary segregation,” we recommend that this procedure not be used with prisoners known to have serious mental illness. If the practice is continued, however, the maximum amount of time allowed in such segregation should be considerably shortened.

Recommendation 20: DOC and DCH must dramatically expand policy directives and operating procedures related to adolescent inmates, as current documents say extremely little about considerations for this population.

Recommendation 21: It is critical that the legislative and executive branches maximize the prospects for initiation or reestablishment of Medicaid coverage as quickly as possible for prisoners returning to community life.

Recommendation 22: DOC’s existing operating procedure on response to prisoner self-mutilation needs to be revised to reflect that the state no longer has a special unit for such prisoners. The revised document needs to describe how DOC will evaluate and deal with self-mutilation, and how and under what circumstances a referral involving such behavior would be made from DOC to the Corrections Mental Health Program.

Recommendation 23: The Psychological Services Unit needs policy updating and expansion, with much more detail on what the unit’s responsibilities and practices shall be in critical areas such as behavioral screening; crisis intervention; treatment of mental illness, emotional disturbance and substance abuse; and response to prisoner self-mutilation.

Recommendation 24: Woodland (inpatient) restraint criteria need revisions to match what is required in the Michigan Mental Health Code.

Recommendation 25: DOC’s operating procedure on “Managing Disruptive Prisoners” needs to incorporate the Mental Health Code Chapter 7 restraint procedures and protections for non-inpatient prisoners known to have mental illness.

Recommendation 26: The Director of the State Office of Recipient Rights within DCH should hold the responsibility to assure investigation and determination of all recipient rights complaints and grievances filed by or on behalf of prisoners in the Corrections Mental Health Program.

Recommendation 27: The use of non-therapeutic “observation rooms” for evaluating prisoner suicide risk should be curtailed.

Recommendation 28: DOC and DCH must resolve conflicts in documents regarding emergency behavioral evaluations occurring in or out of cells and whose responsibility it is to make determinations on this.

Recommendation 29: The definition of “suicidal behavior” in correctional mental health documents should be revised to reflect that suicidal ideation, not solely “a decision to kill oneself,” can yield suicide attempts.

Recommendation 30: Policy directives and operating procedures are needed for the screening of all new inmates for possible mental illness. In addition to laying official groundwork for screening tools and practices, which must be reliable and valid for prison setting populations, these documents should establish protocols for when and under what circumstances a diagnosis that accompanied a prisoner in his/her records or was established upon entry to the DOC system may be changed.

Recommendation 31: DOC’s policy directive and operating procedure on substance abuse service should be revised for more content on treatment, more specificity and inclusion of the Patient Placement Criteria of the American Society of Addiction Medicine.

Recommendation 32: The base MPRI program statement used by DOC should be updated for timeliness.

Recommendation 33: There should be parallel policies/program statements/operating procedures for reentry of youth prisoners with behavioral conditions and offenders with substance abuse problems as exist for adult offenders with mental illness.

Recommendation 34: DCH operating procedure MPRI 4.6.180-A should be revised to require the involvement of mental health professionals in initial parole decisions under the special “D47” designation for MPRI mental health paroles.

Recommendation 35: All MPRI mental health documents should focus on the sustainability of community service plans.

Recommendation 36: Whenever there is a service gap between what an MPRI client needs and what the community can offer, this should be documented by the MPRI for reporting, evaluative and quality improvement purposes.

Recommendation 37: DCH operating procedure MPRI 4.6.180-D should be revised so that a second (psychiatric) certification on an involuntary treatment recommendation for a discharging prisoner is automatically supplied by the correctional mental health program (unless other arrangement for that has been made with a receiving Community Mental Health Services Program).

Recommendation 38: Program and service documents should make clear that there will be evaluative follow-up of behavioral health service requests from a prisoner’s legal guardian; his

or her closest surviving relative within the third degree of consanguinity under civil law; any party holding power of attorney for the prisoner; or the state's Corrections Ombudsman.

Recommendation 39: DOC should have a policy directive on training of all staff (including but not limited to custody, contractual and non-behavioral medical) in behavioral health problems and issues.

Recommendation 40: DOC and DCH should have written policy or operating procedure enhancing the ability of behavioral and non-behavioral medical personnel to access prisoner health records from either domain as warranted and necessary.

Recommendation 41: The Michigan Auditor General should be asked to review and critique DOC's practice of allowing its facilities to self-audit their compliance with correctional policies and procedures.

Introduction

Section 302(j) of Public Act 124 of 2007 required the Michigan Department of Corrections (DOC) to procure an independent review of “all department policies and procedures relating to prisoners and parolees with mental illness, substance abuse disorders, or both.”

The non-profit Mental Health Association in Michigan (MHAM), the state’s oldest advocacy organization for persons experiencing mental illness (incorporated in 1937), was contracted in 2009 by DOC to conduct this investigation. Other elements required by Section 302 were undertaken by the University of Michigan, and still others are being ascertained by DOC from its own records. Between May 2009 and January 2010, the Association, aided by a special advisory committee it recruited (membership listed in Appendix A), reviewed over 100 policies, operating procedures, program statements and other written documents from both DOC and the Michigan Department of Community Health (DCH), which operates several mental health services for DOC. A listing of all documents reviewed is provided in Appendix B.

This investigation could not and didn’t attempt to ascertain how well the two involved state departments perform their behavioral health-related responsibilities on a day-to-day basis. Rather, it centered on the quality of the policy documents setting the table for those day-to-day responsibilities. While policies and guidelines are no guarantee of employee performance, they are critical signs of what is broadly expected of employees; what is (and isn’t) important to departmental administrators; and the priority that departmental administrators place upon the design, implementation and accountability of behavioral health services for individuals who become the responsibility of DOC. That is presumably why the Legislature, with awareness of the problem that mental illness and substance abuse represent in correctional settings, wanted a review of the policies and procedures that underlie behavioral health services in the state correctional system. And that is why MHAM, which primarily focuses on public policy analysis and governmental advocacy, believed such an effort was of significant value and agreed to undertake it.

Our report has three subsequent sections: (1) background information on correctional behavioral services in Michigan, including some overarching recommendations; (2) general findings and recommendations; and (3) issue-specific findings and recommendations.

Background Information on Correctional Behavioral Health Services in Michigan

Responsibility for behavioral health services in the state's correctional system technically rests with DOC. However, the department contracts with DCH to operate the Corrections Mental Health Program (CMHP) for prisoners found to have serious mental illness. The CMHP includes programs of outpatient, residential, crisis, acute inpatient and rehabilitative (longer-term inpatient) care.

Non-CMHP mental health services are performed by the Psychological Services Unit (PSU), which falls under DOC's Bureau of Health Care Services (BHCS), in the Correctional Facilities Administration. Management responsibility for substance abuse service is outside the province of the BHCS, split between two other elements of the department.

Non-behavioral health services in the corrections system are the responsibility of a privately contracted for-profit company, Prison Health Services (PHS), which recently assumed that role after it had been filled for several years by another private for-profit entity, Correctional Medical Services (CMS).

These arrangements are invitations to coordination, communication and accountability problems. This has been noted in various reports, analyses, court documents and legislative testimony. Solutions involve some difficult political and economic steps that the state may not be willing to take in the foreseeable future. Nonetheless, we offer three structural recommendations here.

Recommendation 1: All state prisoners with a known history or current existence of major behavioral disorders should be housed in separate facilities that do not include any other types of inmates. All health care (behavioral and other) in these facilities should be completely managed and operated by one entity.

Correctional environments are greatly concerned with security, safety, discipline, conformity to rules and the certainty of consequences for rule violations. Yet persons with biologically based brain disorders (i.e., those with serious mental illness and substance use disorders) have deficiencies of mood, thought and behavior that make conformance to rules, and the connection of behavior to consequences, more difficult. With behavioral health prisoners spread throughout the system, that system must come up with policies for their care that attempt to mesh will all the other policies that apply to general issues of security and punishment. (For example, there is considerable tension between the security desire to restrain someone who might "act out" and the concern over the negative psychological effect such restraint may have on someone experiencing severe mental distress.) Striking a proper balance between the two is most difficult – perhaps unachievable – and would be less of a dilemma if those with major behavioral health needs were housed in separate facilities. All policies and procedures for these facilities could be tailored to their circumstances, as could staffing levels, qualifications and training.

Unified responsibility for all health care in such facilities would recognize that persons with behavioral health problems often experience other medical conditions.¹⁸

Regarding which entity could or should be the unified provider of all health care under this recommendation, please see the discussion that immediately follows Recommendation #2, as the same candidates identified under that recommendation would apply here.

Recommendation 2: Until and unless the state was to undertake the recommendation above, behavioral health services should be completely managed and operated by one entity.

The current bifurcation of DOC and DCH for mental health service responsibility may have made sense in the past (it grew out of a federal consent decree in response to legal cases), but in the year 2010, it probably presents an impediment to the most effective correctional mental health care possible. This bifurcation blurs lines of accountability; requires time and resource expenditures for attempted coordination of efforts between two large bureaucracies; and has contributed to a cumbersome and confounding maze of state policies and procedures when it comes to corrections mental health (discussed next section).

There are three major alternatives for unifying correctional mental health services (or for unifying all health services per Recommendation #1); i.e., vest all responsibility in either: (1) DOC, (2) DCH or (3) a privately contracted entity. Each of these carries significant key questions.

If DOC were totally in charge, does the department have the necessary leadership and expertise for designing, implementing, overseeing and evaluating behavioral health treatment? If not, can the department reasonably and effectively develop such leadership?

If DCH were totally in charge, how does the state resolve the tension – discussed under Recommendation #1 – between treatment and custody (the latter of which DCH would not be responsible for)?

If the private sector were in charge through a contract, how is accountability for tax dollars ensured? There has already been several years experience with private sector control of prison health care through CMS. To many observers, the arrangement with CMS proved unsatisfactory, and the state shifted its contract to PHS in 2009. It remains to be seen whether or not this proves more effective.

These are difficult questions, but the state should develop the best answers possible and select a single manager for at least all behavioral health care services. Perhaps one of the keys in reaching a decision would be which approach best facilitates an effective integration of the disciplines of psychiatry (presently provided by DCH) and psychology (currently under the PSU

¹⁸ According to the National Association of State Mental Health Program Directors (“Morbidity and Mortality in People with Serious Mental Illness,” 2006), persons with major mental illness typically lose more than 25 years of normal life span, in part because of co-occurring medical conditions, compared to the rest of the population.

services offered through DOC). Combining the two seamlessly is not a simple task and would require careful thought and planning.¹⁹

{NOTE: The remainder of this report recognizes that we cannot predict whether or when either of the preceding recommendations might happen. Therefore, from this point on, the content of the report should be viewed within the framework of DOC and DCH continuing to share responsibility for behavioral health services in the corrections system.}

Recommendation 3: Until and unless the state was to undertake either of the recommendations above, DOC and DCH should take steps to fully integrate correctional mental health and substance abuse services.

Given the fact that mental illness and substance abuse represent commonly co-occurring conditions,²⁰ it is not sensible – and likely unproductive – to have management responsibility for substance abuse services stand separately from responsibility for mental health. The authority for correctional substance abuse services should be placed in DOC’s Bureau of Health Care Services, with both DCH’s Corrections Mental Health Program and DOC’s Psychological Services Unit implementing care-and-treatment responses to substance abuse when and where appropriate.

¹⁹ Dr. Robert Walsh was a DOC psychologist for a quarter-century. Writing of a time when DOC was responsible for all mental health services, he said, “Historically, there had been a division and conflict between psychological and psychiatric services in the (DOC).” *State Bar’s Prisons and Corrections Forum*. Vol. 6, No. 1, Summer 2004.

²⁰ A U.S. Bureau of Justice Statistics 2006 special report, “Mental Health Problems of Prison and Jail Inmates,” found that state prison inmates (nationally) with mental health problems were 34% more likely to have substance dependence conditions than were inmates without mental health problems.

General Findings and Recommendations

The policy underpinnings for behavioral health services in state correctional settings represent a confounding bureaucratic maze. We encountered many instances across the documents reviewed of outdated references; definitional and other inconsistencies; redundancy; and improper (thus at times confusing) grammar.

To cite every instance we found of the above would take more space than we will devote to it. Some examples are listed below:

- There are references across the documents to the Bureau of Forensic Mental Health Services (which doesn't exist); to the Michigan Department of Mental Health (which doesn't exist); to the Huron Valley Center psychiatric inpatient facility (which has a newer name and location); to "the mentally ill" (as opposed to generally preferred person-first language such as "individuals with mental illness"); and to other dated items.
- We encountered at least four documents that define Community Mental Health Services but then never subsequently refer to Community Mental Health. Similarly, Special Education policy 5.2.114 defines a Secondary Resource Room but then never subsequently refers to such a room.
- There are many definitional references across documents to a "typical" CMHP outpatient mental health team consisting of certain specified professionals. While the definition is consistent across documents, its use of the word "typical" is inappropriate, leaving room for there to be instances where team membership is different.
- We reviewed a recent series of Woodland Center Correctional (psychiatric inpatient) operating procedures. We were told these were nearly-completed drafts, though only one document was labeled "draft." In some of these documents, it was stated that the treatment team chair is the psychiatrist; in others, the unit chief was so designated.
- In the same Woodland documents, there are a number of other issues:
 - ◆ Several of the documents in effect indicate that there are only two inpatient admission status designations, inconsistent with (and far narrower than) statewide policies and procedures on psychiatric inpatient service.
 - ◆ One of the documents in effect indicates very narrow pathways for entry into crisis stabilization service, inconsistent with broader guidelines in statewide policy/procedure for this service.
 - ◆ One document on suicide prevention (that has no procedure number but an effective date of 4-20-09) talks about what do if seclusion is deemed necessary for someone at suicide risk, just one page after stating that "Seclusion and other continuous cell restrictions are inappropriate for management of suicidal inpatient prisoners."

◆ Of three documents in the Woodland series that have material on prisoners leaving DOC through parole or realization of maximum sentence, one appropriately references possible involvement of the Michigan Prisoner Reentry Initiative (MPRI), but the other two do not.

◆ The definition of Comprehensive Individual Treatment Plan (CITP) is not consistent across all documents in the Woodland series.

● DCH operating procedure 4.6.180J says the response time for a routine psychiatric referral is ten business days, but DCH operating procedure 4.6.180A says the response time is five business days.

● The Ionia facility operating procedure for Secure Status Outpatient Treatment, after duplicating virtually word-for-word DCH's program statement for this service, suddenly shifts into a statement of general mental health accreditation procedures that have no specific relationship to secure status outpatient programming.

● DCH's program statement on crisis stabilization refers readers to an operating procedure for "delineation" of an appeals process, but there is no such delineation in the operating procedure referenced.

● DCH operating procedures 5.1.140 and 4.6.180H-Residential list two different sets of admission priorities for the same service (residential treatment).

● DOC operating procedure 4.6.180H-Secure Status Residential contradicts itself on the minimum number of weeks someone shall be in Phase IV secure status (8 vs. 12), and contradicts secure status material in DCH's Residential Treatment program statement in at least four places.

● DCH operating procedure 4.6.183 has a "Note" on p. 2, the first sentence of which reads precisely as follows: "No restraint mechanisms are not to be recommended by mental health." (We assume the sentence should read as it does in the "Note" on p. 3 of DCH operating procedure 4.6.183A. These two procedures are for emergencies in facilities with and without, respectively, residential treatment. They could easily be combined.)

● Are separate DCH operating procedures needed for suicide prevention in, respectively, facilities with outpatient treatment and facilities with residential treatment? Couldn't there be one document with special notations as needed for outpatient and residential, respectively? Additionally, across these two separate operating procedures, one says that if suicide risk increases, staff should proceed to completion of a management plan, while the other says staff should proceed to an Evaluation of Suicide Risk Prevention Form when risk has increased.

● DOC policy directive 4.6.115 says at one point that someone cannot be held in segregation observation without a hearing for more than seven days, but at another point in the same document (and in DCH operating procedure 4.6.183A) the limit is four days.

- The DCH program statements for acute care psychiatric inpatient and rehabilitative psychiatric inpatient are highly duplicative and could be blended into one piece that points out, when necessary, differences related to acute and rehabilitative, respectively.
- Does DOC need two separate policy documents pertaining to special education (both of which are over a decade old), or could these be combined into one? Are separate DCH operating procedures needed for telemedicine general exams and telemedicine medication reviews, or could these come together in one piece?
- Several entries in DOC’s drug formulary have one or more dollar sign symbols after the drugs’ names without explaining what that means. What are the implications of one dollar sign symbol vs. none? How about five dollar sign symbols vs. two? And what, if anything, do prescribers have to do based on the appearance and/or level of dollar sign symbols?
- The operational definition of “responsibility for misconduct” that appears in some documents includes an outdated British insanity defense component of “knowing” right from wrong, as opposed to more modern approaches of whether one has the capacity to “appreciate the difference between right and wrong.”²¹
- There are some references across documents to the Psychological Services Unit being the only gatekeeper for initial evaluation by the Corrections Mental Health Program, but there are other references that in effect allow the CMHP to be its own gatekeeper on whether someone needs an initial CMHP assessment.

Why do we confront such a situation? There are multiple factors, including but not limited to the following:

- Timing (e.g., the system’s psychiatric inpatient facility switched from Huron Valley Center to Woodland Center Correctional in 2009).
- The fact that two different state departments (both large bureaucracies) are involved.
- The apparent unwillingness of the two departments (given how dated some of the material and references are) to regularly update their documents.
- The fact that DOC allows its facilities to write their own operating procedure amplifications when desired.

The above points help explain, but do not justify (excepting the difficulty of catching up with recent changes) the existing situation. To make matters more coherent and efficient, we recommend the following:

Recommendation 4: In 2010, all DOC and DCH documents related to mental health should be cleaned up for dated references; consistency of definitions and timetables; elimination of inter-document contradictions; and grammatical correctness.

²¹ Mental Health America. *Position Statement 57: In Support of the Insanity Defense*. June 13, 2009.

Recommendation 5: DOC and DCH should work toward simplification and numerical reduction of their respective departmental documents, and should explore the degree to which the two departments are able to issue joint pieces.

Recommendation 6: Corrections behavioral health documents should be formally revised annually to incorporate any changes in law; new DOC or DCH memoranda; or other significant actions that affect policies/procedures.²²

Recommendation 7: If DOC is going to continue to allow its facilities to amplify statewide policies/procedures (a questionable practice in what is a statewide – not a local – system), these should truly be add-on amplifications only, and not substantive modifications. Individual facility operating procedures must be regularly checked by DOC administration for consistency with statewide requirements, and individual facility operating procedures should be required to state how the procedures vary from statewide material.

Recommendation 8: DOC and DCH should create a joint document providing a glossary of key definitions that appear frequently in policy and procedure documents, as well as an explanation of acronyms often used. Individual documents should continue using the involved definitions (with assurance they are uniformly consistent), and individual documents should specify and re-explain whatever acronyms appear in a given document.

²² Similar language has appeared in DOC appropriations acts since at least October 2008.

Issue-Specific Findings and Recommendations

This section of the report attaches recommendations and findings to specific issues. In some cases, recommendations and findings can and do fit more than one issue. In those cases, we have attempted to minimize (to the degree possible) such crossover through determination of the primary issue heading that best fits the material.

Personnel

Recommendation 9: DOC should recruit, maintain and have written roles and responsibilities for a departmental position of Chief Psychiatrist. To assist the work of this office (including but not limited to medication matters), the department should maintain, and have ascribed roles and responsibilities for, a psychiatric advisory committee recruited by the Chief Psychiatrist.

Since DOC is technically accountable for all behavioral health service to state prisoners, and directly supervises the system's psychologists, it is imperative that DOC have its own (internal) points of leadership for psychiatry.

Recommendation 10: There should be written documentation of roles and responsibilities for DOC's Medical Services Advisory Committee.

This committee already exists, but in all the documents we reviewed it may have been briefly mentioned once or twice. It can play a helpful role in several areas (e.g., communication/coordination between behavioral health and other health care providers), and these roles should be referenced in written policy or procedure.

Recommendation 11: DOC, DCH, the Michigan Civil Service Commission and legislative leadership should collaboratively explore steps to increase the effectiveness and efficiency of permanent staff recruitment and hiring for the Corrections Mental Health Program.

The CMHP has great difficulty filling permanent staff positions, most especially in the discipline of psychiatry. The Legislature has specifically recognized this in section 207 of the FY-10 DOC appropriations act. In concert with that section, DOC is pursuing a vendor contract for psychiatrists as a temporary alternative measure. This will introduce another bureaucratic layer (the contractual vendor) into the CMHP picture and, thus, does not represent an appropriate long-term solution to the problem of recruiting and hiring permanent staff for the most effective continuity of the CMHP.

Medications

Recommendation 12: DOC's medication formulary document (MDOC, BHCS, Clinical Formulary, 6-23-09) should be revised so that it:

- ~Is understandable to persons outside the department;*
- ~Assures access to medications for attention deficit disorders, post-traumatic stress disorder and substance abuse/dependence (presently missing in total);*
- ~Gives better attention to long-acting psychotropic injectables and to hypnotic medications;*
- ~Is consistent throughout in its terminology, definitions and references;*
- ~Includes among its "criteria of choice" the elements of Community Viability and Abuse Potential;*
- ~Corrects the current misstatement that "preferred" and "non-preferred" products will be "typically,...therapeutically equivalent";*
- ~Clearly provides allowance for someone with a history of clinical benefit from a medication used to treat mental illness to remain on or resume use of that product (including injectable medications), irrespective of how "difficult to manage" the consumer had ever been.*

The DOC drug formulary was perhaps the most confounding document dealt with by our project advisory group – this despite the fact that several members have experience with formularies, and two members are psychotropic pharmacology experts. The document is presented in an unusual manner, especially regarding mental health, when compared to typical formularies. It was difficult – in some cases, not possible – to determine which drugs for mental health (the area we focused on) are available without restriction, and which have what types of restrictions under what circumstances. Better transparency is needed here. Even DOC officials could not answer all of our formulary questions. One thing that was clearly discernible was the absence of any product listings related to attention deficit disorder, post-traumatic stress disorder and substance abuse/dependence. Further, there was minimal attention to long-acting psychiatric injectables, and there was no “preferred” hypnotic medication listed under the heading of “anti-anxiety/hypnotic medications.”

With additional respect to the drug formulary document, it makes the mistake often seen in formularies in stating the assumption that “preferred” and “non-preferred” drugs are therapeutically equivalent. In any drug category with multiple products, a single “preferred” drug is not going to be therapeutically equivalent to all other products in that category for all consumers. Finally, the closest the document comes to recognizing the importance of mental health medication continuity is when it states (in discussing potential reasons to support use of a “non-preferred” psychotropic drug), “This might include clinical benefit already established on a non-preferred drug in a patient/prisoner who had been difficult to manage.” The use of the word “might” here is not strong enough; psychiatric medication continuity is more important, and less costly ultimately, than strict formulary adherence. (It is also an unethical and dangerous practice

to discontinue a medication that has satisfactorily controlled a consumer's condition.²³) *And, history of "management difficulty" is not always ascertainable and is not a legitimate medical reason for qualifying the importance of medication continuity.*

Recommendation 13: Better clarity is needed regarding procedures for a prescriber to request a medication that requires some manner of administrative approval, and the appeal process for an administrative denial of the prescriber's desired medication should be simplified.

A DOC 2008 memo says that a "Non-Formulary" psychotropic medication can be prescribed for up to 30 days without administrative approval. DOC's June 2009 formulary document states an "off formulary" medication can be prescribed in an urgent situation for up to 10 days. This creates a couple of potential problems. First, what happens after a consumer has been on the prescribed medication for 10 days or 30 days and the medication chosen by the prescriber and used by the consumer is then administratively denied? Secondly, the DOC formulary document makes multiple references to both "non-formulary" and "non-preferred" psychiatric drugs; what are the approval procedures and grace period(s) – if any – a prescriber may utilize for a "non-preferred" product?

When it comes to appeals, the DOC formulary document sets up a potential two-step process (for at least "off formulary") of appealing a denial to a Regional Medical Officer and, if unsuccessful at that step, then going to the department's Chief Medical Officer. There should be only a one-step appeal; it should be available for any administrative denial of a prescriber's medication of choice; and the appeal should be heard by the office of the Chief Psychiatrist position we suggested for DOC in Recommendation #9.

Recommendation 14: DOC and DCH need to describe in policy directive and/or operating procedure what the departments will at least attempt to do toward facilitating psychotropic medication continuity for persons on such medication at the time they leave the Michigan prison system.

In medication and discharge documents, the closest statements we could find for the above were: (a) the requirement to give someone leaving the system a 30-day supply of medication; and (b) the need to share medication lists with a receiving Community Mental Health Services Program. This is not to suggest the two departments are only addressing these two modest points. At least the MPRI program should be capable of and presumably is doing more in this area. If so, that should be spelled out. And for those leaving the system with mental illness and no MPRI enrollment, a written prescription given to the consumer would be helpful, as would appointment facilitation and information on prescription assistance programs. Colorado's Department of

²³ Psychopharmacology experts on our advisory committee noted cases they have experienced where a consumer was switched off an effective medication; the replacement medication did not work; and then a return to the original medication no longer worked either.

Corrections has gone so far as to establish and procure legislative funding for financially assisting some mental illness offenders with the cost of medications in the community.²⁴

Recommendation 15: All prisoners with mental illness who are not in DCH's Corrections Mental Health Program should have access to psychiatric medication as clinically warranted.

We did not encounter a policy directive or operating procedure stating that psychiatric medication may only be connected to DCH's Corrections Mental Health Program. But we were informed by DOC that this is the practice in place and being followed. This is an open invitation for prisoners with mild or moderate mental illness to decompensate; become major problems for the prison system; and cost Michigan taxpayers significantly more dollars. Medications for mild or moderate disorders are perhaps the most effective tool available to an environment like a state prison system for controlling those disorders and keeping them from regressing. The current practice must be broadened.

Recommendation 16: In general, across the entirety of DOC and DCH documents we encountered regarding mental health medication, the materials would benefit from more references to guidelines for psychiatric consultation and monitoring of medication management.

Segregation

Recommendation 17: Numerous DOC and DCH policy directives and procedures must be revised to comply with a legislative directive against administrative and punitive segregation of prisoners with mental illness that has existed since October 2008.

Section 924 of the FY-09 and -10 DOC appropriations acts prohibits what the two departments would consider to be administrative segregation or punitive segregation (i.e., non-therapeutic seclusion for disciplinary reasons) of prisoners with a serious mental illness as defined in Chapter 1 of the Michigan Mental Health Code.²⁵ Meeting the requirements of such law is not reflected anywhere in existing correctional behavioral health policy directives or operating procedures. These need extensive revision to assure compliance with the prohibition; development of therapeutic alternatives to segregation (as required under section 924); and implementation of procedures for regularly checking the psychological status of inmates who were not known to have a serious mental illness at the time their segregation began.

²⁴ Colorado Department of Corrections. *Psychotropic Medication Program for Community-Based Offenders with Mental Illness: A Legislative Footnote Report for Senate Bill 07-160*. February 1, 2009.

²⁵ For FY-10, the Legislature added minors to the prohibition, via section 929. Within that section, the Legislature used the section 924 terminology of serious mental illness as defined in Chapter 1 of the Mental Health Code. That definition technically applies only to adults. Since the language specifically says, "Prisoners under 19 years of age...shall not be placed in administrative segregation" (and defines administrative segregation as including punitive segregation), our interpretation is that legislative intent would want "serious emotional disturbance" (as defined in Code Chapter 1) to accompany "serious mental illness" in section 929.

Recommendation 18: The most segregation-heavy documents in the correctional behavioral health program must not only be revised for compliance with law, but should be distributed in revised draft form in 2010 for a public review and comment period.

Because the program's main segregation documents need substantial revision, there are ten documents that we did not subject to comprehensive analysis. These were:

- DOC Director's Memo 2010-7, January 1 2010, "Incentives in Segregation Program"
- DCH Corrections Mental Health Program Memo 2009-1, Jan. 28 2009, "Management Plans"
- DOC policy directive 3.3.105, "Prisoner Discipline" (6-29-09)
- DCH operating procedure CMHP 3.3.105, "Misconduct Evaluations for Mentally Ill Prisoners" (7-1-07)
- DOC policy directive 4.6.182, "Mentally Disabled Prisoners in Segregation" (6-29-09)
- DOC policy directive 4.5.120, "Segregation Standards" (6-29-09)
- DCH Corrections Mental Health Program Memo dated 10-6-06, "Clarification of Administrative Appeal Process"
- DCH operating procedure CMHP 4.6.182A, "Mental Health Services to RTP Prisoners in Segregation and Appeal Process" (7-1-07)
- DCH operating procedure CMHP 4.6.182B, "Mental Health Services to Mentally Ill Prisoners in Segregation & Appeal Process" (7-1-07)
- DCH operating Procedure CMHP 4.6.182C, "Mental Health Services to Mentally Ill Prisoners in Temporary Segregation" (7-1-07)

We recognize that the two departments may desire other changes upon reviewing these documents beyond just effectuating compliance with the last two years' budget law. (For example, DOC has informed us a work group will be convened in 2010 on what the department terms "protective segregation" – i.e., separation from other inmates at a prisoner's request or because it is determined the prisoner needs to be protected from others.) Thus, it is critical that there still be outside input into those documents, and a public review and comment period would enable such input.

Recommendation 19: While the correctional behavioral health program is not legally prohibited from all instances of what is called "temporary segregation," we recommend that this procedure not be used with prisoners known to have serious mental illness. If the practice is continued, however, the maximum amount of time allowed in such segregation should be considerably shortened.

Temporary segregation is a holding pattern mechanism for prisoners “when it is necessary to remove a prisoner from general population pending a hearing for a major misconduct violation, classification to administrative or protective segregation, or transfer.” It has a great potential to feed into ultimate administrative or punitive segregation, which legally cannot be utilized when serious mental illness is present. Allowing temporary segregation under such circumstances is inefficient and counter-productive. And allowing it for up to seven days – or even longer under certain circumstances – carries great risk of psychological damage and deterioration for prisoners with serious mental illness who experience it for too long. If the practice of temporary segregation is going to be continued, the maximum period of segregation should be shortened to no more than three days, with no qualifiers for time extensions.

Youth Prisoners

Recommendation 20: DOC and DCH must dramatically expand policy directives and operating procedures related to adolescent inmates, as current documents say extremely little about considerations for this population.

In December 2008, 1.4% of state correctional facility inmates (695 of 48,713) were age 19 or under.²⁶ Listed below are some major areas lacking in written policy and procedure when it comes to youth inmates:

- The categorization of “serious emotional disturbance” (a comparable term among minors to “serious mental illness” among adults) is not used or defined.
- Illustrative lists of psychiatric conditions do not include common emotional disorders of youth.
- There are no child-specific standards for treatment of and programming for youth at every level and setting of the continuum of care and in the general population.
- There is no requirement that juveniles be screened, diagnosed and treated by a child psychiatrist (presently not utilized by DOC and DCH) according to community standards of care, or – if such personnel cannot be recruited – clinicians with specialized training in child and adolescent diagnosis and treatment.
- Scant attention to child-appropriate standards for utilization of discipline.²⁷ For example, there is no prohibition against top-of-bed restraints, which – per the Michigan Association for Children with Emotional Disorders – is contra-indicated in the professional literature for use with minors (if not for all ages).
- No particularized standards for response to youth with co-occurring disorders (emotional disturbance and addiction disorder or emotional disturbance and other health condition).

²⁶ Michigan Department of Corrections. *2008 Statistical Report*.

²⁷ We reviewed draft material related to new approaches to behavioral management of youth prisoners. The material in the form we saw it did not represent a comprehensive approach to child-appropriate standards for use of discipline.

- No policy reference to or incorporation of child-appropriate instruments or measures for assessing mental disorders among minors.
- DOC's drug formulary does not include products commonly utilized in treatment of emotional disturbance (e.g., there are no drugs listed for attention deficit disorders, which are often initially diagnosed in one's youth).
- DOC's special education policy directives are dated 1997 and 1998, respectively. Because this is an area heavily dependent on federal regulation, the documents should be vetted for consistency with law as of 2010.²⁸

Medicaid

Recommendation 21: It is critical that the legislative and executive branches maximize the prospects for initiation or reestablishment of Medicaid coverage as quickly as possible for prisoners returning to community life.

DOC and DCH cannot make this happen of their own volition and efforts. Involvement from the Legislature and the Department of Human Services (DHS) will also be required. This is a crucial area for sustaining those discharged and paroled in the community, as Medicaid does not cover on-site health care for those who are incarcerated. Respective DCH (section 483) and DOC (section 812) boilerplate for FY-09 and -10 establish a state policy base of improved DOC-DHS coordination, and of Medicaid suspension rather than termination for those who already had Medicaid upon entry to incarceration. Additionally, we are informed that there will soon be a Medicaid eligibility worker available to the state prisons, which is a positive development. More will be needed, however, from the Legislature and the three state departments involved to assure the following: (1) effective implementation of the legislative policy for suspension rather than termination of pre-incarceration Medicaid status; (2) determination of whether an inmate who lacked pre-incarceration coverage would meet Medicaid eligibility criteria; (3) annual re-determination of eligibility status as required by Medicaid; and (4) the immediate resumption or initiation of coverage upon discharge or parole.

Self-Mutilation

Recommendation 22: DOC's existing operating procedure on response to prisoner self-mutilation needs to be revised to reflect that the state no longer has a special unit for such prisoners. The revised document needs to describe how DOC will evaluate and deal with self-mutilation, and how and under what circumstances a referral involving such behavior would be made from DOC to the Corrections Mental Health Program.

²⁸ DOC is in the midst of a lengthy negotiation with Michigan Protection & Advocacy Service over a suit by the latter with correctional special education claims. DOC stated it was forbidden by the courts from telling us anything about these negotiations. Thus, we could not benefit from any of this information in reviewing special education.

DOC Psychological Services Unit

Recommendation 23: The PSU needs policy-and-procedure updating and expansion, with much more detail on what the unit's responsibilities and practices shall be in critical areas such as behavioral screening; crisis intervention; treatment of mental illness, emotional disturbance and substance abuse; and response to prisoner self-mutilation.

While there are voluminous policy and procedure documents relating to the Corrections Mental Health Program, we only encountered one document, written in 1995, for the PSU. In addition to being dated, it is highly generalized and lacks depth on the points noted above. In fact, the document does not include among its "service priorities" behavioral health treatment interventions, other than crisis intervention "short-term" treatment. It also has a significant gap by failing to address how and under what circumstances someone steps down from the CMHP to actual PSU services. (CMHP documents do not adequately address this point either.)

Restraint and Seclusion

Recommendation 24: Woodland (inpatient) restraint criteria need revisions to match what is required in the Michigan Mental Health Code.

Sec. 2004a of the Code says that corrections mental health service recipients fall under the Code's Chapter 7 restraint procedures and protections, unless there is a conflict with security and staff safety. The Woodland operating procedure comes close to duplicating Chapter 7 of the Code, but there are a small number of inconsistencies (e.g., doubling the time a minor can remain secluded without a new psychiatric exam), and correcting those would pose no security or staff safety risks.

Recommendation 25: DOC's operating procedure on "Managing Disruptive Prisoners" needs to incorporate the Mental Health Code Chapter 7 restraint procedures and protections for non-inpatient prisoners known to have mental illness.

This procedure makes extensive mention of prisoner restraint, but its only significant reference to the prisoner's possible mental health status is the statement that "A disruptive prisoner housed in (Woodland inpatient) shall be subdued and restrained in accordance with procedures of (DCH)." The Woodland Center is not the only environment in which a prisoner with mental illness may face possible restraint.

Rights Complaints and Grievances

Recommendation 26: The Director of the State Office of Recipient Rights within DCH should hold the responsibility to assure investigation and determination of all recipient rights complaints and grievances filed by or on behalf of prisoners in the Corrections Mental Health Program.

Those in the CMHP have certain rights as recipients of publicly funded mental health services under the state's Mental Health Code. When there are issues of potential violations of those rights, matters are investigated by someone who reports to the Director of the CMHP, not someone who reports to the Director of DCH's Recipient Rights Office. This is a potential conflict-of-interest issue that violates one of the bedrocks of rights investigation – i.e., independent review. If DOC and DCH are unwilling to change the current situation, the Legislature should take action to do so.

Turning to the more generalized matter of prisoner grievances, DOC's policy directive on this subject is set up in a way that promotes the likely failure of any grievances filed. While it is not our assignment to say what should or shouldn't happen with all prisoners, we can say that prisoners in the CMHP (i.e., they possess serious mental illness) will have an especially difficult time understanding the grievance policy and DOC's "Prisoner Handbook"; meeting all the technicalities in the grievance policy so that their complaints aren't automatically disqualified; and going before "grievance coordinators" who are not required to have any mental health background and are appointed by facility wardens. DCH's Office of Recipient Rights would constitute a much preferable vehicle – on several fronts – for dealing with grievances involving prisoners with serious mental illness. Once again, the Legislature should act here if DOC and DCH are unwilling.

Suicide Risk – Mental Health Emergency

Recommendation 27: The use of non-therapeutic "observation rooms" for evaluating prisoner suicide risk should be curtailed.

We encountered several documents involving this practice, which in effect places someone who may have suicidal ideation in a form of non-therapeutic segregation. For individuals with serious mental illness and/or real suicidal ideation, being so isolated can have major exacerbating effects upon their conditions. And, for custody staff, getting a prisoner into an observation room can be used as unofficial punishment or to turn a prisoner into someone else's problem. The policies and procedures of DOC and DCH should assure that a prisoner deemed a possible suicide risk is immediately moved (including inter-facility transfer) to a therapeutic environment for evaluation and other response. If an immediate move is not possible, then the individual should be evaluated immediately under confidential circumstances by a Qualified Mental Health Professional. If the latter approach must be utilized and suicide risk is affirmed by the evaluation, the prisoner should not be left alone until s/he can be moved to a safe and appropriate therapeutic setting.

Recommendation 28: DOC and DCH must resolve conflicts in documents regarding emergency behavioral evaluations occurring in or out of cells and whose responsibility it is to make determinations on this.

DCH CMHP Director's Office Memo 2009-2 calls for suicide evaluations to take place outside of observation rooms/cells, and states that custody staff cannot override this. DOC policy directive 4.6.115 ("Suicide Prevention") says that "there shall be no out-of-(observation) cell activity except for life-threatening emergencies or as otherwise approved by the QMHP

(Qualified Mental Health Professional).” DCH operating procedures 4.6.183 and 183A (“Mental Health Emergencies”) read, “Prisoner is to be evaluated/treated out of cell unless custody determines prisoner poses threat to safety/security.” We would note that confidentiality cannot be maintained with an in-cell evaluation. This may limit what a prisoner is willing to say or reveal, and may prevent the true extent of his or her condition being discovered.

Recommendation 29: The definition of “suicidal behavior” in correctional mental health documents should be revised to reflect that suicidal ideation, not solely “a decision to kill oneself,” can yield suicide attempts.

We encountered definitions of “suicide prevention” that brought suicidal ideation into play, but this did not appear in the definition provided more than once for “suicidal behavior.”²⁹

Screening

Recommendation 30: Policy directives and operating procedures are needed for the screening of all new inmates for possible mental illness. In addition to laying official groundwork for screening tools and practices, which must be reliable and valid for prison setting populations, these documents should establish protocols for when and under what circumstances a diagnosis that accompanied a prisoner in his/her records or was established upon entry to the DOC system may be changed.

We encountered no policy directive or operating procedure with any depth on the mental health screening process for new DOC admissions. Given what the recent U-M study of prison prevalence found (that 65% of those identified by U-M as having serious mental disability were not receiving current service from the Corrections Mental Health Program), it is imperative that policy and procedure documents for initial screening be promulgated.³⁰

The best way to look at initial screening is to compartmentalize the separate populations of youth, adult female and adult male prisoners. The biggest problem appearing to us is with the adult male population, which represents the vast majority of prison inmates (83% of commitments in 2008 were of men above age 19).³¹

Prisoners under the age of 17 are supposed to be automatically admitted to the CMHP outpatient program (per a 2009 CMHP memorandum), and DOC reports that juvenile admissions also get face-to-face evaluation from a Qualified Mental Health Professional and a psychiatrist’s assessment, among other testing. (At present, the psychiatric assessment would not, however, be from a child psychiatrist.)

DOC reports that adult females, among other testing, receive the Minnesota Multiphasic Personality Inventory-2 (MMPI-2), which has been validated for use with prison inmates.³²

²⁹ The Mayo Clinic, on its website, says that suicidal ideation is a form of suicidal behavior, and that, “Suicide is actually a complex set of behaviors that exists on a continuum, from ideas to actions...”

³⁰ References to U-M report based on version seen by MHAM late February.

³¹ Michigan Department of Corrections. *2008 Statistical Report*.

³² Megargee. *MMPI-2 Criminal Justice and Correctional Report*. 2001 revised.

For adult males, however, the closest test to a diagnostic mechanism in DOC's reported package is the Correctional Mental Health Screen-Men (CMHS-M). This is an extremely brief instrument that had its research validation in jails and has an inaccuracy rate of 25% when it comes to identification of previously undetected psychiatric disorders.³³ We believe this instrument can be a helpful tool (e.g., immediate identification of potential emergencies) within an overall package. But given what's in the current overall adult-male package as reported to us by DOC, we recommend that the MMPI-2 (which used to be used with all prison admissions) be reinstated for adult males soon after their admission.³⁴

Additionally, given what has been suggested in certain court cases and reports, clear procedures have to be in place for clinical peer and/or supervisory review of changes that are made in a prisoner's mental health diagnosis – either the diagnosis they arrived with or, absent such a diagnosis in their accompanying records, the diagnosis they were given upon entry to the DOC system. The recent U-M study examined this subject in part, but only from the standpoint of someone with an Axis I (“clinical disorder”) diagnosis being changed to another Axis I diagnosis in the past year. The U-M report found 76.4% of those with a mental health diagnosis had a single Axis I diagnosis in the previous twelve months, but the report did not provide information on the degree to which Axis I diagnoses might ever have been changed to Axis II (“personality disorders”), the designation of which eliminates someone from qualifying for or remaining in the Corrections Mental Health Program. It is this form of diagnosis change (Axis I to Axis II) that has been called into question by some litigants and advocates over the years.³⁵

Substance Abuse

Recommendation 31: DOC's policy directive and operating procedure on substance abuse service should be revised for more content on treatment, more specificity and inclusion of the Patient Placement Criteria of the American Society of Addiction Medicine.³⁶ {NOTE: See also Recommendation #3 earlier in this report for our overarching structural recommendation regarding substance abuse.}

Michigan Prisoner Reentry Initiative (MPRI) and Prisoner Discharge

Recommendation 32: The base MPRI program statement used by DOC should be updated for timeliness.

The base statement was written in 2006. The program is larger now; deals with some populations it didn't originally; and has a new contractor for mental health.

³³ National Institute of Justice. *Mental Health Screens for Corrections*. May 2007.

³⁴ DOC informs us that it hopes to utilize the women's version of the CMHS soon. If and when that happens, we recommend that it be a supplement to, not a replacement for, the MMPI-2 testing currently given to adult females.

³⁵ American Friends Service Committee & Prison Legal Services of Michigan, Inc. *Tolerating Failure: The State of Health Care and Mental Health Delivery in the Michigan Department of Corrections*. December 2007.

³⁶ American Society of Addiction Medicine. *Patient Placement Criteria, Second Edition Revised (ASAM PPC-2R)*, 2001.

Recommendation 33: There should be parallel policies/program statements/operating procedures for reentry of youth prisoners with behavioral conditions and offenders with substance abuse problems as exist for adult offenders with mental illness.³⁷

Recommendation 34: DCH operating procedure MPRI 4.6.180-A should be revised to require the involvement of mental health professionals in initial parole decisions under the special “D47” designation for MPRI mental health paroles.

Recommendation 35: All MPRI mental health documents should focus on the sustainability of community service plans.

Field professionals who have worked with MPRI mental health tell us that when MPRI funding reaches its endpoint for an individual’s community mental health service, local agencies often cannot afford to continue the same service in the same way. Discontinuity can have dire consequences for service recipients. MPRI documents need to better recognize the importance of initially working with community planners on service packages that have the potential for long-term continuation.

Recommendation 36: Whenever there is a service gap between what an MPRI client needs and what the community can offer, this should be documented by the MPRI for reporting, evaluative and quality improvement purposes.

Recommendation 37: DCH operating procedure MPRI 4.6.180-D should be revised so that a second (psychiatric) certification on an involuntary treatment recommendation for a discharging prisoner is automatically supplied by the correctional mental health program (unless other arrangement for that has been made with a receiving Community Mental Health Services Program).

If mental health staff believe that involuntary civil commitment is needed upon a prisoner discharging to the community, the Michigan Mental Health Code is going to require a second (psychiatric) certification beyond the initial certification of treatment need filled out by the correctional mental health program. Unless an arrangement for the second certification has already been made with Community Mental Health, the correctional mental health program should take care of both certifications so that the courts and discharging consumers get final determinations as quickly as possible. DCH operating procedure MPRI 4.6.180-D presently requires only the first certification from the correctional mental health program.

Request for Services

Recommendation 38: Program and service documents should make clear that there will be evaluative follow-up of behavioral health service requests from a prisoner’s legal guardian; his or her closest surviving relative within the third degree of consanguinity under civil law; any party holding power of attorney for the prisoner; or the state’s Corrections Ombudsman.

³⁷ Section 929c of the FY-10 DOC appropriations act requires the department to “Implement a specialized re-entry program that recognizes the need of prisoners less than 19 years old for supervised re-entry.”

Existing documents do not state requests from these entities will be ignored, but they generally specify only staff and prisoners themselves as sources of requests guaranteed to yield evaluations.

Training

Recommendation 39: DOC should have a policy directive on training of all staff (including but not limited to custody, contractual and non-behavioral medical) in behavioral health problems and issues.

FY-09 and -10 DOC budget boilerplate (section 505) requires staff mental health training, and department officials have informed us that such training takes place, but we could find no significant written policies or operating procedures on this.

Records Access

Recommendation 40: DOC and DCH should have written policy or operating procedure enhancing the ability of behavioral and non-behavioral medical personnel to access prisoner health records from either domain as warranted and necessary.

There is no centralized electronic repository of all corrections health records. Given the present situation, and the potential for different players to be involved with serious mental illness, moderate mental illness, substance abuse and non-behavioral health, we believe it important that the system have high-level written guidelines covering providers' access to different types of health records.

Self-Auditing

Recommendation 41: The Michigan Auditor General should be asked to review and critique DOC's practice of allowing its facilities to self-audit their compliance with correctional policies and procedures.

We encountered in many written documents that correctional system compliance with policies and procedures would at least partly be determined by facility self-audits under DOC policy directive 1.5.100. The directive states that the DOC director's office shall annually select policies to be self-audited, and each warden shall annually select at least five additional policies for self-auditing. DOC reports that self-audits have yielded considerable information of value, but the practice of self-auditing raises potential conflict-of-interest issues. This analysis did not have the time to evaluate whether and how the practice is working. Thus, if it is going to continue, the Legislature should request that the state's Auditor General review the degree to which policy directive 1.5.100 is being followed, and the quality of information about system policy compliance that is being yield under the directive.

Appendix A – Voting Members of the Project Advisory Committee

Keith Barber

Ombudsman, Office of Legislative Corrections Ombudsman

Richard Berchou, Pharm.D.

Associate Clinical Professor, Department of Psychiatry and Behavioral Neurosciences, Wayne State University

Oliver G. Cameron, M.D., Ph.D.

Emeritus Professor, Department of Psychiatry, Medical Center, University of Michigan

Greg Dziadosz, Ph.D.

President and CEO, Touchstone-innovare

Craig Finger, Ph.D.

Consulting Psychologist

Betsy Hardwick, LMSW

COO/Program Administrator, Professional Consulting, ReEntry Project for Offenders with Special Needs

Susan McParland, J.D.

Executive Director, Michigan Association for Children with Emotional Disorders

Michael Reagan

President, Proaction Behavioral Health Alliance

Mark Reinstein, Ph.D.

President & CEO, Mental Health Association in Michigan

Notes

- Michael Reagan and Drs. Berchou, Cameron and Dziadosz are members of the Mental Health Association in Michigan's Board of Directors.
- Betsy Hardwick was recused from voting on matters pertaining to the Michigan Prisoner Reentry Initiative.
- Service on the project advisory committee does not mean any given member automatically endorses every statement made in this report.
- We gratefully acknowledge consultative and technical assistance to this project from Dr. Jeffrey Stieve and Lynda Zeller of the Michigan Department of Corrections, as well as Greg Boyd from the *Michigan Partners in Crisis* coalition.

Appendix B – Documents Reviewed

Policy Directives, DOC

- ~1.5.100, “Self-Audit of Policies and Procedures,” 12-2-02
- ~2.5.100, “New Employee Training Program,” 1-6-09
- ~2.5.101, “In-Service Training,” 1-1-04
- ~2.6.111, “Employment Screening,” 9-19-05
- ~3.2.100, “Michigan Prisoner Reentry Initiative,” 7-30-07
- ~3.2.130, “Prisoner/Parolee Grievances,” 7-9-07
- ~3.3.105, “Prisoner Discipline,” 6-29-09
- ~3.3.115, “Substance Abuse Programming and Testing,” 1-1-02
- ~3.4.125, “Medical Emergencies,” 1-26-09
- ~4.1.105, “Reception Facility Services,” 1-1-10
- ~4.1.140, “Prisoner Orientation,” 8-12-02
- ~4.6.115, “Suicide Prevention,” 12-20-99
- ~4.5.112, “Managing Disruptive Prisoners,” 1-13-03 (restricted document, reviewed only by MHAM CEO)
- ~4.5.120, “Segregation Standards,” 6-29-09
- ~4.6.110, “Deaths: Natural, Accidental, Suicide, Homicide,” 5-28-84
- ~4.6.180, “Mental Health Services,” 10-9-95
- ~4.6.182, “Mentally Disabled Prisoners in Segregation,” 6-29-09
- ~4.6.183, “Voluntary & Involuntary Treatment of Mentally Ill Prisoners,” 10-9-95
- ~5.2.114, “Special Education Services for Prisoners,” 4-20-98
- ~5.2.115, “Special Education – Procedural Safeguards,” 12-30-97

Operating Procedures, DOC

- ~3.3.115B, “Substance Abuse Assessment and Program Referral,” 10-2-02
- ~3.4.100C, “Pharmacy Services and Medication Management,” 11-3-08
- ~4.5.120A, “Self-Mutilation Prevention Unit Admission and Discharge,” 5-15-00
- ~4.6.180B, “Crisis Stabilization Program Referral/Admissions,” 12-16-02
- ~4.6.180C, “Referral and Review Process for Mental Health Services Requested by DOC Primary Care Physicians,” 3-20-00
- ~4.6.183, “Implementation of Involuntary Mental Health Treatment,” 3-28-04
- ~4.6.183, “Voluntary and Involuntary Treatment of Mentally Ill Prisoners,” 10-9-95
- ~4.6.183C, “Review of Mental Health Treatment Dispositions,” 11-22-99
- ~4.6.183D, “Involuntary Treatment Hearings of Mentally Ill Prisoners in Corrections Mental Health Program,” 9-24-00
- ~CMHP 4.6.180H, “Secure Status Residential Treatment Program (SSRTP): Admission, Treatment and Management of SSRTP Prisoners,” 7-1-07
- ~ICF 4.6.183, “Secure Status Outpatient Treatment Program (SSOTP),” 10-25-06
- ~WCC 4.5.112A, “Therapeutic Restraint and Seclusion of Mentally Ill Prisoners,” undated draft
- ~WCC 4.6.180A, “Crisis Stabilization, Program Admission, Treatment, and Discharge,” 9-18-09
- ~WCC 4.6.180B, “Admission, Treatment, & Discharge in Acute Care Inpatient Settings,” 9-18-09

- ~WCC 4.6.180C, “Inpatient Program: Corrections Medical Unit Officer Involvement in Delivery of Mental Health Services,” 9-18-09
- ~WCC 4.6.180D, “Mental Health Therapy Occurring during Major Count Time for Inpatient Prisoners,” 9-18-09
- ~WCC 4.6.180E, “Duty to Warn on Inpatient Mental Health Units,” 10-3-09
- ~WCC 4.6.180F, “Prisoner Status in Inpatient Services,” June ‘09
- ~HVCC unnumbered, “Admission, Treatment & Discharge in Rehabilitative Treatment Services Inpatient Program,” 4-20-09
- ~Unnumbered, “Suicide Prevention – Inpatient Units,” 4-20-09

Operating Procedures, DCH

- ~CMHP 3.3.105, “Misconduct Evaluations for Mentally Ill Prisoners,” 7-1-07
- ~CMHP 4.5.120, “RTP Prisoners Who Require Protective Custody,” 7-1-07
- ~CMHP 4.6.115A, “Suicide Prevention – Facilities with Only OPMHT,” 7-1-07
- ~CMHP 4.6.115B, “Suicide Prevention – Facilities with RTP Units,” 7-1-07
- ~CMHP 4.6.180A, “Initial Referral & Intakes to Corrections Mental Health Services & Outpatient Mental Health Services,” 7-1-07
- ~CMHP 4.6.180B, “Corrections Mental Health Program Outpatient Mental Health Services and Treatment,” 7-1-07
- ~CMHP 4.6.180C, “Transfers from Other Outpatient Mental Health Teams, Residential Treatment Programs, and Inpatient Settings to Facility Outpatient Mental Health Team,” 7-1-07
- ~CMHP 4.6.180D, “Discharge from the Corrections Mental Health Program OPMHT,” 7-1-07
- ~CMHP 4.6.180G, “BSI/BPRS Data Collection,” 7-1-07
- ~CMHP 4.6.180H, “Admission, Treatment, and Discharge in Residential Treatment Program,” 7-1-07
- ~CMHP 4.6.180I, “Use of Telemedicine Orders/Renewals and Comprehensive Examinations for CMHP Prisoners in Absence of a Psychiatrist/Medical Provider On-site,” 8-6-08
- ~CMHP 4.6.180J, “Initial Referrals & Intakes to Corrections Mental Health Services via Telemedicine,” 8-6-08
- ~MPRI 4.6.180A, “Michigan Prisoner Re-entry Initiative (MPRI) for Mental Health (MH) Prisoners – D47 Parolees,” 5-12-08
- ~MPRI 4.6.180B, “Aftercare Planning for Prisoners with Mental Illness Discharging from Prison,” 5-12-08
- ~MPRI 4.6.180C, “Aftercare Planning for Prisoners with Mental Illness or Mental Retardation/Developmental Disabilities with Positive Parole Action,” 5-12-08
- ~MPRI 4.6.180D, “CMHP Review of Mental Health Code Criteria and Petition/Clinical Certification Process,” 5-12-08
- ~CMHP 4.6.182A, “Mental Health Services to RTP Prisoners in Segregation and Appeal Process,” 7-1-07
- ~CMHP 4.6.182B, “Mental Health Services to Mentally Ill Prisoners in Segregation & Appeal Process,” 7-1-07
- ~CMHP 4.6.182C, “Mental Health Services to Mentally Ill Prisoners in Temporary Segregation,” 7-1-07

- ~CMHP 4.6.182D, "Prisoner Status in Residential Treatment Programs," 5-3-04
- ~CMHP 4.6.183, "Mental Health Emergency – Facilities without RTP Units," 7-1-07
- ~CMHP 4.6.183A, "Mental Health Emergency – Facilities with RTP," 7-1-07
- ~CMHP 5.1.140, "Coordination of RTP Referrals," 7-1-07

Program Statements

- ~Acute Inpatient Program, January 2009 draft
- ~Crisis Stabilization Program, January 2009
- ~Criteria and Guidelines, Corrections Mental Health Program, 8-22-03 revised
- ~Michigan Prisoner ReEntry Initiative MPRI Mental Health ReEntry and Community Integration Services Targeted Care Coordination, August 2006 revised
- ~Outpatient Mental Health Treatment Program, November 2006
- ~Psychological Services Unit, June 1995
- ~Rehabilitative Treatment Services, January 2009 draft
- ~Residential Treatment Program, November 2006
- ~Secure Status Outpatient Treatment Program (SSOTP), 9-12-06 revised

Memos

- ~DOC Memo of 3-20-08, "Ten Day Psychiatric Medication Bridge"
- ~DOC Director's Memo 2009-2, "Huron Valley Complex," 1-1-09
- ~DOC Director's Memo 2009-15, "Maxey/Woodland Center Correctional Facility," 4-17-09
- ~DOC Director's Memo 2009-16, "Incentives in Segregation Program," 5-27-09
- ~DOC Memo of 6-23-09, "Formulary Update"
- ~DOC Director's Memo 2010-5, "Social Security Cards," 1-1-10
- ~DOC Director's Memo 2010-6, "Maxey/Woodlands Center Correctional Facility," 1-1-10
- ~DOC Director's Memo 2010-7, "Incentives in Segregation Program," 1-1-10
- ~DOC Memo of 2-4-10 (with multiple document attachments), "Reception Mental Health Screening"
- ~CMHP Memo of 10-6-06, "Clarification of Administrative Appeal Process"
- ~CMHP Memo of 5-7-08, "MPRI Mental Health Operating Procedures Update"
- ~CMHP Memo 2009-1, "Management Plans," 1-28-09
- ~CMHP Memo 2009-2, "Suicide Evaluation & Follow up Treatment," 1-28-09
- ~CMHP Memo 2009-4, "Treatment Priority for Outpatient Mental Health Caseload," 1-5-09
- ~CMHP Memo 2009-6, "Automatic Admission to Outpatient Mental Health Team for Prisoners Under the Age of 17," 1-28-09
- ~CMHP Memo 2009-8, "K-Plan Category Changes," 1-28-09
- ~CMHP Memo of 4-21-09, "Suicide Prevention Plan Guidelines"

Other

- ~"BMU – Core B Programming Proposal," 8-10-09 draft
- ~"Brief Psychiatric Rating Scale"
- ~"Brief Symptom Inventory"
- ~"Bureau of Health Care Services Clinical Formulary," 6-23-09 revision

- ~“Case Management Defined and Standards for RTPs,” undated
- ~“Corrections Mental Health Program (CMHP) Guidelines on Follow-Up of Patients After Discontinuation of Significant Changes of Psychotropic Medication,” 5-21-07
- ~“Corrections Mental Health Program Mental Health Services Guidebook,” 1-28-08
- ~“DOC Prisoner Guidebook (CSJ-166),” August 2009 revised
- ~“Documentation Requirements: Aftercare Packets and Legal Review and Petition Process,” undated
- ~“Michigan Prisoner Mental Health Care Improvement Project: A Blueprint for Transforming Prisoner Mental Health Care,” February 2009
- ~“Thumb Correctional Facility Youthful Offender Program HOPE,” 8-10-09 draft
- ~“Verified/Unverified Medication Process,” undated