

**Investing in Health and Justice Outcomes:  
An Investment Strategy for Offenders with Mental Health Problems in New Jersey**

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Mental illness is over-represented in the incarcerated population.<sup>1, 2</sup> As incarcerated populations grow in size and in their representation of mental illness, state and local officials are looking for ways to respond that comply with constitutional requirements and legal mandates, fit the contours of a fragmented public system, which relies increasingly on the private sector, and are affordable. Their affordability is perhaps the most limiting and vexing challenge, especially in contemporary times of huge budget shortfalls. The needs of mentally disordered offenders are complex and multi-dimensional, often including addiction problems, HIV/AIDS, and some form of personality disorder, and they are expensive if managed comprehensively. It is unlikely that there will ever be enough public funding, even in more prosperous times, to meet all their needs. For this reason, it is vital that policy makers carefully invest available funds in responses that are most likely to address needs that produce health and justice outcomes most valued by society.

This paper argues that the most sensible way to respond to the needs of offenders with mental illness is to treat their needs as an investment, and to evaluate alternative responses to their needs in terms of the health and justice outcomes they produce. States and local governments that seek to get the most out of their investment dollars need to consider what outcomes are produced by their investments and whether these outcomes are protected from loss. For example, it makes no social or economic sense to invest public dollars in stabilizing chronic mental health problems of inmates and then lose the "outcome" by gaps in treatment when the person moves from prison or jail to the community. Framing social problems as investment opportunities changes the point of reference and lengthens the time frame. Here the challenge facing public officials is not mental illness in correctional or community settings but rather how to use scarce public dollars to produce and protect mental health and prosocial behavior.

This paper has three parts. The first part describes the prevalence of mental health and addiction problems among inmates in New Jersey jails and prisons. These rates are contrasted with those for the nation and are used to identify the scope and nature of the state's investment opportunity. The next part describes the "investment" responses by New Jersey prisons and jails. The third part discusses obstacles to "protecting" investments in health and justice outcomes and recommends an investment strategy and operational changes that might minimize the loss and maximize the return on the public's investment dollar.

## **I. Behavioral Health Problems Among New Jersey Inmates: An Investment Opportunity**

Federal statistics show that approximately 16 percent of jail and prison inmates have some type of mental health problem.<sup>1</sup> A recent report prepared by the National Commission on Correctional Healthcare estimates higher rates of mental illness, especially among women.<sup>2</sup> It is also known that inmates with mental health problems are likely to have co-occurring addiction problems. According to federal statistics, roughly 60 percent of state prison inmates with mental health problems were under the influence of drugs or alcohol at the time of their index arrest.<sup>1</sup> This estimate is consistent with epidemiologic evidence on the co-morbidity between mental illness and addiction problems.<sup>3-5</sup> Combined together, these estimates suggest that mental illness is over-represented in the incarcerated population, and it ranges in its severity and persistence. But these are rather "soft" estimates, lacking the detail and specificity required for informed policy making and planning, in part because state and local correctional authorities do not routinely collect mental health statistics, and those numbers that are collected are typically not published.

*Prevalence Estimates of Behavioral Health Problems in New Jersey Prisons.* The estimates presented here are drawn from a study on reentry planning that was commissioned by the New Jersey Department of Corrections (NJDOC) and Division of Mental Health Services.<sup>6</sup> The prevalence estimates are based on the universe of inmates housed at nine (adult) New Jersey correctional institutions. **Of the approximately 19,000 inmates at these facilities, roughly 3,200 inmates (or 17 percent) were classified as special needs inmates.** These are individuals who need or receive "mental health treatment of some type" while in prison.<sup>7</sup> Prison mental health staff determines whether an individual has symptoms requiring mental health treatment. An inmate may be placed on the special needs roster during the intake process or at any time during incarceration. Special needs inmates in New Jersey prisons are most likely to be male (68 percent), African American (48 percent), and between the ages of 25 and 44 (68 percent).

Table 1 shows the distribution of the most serious psychiatric diagnoses within the special needs population. The pattern of diagnoses differs among male and female offenders.<sup>φ</sup> Schizophrenia, psychotic disorders, and dementia are more common disorders among male than female inmates.

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<sup>φ</sup>All gender differences reported in this section are significant at the 1 percent level.

Rates of major depression, bipolar, major mood disorder, and borderline personality are higher for female than for male inmates.

Table 1. Most serious Axis I diagnosis of special needs inmates in New Jersey prisons by gender, August 2002.

Characteristic	Male Inmates (n=2715)	Female Inmates (n=474)
<b>Most Serious Axis I Diagnosis</b>		
Schizophrenia/affective, Psychotic disorder, Delusional disorder, OR Dementia	34.2%	15.8%
Major depression, Bipolar, Major mood disorder, OR Borderline personality	37.3	47.7
Depression, Dysthymia, Obsessive compulsive disorder, PTSD, OR Dissociative identity disorder	16.7	21.9
Anxiety disorder, Panic disorder, Brief psychotic disorder, Phobia, ADD/ADHD, Somatoform disorders, OR Impulse control disorders	9.2	10.1

Male and female inmates also differed in the relative frequency of personality disorder and addiction disorders (Table 2). The percentage of male inmates with a diagnosis of personality disorder was larger than for female inmates. By contrast, female inmates were more likely to have a diagnosis of an addiction disorder.

Table 2. Other behavioral health problems of special needs inmates in New Jersey prisons by gender, August 2002.

Characteristic	Male Inmates (n=2715)	Female Inmates (n=474)
<b>Axis II Disorder</b>		
Personality disorder	27.9%	13.5%
<b>Mental Retardation Diagnosis</b>		
Some level of mental retardation	1.5	0.8
<b>Addiction Disorder Diagnosis</b>		
Alcohol or substance dependence	31.6	36.7
Alcohol or substance abuse	12.2	27.0

These inmates also differ by criminal history (Table 3). Overall, special need inmates were more likely to be serving their first prison sentence (77 percent) but the length of their sentences and the type of offense varied by gender. Compared to female inmates, a larger proportion of male

inmates was serving sentences longer than 5 years and for crimes involving violence. But, the females inmates were more likely to be rearrested on parole/probation violations than their male counterparts.

Table 3. Criminal history of special needs inmates in New Jersey prisons by gender, August 2002.

Characteristic	Male Inmates (n=2715)	Female Inmates (n=474)
Incarcerated 2 or more times	21.4%	28.5%
Current sentence longer than 5 years	69.2	45.1
Convicted of arson	2.2	1.7
Convicted of violent offense	54.4	35.6
Convicted of sex offense	15.4	1.1
Rearrested on parole/probation violation	33.0	58.0

Speaking nationally, this is the most comprehensive portrait of a special needs population in a prison system that is currently available. Its availability is due in part to the electronic management information systems developed by the NJDOC and in part to the Commissioner's willingness to make the data available to researchers. Both are necessary if we are to move past the sketchy impressions of the present to a more fact-based future.

***Prevalence Estimates of Behavioral Health Problems in New Jersey Jails.*** Estimates reported here are based on responses from health services administrators from 17 jails participating in the Correctional Health Care Study.<sup>8-9</sup> In 2000, all participating jails were using standardized screens at booking to identify behavioral health problems in inmates. These screens included questions about mental health problems, as well as substance and alcohol use and abuse. Medical histories were conducted within four hours and physical examinations within 48 to 72 hours of booking. The rates of behavioral health problems identified through screening are shown in Table 4. **Approximately 16 percent of jail inmates were reported to have a mental illness.** Psychotropic medications are also commonly used at these facilities. On any given day, roughly 20 percent of inmates in New Jersey jails is receiving psychotropic medications. Again, the rates of inmates receiving these medications varied considerably among jails.

Table 4. Rates of Behavioral Health Problems in New Jersey Jails, 2000

Behavioral Problem	Percentage of Inmates in Average Month	
	Average	Range
Mental Illness	16	2-30
Drug/Alcohol Addiction	60	15-85

These rates should be interpreted with caution because they are based on the best estimates of respondents. In most cases, respondents did not have access to or collect behavioral health statistics. Most medical units of New Jersey jails did not, at the time of the study, have a medical information system, nor did they have the capacity to integrate health data across behavioral health and medical divisions. Considerable amounts of information were being lost between the cracks of health care units operated by different private contractors. Most of the jails were contracting with private companies for health services, and many jails had different private contractors for medical, mental health, and substance abuse services. Although the private contractors had automated record keeping systems, the staff at the jail relied on medical records stored as paper files at the facility.

## II. Intervention Investments that Yield Health and Justice Outcomes

On average, rates of mental illness and substance abuse reported above for inmates in New Jersey prisons and jails are consistent with federal estimates for state prison and local jail populations. **They suggest the following investment opportunity for the State of New Jersey: On any given day, 16 percent of New Jersey jail and prison inmates -- approximately 5400 people --- have a mental health problem.** But, as described above, there is considerable diversity among the special needs population. There is not one type of special needs inmate, just like there is not one type of person with mental illness in the community. These individuals vary in their behavioral health problems (e.g., severe versus non-severe mental illness; the presence of addiction problems or personality disorder) and criminal histories (e.g., violent versus non-violent) and, as a consequence, they require different types of investments.

Standards for mental health care have been defined by the National Commission on Correctional Health Care<sup>10,11</sup> and the American Psychiatric Association.<sup>12</sup> Typically, these standards include, but are not limited to, screening, evaluation, crisis intervention, suicide prevention, psychiatric medications, case management, therapy/counseling, special programs and housing units, and reentry planning. In addition to constitutional mandates and professional standards, the public expects that, through the incarceration experience, these individuals will be readied for community living. Public funding of corrections is intended to protect the public's welfare in the short-term by isolating offenders from the community and in the longer term by restoring them. The public's expectations are affirmed in the NJDOCs' mission statement, which states "that all persons committed to the state correctional institutions are confined with the level of custody necessary to protect the public and that they are provided with the care, discipline, training, and treatment needed to prepare them for reintegration into the community."<sup>13</sup>

The challenge here is not understanding the intent of the court, the standards for treatment, or the public's expectations but to fund their implications. In general, there is very little information available on correctional health care spending, and even less on its appropriateness relative to need and public expectations. The estimates that are available pertain to prisons in large measure because prisons are centrally funded by the state, whereas jails rely on local funding sources.

***Correctional Health Care Spending by Prisons.*** In aggregate, the prison systems for the 50 states spent approximately \$2.5 billion on prisoner medical and dental care in fiscal year 1996, which represented approximately 12 percent of total prison operating expenditure. States vary in their spending on correctional health care. For example, correctional health care spending as a percentage of total prison operation expenditures is estimated at approximately 20 percent for New Hampshire, Nevada, and Wyoming, compared to 5 to 6 percent for Nebraska, Iowa, and Oregon. The prison system in New Jersey reportedly spent 7.5 percent of its annual operating budget, or \$62 million, on correctional health care in fiscal year 1996. This translates into roughly \$2,300 per inmate per year, or \$6.30 per day.<sup>14</sup> Correctional health care spending has increased in New Jersey in recent years. **In 2002, approximately \$97 million, or 11 percent of the prison's operating budget, was spent on medical and mental health care, equaling about \$4,000 per inmate per year.**<sup>15</sup> Metzner reports data on mental health spending by 16 state

prison systems. These states spent, on average, 17 percent of their correctional health care budget on mental health services, with a range among states from 5.4 percent (Minnesota) to 42.7 percent (Michigan).<sup>16</sup> **Mental health spending represented roughly 18 percent of the correctional health care budget for New Jersey prisons in 2002.**<sup>15</sup>

The NJDOC's spending on behavioral health has increased in recent year as a result of the consent decree associated with the *C.F. v. Terhune* class action suit brought against the NJDOC on behalf of prisoners with mental health problems confined in New Jersey prisons. As part of the settlement, the NJDOC was required to build a comprehensive psychiatric capacity inside its prisons, and to coordinate mental health treatment post release.<sup>17</sup> The New Jersey prison system now provides comprehensive mental health treatment to special needs inmates in five locations: a forensic psychiatric hospital, stabilization units, residential treatment units, transitional care units, and outpatient care for those in the general population. A complete description of the New Jersey prison system of care can be found in Cevalasco and Moratti.<sup>7</sup> Having complied with the first part of the consent decree, the NJDOC is now developing a plan for a reentry program.

***Correctional Health Care Spending by Jails.*** It is very difficult to determine the level of spending on correctional health care in jails in part because spending is determined locally and by a county budgetary process. All counties set total correctional budgets but vary in the discretion and proportions granted to correctional officials. Some counties grant lead correctional officials full discretion over the total corrections budget, while others target a portion of the total budget for health care. In some cases, health budgets are carved out and the freeholders either negotiate directly with private contractors or assign this responsibility to another county agency. Counties choosing the carve-out approach frequently do not involve local correctional officials in the negotiation process. Given the complexity associated with budgeting and the variation among counties in New Jersey, it is not surprising that correctional officials are unaware of correctional health care spending levels there. **Those few respondents in the Correctional Health Care Study who were aware of fiscal arrangements in New Jersey jails reported that health care spending represented about 10 percent of their operating budgets.**

How adequate this spending is relative to the size of the needed investment is unclear. The majority of jails reportedly have written guidelines for serious mental illness (50 percent), suicide prevention (60 percent), and detoxification (75 percent). Clinical guidelines for the treatment and management of serious mental illness were available at half the reporting facilities and these facilities reportedly have sufficient resources to meet these standards of care. The other half reported no clinical guidelines, and the majority of them (83%) reported that the resources that were available were inadequate to provide appropriate mental health care. To meet standards for appropriate care, more behavioral health professionals, including psychologists, social workers, and substance abuse counselors, would be needed to develop special programs and manage the level of need within the inmate population. Physical space was also needed to conduct group therapy and for special units (e.g., MICA program, residential substance abuse treatment program, and residential mental health program).

The typical treatment plan for serious mental illness at the reporting jails always included medications. These plans also included other components but these varied among facilities. In general, inmates with serious mental illness had access to individual therapy at a majority (60 percent) of jails, while few jails offered these inmates group therapy (33 percent), case management (25 percent), or support groups (13 percent). The majority (80 percent) of respondents reported little or no difficulty getting inmates with acute psychiatric problems evaluated by a psychiatric crisis evaluator or admitted to a hospital. However, some facilities had problems getting crisis evaluations conducted on or off site and extreme difficulty gaining admission to a hospital bed because of changing hospital admission criteria and overcrowding.

Inmates with substance and alcohol problems were typically detoxified and offered access to support groups, such as narcotics or alcoholics anonymous. Inmates are usually treated symptomatically during the detoxification process, with careful monitoring of blood pressure. Most respondents reported that no active pharmacological treatment was offered to inmates during the withdrawal phase (the first 72 hours of admission) in an effort to prevent the substitution of legal drugs for illegal drugs. Substance abuse counselors provide individual or group therapy at roughly half of the jails. Several facilities reported having special drug treatment units, therapeutic communities, or boot camp programs.

## II. Structural and Systemic Investments that Preserve Health and Justice Outcomes

As inmates move from correctional settings to the community, their behavioral health problems move with them and require continuous treatment. Reentry planning is the mechanism by which treatment is coordinated and continued after incarceration. It is also the way in which the public's investment in health is protected. Such planning typically includes an individualized written post-release plan, provision of a temporary supply of medications for those inmates receiving medication, referrals and linkages to appropriate community mental health care providers, and assistance in obtaining necessary financial benefits and housing.<sup>12</sup>

### A. The State of Reentry Planning in New Jersey Prisons and Jails

This section summarizes how correctional facilities in New Jersey are working with special needs inmates and community providers to protect the public's investment in mental health.

***Reentry Planning by New Jersey Prisons.*** In an average year, roughly 600 special needs inmates are released from New Jersey prisons. According to the settlement, the NJDOC is required to provide reentry planning for special needs inmates that includes, at a minimum, an appointment with a community provider, two weeks of medications, and county-specific information necessary for the reestablishment of public benefits. The NJDOC is also required to develop connections with community based providers and provide treatment information at the request of community providers and in accordance with patient consent.<sup>18</sup> In accordance with the settlement, The NJDOC and the Division of Mental Health Services jointly commissioned a study to estimate the need for and cost of reentry planning for New Jersey prison inmates with mental health problems.<sup>6</sup> Here we describe the plan proposed by that study. The proposed plan calls for classifying special needs inmates into three need-risk groups that correspond to reentry tiers offering different levels of coordination effort. The program tiers are matched to three need-risk risk levels (high, moderate, and low) identified within the special needs population. The program tiers are:

- ❖ Tier 3: **Intensive Case Coordination.** 18 months of specialized coordination by a mental health professional with forensic experience, beginning 6 months before release.
- ❖ Tier 2: **Intermediate Case Coordination.** 6 months of specialized coordination by a mental health professional with forensic experience, beginning 3 months before release.

- ❖ Tier 1: **Limited Appointment Coordination.** 4 weeks of engagement by a mental health professional with forensic experience, beginning 2 weeks before discharge. Responsibility is limited to scheduling an appointment with an outside mental health provider and following up on any problems.

This program is designed to respond to the need-risk clusters of inmates with particular types of mental health, addiction, and criminal problems. It is estimated that the percentage of special needs inmates assigned to the high, medium, and low reentry tiers would be 27, 52, and 21, respectively. The reentry study estimated the cost of a three-tiered reentry program with a caseload of 600 special needs inmates at approximately \$930,000 annually, with 47 percent of the cost allocated to the highest need-risk group (tier 3). The estimates of need and cost for this program do not include the cost of community-based care. The success of this program, or any reentry program, depends in large measure on the availability of appropriate services in the community, and the willingness of service providers there to treat persons with mental health problems who also have criminal histories, personality disorders, and addiction problems.

***Reentry Planning by New Jersey Jails.*** One of the primary objectives of the Correctional Health Care Study was to evaluate the state of reentry planning in New Jersey jails. The central finding of this study was the near universal opinion among the medical staff that reentry planning is critically important for inmates with mental health problems but that in practice it was not part of the treatment plan at most facilities.<sup>9</sup> This is not to say that New Jersey jails do nothing to assist inmates with behavioral health problems connect with community providers post release. But what is done can be reasonably considered "minimal," and the minimal effort varies by facility and type of problem. Some type of reentry planning was reported for inmates with serious mental illness by 73 percent of respondents and 53 percent for substance abuse. But, for each type of behavioral health problem, less than 10 percent of inmates with a behavioral health were released from these facilities with reentry plans. Reentry planning for particular behavioral health problems was most common and complete in facilities with special treatment programs (e.g., drug treatment programs, special mental health unit). In such cases, the reentry planning was particular to the program, not to the entire facility.

Reentry planning, if it existed, most often consisted of a connection to community resources or a family member. The most typical reentry plan involved giving the inmate a telephone number of

a provider, treatment center, or clinic. Other forms of reentry planning were more idiosyncratic, and may include the occasional telephone call to an outside agency to give them a "heads up," or scheduling an appointment for the person with a community provider. Some facilities reportedly provide a summary of the inmate's clinical record or treatment plan to community providers but this was a fairly uncommon practice.

Most facilities have a policy against releasing inmates with their medications. However, some facilities reportedly release inmates with medications or a prescription for medications if they have a serious mental illness, although this is not a common practice among facilities. Facilities tend to shy away from releasing inmates with medications because they are concerned that inmates will sell the medications instead of using them as prescribed. Doctors also prefer not to release inmates with prescriptions because it implies that the prescribing doctor is responsible for follow-up care in the community.

## **B. Obstacles to Protecting the Public's Investment in the Mental Health of Offenders**

Connecting offenders with mental illness to community mental health services is critically important according to the position statement on post-release planning issued by the American Association of Community Psychiatrists<sup>19</sup> and the Task Force of the American Psychiatric Association.<sup>12</sup> Yet while important, these standards have not made their way into practice in New Jersey. **Approximately 16 percent of New Jersey inmates is identified as having mental health problems. Most of these inmates are released without effective linkages to medications or psychiatric services, both of which are essential for maintaining their mental health.** The situation in New Jersey is consistent with anecdotal reports from other states. Delivering seamless care to individuals who move between corrections and the community requires communication, coordination, and cooperation among correctional health care, the court, and community services. This section begins by focusing on obstacles -- the reasons, as described by correctional health care staff and the broader literature, for why the public's investments in inmate mental health are lost or not maximized. The concluding section develops a set of recommendations for guiding and protecting the public's investments .

***Obstacles Related to Coordination.*** Obstacles here center directly on the lack of coordination and communication within the criminal justice system.

**Obstacle #1: Uncoordinated Release People are released from correctional settings without medical clearance and without advance notice.**

Jails in New Jersey screen for mental health problems within the first four to 72 hours of detention but detainees may be released at any point during their adjudication -- at arraignment, during the trial, or at sentencing. As a result, these individuals are released from the jail at all hours of the day and night. Most detainees/inmates are released before the medical unit is informed of their disposition. Issues of timing and lack of coordination are more problematic for jails than prisons, which generally have more advanced notice of release dates (except in times of severe budget shortfalls, when release dates become less predictable).

**Obstacle #2: Insufficient Case Management There are too few behavioral staff to deliver services, and most do not have case management responsibilities.**

Most jails lack the professional staff to offer mental health or substance abuse services to inmates and what staff they have focus on screening first and then treating, leaving little or no time for reentry planning. Case management is not a responsibility typically assigned to medical units. While case management may be the responsibility of other service units within or affiliated with the correctional setting, the medical staff typically functions separate from social service units, as well as probation and parole. For this reason, they are ill-prepared for service coordination activities, and isolated enough to be ineffective at this task. Understaffing and informational deficiencies are also problems for prisons. Prison inmates may be housed in prisons that are hundreds of miles away from the communities where they will eventually live upon release. Social workers at the host facility may be unaware of resources in those local communities, and unconnected to their counterparts at prisons located closer to these communities.

***Obstacles Related to Information Sharing and Eligibility.*** Obstacles to reentry planning for inmates with behavioral health problems expand past the gates of jails and prisons.

**Obstacle #3: Information Gaps Information bottlenecks exist which limit the clinical information available to correctional and community providers treating the same patient at different times.**

One of the most common and persistent obstacles concerns the chasm between correctional and community settings. Inmates, as well as correctional health staff, are isolated from the community in ways that limit their contact and communication with community providers, creating information gaps. Very little effort is extended on either side of the gate to bridge the information gaps that lead to discontinuities in treatment. Failure to provide information to correctional or community health care staff can result in the substitution of medication or treatment approaches that are less effective, while failure to make treatment plans available can result in treatment discontinuities and symptom decompensation.

**Obstacle #4: Treatment Eligibility Requirements Treatment histories in correctional settings imperfectly translate into eligibility requirements for community treatment.**

All counties in New Jersey have community-based programs in operation that could serve as a bridge between correctional and community treatment settings. These special community-based programs, referred to as programs of assertive community treatment (PACT)<sup>20</sup> or intensive case management services (ICMS), are designed for persons with severe mental illness who tend to be treatment resistant. Eligibility for these programs require either prior hospitalization or failure to thrive in a previous intensive outpatient program, usually within the past 18 months. Most inmates do not meet these eligibility criteria. Without recent evidence of treatment failure in the community, most inmates fail the eligibility test for intensive community-based treatment, even though it may be equivalent to the treatment they received while incarcerated or prior to their incarceration. Yet, even when inmates with serious mental illness meet these criteria, there are often no available openings.

**Obstacle #5: Public Funding Eligibility People released from prison and jail are without public benefits and re-qualifying for them takes months.**

Funding issues, however, further complicate the individual's ability to connect with treatment resources in the community. It is remarkably easy to process the paperwork to terminate public entitlements, such as Medicare, Medicaid, and welfare, but extraordinarily cumbersome to

reactivate them. Re-qualifying for Medicaid or Medicare takes time and requires a community address. As a consequence, most people are released from jail and prison without any health care insurance coverage. Without a means to pay for treatment, community providers may be unwilling to deliver services and prescribe medications. In the interim, the public's investment in the inmate's mental health depreciates, as effective treatments are withheld until funding is determined, eligibility criteria are satisfied, and treatment slots become available.

### **C. An Investment Strategy for Restoring and Protecting the Mental Health of Offenders**

Restoring mental health begins and continues with effective treatment. Research evidence has shown that there are effective programs available for people with mental illness, including assertive community treatment, supportive employment programs, programs for the mentally ill, chemical abusers, as well as medications management regimes.<sup>21-25</sup> In addition, programs are developing that respond to the special needs of people with mental illness and criminal histories.<sup>26-30</sup> The issue is not whether effective treatment exists but whether it is *consistently* available to the people who need it, and whether these individuals *continuously* avail themselves of treatment. The public's investment in the mental health of its citizens must be consistent and continuous to yield health and justice outcomes that endure.

***Investments in Mental Health and Prosocial Outcomes.*** The public (or the state as its agent) cannot afford to fully meet the needs of this population, but there is some level of care that is within the public's budget. The level of care to be provided will be determined in large measure by the size of the investment budget, which depends on how much the public is willing to spend on a standard of care for this population. But, once the investment budget is determined, an investment strategy is needed. The three recommendations presented here are intended to set the foundation for the state's investment strategy. These recommendations require deliberative effort and consensus building, which will take time and the active involvement of policy makers, system officials, and the public. The strategic recommendations include: treatment parity, treatment capacity, and need-treatment matching. Fiscal politics and administrative dynamics will undoubtedly shape the standards for parity, the extent of treatment specialization, and the

sophistication of needs-treatment matching. Nonetheless, the state can take the lead to guide the process and assure some reasonable baseline for all three.

**Strategic Recommendation #1: Treatment Parity Standards of care and treatment opportunities must be equivalent between correctional and community settings.**

Whatever treatment opportunities exist on one side of the gate must exist on the other side if treatment is to be consistent and continuous. Treatment must follow the person, and it cannot follow if the capacity is absent or changes with residency. National standards for correctional health care may make clinical sense in an abstract social context but they are not socially useful if they are not paired with equivalent service standards in the community.

**Strategic Recommendation #2: Treatment Capacity The degree of specialization within the treatment capacity must fit the case mix of the population.**

The complexity and diversity of the treatment capacity is determined in large measure by the variation in need within the special needs population. A "one size fits all" treatment approach is not likely to fit the case mix within the special needs population, which includes people with severe mental illness combined with HIV/AIDS, addiction problems, and personality disorders, those with mild forms of acute depression, and everyone else in between. An array of services contoured to the multi-dimensional nature of the problems within the population will most likely be needed, especially in areas with high concentrations of HIV/AIDS and addiction problems.

**Strategic Recommendation #3: Treatment-Problem Matching Screening and assessment must be comprehensive and used to guide the assignment of treatment intensity.**

Matching people with mental health problems to appropriate treatment services is critical. It requires accurate screening for mental health problems and a comprehensive accounting of co-occurring conditions and risk factors. Without this information, people may be assigned to services that are more or less intensive than what they need, which is wasteful and inconsistent with clinical standards.

***Preserving and Protecting the Public's Investments in Mental Health.*** Mental health is lost when treatment is disrupted or discontinued against clinical advice. Even if the strategic recommendations are adopted, treatment may still lapse if the obstacles described above are not eliminated or, at least, managed effectively. The recommendations here are operational in nature and require administrative changes and/or additional funding. Many are amendable to immediate responses, while others may require more deliberative active.

Coordination Obstacles. People are typically released from prisons and jails in an uncoordinated way. Often there is little or no coordination within the correctional facility (obstacle #1) or between corrections and the community (obstacle #2). The first two recommendations are intended to facilitate coordination inside the gate. They are:

**Operations Recommendation #1: Cross Train Provide correctional and medical staff with opportunities to learn each other's jobs, train specialty correctional staff for special mental health units, and establish protocols that guide access to treatment, which are respectful of and consistent with security and therapeutic concerns.**

**Operations Recommendation #2: Coordinate Release Develop protocols for release that include clearance by the medical unit and the provision of two weeks of medication as "personal property."**

Fragmentation exists between the medical and correctional staff. The professional philosophy of these two groups is different in focus and objective, each seeing the inmate and his/her needs differently. These differences can lead to frequent disagreements regarding when and if inmates need access to treatment and how treatment will be delivered. Serious gaps in communication also exist between the correctional staff in charge of release and the medical staff. The lack of communication here can begin the cycle of relapse for inmates who are chronically ill and need medications and continued treatment to maintain their health.

The next recommendation is intended to coordinate treatment activities between correctional and community providers (obstacle #2).

**Operations Recommendation #3: Agency Responsibility Assign one public agent with the responsibility to coordinate treatment between the correctional and community settings and fund it appropriately.**

Treatment is disrupted upon release from prison and jail because no public agent has responsibility for coordinating treatment between the correctional setting and the community. In the breach, no one accepts responsibility and the public's investment in inmate health is placed at risk. To protect the public's investment, some public system must become the responsible agent, and to act responsibly the agent must be adequately funded and provided with the information necessary to make the treatment connections inside and outside the gate.

Information Obstacle. Timely and complete medical information is required to efficiently and effectively respond to inmate health problems. The goal here is to remove information bottlenecks (obstacle #3) that impede the flow of clinically appropriate information to providers.

**Operations Recommendation #4: Automate Records Invest in interactive, integrated information management systems that combine clinical information on health, mental health, substance abuse problems.**

**Operations Recommendation #5: Integrate Health Records Integrate health information between health care settings to improve detection and treatment engagement.**

Having access to more complete historical information at booking, saves money on testing and screening (which can be very expensive), and frees up staff and resources for treatment, yielding more treatment and health per correctional health care dollar. These records also could be used to identify so-called "frequent flyers" and engage them in treatment. Automated systems also facilitate the construction of health profiles that document the level of illness among inmates and how illness patterns are changing over time.

**Operations Recommendation #6: Regulate Information Sharing Develop protocols for sharing health information that are consistent with federal and state protections on privacy and applicable to public and private providers.**

Idiosyncratic interpretations of federal and state regulations on confidentiality typically limit information sharing between health providers treating the same person in different settings. Information barriers can impair clinical decision-making and create unnecessary disruptions in treatment.

Eligibility Obstacles. There are two types of eligibility obstacles. The first obstacle concerns the difficulty of matching offenders' treatment histories to the eligibility requirements for community-based services (obstacle #4).

**Operations Recommendation #7: Eligibility Crosswalk Develop a way to identify case equivalents between community and correctional setting and protocols for assuring equal access for those in equal need.**

Eligibility for intensive treatment in the community requires a severe mental illness and evidence of extreme treatment noncompliance during the past 18 months. While these criteria are designed to restrict access to those who are most in need of intensive treatment, they are not compatible with the treatment and confinement experience of inmates. While in prison, some inmates may be receiving treatment equivalent to that provided by PACT or ICMS, and their mental health status may depend on receiving that level of treatment. Barring them from appropriate community care because they were incarcerated is not inconsistent with the clinical intent of these programs or the public's investment in them.

The second eligibility obstacle concerns access to public benefits, especially Medicaid (obstacle #5). Access to treatment depends critically on the ability to pay. Federal and state entitlements, including health benefits, are typically suspended or terminated if a person is incarcerated for more than a month. The next recommendation addresses access to public entitlements.

**Operations Recommendation #8: Eligibility Continuity Create a mechanism by which inmates can reactivate their Medicaid eligibility prior to release.**

Termination or suspension of benefits has serious consequences for reentry planning. It can take up to six months to get Medicaid and SSI benefits reinstated (after release) but in the interim these individuals need medical care and housing, which are tied to the having public support and Medicaid. Establishing benefits that cover medical services is vital for this population.

The strategic and operational recommendations suggested here are not exhaustive. They are intended to be illustrative of the types of investments that are necessary to produce and protect health and justice outcomes. Outcomes that are consistent with society's preferences and willingness to pay. These recommendations also serve to move corrections-and community-

based services closer together. Closing this gap reduces the likelihood of treatment discontinuities, which wastes the public's money and places the public at undue risk. But, to move the state's investment strategy more in keeping with that outlined here, there must be the political will to change systems, remove structural barriers, and regulate performance. It is not clear that the proposed investment strategy will cost the public more, but it is clear that the public dollar would be invested differently and more purposefully.

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