Report 09-4
March 2009

An Evaluation

Inmate Mental Health Care

Department of Corrections
Department of Health Services

2009-2010 Joint Legislative Audit Committee Members

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CONTENTS

Letter of Transmittal 1

Report Highlights 3

Introduction 9

Mental Health Care Expenditures 11
Mental Health Care Organization and Staffing 12
Wisconsin Resource Center Staffing 15

Screening, Assessment, and Identification 19

Mental Health Classification System 19
Mental Health Screening and Assessment 21
Numbers and Characteristics of Mentally Ill Inmates 24
Developmentally Disabled Inmates 29

Monitoring and Treatment 33

Housing of Mentally Ill Inmates 33
Staffing Ratios 34
Psychological Services 37
Psychiatric Services 40
Inmates Prescribed Psychotropic Medications 42
DOC's Formulary 44
Medication Delivery 46
Other DOC Programs 48

Wisconsin Resource Center 51

Capacity and Population 51
Transfers and Departures 53
Admissions Process 57
Treatment 59
Civil Commitments 61

Improving Safety and Discipline 63
Inmate Self-Harm 63
Inmate Suicides 67
Assaults on Staff 70
Segregation 73
Segregation Populations 75
Monitoring and Treatment of Mentally Ill Inmates in Segregation 77
Enhancing Information and Training 79

Release Planning 83
General Release Planning Initiatives 83
Release Planning for Inmates with Mental Illnesses 85
Release Medications 86
Benefits Assistance 87
Post-Release Treatment Appointments 90
Community Supervision of Inmates with Mental Illnesses 93
Specialized Mental Health Agents 93
The Conditional Release Model 94

Future Considerations 97
Recent Improvements in the Provision of Services 97
Changes at Taycheedah Correctional Institution 98
Setting Priorities for Improving Inmate Mental Health Services 100

Appendices
Appendix 1—Mental Health Care Expenditures by Institution
Appendix 2—Prescription Drugs with Highest DOC Expenditures
Appendix 3—Authorized Full-Time Equivalent Mental Health Positions by Institution
Appendix 4—Limited-Term Employees Providing Mental Health Care
Appendix 5—Descriptions of Selected Mental Health Disorders
Appendix 6—Worker's Compensation Awards Related to Assaults by Mentally Ill Inmates
Appendix 7—DOC's Time Line for Benefits Application Assistance
Appendix 8—Standards of Mental Health Care at Taycheedah Correctional Institution

Responses
From the Department of Corrections
From the Department of Health Services

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Janice Mueller
State Auditor

March 25, 2009

Senator Kathleen Vinehout and
Representative Peter Barca, Co-chairpersons
Joint Legislative Audit Committee
State Capitol
Madison, Wisconsin 53702

Dear Senator Vinehout and Representative Barca:

We have completed an evaluation of mental health care services in adult correctional facilities, as requested by the Joint Legislative Audit Committee. In fiscal year (FY) 2007-08, expenditures for inmate mental health care totaled approximately $59.8 million. In June 2008, 6,957 inmates, or 31.0 percent of all inmates incarcerated in adult correctional facilities, were identified as mentally ill, including 299 inmates at the Wisconsin Resource Center operated by the Department of Health Services (DHS). For the two-year period from June 2006 through June 2008, the inmate population increased by 3.9 percent but the number of mentally ill inmates increased by 14.3 percent.

In FY 2007-08, the Department of Corrections (DOC) had 127.35 authorized full-time equivalent positions to provide mental health services, including psychologists, crisis intervention workers, and other mental health staff. A range of mental health services and programs is provided. Psychotropic medications are prescribed by psychiatrists, who are typically limited-term employees. Because most medications are delivered by correctional officers rather than health services staff, we include a recommendation that DOC ensure all officers receive appropriate training in medication delivery.

Mentally ill inmates have a disproportionate effect on safety and discipline in adult correctional facilities. For example, during our review period they accounted for more than 90.0 percent of self-harm incidents, 80.0 percent of inmate suicides, and nearly 80.0 percent of assaults on staff. Mentally ill inmates are also overrepresented in segregation. We include recommendations for better information and training to improve safety for both inmates and staff.

DOC has taken steps to improve inmate mental health care in recent years, including at Taycheedah Correctional Institution, where a 2008 settlement agreement with the federal Department of Justice sets specific benchmarks for improving mental health care services. Setting priorities for future improvements will be important as the State seeks to improve the provision of inmate mental health services at a time of significant budget constraints.

We appreciate the courtesy and cooperation extended to us by DOC and DHS staff. Responses from both agencies follow our report.

Respectfully submitted,

Janice Mueller
State Auditor

JM/KW/ss

Report Highlights ▪

In FY 2007-08, expenditures for inmate mental health care totaled approximately $59.8 million.

Mentally ill inmates are screened and monitored regularly, but treatment programming is limited at some institutions.

Mentally ill inmates account for a disproportionate share of self-harm incidents and assaults on staff.

A September 2008 settlement agreement requires improvements to mental health care services at Taycheedah Correctional Institution.

Adult inmates in Department of Corrections (DOC) custody, including those with mental illnesses, are housed in 20 maximum, medium, and minimum security institutions; 16 minimum security correctional centers; and the Wisconsin Resource Center (WRC) operated by the Department of Health Services (DHS). In June 2008, 6,957 inmates were identified as mentally ill, including 299 housed at WRC. Expenditures for inmate mental health care totaled approximately $59.8 million in fiscal year (FY) 2007-08.

Concerns have been raised regarding the cost and availability of treatment for mentally ill inmates, including the services they receive while incarcerated and in preparation for release into the community. Therefore, at the request of the Joint Legislative Audit Committee, we analyzed:

- staffing and expenditures for mental health services;
- DOC's process for identifying mentally ill and developmentally disabled inmates, and their locations and characteristics;
- the monitoring and treatment of mentally ill inmates;
- safety and discipline, including self-harm and assaults by mentally ill inmates and their placement in segregation;
- placements at WRC and services provided;

- planning and preparation for the release of inmates into the community; and
- DOC's activities to improve mental health care services, including those undertaken in response to a recent legal settlement.

Expenditures and Staffing

DOC's expenditures for inmate mental health care totaled approximately $27.0 million in FY 2007-08. They included $20.6 million in staff costs and $6.1 million for psychotropic medications. Expenditures by DHS for housing and treating inmates at WRC totaled $32.8 million. In FY 2007-08, DOC employed 127.35 full-time equivalent (FTE) mental health care staff.

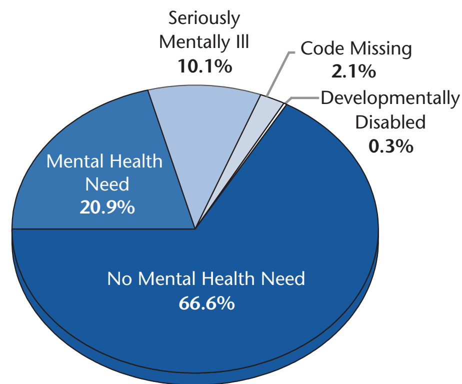
Identification, Monitoring, and Treatment

Over the past two years, DOC's inmate population increased 3.9 percent, from 21,610 in June 2006 to 22,451 in June 2008. The number of inmates with mental illnesses increased 14.3 percent, from 6,084 to 6,957.

In June 2008, 20.9 percent of inmates were classified as having mental health needs but not seriously mentally ill, and 10.1 percent were classified as seriously mentally ill, as shown in Figure 1. Mental illnesses were more than twice as common among female inmates.

Figure 1

Inmate Mental Health Status
June 2008



Most DOC facilities house inmates with mental illnesses. In a random sample, we found that 67.7 percent of inmates were screened for mental illness within two days of entering DOC custody. When mentally ill inmates were transferred between institutions, their files were generally reviewed by DOC staff in a timely manner.

Psychologists monitor mentally ill inmates on a regular basis, but group and individual therapy is limited. Psychiatrists focus on monitoring the approximately 3,900 inmates who are prescribed psychotropic medications. Neither psychology nor psychiatry staffing ratios at all DOC institutions meet national standards.

Correctional officers deliver most medications, including psychotropic medications, to DOC inmates. In neighboring states, inmates' medications are delivered primarily by health care staff.

Wisconsin Resource Center

Some male inmates with serious mental illnesses are housed at WRC, which currently has an operating capacity of 314 inmates. Nearly three-quarters of WRC staff positions provide direct services to inmates. Most WRC inmates participate in one or more treatment programs and have frequent contact with mental health care staff.

In FY 2007-08, the average length of stay at WRC was 392 days. WRC admissions are negotiated with DOC staff on a case-by-case basis. Clearer policies, more centralized decision-making, and more detailed record-keeping could help ensure that WRC resources are used effectively.

Improving Safety and Discipline

Mentally ill inmates have had a disproportionate effect on safety and discipline in DOC institutions. From FY 2005-06 through FY 2007-08, they accounted for more than 90.0 percent of 1,231 special placements made as a result of self-harm. These placements require monitoring by DOC personnel at least every 15 minutes.

Mentally ill inmates also accounted for nearly 80.0 percent of the 755 inmate assaults on staff in the past three fiscal years. These assaults resulted in $874,200 in worker's compensation awards to DOC and DHS staff from FY 2005-06 through FY 2007-08.

Mentally ill inmates have been overrepresented in segregation. In January 2008, 46.1 percent of inmates in segregation were mentally ill.

Release Planning

DOC has developed a standardized curriculum to help prepare all inmates for re-entry into the community. DOC policy also directs special services to mentally ill inmates, including a two-week supply of medications and post-release appointments with treatment providers. However, DOC's implementation of policies developed in 2004 to ensure timely application for disability and medical benefits could be strengthened.

Improving Inmate Mental Health Services

DOC has taken steps to improve inmate mental health care services in recent years. However, the federal Department of Justice found in 2006 that inmate mental health care at Taycheedah Correctional Institution did not meet constitutional standards. In September 2008, DOC reached a conditional settlement with the federal Department of Justice that requires specific improvements by September 2012.

To improve mental health services for female inmates, a 45-bed addition to WRC is scheduled for completion in February 2011, at a cost of approximately $11.1 million. DOC has also requested $7.6 million in general purpose revenue (GPR) bonding to build additional treatment space at Taycheedah.

2009 Assembly Bill 75, the Governor's 2009-11 biennial budget proposal, requests a total of 149.0 FTE positions and $6.6 million in GPR to operate the WRC addition for female inmates and to provide additional mental health services at Taycheedah.

If the Legislature appropriates additional funding for inmate mental health services in the future, costs in other areas may be reduced. For example, the Wisconsin Department of Justice (DOJ) estimates that its staffing costs to defend the State in inmate health care litigation total approximately $1.1 million annually, a portion of which relates specifically to inmate mental health. In addition, settlements or judgments resulting from such litigation have totaled $4.8 million in payments by the State over the past five years.

Recommendations

Our report includes recommendations for DOC to report to the Joint Legislative Audit Committee by January 4, 2010, regarding:

- ☑ options for improving screening for developmental disabilities *(p. 31)*;
- ☑ its plans for providing correctional officers with more specific information on inmates' mental health needs and with enhanced training *(p. 81)*;
- ☑ the allocation of designated release planning funds and its progress in implementing a pre-release curriculum (*p. 84)*;
- ☑ its efforts to improve both release planning for mentally ill inmates and, after release, their supervision in the community *(pp. 90, 93, 94)*;
- ☑ the feasibility of incorporating elements of the Conditional Release Program model into its supervision of released inmates *(p. 96)*; and
- ☑ progress in implementing its settlement agreement with the federal Department of Justice *(p. 99)*.

In addition, we include a recommendation for DOC and DHS to:

- ☑ report to the Joint Legislative Audit Committee by January 4, 2010, regarding policies for WRC admissions and transfers *(p. 58)*.

Finally, we recommend that DOC:

- ☑ ensure all correctional officers have been trained in medication delivery *(p. 48)*; and
- ☑ improve its collection and management of data related to inmate self-harm, assaults on staff, and segregation placements *(p. 80)*.

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Introduction ▪

Inmates have a constitutional right to mental health care.

In 1976, the United States Supreme Court ruled that failure by a correctional system to provide minimally adequate health care violates the Eighth Amendment prohibition of cruel and unusual punishment. Subsequent rulings have clarified that inmates' constitutional right to health care extends to mental health care for those with serious mental illnesses. These rulings establish minimum standards; they also indicate inmates do not have the right to the best care available in the community.

Wisconsin statutes and administrative code do not set specific requirements for mental health care in correctional facilities. However, s. 302.385, Wis. Stats., requires DOC to base its standards for health services on those issued by a recognized professional organization. DOC has consulted the standards of several organizations and reports that its policies and practices are based primarily on those published by the National Commission on Correctional Health Care (NCCHC). DOC does not, however, establish policies that fully meet those standards when staffing, budgetary, or other limitations would prevent compliance.

NCCHC also offers accreditation to facilities that substantially comply with its standards. No DOC facilities are accredited at present, although WRC was accredited in 2006.

Recent legal action against DOC has resulted in the establishment of more specific mental health care-related standards at two institutions. In 2000, a lawsuit was filed on behalf of mentally ill inmates at the Wisconsin Secure Program Facility in Boscobel, which was then known as the Supermax Correctional Institution, alleging that the institution's restrictive conditions of confinement constituted cruel

and unusual punishment for inmates with serious mental illnesses, because of the tendency for those conditions to worsen such inmates' mental states. DOC reached a settlement with the plaintiffs in January 2002 that included a provision to exclude inmates with serious mental illnesses from residing in the institution. DOC achieved compliance with that provision in 2003. The settlement agreement has not been in effect since May 2008, but DOC reports that it continues to comply with its terms.

A federal settlement agreement requires improvements in mental health care at Taycheedah.

The federal Department of Justice investigated conditions at Taycheedah Correctional Institution in 2005 and issued a findings report in May 2006 which argued that the provision of mental health care did not meet constitutional standards. A settlement was reached in September 2008, under which a complaint filed by the federal Department of Justice in September 2008 will be dropped if DOC complies by September 2012 with a set of standards designed to improve mental health care at Taycheedah. The standards are more stringent than either current DOC policy or NCCHC standards. For example, they require higher staffing levels and specify stricter standards for the timeliness of mental health assessments upon intake and the amount of therapeutic programming provided.

In addition to the 2002 and 2008 settlements, there have been three major external reviews of inmate health care, including mental health care, provided by DOC:

- our 2001 evaluation of prison health care (report 01-9);
- a 2002 report conducted by NCCHC at the direction of the federal Department of Justice National Institute of Corrections; and
- a 2006 review of eight facilities, conducted by NCCHC under contract with DOC, to review compliance with NCCHC standards and identify reforms needed to qualify those facilities for accreditation.

Three recent evaluations found shortcomings in inmate mental health care services.

All three reviews found shortcomings, including:

- lack of central oversight and limited coordination between psychological and psychiatric treatment;
- inadequate training and knowledge among correctional officers who deliver medications;
- mental health treatment that is insufficient in type and frequency to meet inmates' needs; and
- insufficient staffing, which was cited by NCCHC as a primary cause of many of the other shortcomings.

Mental Health Care Expenditures

Wisconsin's expenditures for inmate mental health care increased from $46.1 million in FY 2003-04 to $59.8 million in FY 2007-08. As shown in Table 1, most are related to staffing. Salaries and fringe benefits represented 83.1 percent of expenditures for inmate mental health care in FY 2007-08, and DOC's expenditures for inmate mental health care increased by $7.4 million, or 37.8 percent, during the five-year period shown, primarily because of increased staffing costs.

Table 1

Expenditures for Inmate Mental Health Care
(in millions)

Expenditure Type	FY 2003-04	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08
Department of Corrections					
Salaries[1]	$10.2	$12.0	$11.9	$14.4	$15.2
Fringe Benefits[1]	3.8	4.2	4.6	5.0	5.4
Psychotropic Medications	5.4	5.4	4.6	5.0	6.1
Contract Costs[2]	0.1	0.1	0.3	0.2	0.3
Other[3]	0.1	0.1	0.1	0.1	0.1
Subtotal[4]	19.6	21.7	21.6	24.8	27.0
Department of Health Services[5]					
Salaries	16.8	17.0	17.4	18.8	20.0
Fringe Benefits	7.2	7.8	8.0	8.5	9.1
Psychotropic Medications	–[6]	1.1	1.0	1.0	1.2
Other[3]	2.5	2.9	2.7	3.0	2.5
Subtotal[4]	26.6	28.8	29.1	31.4	32.8
Total[4]	**$46.1**	**$50.5**	**$50.7**	**$56.2**	**$59.8**

[1] Includes mental health managers, psychologists, psychological services assistants, crisis intervention workers, clerical staff in the psychological services unit, and psychiatrists. Also includes DOC correctional officers who provide security services at WRC; their costs totaled $6.4 million in FY 2007-08.

[2] Contracts for psychiatric services provided by temporary staffing companies and through the Forensic Psychiatry Fellowship Program at the Medical College of Wisconsin.

[3] Travel, training, supplies, and services other than medications.

[4] Totals may not sum because of rounding.

[5] Represents expenditures for services to DOC inmates at WRC, including costs for non-mental health care staff and other operating costs.

[6] Included in Other for FY 2003-04, because detail was not available.

It should be noted that DOC's expenditures shown in Table 1 include only those specifically attributable to mental health staffing and treatment programs for mentally ill inmates. They do not include, for example:

- the general costs of housing or supervising inmates with mental illnesses;
- the costs of treatment in programs and activities that serve all inmates, such as education or substance abuse treatment; or
- costs related to staff who schedule psychiatric appointments and file psychiatry reports as part of their clerical duties, nurses who take orders for psychotropic medications and review psychological services requests when psychological services staff are not on duty, nurses or correctional officers who deliver medications, and DOC Central Pharmacy staff who fill prescription medication orders.

DOC's Central Pharmacy purchases medications through a national purchasing consortium that negotiates high-volume contracts with pharmaceutical companies. The number of psychotropic medication orders it filled increased by 32.6 percent from FY 2003-04 through FY 2007-08, while expenditures for psychotropic medications increased by only 13.0 percent. The difference suggests that DOC's efforts to limit costs have been successful. Appendix 1 presents mental health care expenditures by DOC institution. Appendix 2 details DOC expenditures for the 20 prescription drugs for which expenditures were highest in FY 2007-08.

Mental Health Care Organization and Staffing

DOC's Bureau of Health Services oversees mental health care services.

The Bureau of Health Services oversees the delivery of health care and mental health care throughout DOC facilities. At individual facilities, mental health care includes both psychiatry and psychology services. Psychiatrists, who are licensed physicians, provide psychiatric assessments of inmates and prescribe and monitor psychotropic medications. They are primarily limited-term employees and report directly to the psychiatry director in the Bureau of Health Services.

Psychology staff are organized into psychological services units that report to the deputy warden at each institution. Most correctional centers send inmates to nearby adult institutions to receive mental health treatment. Psychological services unit staff include:

- masters- and doctoral-level psychologists who administer mental health assessments, monitor the mental health status of inmates, and provide group and individual therapy;
- psychological services assistants, who provide support services to psychologists such as administering and analyzing psychological tests;
- crisis intervention workers, who help identify, prevent, and manage sources of stress that may lead to crises within an institution, primarily in segregation units;
- psychological services unit clerical staff, who provide general office support duties, such as maintaining inmates' psychological services unit files; and
- psychologist interns, who are enrolled in doctoral-level psychology programs and undertake a variety of assignments, including assisting in psychological assessments and individual and group therapy.

In FY 2007-08, DOC had 127.35 FTE authorized mental health positions.

As shown in Table 2, DOC had 127.35 authorized full-time equivalent (FTE) mental health positions in FY 2007-08, which is an increase of 5.8 percent from FY 2003-04 staffing levels. In FY 2007-08, 69.9 percent of all FTE mental health positions were psychologists. The number of psychologists has increased in part because DOC is in the process of converting crisis intervention worker positions to psychologist positions, which it believes will improve mental health treatment. Appendix 3 shows FTE staffing by institution.

Table 2

Authorized FTE Mental Health Positions
Department of Corrections

Position Type	FY 2003-04	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08
Psychology Staff					
Psychologists	72.50	81.00	84.00	85.50	89.00
Psychological Services Unit Clerical Staff	15.85	15.35	15.35	15.35	15.35
Psychological Services Assistants	5.00	4.00	4.00	4.00	4.00
Other Mental Health Staff[1]					
Crisis Intervention Workers	18.00	13.00	11.00	10.00	10.00
Social Workers	3.00	3.00	3.00	3.00	3.00
Treatment Specialists	2.00	2.00	2.00	2.00	2.00
Nurse Clinicians	1.00	1.00	1.00	1.00	1.00
Correctional Officers	1.00	1.00	1.00	1.00	1.00
Psychiatrists[2]	2.00	2.00	2.00	2.00	2.00
Total	**120.35**	**122.35**	**123.35**	**123.85**	**127.35**

[1] 1.0 FTE clinical social worker provided mental health treatment services at the Milwaukee Secure Detention Facility from FY 2003-04 through FY 2007-08. All other social work, treatment specialist, nurse clinician, and correctional officer positions were assigned to substance abuse and mental health treatment programs at Oshkosh and Taycheedah correctional institutions.

[2] Most psychiatrists are limited-term employees; see Table 3.

Most institution psychiatrists are limited-term employees.

Limited-term employees (LTEs) provide a significant proportion of mental health services to inmates. In particular, all psychiatrists at DOC institutions hold LTE positions because DOC reports it is unable to recruit psychiatrists as permanent, full-time employees. As shown in Table 3, LTE positions increased from the equivalent of 9.84 full-time positions in FY 2003-04 to the equivalent of 21.51 full-time positions in FY 2007-08. Psychiatrists accounted for 53.4 percent of all LTE hours in FY 2007-08, when a total of 36 individuals filled the equivalent of 11.49 full-time positions. Appendix 4 shows LTE staffing by institution.

Table 3

Estimated LTE Mental Health Positions[1]
Department of Corrections

Position Type	FY 2003-04	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08
Psychiatrists[2]	7.23	8.41	8.05	10.72	11.49
Psychologist Interns	1.78	1.86	3.43	3.77	3.60
Psychological Consultants	0.78	1.83	1.40	3.47	3.36
Psychological Services Assistants	0.00	0.00	0.00	1.06	1.89
Psychological Services Unit Clerical Staff	0.00	0.00	0.25	0.03	0.63
Crisis Intervention Workers	0.05	0.18	0.20	0.70	0.54
Total	**9.84**	**12.28**	**13.33**	**19.75**	**21.51**

[1] Estimates based on hours worked during the fiscal year.

[2] Does not include contract psychiatrists.

Wisconsin Resource Center Staffing

There were 404.10 FTE positions authorized to provide services to inmates at WRC in FY 2007-08.

WRC is a DHS facility that houses some seriously mentally ill DOC inmates, along with sexually violent persons who have been civilly committed under s. 980.06, Wis. Stats. Most staff at WRC are DHS employees. As shown in Table 4, the number of FTE staff providing services to WRC inmates remained relatively stable from FY 2003-04 through FY 2007-08. Nearly one-half of those positions were filled by psychiatric care staff, who help implement and document mental health treatment plans and provide security on housing units. WRC infrequently relies on LTE staff to provide mental health services. In FY 2007-08, LTE mental health staff worked the equivalent of 0.64 full-time positions.

Table 4

Authorized FTE Positions at WRC[1]
Department of Health Services

Position Type	FY 2003-04	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08
Mental Health Staff					
Psychiatric Care Staff	201.10	201.10	201.10	201.10	201.10
Psychologists	15.00	15.00	15.00	15.00	15.00
Psychiatrists	9.00	8.50	8.50	7.50	7.50
Psychiatric Nurses	0.00	0.00	0.00	1.00	3.00
Subtotal	225.10	224.60	224.60	224.60	226.60
Other Direct Care Staff					
Nursing Staff	29.00	29.00	29.00	29.00	29.00
Social Services Staff	13.00	14.00	14.00	14.00	14.00
Teaching Staff	11.50	11.50	11.50	11.50	11.50
Occupational Therapists	8.00	8.00	8.00	8.00	8.00
Recreation Leaders	4.00	4.00	4.00	4.00	4.00
Physicians	0.75	1.25	1.25	2.15	2.20
Chaplain	1.00	1.00	1.00	1.00	1.00
Dietitians	1.14	1.14	1.00	1.00	1.00
Dental Staff	1.00	1.00	1.00	1.00	1.00
Client Rights Facilitator	0.50	0.50	0.50	0.50	0.50
Subtotal	69.89	71.39	71.25	72.15	72.20
Administrative and Service Staff[2]	110.11	108.11	104.80	104.80	105.30
Total	**405.10**	**404.10**	**400.65**	**401.55**	**404.10**

[1] DHS positions serving DOC inmates. Does not include positions devoted to civilly-committed sexually violent persons. However, some WRC inmate service staff provide sexually violent persons services in the event of staff shortages, while psychiatrists' caseloads routinely include inmates and sexually violent persons.

[2] Includes staff assigned to the Winnebago Mental Health Institute, which is located on the same grounds as WRC, who provide services such as food service for WRC inmates.

Although WRC employs psychiatrists in permanent positions, officials noted difficulties with recruitment and retention. For example, in FY 2006-07, 2.5 of the 7.5 authorized psychiatrist positions were filled. In FY 2007-08, 2.0 positions remained vacant. To address these vacancies, WRC began a pilot program in FY 2006-07 that employed specialized nurse clinicians to assist psychiatrists in providing services such as aiding with psychiatric assessments. WRC officials believe the pilot program was successful.

DOC correctional staff provide security services at WRC.

As noted, DHS psychiatric care staff provide security services directly on WRC's housing units, while DOC correctional staff provide security services elsewhere in the facility. In FY 2007-08, there were 96.0 FTE DOC correctional staff positions at WRC, as shown in Table 5.

Table 5

Authorized Correctional Staff Positions at WRC[1]
Department of Corrections

Position Type	FY 2003-04	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08
Correctional Officers	64.0	64.0	64.0	64.0	63.0
Correctional Sergeants	26.0	26.0	26.0	26.0	26.0
Supervising Officers	7.0	7.0	8.0	7.0	7.0
Total	**97.0**	**97.0**	**98.0**	**97.0**	**96.0**

[1] All position counts are full-time equivalent.

Screening, Assessment, and Identification ■

When inmates enter DOC custody, they are screened for mental health problems and assigned mental health codes based on the severity of their illnesses. We reviewed DOC's classification system, analyzed institutions' compliance with DOC policies on mental health screening and assessment, and analyzed DOC data on the number and characteristics of mentally ill inmates. We also analyzed available information on the number of developmentally disabled inmates.

Mental Health Classification System

At the time of our 2001 report on prison health care (report 01-9), DOC did not maintain statistics on the number of inmates with diagnosed mental illnesses. Therefore, that report estimated the number of mentally ill inmates based on the number of inmates for whom psychotropic medications were prescribed by DOC psychiatrists, or who were receiving treatment at WRC. This estimate likely undercounted the number of mentally ill inmates, and the lack of a consistent classification system made it difficult for DOC or others to assess mental health care needs in state prisons.

DOC implemented a mental health classification system in 2004.

In an effort to track the number of mentally ill inmates and improve mental health care, DOC implemented a mental health classification system in mid-2004. As shown in Table 6, inmates are classified based on the severity of their illnesses: a code of MH-0 identifies inmates who do not have any mental health needs, a code of MH-1 identifies inmates who have some mental health needs but are not seriously mentally ill, and a code of MH-2 identifies inmates who are seriously mentally ill. The MH-1 code is used to identify inmates whose mental health needs are short-term or do not meet the criteria

for a formal diagnosis, as well as those with mental illnesses that are less severe than those categorized as serious mental illnesses (MH-2). In this report, we use the general term "mental illness" to encompass either an MH-1 or MH-2 code. This definition is more inclusive than some definitions of mental illness, but it serves to include the inmates on DOC's mental health caseload. Appendix 5 includes descriptions of selected disorders.

Table 6

Mental Health Classification Codes Used by DOC
Mid-2004 through June 2008

Code	Classification	Common Diagnoses
MH-0	No mental health need	None.
MH-1	Mental health need; not seriously mentally ill	Anxiety disorders; adjustment disorder; impulse control disorder; mood disorders; borderline personality disorder (mild or moderate).
MH-2	Seriously mentally ill	Psychotic disorders; major depression; bipolar disorder; dementia (moderate or severe); borderline personality disorder (severe); severe dysthymia; severe anxiety disorders; mood disorders; organic brain syndrome.
MH-3	Mental retardation	IQ of approximately 70 or below with concurrent impairments in adaptive functioning.

All inmates prescribed psychotropic medications are to be classified as either MH-1 or MH-2. DOC's definition of serious mental illness was first established by the federal district court under the terms of the January 2002 Supermax settlement agreement and is consistent with definitions that resulted from litigation elsewhere in the country. A code of MH-3 identifies inmates with mental retardation, which DOC defines as an IQ of approximately 70 or below with concurrent impairments in adaptive functioning. Mental health classification codes are assigned when inmates enter DOC custody and are to be updated as needed.

To address limitations in its mental health classification system, DOC further refined its mental health codes in June 2008. DOC divided the MH-2 code into two categories. A code of MH-2a identifies inmates with disorders that include schizophrenia, bipolar disorder, and major depressive disorder. It is also used to identify inmates who have any diagnosed mental illness that significantly impairs their ability to function. A code of MH-2b identifies inmates with personality disorders that are severe and accompanied by significant functional impairment, such as borderline personality disorder.

In June 2008, DOC also eliminated the MH-3 code, which it replaced with a separate designation of developmentally disabled. The criteria used to identify inmates who are developmentally disabled are the same as those used for the MH-3 code. However, an inmate could not be assigned more than one mental health code under the old system. Under the revised system, an inmate can be classified as both mentally ill and developmentally disabled. Because DOC began implementing the revised codes in June 2008, we did not use them in our data analysis or case file review.

Mental Health Screening and Assessment

Inmates are screened for mental illnesses upon entering DOC custody.

Offenders placed under DOC custody typically enter the prison system through one of two facilities. Dodge Correctional Institution is the intake facility for male inmates, while Taycheedah Correctional Institution is the intake facility for female inmates. During the intake and assessment process, which occurs over a period of approximately one month, DOC staff conduct a variety of screenings and assessments, including medical and mental health screenings, to determine each inmate's security classification and programming needs. Inmates may also be screened or assessed upon transfer to a new institution and at other times as needed.

DOC policy requires staff in the psychological services units at intake facilities to perform a mental health intake screening within two working days of an inmate's arrival. However, inmates may be screened immediately if they had been on suicide watch while in the county jail, if they report having recently experienced suicidal thoughts or behaviors or are experiencing visual or auditory hallucinations, or if they appear to be disoriented or in psychological distress.

During the mental health screening, inmates are asked a series of questions to assess their current mental health status and mental health history, including whether they:

- are currently or have previously taken psychotropic medication;
- have ever been hospitalized for psychological problems;
- have a history of self-harm behaviors or suicide attempts; and
- are currently experiencing any symptoms of mental illness, including suicidality.

The screening psychologist then assigns a provisional mental health classification code and makes follow-up and placement recommendations. Psychological services staff at Dodge Correctional Institution estimated that 98 percent of inmates are screened within 24 hours of arrival, while psychological services staff at Taycheedah Correctional Institution reported that while they try to screen inmates within one working day of arrival, the average time frame in which inmates are screened is slightly over two days.

In order to evaluate the extent to which institutions comply with DOC policies and procedures regarding inmate mental health, as well as the types and extent of services received by mentally ill inmates, we interviewed staff at 13 adult institutions and 4 correctional centers. We also conducted a detailed file review of a random sample of 200 inmates who were incarcerated between July 1, 2006, and June 30, 2008, including 100 who were assessed as having mental health needs but not seriously mentally ill (MH-1) and 100 who were assessed as seriously mentally ill (MH-2). Of the 200 inmates, 150 were male and 50 were female.

Most inmates in our sample were screened within two days of entering DOC custody.

Intake screening data were available for 158 of the 200 inmates. As shown in Table 7, 67.7 percent were screened within two days of arrival, including 20 who were screened the same day. However, 20 other inmates, or 12.7 percent, were screened five or more days after arrival.

Table 7

Time Frame for Completion of Intake Mental Health Screenings[1]

Days after Arrival	Male Inmates	Female Inmates	All Inmates	Percentage of Total
Same day	10	10	20	12.7%
1 day	65	12	77	48.7
2 days	6	4	10	6.3
3 days	21	3	24	15.2
4 days	2	5	7	4.4
5 or more days	8	12	20	12.7
Total	**112**	**46**	**158**	**100.0%**

[1] For a sample of 200 inmates incarcerated between July 1, 2006, and June 30, 2008. Intake screening data were available for 158 inmates.

When a mentally ill inmate (MH-1 or MH-2) is transferred between facilities, DOC policy requires that psychological services staff at the receiving facility conduct a transfer file review within five working days to assess the inmate's prior mental health treatment, history of self-harm, and suicide risk; determine his or her need for follow-up treatment; and prioritize inmates for face-to-face interviews. Of the ten receiving institutions we visited, four reported that they perform the transfer file reviews for inmates with mental illnesses as required by policy, while six reported that they exceed the requirements of policy and perform file reviews for all inmates, including those without identified mental illnesses, in part because inmates may have been misclassified or have a history of mental health problems that were not identified.

DOC staff generally complete timely file reviews when mentally ill inmates are transferred between institutions.

As shown in Table 8, 69 of the 96 transfer file reviews we analyzed, or 71.9 percent, occurred within seven days of an inmate's transfer. However, 11 were completed 15 or more days following the transfer. While the reasons for the delays are not recorded in the files, staff noted that on occasion files may not arrive on time or may be sent to the wrong location, and staffing shortages sometimes preclude timely completion of the file reviews. Staff also noted that performing file reviews reduces time spent providing direct care.

Table 8

Time Frame for Completion of Transfer File Reviews[1]

Days after Transfer	Male Inmates	Female Inmates	All Inmates	Percentage of Total
7 days or less	59	10	69	71.9%
8-14 days	14	2	16	16.7
15 days or more	10	1	11	11.4
Total	**83**	**13**	**96**	**100.0%**

[1] For a sample of 200 inmates incarcerated between July 1, 2006 and June 30, 2008. Not all inmates were transferred between institutions during this time, and some were transferred more than once.

Numbers and Characteristics of Mentally Ill Inmates

As of June 2008, 31.0 percent of adult inmates were identified as mentally ill.

As shown in Table 9, the inmate population increased from 21,610 in June 2006 to 22,451 in June 2008, which is 3.9 percent. During that time, the number of mentally ill inmates increased from 6,084 to 6,957, or 14.3 percent. The percentage of inmates classified as having mental health needs but not seriously mentally ill (MH-1) increased slightly, from 17.9 percent to 20.9 percent, while the percentage of inmates classified as seriously mentally ill (MH-2) remained relatively stable.

Table 9

Inmates by Mental Health Code[1]

	June 2006		June 2007		June 2008	
Mental Health Code	Inmates	Percentage of Total	Inmates	Percentage of Total	Inmates	Percentage of Total
MH-0	14,900	68.9%	15,174	68.2%	14,943	66.6%
MH-1[2]	**3,860**	**17.9**	**4,359**	**19.6**	**4,694**	**20.9**
MH-2[2]	**2,224**	**10.3**	**2,241**	**10.1**	**2,263**	**10.1**
MH-3	60	0.3	74	0.3	72	0.3
Code Missing	566	2.6	399	1.8	479	2.1
Total	**21,610**	**100.0%**	**22,247**	**100.0%**	**22,451**	**100.0%**

[1] Excludes inmates incarcerated on certain temporary holds, as well as those at the Milwaukee Secure Detention Facility, for whom limited mental health information was available.

[2] Inmates with mental illnesses.

The percentage of inmates who are mentally ill is highest at maximum security institutions.

As shown in Table 10, 43.0 percent of inmates at maximum security institutions in June 2008 were identified as mentally ill, followed by 29.9 percent at medium security institutions and 16.6 percent at minimum security institutions. There were 3,354 mentally ill inmates at medium security facilities, which house one-half of all inmates.

Table 10

Mentally Ill Inmates by Institution[1]
June 2008

Institution	Mentally Ill Inmates[2]	All Inmates	Percentage of Inmates Who Are Mentally Ill[2]
Maximum Security			
Taycheedah[3]	528	683	77.3%
Columbia	413	827	49.9
Waupun	546	1,240	44.0
Green Bay	443	1,091	40.6
Dodge	507	1,693	29.9
Wisconsin Secure Program Facility[4]	120	418	28.7
Subtotal	2,557	5,952	43.0
Medium Security			
Oshkosh	722	2,026	35.6
Jackson	334	959	34.8
Kettle Moraine	390	1,192	32.7
Redgranite	322	996	32.3
Fox Lake (Medium Security)	313	1,027	30.5
Racine	472	1,547	30.5
Racine Youthful Offender	126	431	29.2
New Lisbon	277	1,010	27.4
Stanley	316	1,536	20.6
Prairie du Chien	82	491	16.7
Subtotal	3,354	11,215	29.9
Minimum Security			
Wisconsin Correctional Center System[5]	447	2,437	18.3
Chippewa Valley	69	437	15.8
Sturtevant Transitional Facility	16	110	14.5
Fox Lake (Minimum Security)	39	298	13.1
Oakhill	88	677	13.0
Subtotal	659	3,959	16.6
Other			
Wisconsin Resource Center	299	311	96.1
Other	10	58	17.2
County Jails	73	826	8.8
Out of State	5	130	3.8
Subtotal	387	1,325	29.2
Total	**6,957**	**22,451**	31.0

[1] Excludes inmates incarcerated on certain temporary holds, as well as those at the Milwaukee Secure Detention Facility, for whom limited mental health information was available.

[2] Includes inmates identified as having mental health needs (MH-1) and inmates identified as seriously mentally ill (MH-2).

[3] Taycheedah Correctional Institution houses both maximum and medium security female inmates.

[4] All 120 mentally ill inmates at the Wisconsin Secure Program Facility were identified as having mental health needs (MH-1). Inmates with serious mental illnesses (MH-2) are not placed at the facility as a result of the 2002 settlement agreement.

[5] Includes inmates at both men's and women's correctional centers.

A greater percentage of female inmates are identified as mentally ill.

Table 11 shows the characteristics of mentally ill inmates as of June 2008. Female inmates had a significantly higher incidence of identified mental illnesses, 64.3 percent, compared to male inmates, for whom the rate was 28.8 percent. The incidence of mental illnesses was highest among white and American Indian inmates. In addition, younger inmates were less-frequently diagnosed with mental illnesses than were older inmates. We also found that mentally ill inmates were slightly more likely to report prior military service.

Table 11

Inmate Characteristics[1]
June 2008

Characteristic	Mentally Ill Inmates[2]	All Inmates	Percentage of Inmates Who Are Mentally Ill[2]
Gender			
Female	877	1,364	64.3%
Male	6,080	21,087	28.8
Total	**6,957**	**22,451**	31.0
Race/Ethnicity			
White	3,886	9,988	38.9%
American Indian	270	695	38.8
Hispanic	471	1,828	25.8
African-American	2,291	9,670	23.7
Asian or Pacific Islander	29	192	15.1
Unknown/Other	10	78	12.8
Total	**6,957**	**22,451**	31.0
Age			
18 and under	45	184	24.5%
19 to 24	986	3,678	26.8
25 to 34	2,149	7,593	28.3
35 to 44	2,016	5,973	33.8
45 to 54	1,292	3,696	35.0
55 and older	469	1,327	35.3
Total	**6,957**	**22,451**	31.0
Prior Military Service			
No	6,044	19,506	31.0%
Yes	608	1,771	34.3
Unknown	305	1,174	26.0
Total	**6,957**	**22,451**	31.0

[1] Excludes inmates incarcerated on certain temporary holds, as well as those at the Milwaukee Secure Detention Facility, for whom limited mental health information was available.

[2] Includes inmates identified as having mental health needs (MH-1) and inmates identified as seriously mentally ill (MH-2).

Although reliable and comparable data are not readily available on a national basis, research suggests that the gender and racial/ethnic differences among DOC inmates are consistent with national trends. DOC officials attribute these differences, in part, to gender and cultural differences in inmates' willingness to seek mental health care.

Similar percentages of mentally ill inmates and inmates without identified mental illnesses committed crimes against persons.

As shown in Table 12, similar percentages of mentally ill inmates and inmates without mental health needs committed crimes against persons, such as battery, robbery, or homicide. Mentally ill inmates were slightly more likely to have committed sexual offenses than were inmates with no identified mental health needs, but they were somewhat less likely to have committed drug offenses.

Table 12

Mental Illness Status and Criminal Offenses[1]
June 2008

	No Mental Health Needs		**Mentally Ill[2]**	
Type of Offense	Inmates Convicted of Offense	Percentage Convicted of Offense	Inmates Convicted of Offense	Percentage Convicted of Offense
Crimes Against Persons	9,357	62.6%	4,551	65.4%
Drug Offense	3,319	22.2	939	13.5
Sexual Offense	2,906	19.4	1,764	25.4
Number of Inmates[3]	14,943		6,957	

[1] Excludes inmates incarcerated on certain temporary holds, as well as those at the Milwaukee Secure Detention Facility, for whom limited mental health information was available.

[2] Includes inmates identified as having mental health needs (MH-1) and inmates identified as seriously mentally ill (MH-2).

[3] Inmates may have committed more than one type of offense or an offense that does not fall into one of these categories.

DOC does not maintain automated data on inmates' diagnoses. However, as part of our file review, we noted mental illness diagnoses for 185 of the 200 inmates in our sample. Multiple categories were recorded for 162 inmates, including 20 inmates with diagnoses in five or more categories. However, it was unclear whether the diagnoses occurred simultaneously or at different times, in part because inmates' diagnoses were not consistently documented or routinely updated.

As shown in Table 13, the most common disorders with which mentally ill inmates in our sample were diagnosed were those related to substance abuse: 113, or 61.1 percent of the 185 inmates for whom we were able to obtain data were diagnosed with these disorders. However, it is important to note that inmates are not assigned a mental health code solely because of substance abuse problems. Personality disorders were the second most common diagnoses, while depressive disorders were third.

Table 13

Inmates' Mental Illness Diagnoses[1]

Diagnosis Category[2]	Female Inmates	Percentage of Female Inmates with Diagnosis	Male Inmates	Percentage of Male Inmates with Diagnosis	All Inmates	Percentage of All Inmates with Diagnosis
Substance Abuse Disorders[3]	30	61.2%	83	61.0%	113	61.1%
Personality Disorders	16	32.7	70	51.5	86	46.5
Depressive Disorders	26	53.1	55	40.4	81	43.8
Schizophrenia/Psychotic Disorders	9	18.4	35	25.7	44	23.8
Other Disorders[4]	6	12.2	37	27.2	43	23.2
Anxiety Disorders	12	24.5	21	15.4	33	17.8
Mood Disorders	10	20.4	18	13.2	28	15.1
Bipolar Disorder	12	24.5	15	11.0	27	14.6
Post Traumatic Stress Disorder	13	26.5	11	8.1	24	13.0
Adjustment Disorder	5	10.2	17	12.5	22	11.9
Attention Deficit Hyperactivity Disorder	6	12.2	8	5.9	14	7.6
Impulsivity/Anger Disorders	0	0.0	12	8.8	12	6.5
Borderline Intelligence/Mental Retardation	1	2.0	7	5.1	8	4.3

[1] For 185 out of a sample of 200 inmates incarcerated between July 1, 2006, and June 30, 2008, including 49 females and 136 males.

[2] Inmates may have been diagnosed with more than one disorder.

[3] Inmates are not assigned a mental health code solely because of substance abuse problems.

[4] Includes a variety of disorders, such as sleep disorders, obsessive-compulsive disorder, eating disorders, dementia, delusional disorders, and bereavement.

Developmentally Disabled Inmates

As noted, DOC defines developmental disability as an IQ of approximately 70 or below with concurrent impairments in adaptive functioning. This definition is narrower than the definition in s. 51.01(5)(a), Wis. Stats., which includes disabilities attributable to brain injury, cerebral palsy, epilepsy, autism, Prader-Willi syndrome, mental retardation, or another neurologic condition closely related to mental retardation or requiring treatment similar to that required for individuals with mental retardation.

Not all inmates are screened for developmental disabilities.

Aside from the mental health intake screening, during which inmates are asked whether they received special education services, DOC does not routinely screen for developmental disabilities because staffing is limited and because IQ tests—the primary method by which developmentally disabled inmates are identified—are time-consuming to administer and score. However, psychologists sometimes choose to administer IQ tests to inmates they suspect are developmentally disabled, and some inmates may be identified as developmentally disabled based on tests administered before their incarceration. For example, psychological services staff at Dodge Correctional Institution reported they administer IQ tests to some inmates they believe may be developmentally disabled and for whom prior test results are not available. Psychological services staff at Taycheedah Correctional Institution reported that they rarely administer IQ tests; however, psychology interns may perform some testing, and the institution may attempt to obtain external test results if inmates report that they received special education services.

As of June 2008, DOC identified 72 inmates as developmentally disabled.

As of June 2008, DOC identified 72 developmentally disabled inmates (those classified as MH-3). As shown in Table 14, Racine Correctional Institution, which has a program for low-functioning sex offenders, housed the largest number, 20.8 percent of the total.

Table 14

Developmentally Disabled Inmates[1]

Institution	June 2006	June 2007	June 2008	2008 Percentage of Total
Maximum Security				
Columbia	3	6	9	12.5%
Green Bay	3	2	5	6.9
Waupun	2	3	3	4.2
Taycheedah[2]	0	0	1	1.4
Dodge	2	7	0	0.0
Wisconsin Secure Program Facility	0	0	0	0.0
Subtotal	10	18	18	25.0
Medium Security				
Racine	12	17	15	20.8
Oshkosh	6	7	7	9.7
Stanley	7	8	6	8.3
Kettle Moraine	4	4	5	6.9
Jackson	0	2	2	2.8
New Lisbon	1	1	2	2.8
Racine Youthful Offender	3	2	2	2.8
Redgranite	1	2	2	2.8
Fox Lake (Medium Security)	1	2	1	1.4
Prairie du Chien	0	1	0	0.0
Subtotal	35	46	42	58.3
Minimum Security				
Oakhill	2	0	1	1.4
Wisconsin Correctional Center System[3]	2	1	1	1.4
Chippewa Valley	0	0	0	0.0
Fox Lake (Minimum Security)	0	0	0	0.0
Sturtevant Transitional Facility	0	0	0	0.0
Subtotal	4	1	2	2.8
Other				
Wisconsin Resource Center	11	8	9	12.5
County Jails	0	1	1	1.4
Other	0	0	0	0.0
Out of State	0	0	0	0.0
Subtotal	11	9	10	13.9
Total	**60**	**74**	**72**	**100.0%**

[1] Includes inmates categorized as MH-3 (mentally retarded). This category was changed to DD (developmentally disabled) in June 2008. Excludes inmates incarcerated on certain temporary holds, as well as those at the Milwaukee Secure Detention Facility, for whom limited mental health information was available.

[2] Taycheedah Correctional Institution houses both maximum and medium security female inmates.

[3] Includes inmates at both men's and women's correctional centers.

Although the figures in Table 14 represent the best available data, they underestimate the number of developmentally disabled inmates in DOC custody. As noted, before June 2008, inmates who were developmentally disabled and seriously mentally ill would be classified only as seriously mentally ill. In addition, because DOC does not routinely screen or test inmates for developmental disabilities, DOC officials as well as interest groups believe that some developmentally disabled inmates remain unidentified under the current classification procedures. We attempted to assess the prevalence of developmental disabilities among inmates; however, institution staff and interest group representatives provided a wide range of estimates, and the extent to which their estimates were based on DOC's definition of developmental disability or a broader definition—for example, the statutory definition or one that includes inmates with borderline intellectual functioning—was unclear.

Interest groups expressed concern that developmentally disabled inmates who fail to be identified may not be housed separately from the general inmate population and, as a result, may be at risk of abuse and victimization. In addition, DOC's current practices for screening and identifying developmentally disabled inmates are not consistent with NCCHC standards, which specify that mental health screenings should include an assessment of intellectual functioning. The NCCHC standards also specify that inmates identified as possibly "mentally retarded" should be further evaluated using a comprehensive instrument, such as the Wechsler Adult Intelligence Scale.

Better screening for developmental disabilities could help ensure proper identification and treatment.

DOC's policies also differ from those of Illinois, Iowa, Michigan, and Minnesota, which reported that inmates are to be screened for developmental disabilities as part of the intake process. Adoption and use of a screening tool to assess intellectual functioning could help ensure that all developmentally disabled inmates are identified.

☑ Recommendation

We recommend the Department of Corrections report to the Joint Legislative Audit Committee by January 4, 2010, on its evaluation of:

- *options for screening tools to assess intellectual functioning;*
- *tests to further evaluate inmates who are identified as potentially developmentally disabled; and*
- *the potential costs of implementing those tools.*

▪ ▪ ▪ ▪

Housing of Mentally Ill Inmates
Staffing Ratios
Psychological Services
Psychiatric Services
Other DOC Programs

Monitoring and Treatment ▪

Some mentally ill inmates are housed in specialized facilities or units, but most are housed with other inmates. Throughout DOC facilities, psychologists respond to crises, provide individual counseling and group therapy, and monitor inmates' conditions. Psychiatrists prescribe psychotropic medications and monitor their effectiveness. We reviewed the types and frequencies of mental health services provided to mentally ill inmates, the number of inmates prescribed psychotropic medications, and the processes by which psychotropic medications are prescribed and delivered.

Housing of Mentally Ill Inmates

An inmate's mental health classification usually does not affect facility assignment.

Following the intake and assessment process, DOC assigns inmates to institutions and correctional centers based on their security classifications, programming recommendations, and treatment needs and the facilities' available space. In most cases, an inmate's mental health classification does not affect facility assignment. However, seriously mentally ill inmates are not placed at the Wisconsin Secure Program Facility (formerly Supermax) under DOC policy, as was required by the terms of the 2002 settlement agreement, and mentally ill inmates are generally not placed at minimum security institutions or the centers unless a psychologist has determined they are mentally stable.

Seriously mentally ill inmates whose needs exceed the services at DOC institutions may be placed at WRC, while other inmates who

are deemed vulnerable or have difficulty functioning in the general population because of their mental illnesses may be assigned to an institution with a special management unit. Special management units—which are located at Dodge, Columbia, and Taycheedah—do not provide the same level of services as WRC. However, they have more flexible disciplinary procedures than general population units, and inmates are monitored more closely.

In addition to the three institutions with formal special management units, a number of institutions have created informal special housing units for some inmates who have difficulty in the general population because of mental illnesses or developmental disabilities. However, inmates are not assigned to institutions with these units specifically because of their mental illnesses, and these units do not provide the same level of services as special management units.

As of January 2008, nine institutions operated specialized units that house some mentally ill inmates.

As of January 2008, nine institutions operated either special management units or other special housing units, as shown in Table 15. However, none of the special management units were located at medium security institutions, despite the fact that one-half of all inmates and the largest number of mentally ill inmates are housed there.

Staffing Ratios

Psychology staffing ratios vary across institutions.

The American Association for Correctional Psychology recommends 1.0 FTE psychological services staff position for every 150 to 160 inmates within an institution. We found that only four institutions met this standard as of June 2008, as shown in Table 16. The systemwide ratio was 197 inmates per psychological services staff position, and the considerable variation across institutions is not explained by differences in the numbers of mentally ill inmates. The staffing ratios at Taycheedah—57 inmates per psychologist and 44 mentally ill inmates per psychologist—reflect recent staffing increases that resulted from the federal Department of Justice investigation.

Table 15

Specialized Housing Units at DOC Institutions
January 2008

Institution	Unit Characteristics	Beds in Unit	Mentally Ill Inmates at Institution[1, 2]
Special Management Units			
Columbia	Lower psychology staffing ratio than general population units. A variety of group sessions are offered. A phase system is used for discipline.	110	413
Dodge	Inmates have more frequent contact with psychologists compared to general population units. Inmates are housed in single cells and receive more out-of-cell time.	30	507
Taycheedah	Mental health staff on the unit. More extensive programming than general population units. Also offers a dual diagnosis substance abuse and mental health program. Staff develop a treatment plan for each inmate.	64	528
Other Special Housing Units			
Milwaukee Secure Detention Facility[3]	Mental health staff on the unit. Inmates participate in weekly groups.	42	–
Green Bay	Inmates have access to a teacher on the unit and receive more out-of-cell time compared to inmates in general population units. Social workers provide 16 hours of group therapy, 6 hours of evaluation, and 4-5 hours of individual counseling each month.	24	443
Oshkosh (Transitional Program)	Mental health staff on the unit. Staff conduct inmate reviews weekly and face-to-face evaluations every 30 days. Inmates may also attend a personal management group.	50	722
Oshkosh (Mentally Ill Chemical Abusers Program)	A dual diagnosis program for seriously mentally ill inmates who also have substance abuse problems. Mental health staff are on the unit and inmates are reviewed weekly. Inmates participate in 8 hours of programming per day.	25	722
Racine	Group sessions are offered on the unit. Inmates receive incentives for good hygiene.	30	472
Redgranite	A recreation leader is on the unit. Inmates may participate in activities such as walks and book club.	250	322
Stanley	More recreation time and more flexible disciplinary procedures than general population units.	50	316

[1] As of June 2008. Excludes inmates incarcerated on certain temporary holds, as well as those at the Milwaukee Secure Detention Facility, for whom limited mental health information was available.

[2] Includes inmates identified as having mental health needs (MH-1) and inmates identified as seriously mentally ill (MH-2).

[3] The number of mentally ill inmates at the Milwaukee Secure Detention Facility is unknown because limited mental health information is available.

Table 16

Psychology Staffing Ratio[1]
June 2008

Institution[2]	Mentally Ill Inmates per Psychologist[1, 3]	Total Inmates per Psychologist
Maximum Security		
Waupun	121	276
Green Bay	81	198
Dodge	51	169
Columbia	69	138
Wisconsin Secure Program Facility	24	84
Taycheedah[4]	44	57
Maximum Security Ratio	***59***	***138***
Medium Security		
Prairie du Chien	82	491
Fox Lake[5]	101	379
Oshkosh	103	289
Kettle Moraine	87	265
Stanley	53	256
Racine[6]	70	237
New Lisbon	55	202
Redgranite	64	199
Jackson	67	192
Racine Youthful Offender	32	108
Medium Security Ratio	***71***	***242***
Minimum Security		
Chippewa Valley	69	437
Oakhill	29	226
Minimum Security Ratio	***39***	***279***
Systemwide Ratio	***64***	***197***

[1] Includes masters- and doctoral-level psychologists, psychological services assistants, and crisis intervention workers.

[2] Does not include the Milwaukee Secure Detention Facility, for which limited inmate mental health information was available, or the correctional centers, which have limited mental health staff.

[3] Includes inmates identified as having mental health needs (MH-1) and inmates identified as seriously mentally ill (MH-2).

[4] Taycheedah Correctional Institution houses maximum and medium security female inmates.

[5] Fox Lake Correctional Institution houses medium and minimum security inmates.

[6] Includes Sturtevant Transitional Facility, with which Racine Correctional Institution shares mental health staff.

DOC institutions do not meet recommended psychiatry staffing ratios.

Because psychotropic medications prescribed by psychiatrists can have serious side effects and reactions to medications can change over time, the American Psychiatric Association recommends a minimum of 1.0 FTE psychiatrist for every 150 inmates on psychotropic medications. We compared the estimated number of psychiatrist positions based on hours worked during FY 2007-08 to the number of inmates on psychotropic medication and found that DOC's systemwide ratio of 345 inmates per psychiatrist was more than two times the American Psychiatric Association's recommendation. DOC records do not allow for complete and accurate identification of psychiatrist hours worked by institution, but they indicate that:

- no institution met the American Psychiatric Association's recommendation;
- maximum security institutions had the fewest inmates on medication per psychiatrist, while medium security institutions had the most; and
- Taycheedah had a significantly lower psychiatry staffing ratio than the institutions for male inmates.

Psychological Services

Psychological services staff, including psychologists, psychological assistants, crisis intervention workers, and psychologist interns, provide a range of mental health services. In 2008, DOC listed crisis intervention as the most important priority for psychological services staff. Although DOC policy does not specify a time frame for crisis intervention services, DOC officials indicated that it is good clinical practice to provide these services on the same day the need is identified, and all of the 13 institutions we visited reported doing so.

Individual counseling on an ongoing basis is offered at some institutions, although usually only on a limited basis to a small number of inmates. Of the 13 institutions we visited:

- 2 reported that they do not offer any individual therapy on an ongoing basis;
- 8 reported that individual therapy is provided to a small number of inmates, usually between 10 and 30, on a regular basis;

- 2 reported that psychologists routinely provide inmates with short-term individual therapy, which usually consists of two to three sessions; and

- 1 reported that psychologists spend the majority of their time providing individual therapy and estimated that around 100 inmates receive weekly or monthly therapy.

The availability of both group and individual therapy is limited.

The availability of group therapy is also limited. Of the 13 institutions we visited, 4 do not offer any group therapy, 4 offer one group each, and 5 offer multiple groups. Group topics vary. For example, some groups have a specific focus, such as anxiety, depression, or trauma and abuse, while others are general psychotherapy groups. Groups generally meet one to two hours per week for between 6 and 16 weeks and can accommodate 12 to 20 inmates. Of the nine institutions that provide group therapy, seven reported that there are not enough groups to meet the inmates' therapeutic needs.

Psychologists are also responsible for monitoring the mental status of inmates on their caseloads. DOC policy does not specify the frequency with which mentally ill inmates should be seen by a psychologist for monitoring. However, DOC officials indicated they would like seriously mentally ill (MH-2) inmates to be seen at least once every three months, and inmates with less serious mental health needs (MH-1) at least once every six months. DOC expects these standards to be incorporated into policy early in 2009.

Staff at some institutions reported that they attempt to meet these time frames. At other institutions, psychologists reported that staffing ratios make it difficult to see inmates on a regular basis. For example, staff at Columbia Correctional Institution estimated that they meet the three-month standard for seriously mentally ill inmates about 80 percent of the time but said they are unable to see inmates with less serious mental health needs at six-month intervals. Staff at Taycheedah Correctional Institution reported that psychologists are not able to monitor inmates at the requested intervals because they are too busy with crisis intervention and other tasks.

Psychologists document their contacts with inmates—including crisis intervention, individual therapy, and others—on a form that includes the date and reason for contact, a summary of the inmate's mental status, the inmate's diagnosis and mental health code, and treatment or follow-up plans. We reviewed psychology contacts between July 1, 2006, and June 30, 2008, for the 200 inmates in our sample and calculated their frequency, adjusting for the time each inmate was incarcerated. As shown in Table 17, the median for inmates with mental health needs was 2.5 psychology contacts annually, which is approximately every 4.8 months. For seriously mentally ill inmates, the median was 3.1, which is approximately every 3.9 months. Eighteen of the 200 inmates in our sample did not have any documented psychology contacts within our two-year review period. However, six of these inmates were incarcerated at WRC, which does not document psychology contacts on the DOC form.

Table 17

Annual Psychology Contacts[1]

	Mental Heath Needs (MH-1)		Seriously Mentally Ill (MH-2)		Total	
Gender	Inmates	Median Contacts	Inmates	Median Contacts	Inmates	Median Contacts
Female	25	2.7	22	5.3	47	3.9
Male	65	2.5	70	3.0	135	2.5
Total	**90**	2.5	**92**	3.1	**182**	2.8

[1] For a sample of 200 inmates incarcerated between July 1, 2006, and June 30, 3008, excluding 18 who did not have any documented psychology contacts.

Psychologists most frequently meet with inmates to monitor their mental health status.

As shown in Table 18, monitoring was the most commonly recorded reason for contact, followed by inmate requests. We found that female inmates were more likely than male inmates to receive individual therapy and group therapy.

Table 18

Reasons for Psychology Contacts[1]

Reason	Contacts	Percentage of Total
Monitoring	313	25.0%
Inmate Request	305	24.3
Individual Therapy	133	10.6
Segregation Review	110	8.8
Referral	98	7.8
Group Therapy	71	5.7
Other	50	4.0
New Admission	48	3.8
Minimum Security Evaluation	38	3.0
Not Indicated	34	2.7
Observation Follow-up	30	2.4
Testing/Assessment	24	1.9
Total	**1,254**	**100.0%**

[1] For a sample of 200 inmates incarcerated between July 1, 2006, and June 30, 3008, excluding 18 who did not have any documented psychology contacts.

Psychiatric Services

Psychiatrists monitor inmates who are prescribed psychotropic medications.

All inmates who are prescribed psychotropic medication when they enter DOC custody are evaluated by a psychiatrist at either Dodge or Taycheedah Correctional Institution. DOC officials indicated that the time frame in which new inmates are seen by a psychiatrist varies with staffing levels and has ranged from two to three weeks after arrival when institutions are fully staffed to eight weeks when positions are vacant. However, under the terms of the federal Department of Justice settlement agreement, inmates at Taycheedah must now be seen within ten days of arrival. Inmates may also be seen by a psychiatrist for an initial evaluation if they are psychotic, suicidal, or unable to control their behavior or if they are referred by psychology or other staff.

DOC policy does not specify the frequency with which inmates on psychotropic medications should be seen by a psychiatrist, in part because the intervals at which follow-up appointments should occur can vary based on an inmate's stability, medication type, and whether the medication needs to be adjusted. Psychiatrists indicated that inmates who are stable can be seen every three to four months, while inmates who are unstable may need to be seen on a weekly or monthly basis.

As shown in Table 19, the median number of psychiatry appointments for inmates with mental health needs (MH-1) was 4.4 annually, which is approximately every 2.7 months, while the median for seriously mentally ill inmates (MH-2) was slightly higher, at 5.2 annually, which is approximately every 2.3 months.

Table 19

Annual Psychiatry Appointments[1]

	Mental Health Needs (MH-1)		Seriously Mentally Ill (MH-2)		Total	
Gender	Inmates	Median Appointments	Inmates	Median Appointments	Inmates	Median Appointments
Female	26	5.2	21	7.0	47	5.5
Male	56	4.1	66	5.0	122	4.4
Total	**82**	4.4	**87**	5.2	**169**	4.8

[1] For a sample of 200 inmates incarcerated between July 1, 2006, and June 30, 3008, excluding 31 who did not have any documented psychiatry appointments.

As shown in Table 20, 888 of 1,090 follow-up psychiatry appointments, or 81.5 percent, occurred within two weeks of the date ordered by the psychiatrist. However, 202 appointments, or 18.5 percent, occurred more than two weeks after ordered follow-up, including 46 that occurred ten weeks or more after ordered follow-up.

Table 20

Time Frames for Follow-Up Psychiatry Appointments[1]

Time Frame	Appointments	Percentage of Total
Within 2 Weeks of Ordered Follow-Up	888	81.5%
More than 2 Weeks After Ordered Follow-Up		
2.1 to 3.9 weeks	71	6.5
4.0 to 5.9 weeks	47	4.3
6.0 to 7.9 weeks	27	2.5
8.0 to 9.9 weeks	11	1.0
10 weeks or more	46	4.2
Subtotal	202	18.5
Total	**1,090**	**100.0%**

[1] For a sample of 200 inmates incarcerated between July 1, 2006, and June 30, 3008, excluding 31 who did not have any documented psychiatry appointments.

Inmates Prescribed Psychotropic Medications

In June 2008, 3,869 inmates were prescribed psychotropic medications.

As shown in Table 21, 3,869 inmates were prescribed psychotropic medications in June 2008. From June 2006 through June 2008, the percentage of seriously mentally ill inmates (MH-2) prescribed psychotropic medications remained relatively steady, ranging from 68.9 to 70.9 percent. For inmates with mental health needs (MH-1), the percentage decreased from 49.3 percent to 43.2 percent. We also found that 190 inmates, or 1.3 percent, who were coded as not having mental health needs (MH-0) were prescribed psychotropic medications. DOC officials indicated that there may have been delays in assigning or recording mental health codes for these inmates.

Table 21

Inmates Prescribed Psychotropic Medications[1]
June 2008

Mental Health Code	Inmates	Number Prescribed Psychotropic Medications	Percentage Prescribed Psychotropic Medications
No Mental Health Needs (MH-0)	14,943	190	1.3%
Mental Health Need (MH-1)[2]	**4,694**	**2,030**	**43.2**
Seriously Mentally Ill (MH-2)[2]	**2,263**	**1,586**	**70.1**
Developmentally Disabled (MH-3)	72	27	37.5
Code Missing	479	36	7.5
Total	**22,451**	**3,869**	17.2

[1] Includes inmates who had a prescription for a psychotropic medication filled in the previous month. Excludes inmates incarcerated on certain temporary holds as well as those at the Milwaukee Secure Detention Facility, for whom limited mental health information was available.

[2] Inmates with mental illnesses.

Anti-depressants were the most commonly prescribed psychotropic medication.

Table 22 shows the 20 psychotropic medications most commonly prescribed to inmates during June 2008. Six of the top ten most commonly prescribed psychotropic medications were anti-depressants, while two were anti-psychotics.

Medications were adjusted at approximately two-thirds of psychiatry appointments.

Psychiatrists are expected to monitor medications' effectiveness and side effects and adjust them as needed. We found that records for about two-thirds of psychiatry appointments noted one or more medication adjustments. For example, new medications were prescribed at 27.9 percent of the appointments, medications were discontinued at 22.0 percent of the appointments, and doses were increased or decreased at 34.9 percent of the appointments.

Table 22

Psychotropic Medications Most Commonly Prescribed to Inmates
June 2008

Drug Name (Brand)[1]	Commonly Prescribed for[2]	Inmates with Prescriptions[3]
Trazodone (Desyrel)	Depression	694
Fluoxetine (Prozac)	Depression	686
Citalopram (Celexa)	Depression	627
Mirtazapine (Remeron)	Depression	461
Diphenhydramine (Benadryl)	Allergies, Sleep Disorders	441
Risperidone (Risperdal)	Psychotic Disorders	402
Amitriptyline (Elavil)	Depression	333
Quetiapine (Seroquel)	Psychotic Disorders	333
Hydroxyzine (Atarax, Vistaril)	Anxiety	275
Venlafaxine (Effexor)	Depression	259
Bupropion (Wellbutrin)	Depression	249
Lithium (Eskalith, Lithobid)	Bipolar Disorder	244
Valproic Acid (Depakene)	Seizure Disorders, Bipolar Disorder	219
Ziprasidone (Geodon)	Psychotic Disorders	213
Benztropine (Cogentin)	Side effects associated with antipsychotic medications	201
Clonazepam (Klonopin)	Panic Disorders	172
Buspirone (BuSpar)	Anxiety	171
Sertraline (Zoloft)	Depression, Anxiety	166
Paroxetine (Paxil)	Depression, Anxiety	142
Doxepin (Sinequan)	Depression, Anxiety	105

[1] DOC reports using generic medications when available. Brand names are listed for reference.

[2] Some drugs may also be prescribed for uses other than those listed.

[3] Inmates may be prescribed more than one psychotropic medication.

DOC's Formulary

A committee of DOC managers and medical providers establishes DOC's drug formulary.

A committee of DOC managers and medical providers is responsible for evaluating medication use, reviewing reports of medication errors, and maintaining a formulary of medications that may be prescribed without prior approval from DOC's medical, mental health, or psychiatry directors. Several factors affect whether a drug is placed on the formulary, including its intended effect, potential alternatives, cost, potential for dangerous or severe side-effects, and whether it is habit-forming or prone to being abused in a correctional setting.

Psychiatrists may request nonformulary medications when medications on the formulary are found to be ineffective or not well-tolerated by an inmate, or if the formulary does not include an alternative. For example, all stimulants, which are used to treat attention deficit hyperactivity disorder, are nonformulary and require prior approval. However, the psychiatrists with whom we spoke believe the formulary contains an adequate selection of medications capable of treating most inmates' mental health needs. An advocacy group we interviewed also spoke positively of DOC's formulary.

Nearly all requests for nonformulary psychotropic medications were approved.

From FY 2003-04 through FY 2007-08, psychiatrists made 847 requests for nonformulary psychotropic medication, and 96.8 percent were approved. DOC officials note that some requests are made because the inmates were already prescribed nonformulary medications when placed in DOC custody. If an inmate is stable on the medication, the request is typically approved. As shown in Table 23, the number of requests for nonformulary psychotropic medication increased from 85 in FY 2003-04 to 246 in FY 2007-08, which is an increase of 189.4 percent. DOC officials attributed this increase to more comprehensive formulary policies put in place in 2005, which increased the number of psychotropic medications requiring approval and added procedures for psychiatrists to follow before submitting requests. The required procedures also increased the likelihood that requests would be approved.

Table 23

Requests for Nonformulary Psychotropic Medications

Fiscal Year	Requests	Number Approved	Percentage Approved
2003-04	85	78	91.8%
2004-05	112	104	92.9
2005-06	105	102	97.1
2006-07	299	295	98.7
2007-08	246	241	98.0
Total	**847**	**820**	96.8

Medication Delivery

A 1977 opinion issued by Wisconsin's Attorney General indicates medication delivery by correctional officers does not violate Wisconsin Statutes. However, NCCHC standards indicate that personnel who deliver prescription medication should be appropriately trained and that it is best to have medications administered by qualified health care professionals.

Most medications are delivered by correctional officers rather than health care staff.

Our 2001 audit of prison health care reported that DOC assigned correctional officers, rather than professional health care staff, to deliver psychotropic and other medications at most institutions. This continues to be the practice. At 8 of the 13 institutions we visited, correctional officers deliver all psychotropic medications on the housing units. However, five institutions employ other methods:

- at the Milwaukee Secure Detention Facility, nurses deliver medications in all of the housing units;
- at Green Bay Correctional Institution, health care staff deliver medications to inmates housed in general population units, while correctional officers deliver medications to inmates housed in the segregation unit and the special housing unit;
- at Taycheedah Correctional Institution, health care staff deliver medications to inmates housed in the segregation unit and the special management unit, while correctional officers deliver medications to inmates housed in general population units;
- at the Chippewa Valley Correctional Treatment Facility, correctional officers deliver medications in the health services unit, where inmates report at designated times and form a "pill line" to receive their medications; and
- at the Wisconsin Secure Program Facility, inmates in the general population unit report to the health services unit at designated times to receive medications delivered by correctional officers.

DOC and DHS managers, mental health staff, and correctional officers, as well as advocacy groups and union officials, raised a number of concerns with delivery of medications by correctional officers, including that:

- medication administration records, which are the responsibility of the officer distributing the medication, are not always complete or accurate, which makes it difficult to maintain a consistent medication regimen for mentally ill inmates;

- under the terms of their collective bargaining agreement, correctional officers cannot be disciplined for unintentional errors when distributing medication, unlike health services staff;

- correctional officers may be less likely than professional health care staff to encourage inmates to take their medication on a regular basis;

- institutions do not have adequate controls in place to prevent staff from misappropriating inmates' medication; and

- unlike professional health care staff, correctional officers are often unaware of what the medications they are delivering are prescribed to treat, cannot evaluate whether doses appear to be effective, and may be unprepared to recognize side effects.

Correctional officer training on medication delivery is limited and not fully documented.

As part of their pre-service training, correctional officers receive four hours of training on medication delivery, which includes the procedures for medication delivery, types of psychotropic medications, and, beginning in 2003, potential side effects. DOC also offers periodic training updates at the institutions upon request. The updates do not include information on side effects, and only 4 of the 13 institutions we visited reported having held such training. No records are available to show when the training was offered at the other institutions. Similarly, DOC does not maintain records indicating which officers have received medication-delivery training or when they received it. It is possible that some officers have worked at DOC since before it began providing medication-delivery training, and it is even more likely that not all officers have received the most recent version of the training, which was updated in 2003 when information on side effects was added. To effectively deliver medication and thereby minimize the potential for potentially dangerous and costly errors, correctional officers should be adequately trained.

☑ Recommendation

We recommend the Department of Corrections ensure that all correctional officers have received updated medication-delivery training.

Illinois, Iowa, Michigan, and Minnesota all reported that nurses deliver the majority of inmate medications. While DOC recognizes that delivery of medication by health care staff would improve quality of services, address union concerns, and improve risk management, it estimated in 2006 that discontinuing delivery of medication by correctional officers at facilities with health services units would require an additional 102.00 FTE positions at an annual cost of $5.2 million, plus one-time startup costs of $700,000. However, we believe DOC could explore less-costly steps to improve its medication delivery practices by, for example, providing more extensive training to designated correctional officers who deliver medication or having correctional officers deliver medication from within the health services units.

Other DOC Programs

Mentally ill inmates may also participate in other DOC programs, which include:

- AODA programs, which are typically offered near the end of the incarceration period to help prepare inmates for release to the community;
- adult basic education and high school equivalency diploma testing;
- sex offender programs to help inmates understand, accept responsibility for, and change sexually assaultive behavior and seek to reduce the risk of reoffending;
- treatment programs such as anger management, domestic violence, and parenting;
- vocational programs in areas such as data entry, horticulture, welding, cosmetology, and food service; and
- work-release programs, which allow minimum security inmates to improve employment skills, pay financial obligations, and prepare for release.

Mentally ill inmates were less likely to complete educational programs.

Inmates may participate in multiple programs, and program involvement is voluntary. We analyzed DOC data on program participation and completion for mentally ill inmates and inmates without mental illnesses. As shown in Table 24, we found that similar percentages of inmates participated, but fewer mentally ill inmates completed programming. For example, while 30.2 percent of mentally ill inmates and 32.7 percent of inmates without mental illnesses participated in some form of educational programming, only 9.7 percent of mentally ill inmates completed this type of programming, compared to 16.3 percent of inmates without mental illnesses.

Table 24

Program Participation and Completion
As of June 2008[1]

	Inmates Participating[2]		**Inmates Completing Program**[3]	
Program	Mentally Ill Inmates[4]	Inmates without Mental Illnesses	Mentally Ill Inmates[4]	Inmates without Mental Illnesses
AODA	10.6%	15.9%	4.2%	8.0%
Education	30.2	32.7	9.7	16.3
Sex Offender Treatment	5.3	5.0	1.4	2.1
Other Treatment[5]	25.2	23.7	17.1	18.9
Vocational	17.0	22.8	8.9	15.4
Work Release[6]	1.4	3.4	n.a.	n.a.
Other	2.5	4.8	0.8	1.2

[1] Program involvement is based on the most recent information recorded for individual inmates, which may be up to 12 months out of date because data are typically recorded only as part of a review of placement and service needs.

[2] Inmates who participated in at least one program in the specified category. Inmates may have participated in multiple programs both within and across categories.

[3] Inmates who completed at least one program in the specified category. Inmates may have completed multiple programs both within and across categories.

[4] Includes inmates identified as having mental health needs (MH-1) and inmates identified as seriously mentally ill (MH-2).

[5] Includes programs such as domestic violence counseling, parenting classes, and anger management.

[6] Work-release programming does not have a completion status.

Wisconsin Resource Center ▪

WRC houses and treats mentally ill inmates.

WRC was created in 1981 and began housing and treating mentally ill male DOC inmates in 1983. It is operated by DHS. 1989 Wisconsin Act 31 mandated that WRC provide "psychological evaluations, specialized learning programs, training, and supervision for inmates whose behavior presents a serious problem to themselves or others in state prisons." We reviewed WRC's capacity, utilization, and treatment services.

Capacity and Population

WRC operates 14 living units for DOC inmates, each staffed by psychological services personnel, as well as a teacher, a social worker, and a therapeutic services staff person to instruct inmates in crafts or recreational activities. The 14 units currently have an operating capacity of 314 inmates and include:

- 3 units to improve inmate daily living skills, such as personal hygiene;
- 3 units to teach more advanced social skills;
- 3 "high management" security units for segregation placements;
- 2 units for inmates with acute psychiatric problems;
- 1 intake and assessment unit;

- 1 unit to prepare inmates for transfer back to DOC facilities; and
- 1 unit to prepare inmates for release into the community.

Since September 1994, WRC has also housed and treated sexually violent persons who are not DOC inmates. Under ch. 980, Wis. Stats., the courts may order indefinite civil commitment for persons who have been convicted of sexually violent offenses, or found not guilty by reasons of mental disease or defect, and are "more likely than not" to engage in further sexual violence. DHS currently manages four WRC units for sexually violent persons. Each has an operating capacity of 29, for a total operating capacity of 116. In addition, the Sand Ridge Secure Treatment Center opened in 2001 to house sexually violent persons. In FY 2007-08, it had an operating capacity of 288. It is also operated by DHS.

As shown in Table 25, WRC's inmate capacity—which excludes units for sexually violent persons—increased from 334 in FY 2003-04 to 344 in FY 2004-05. This increase was achieved by housing two inmates in some cells that had previously housed one. WRC's inmate population has consistently been at or near capacity over the past five years. However, in March 2008 inmate capacity decreased by 30 beds, and average daily population decreased to 309, for the installation of equipment to control humidity and ensure the safety of inmates taking prescribed psychotropic drugs who are prone to overheating. This $2.8 million project is expected to be completed in May 2009. DHS's facilities investment plan for 2009-2015 anticipates a similar $3.4 million project in the 2009-2011 biennium and a final $450,000 project in the 2011-2013 biennium. If these projects are undertaken, capacity will likely remain near its current level.

Table 25

WRC Inmate Capacity and Population

Fiscal Year	Operating Capacity[1]	Average Daily Population	Percentage of Capacity Utilized
2003-04	334	322	96.4%
2004-05	344	342	99.4
2005-06	344	340	98.8
2006-07	344	339	98.5
2007-08 (Before 3/24/08)	344	329	95.6
2007-08 (3/24/08 and After)	314	309	98.4

[1] Operating capacity as of June 30 of each fiscal year.

Transfers and Departures

As shown in Table 26, there were 1,668 inmate transfers to WRC and 1,666 departures from FY 2003-04 through FY 2007-08. Over that time period, the average length of stay increased from 277.2 days to 392.3 days, or by 41.5 percent. As shown in Table 27, most inmate treatment stays at WRC were for three months to one year, and 9.2 percent of stays were for two years or more. The longest was 9.5 years.

Table 26

WRC Inmate Transfers and Departures

Fiscal Year	Transfers In	Departures[1]	Average Length of Stay (Days)[2]
2003-04	420	395	277.2
2004-05	354	356	282.9
2005-06	315	312	318.4
2006-07	296	301	374.0
2007-08	283	302	392.3
Total	**1,668**	**1,666**	324.5

[1] Includes transfers to other DOC institutions and releases to the community.

[2] Based on 1,666 departures from FY 2003-04 through FY 2007-08.

Table 27

Length of Inmate Treatment Stays at WRC[1]
FY 2003-04 through FY 2007-08

Length of Stay	Treatment Stays	Percentage of Total
Less than 3 months	366	21.9%
3 months up to 1 year	746	44.8
1 year up to 2 years	401	24.1
2 or more years	153	9.2
Total	**1,666**	**100.0%**

[1] Based on 1,666 departures from FY 2003-04 through FY 2007-08.

Slightly more than three-fourths of inmates had only one treatment stay at WRC from FY 2003-04 through FY 2007-08, as shown in Table 28.

Table 28

Inmates Completing Treatment Stays at WRC
FY 2003-04 through FY 2007-08

Treatment Stays during Five-Year Period	Inmates	Percentage of Inmates
One	1,007	77.9%
Two	223	17.3
Three	43	3.3
Four or more	19	1.5
Total	**1,292**	**100.0%**

As shown in Table 29, inmates from DOC's five maximum security institutions accounted for 991, or 59.4 percent, of the 1,668 transfers to WRC over the past five fiscal years, including 274 from the intake facility at Dodge Correctional Institution. Medium security facilities accounted for 631 transfers, and minimum security facilities accounted for 24.

Just over one-third of inmate departures from WRC were releases to the community.

As shown in Table 30, just over one-third of inmate departures from WRC were releases from DOC custody into the community. However, most inmates returned to DOC facilities.

Table 29

Transfers to WRC by Institution
FY 2003-04 through FY 2007-08

Institution	Transfers	Percentage of Total
Maximum Security		
Columbia	310	18.6%
Dodge	274	16.4
Green Bay	204	12.2
Waupun	183	11.0
Wisconsin Secure Program Facility	20	1.2
Subtotal	991	59.4
Medium Security		
Oshkosh	147	8.8
Racine	80	4.8
Redgranite	71	4.3
Milwaukee Secure Detention Facility	64	3.8
Kettle Moraine	63	3.8
Fox Lake[1]	54	3.2
Stanley	44	2.7
New Lisbon	39	2.4
Jackson	31	1.9
Prairie du Chien	24	1.4
Racine Youthful Offender	14	0.9
Subtotal	631	37.9
Minimum Security		
Oakhill	14	0.8
Wisconsin Correctional Center System	7	0.4
Chippewa Valley	2	0.1
Sturtevant Transitional Facility	1	0.1
Subtotal	24	1.4
Other[2]	22	1.3
Total	**1,668**	**100.0%**

[1] Fox Lake Correctional Institution houses medium and minimum security inmates.

[2] Includes DOC inmates transferred from county jails and persons civilly committed as sexually violent persons who became inmates after court actions.

Table 30

Departures from WRC
FY 2003-04 through FY 2007-08

Destination	Departures	Percentage of Total
Released from DOC Custody	568	34.1%
Maximum Security		
Columbia	280	16.8
Green Bay	174	10.4
Waupun	160	9.6
Dodge	28	1.7
Wisconsin Secure Program Facility	5	0.3
Subtotal	647	38.8
Medium Security		
Oshkosh	173	10.4
Racine	53	3.2
Milwaukee Secure Detention Facility	39	2.3
Redgranite	39	2.3
Kettle Moraine	36	2.2
Fox Lake[1]	33	2.0
Jackson	17	1.0
Stanley	16	1.0
New Lisbon	10	0.6
Prairie du Chien	7	0.4
Racine Youthful Offender	3	0.2
Subtotal	426	25.6
Minimum Security		
Wisconsin Correctional Center System	4	0.2
Sturtevant Transitional Facility	3	0.2
Oakhill	1	0.1
Subtotal	8	0.5
Other[2]	17	1.0
Total	**1,666**	**100.0%**

[1] Fox Lake Correctional Institution houses medium and minimum security inmates.

[2] Includes deaths, transfers to DHS Mental Health Institutes, a sexually violent persons commitment, and a vacated sentence.

Admissions Process

Transfers to WRC are not governed by written policies and procedures.

Inmate transfers to WRC are not governed by written policies and procedures. Rather, WRC and individual DOC institutions negotiate most transfers case by case. The admission request begins with a telephone or e-mail contact from an individual DOC institution to WRC's admissions coordinator to discuss the mental health needs of a particular inmate. If the institution requests a transfer, a WRC screening committee of two psychologists, a social worker, a therapist, and a unit manager assesses the inmate's treatment needs and potential security risks and advises the WRC admissions coordinator on the benefits and risks of the transfer. In addition, WRC occasionally accepts an emergency transfer with minimal review if, for example, an inmate has made a suicide attempt and cannot be stabilized by his institution's mental health staff. DOC officials also report that transfer decisions for some inmates may be reviewed by the Better Treatment Options Committee, which is a group of DOC and WRC mental health professionals.

WRC does not routinely compile information on inmate transfer requests, but managers stated that most requests are approved. However, they estimated that approximately 10 percent of all requests are denied. For example, in FY 2007-08:

- 16 requests were denied because WRC clinical staff determined that an inmate who had previously been treated at WRC would not benefit from further services;
- 7 were denied because WRC clinical staff determined that the inmate did not have a significant enough mental illness to benefit from WRC treatment;
- 8 were denied because WRC did not accept transfers of inmates who were within two to three months of their release dates, as more time is typically needed for treatment to be effective; and
- 2 were denied because WRC raised security concerns, such as previous escape attempts or attacks on WRC staff.

A DOC institution transferring an inmate to WRC typically must accept the return of another inmate.

When an institution transfers an inmate to WRC, it is typically required to accept the return of an inmate it previously sent to WRC. We reviewed transfers from maximum and medium security institutions and found that 71.3 percent of inmates who returned to DOC institutions at the same security level were returned to their original institution. Institution staff told us that they try to be conservative in how often they request transfers. WRC managers

believe some institutions may delay requesting a new transfer because they are hesitant to accept the return of a previously transferred inmate. As a result, both DOC and WRC officials reported that inmates may stay at WRC longer than clinically necessary. WRC officials reported that approximately 85 inmates have typically completed their treatment and are waiting to return to a DOC institution.

As noted, WRC has operated near its capacity over the past five years. However, the extent to which the need for WRC services exceeds capacity cannot be reasonably estimated because WRC does not maintain a waiting list and there is no systematic process by which DOC identifies the inmates it believes could most benefit from WRC services. We also could not determine whether WRC serves the inmates most in need of its services because there is no centralized system for prioritizing transfers to WRC. However, given that some inmates reportedly stay at WRC longer than necessary and correctional institutions report limiting the frequency of their transfer requests, it seems likely that there are inmates in DOC institutions who would be more in need of WRC services.

Clearer policies, decision-making, and record-keeping could help ensure WRC is used most effectively.

Managers reported that WRC has chosen not to develop written criteria to assess transfer requests in order to maintain maximum flexibility in the transfer of inmates. While some flexibility is needed, given the diversity of inmate mental health needs and available services, we believe it is important that limited resources such as WRC be used as efficiently and effectively as possible. Clearer policies, more centralized decision-making, and more detailed record-keeping could help ensure that this is the case.

☑ Recommendation

We recommend the Department of Corrections and the Department of Health Services report to the Joint Legislative Audit Committee by January 4, 2010, on their progress in developing written policies that:

- *outline steps in the transfer application process;*
- *specify the criteria that will be used to assess inmates for transfer to the Wisconsin Resource Center;*
- *require documentation of inmate transfer applications and decisions; and*
- *ensure the timely identification and transfer of inmates as they complete their treatment at the Wisconsin Resource Center.*

Treatment

WRC managers report that their primary goal is to stabilize mentally ill inmates so they can return to DOC institutions or be released at the end of their sentences. All staff at WRC are regarded as part of the facility's treatment team. In addition, all staff, including managers, clinicians, and office support personnel, receive training in physical and verbal control techniques for managing dangerous inmates.

We reviewed the types and extent of services provided to DOC inmates at WRC and conducted a file review of a random sample of 23 DOC inmates who received services at WRC between July 1, 2006, and June 30, 2008. Of the inmates whose records we reviewed:

- nine were transferred to WRC because their ability to function in prison was impaired by their mental illnesses;
- eight were transferred to WRC for mental health assessments, which can lead to longer-term treatment at WRC;
- three were transferred because of suicide attempts or other incidents of serious self-harm; and
- three were transferred to have their psychotropic medications adjusted.

WRC staff develop and routinely update treatment plans for all admitted inmates.

When inmates enter WRC, they are assigned to the facility's intake and assessment unit for a two- to three-week period during which staff assess their needs and develop a treatment plan. We found these plans are consistently developed and revised on a regular basis and appear to be used to direct services and assess progress.

Within our sample, inmates had a median of 20.3 documented mental health appointments annually during their stays at WRC, which is approximately one appointment every two-and-one-half weeks. Approximately one-half of the appointments were with psychologists. One-quarter were with psychiatrists, and one-fifth were with nurses, social workers, or therapists. The recorded reasons for appointments varied and included admissions screenings, therapy, medication reviews, psychological assessments, and treatment plan reviews.

19 of 23 inmates in our sample participated in clinical treatment programming.

Of the 23 inmates whose files we reviewed, 19, or 82.6 percent, participated in clinical treatment programs during their stays at WRC. Three of the four who did not may not have been mentally stable enough to participate, and one had a relatively short stay of two months. On average, inmates who participated in clinical treatment programs were in two programs each during their WRC stays. The program in which inmates most commonly participated was mental health education, as shown in Table 31.

Table 31

Inmate Participation in Clinical Treatment Programs at WRC[1]

Program Category	Participating Inmates[2]	Percentage Participating
Mental Health Education	12	52.2%
Coping Skills	5	21.7
Personal Development	5	21.7
Anger Management	4	17.4
Self-Reliance	3	13.0
Mental Health Fundamentals	2	8.7
Pre-Release	2	8.7
Cognitive Intervention[3]	1	4.3
Daily Living Skills	1	4.3
AODA	1	4.3
Vocational Workshop	1	4.3

[1] For a sample of 23 inmates incarcerated at WRC between July 1, 2006, and June 30, 2008.

[2] Some inmates participated in more than one program.

[3] Cognitive intervention therapy teaches inmates to identify the thinking that leads to criminal behaviors and to understand the consequences of their actions.

WRC offers 17 different structured mental health and therapy groups in addition to clinical treatment programs.

In addition to clinical treatment programs, WRC offers 17 different structured mental health and therapy groups that provide support for inmates with specific mental health issues such as depression, schizophrenia, alcohol and drug abuse, auditory hallucinations, and trauma histories. We found that 13 of the 23 inmates in our sample participated in at least one group. The group in which inmates most commonly participated was Wellness Recovery Action Planning, which is designed to encourage responsibility for monitoring mental health symptoms and handling crisis situations and served six inmates in our sample.

WRC also operates other classes and work assignments. For example, of the 23 inmates in our sample:

- 9 participated in work programs such as food service or custodial, laundry, or groundskeeping duties, which paid from $0.12 to $0.42 per hour;
- 8 participated in activities such as creative writing, film, current events, music, and arts; and
- 5 attended classes such as adult basic education or high school equivalency preparation.

WRC stays most segregation orders so that inmates remain in non-segregated housing.

In order to ensure access to programming, WRC managers minimize the time inmates spend in isolated cells. Although inmates are ordered to segregation for disciplinary violations, most segregation orders are stayed and the inmates remain in a non-segregated housing unit unless the violation was particularly dangerous or further violations occur. We found that 11, or 47.8 percent, of the 23 inmates in our sample had segregation placement orders, but we were unable to determine which inmates had actually been placed in segregation cells. We also determined that five, or 21.7 percent, of the inmates in our sample had been placed in observation cells to be monitored for self-harm. We were unable to determine the reasons for individual placements or for how long inmates were housed in observation cells.

Civil Commitments

Under s. 51.20(1), Wis. Stats., DOC may petition a court to compel inmates to receive psychotropic drug treatments or allow the transfer of inmates to a state mental health institution for possible psychotropic drug treatments. Almost all male inmates subject to these orders are treated at WRC. Female inmates are either treated at Taycheedah Correctional Institution or transferred to the Winnebago Mental Health Institute for treatment. Because WRC does not currently serve female inmates, Winnebago is the only alternative placement available to provide intensive clinical mental health services to female inmates.

From 2004 through 2008, 334 civil commitment orders were issued for inmates, as shown in Table 32. Of those, 268, or 80.2 percent, were issued for male inmates, all but 9 of whom were treated at WRC. A total of 66 civil commitment orders were issued for female inmates, including 35 used to treat female inmates at Taycheedah and 31 to treat inmates at Winnebago Mental Health Institute.

Table 32

Inmate Civil Commitment Orders

Treatment Location	2004	2005	2006	2007	2008[1]	Total
Male Inmates Treated at WRC	44	57	58	59	41	259
Male Inmates Transferred to Mendota Mental Health Institute	3	–	–	1	5	9
Female Inmates Treated at Taycheedah	13	9	3	7	3	35
Female Inmates Transferred to Winnebago Mental Health Institute [2]	6	8	9	4	4	31
Total	**66**	**74**	**70**	**71**	**53**	**334**

[1] As of December 11, 2008.

[2] In 2007, two additional Taycheedah inmates were voluntarily transferred to Winnebago Mental Health Institute for treatment services, increasing the total female inmate transfers to Winnebago Mental Health Institute to 33 over the five-year period.

■ ■ ■ ■

Improving Safety and Discipline ■

Mentally ill inmates can have a disproportionate effect on the safety and discipline of a correctional facility, including by harming themselves, assaulting institution staff, or committing violations that result in segregation placements. We reviewed DOC's ability to monitor and analyze the effect of mentally ill inmates on employee and inmate safety.

Inmate Self-Harm

Under DOC 311, Wis. Adm. Code, inmates who harm themselves may be placed in temporary observation confinement, where they are typically housed in a cell isolated from other inmates, provided special clothes and bedding that cannot be used as a noose, and checked by DOC personnel at least every 15 minutes.

More than 90.0 percent of self-harm incidents that resulted in observation placements involved mentally ill inmates.

Over the past three fiscal years, there were 1,341 incidents of inmate self-harm at DOC facilities that resulted in observation placements, including 1,231 for which we were able to determine the inmate's mental health status before placement. As shown in Table 33, more than one-half of self-harm observation placements were of inmates identified as seriously mentally ill (MH-2), and more than one-third were of inmates identified as having mental health needs but not seriously mentally ill (MH-1).

Table 33

Self-Harm Observation Placements at DOC Facilities[1]

Mental Health Classification before Placement	FY 2005-06 Placements	FY 2005-06 Percentage of Total	FY 2006-07 Placements	FY 2006-07 Percentage of Total	FY 2007-08 Placements	FY 2007-08 Percentage of Total
No Mental Health Needs (MH-0)	30	6.8%	35	8.4%	27	7.2%
Mental Health Need (MH-1)[2]	**148**	**33.6**	**150**	**36.0**	**150**	**40.2**
Seriously Mentally Ill (MH-2)[2]	**251**	**56.9**	**231**	**55.4**	**191**	**51.2**
Developmentally Disabled (MH-3)	12	2.7	1	0.2	5	1.4
Total	**441**	**100.0%**	**417**	**100.0%**	**373**	**100.0%**

[1] Excludes inmates at WRC and 110 observation placements for which we could not determine the inmates' mental health status.

[2] Inmates with mental illnesses.

Mentally ill inmates also remained in observation slightly longer during this three-year period. Inmates with serious mental illnesses spent an average of 4.2 days in observation, inmates with mental health needs spent an average of 4.6 days, and inmates with no prior mental health needs spent an average of 3.3 days. DOC staff reported that although some inmates who were not previously identified as mentally ill may have been misclassified, in other cases an inmate's mental health may have deteriorated or the self-harm incident may have been precipitated by something other than mental illness, such as a family death or an unsuccessful appeal of conviction.

Table 34 shows self-harm observation placements by institution. At nearly every institution, mentally ill inmates represented more than three-quarters of these placements.

As shown in Table 35, the most common self-harm action by inmates was biting, cutting, or stabbing, which accounted for 432, or 35.1 percent, of self-harm observation placements over the past three fiscal years.

Table 34

Locations of Self-Harm Observation Placements[1]
FY 2005-06 through FY 2007-08

Institution	Placements	Number Involving Mentally Ill Inmates[2]	Percentage Involving Mentally Ill Inmates[2]
Maximum Security			
Taycheedah[3]	278	269	96.8%
Columbia	162	152	93.8
Waupun	150	136	90.7
Green Bay	127	103	81.1
Dodge	118	112	94.9
Wisconsin Secure Program Facility	45	42	93.3
Medium Security			
Milwaukee Secure Detention Facility	69	57	82.6
Oshkosh	63	59	93.7
Racine	37	35	94.6
New Lisbon	35	29	82.9
Racine Youthful Offender	30	27	90.0
Redgranite	25	22	88.0
Kettle Moraine	24	22	91.7
Jackson	19	15	78.9
Stanley	19	18	94.7
Fox Lake[4]	13	11	84.6
Minimum Security[5]			
Oakhill	7	6	85.7
Sturtevant Transitional Facility	7	5	71.4
Women's Correctional Centers[6]	1	0	–
Unknown	2	1	50.0
Total	**1,231**	**1,121**	91.1

[1] Excludes inmates at WRC and 110 observation placements for which we could not determine the inmates' mental health status.

[2] Includes inmates identified as having mental health needs (MH-1) and inmates identified as seriously mentally ill (MH-2) before the self-harm observation placement.

[3] Taycheedah Correctional Institution houses maximum and medium security female inmates.

[4] Fox Lake Correctional Institution houses medium and minimum security inmates.

[5] Inmates housed at Wisconsin Correctional Center System facilities are typically sent to nearby institutions for observation placements.

[6] Includes the three minimum security correctional centers that are part of the Wisconsin Women's Correctional System.

Table 35

Types of Self-Harm Resulting in Observation Placements[1]
FY 2005-06 through FY 2007-08

Description of Self-Harm	Placements	Percentage of Total	Number Involving Mentally Ill Inmates[2]	Percentage Involving Mentally Ill Inmates[2]
Biting, Cutting, or Stabbing	432	35.1%	408	94.4%
Attempted Hanging	256	20.8	229	89.5
Medication Overdose	153	12.4	137	89.5
Head Banging	145	11.8	127	87.6
Other or Unknown	125	10.1	116	92.8
Ingesting or Inserting Objects	70	5.7	63	90.0
Refusing Food or Liquids	50	4.1	41	82.0
Total	**1,231**	**100.0%**	**1,121**	91.1

[1] Excludes inmates located at WRC and 110 observation placements for which we could not determine the inmates' mental health status.

[2] Includes inmates identified as having mental health needs (MH-1) and inmates identified as seriously mentally ill (MH-2) before the self-harm observation placement.

Emergency room costs for self-harm incidents by mentally ill inmates totaled $179,400 over three years.

Inmates in need of emergency medical care are transferred to emergency rooms at local hospitals. From FY 2005-06 through FY 2007-08, 157 of the 1,231 self-harm incidents resulted in emergency room treatment, at a total cost of $200,800. Mentally ill inmates accounted for 89.3 percent of those costs, or $179,400. These costs do not include inpatient or outpatient costs associated with these self-harm incidents, nor do they include the costs of follow-up care.

Inmate Suicides

From FY 2003-04 through FY 2007-08, 29 inmates committed suicide.

Over the past five fiscal years, 29 inmates committed suicide, as shown in Table 36. Of the 20 for whom mental health data were available, 16, or 80.0 percent, had been previously identified as mentally ill, including 7 with serious mental illnesses.

Table 36

Inmate Suicides

Fiscal Year	Inmate Suicides	Inmates with Recorded Mental Health Assessment	Inmates Identified as Mentally Ill[2]	Percentage Identified as Mentally Ill[2]
2003-04[1]	7	–	–	–
2004-05	3	2	2	100.0%
2005-06	10	9	7	77.8
2006-07	5	5	4	80.0
2007-08	4	4	3	75.0
Total	**29**	**20**	**16**	80.0

[1] Before FY 2004-05, DOC did not record inmate mental health codes.

[2] Includes inmates identified as having mental health needs (MH-1) and inmates identified as seriously mentally ill (MH-2) before the suicides.

As shown in Table 37, the 29 suicides took place in 15 different facilities. The most common method employed by inmates to commit suicide was hanging, which accounted for 25 of the 29 suicide deaths.

Table 37

Locations of Inmate Suicides
FY 2003-04 through FY 2007-08

Institution	Number	Percentage of Total[1]
Maximum Security		
Waupun	4	13.8%
Dodge	3	10.3
Green Bay	3	10.3
Columbia	2	6.9
Taycheedah[2]	1	3.4
Wisconsin Secure Program Facility	1	3.4
Medium Security		
Milwaukee Secure Detention Facility	3	10.3
Oshkosh	3	10.3
Fox Lake[3]	2	6.9
Racine	2	6.9
Jackson	1	3.4
New Lisbon	1	3.4
Stanley	1	3.4
Minimum Security		
Sturtevant Transitional Facility	1	3.4
Wisconsin Resource Center	1	3.4
Total	**29**	**100.0%**

[1] Percentages are rounded.

[2] Taycheedah Correctional Institution houses maximum and medium security female inmates.

[3] Fox Lake Correctional Institution houses medium and minimum security inmates.

Wisconsin's prison inmate suicide rate significantly exceeds those of the nation and of other midwestern states.

Suicide rates are significantly higher in Wisconsin's prisons than in those of other states. Although dated, the most recent federal data available indicate there were 32 suicides per 100,000 inmates in Wisconsin prisons from 2001 through 2002. By contrast, during that same period there were 14 suicides per 100,000 inmates in state prison systems nationally. The rates were 22 per 100,000 in Illinois, 11 per 100,000 in Michigan, 15 per 100,000 in Minnesota, and 9 per 100,000 in Ohio. More recent DOC data show there were 26.5 suicides annually for every 100,000 inmates over the past five fiscal years.

DOC officials report that since 2006, all staff who have personal contact with inmates have attended a two-hour annual training session that discusses the inmate suicide rate and warning signs of inmates at risk for suicide and that provides detailed instructions for responding to inmate suicide attempts. In addition, all institutions schedule quarterly emergency drills on responding to a hanging in a locked cell. A similar annual training presentation and rescue drill is performed at WRC.

DOC fully implemented a suicide prevention policy in May 2007.

DOC officials recognized that Wisconsin has a higher rate of suicide than other state prison systems and began implementing a suicide prevention policy in 2005. Officials report the policy was phased in over two years and was fully implemented in May 2007. The suicide prevention policy includes the intake and transfer screening requirements described earlier, as well as other measures such as:

- weekly meetings of multi-disciplinary committees within institutions, which review the care of mentally ill inmates and inmates in segregation and include security, mental health, health services, and other staff;

- "continuous line-of-sight monitoring" by correctional staff for inmates placed in observation with "imminent suicide behavior," as well as frequent examinations by psychological services staff;

- training on cardiopulmonary resuscitation and automated defibrillator machine operation for an "adequate" number of staff, defibrillator machine placement to ensure five-minute access, and placement of first aid and suicide response tools in all work and housing areas; and

- data collection and investigation of inmate suicides or serious suicide attempts that require emergency care by a physician, other medical staff, an emergency room visit, or hospitalization.

Assaults on Staff

Mentally ill inmates accounted for 79.2 percent of assaults on staff.

Security directors at DOC's adult institutions and at WRC prepare monthly reports that summarize all inmate assaults on staff. From FY 2005-06 through FY 2007-08, there were 785 assaults on staff, including 755 for which we were able to determine the inmate's mental health classification before the assault. As shown in Table 38, for each of the past three fiscal years approximately one-half of all staff assaults were committed by inmates with serious mental illnesses (MH-2). Over the three-year period, a total of 598, or 79.2 percent, of all staff assaults were committed by inmates with mental health needs (MH-1) or serious mental illnesses (MH-2). This substantially exceeds their overall representation in the inmate population, which ranged from 28.2 percent in June 2006 to 31.0 percent in June 2008.

Table 38

Mental Health Status of Inmates Who Assaulted Staff[1]

Mental Health Classification before Staff Assault	FY 2005-06		FY 2006-07		FY 2007-08	
	Inmates	Percentage of Total	Inmates	Percentage of Total	Inmates	Percentage of Total
No Mental Health Needs (MH-0)	53	22.7%	45	18.8%	43	15.3%
Mental Health Need (MH-1)[2]	**61**	**26.2**	**80**	**33.3**	**90**	**31.9**
Seriously Mentally Ill (MH-2)[2]	**116**	**49.8**	**110**	**45.8**	**141**	**50.0**
Developmentally Disabled (MH-3)	3	1.3	5	2.1	8	2.8
Total	**233**	**100.0%**	**240**	**100.0%**	**282**	**100.0%**

[1] Does not include 30 assaults for which we could not determine the inmates' mental health status.

[2] Inmates with mental illnesses.

Table 39 shows the locations of inmate assaults on staff over the past three fiscal years. Table 40 shows the types of assaults committed.

Table 39

Locations of Inmate Assaults on Staff
FY 2005-06 through FY 2007-08

Institution	Assaults[1]	Percentage of Total	Number Committed by Mentally Ill Inmates[2]	Percentage Committed by Mentally Ill Inmates[2]
Maximum Security				
Columbia	130	17.2%	123	94.6%
Green Bay	105	13.9	85	81.0
Waupun	98	13.0	74	75.5
Dodge	60	7.9	49	81.7
Taycheedah[3]	40	5.3	40	100.0
Wisconsin Secure Program Facility	17	2.3	9	52.9
Medium Security				
Racine Youthful Offender	32	4.2	23	71.9
Milwaukee Secure Detention Facility	25	3.3	18	72.0
Racine	23	3.0	18	78.3
Oshkosh	21	2.8	15	71.4
Kettle Moraine	19	2.5	10	52.6
New Lisbon	17	2.3	9	52.9
Fox Lake[4]	13	1.7	9	69.2
Redgranite	9	1.2	3	33.3
Stanley	5	0.7	2	40.0
Prairie du Chien	4	0.5	–	–
Minimum Security				
Oakhill	12	1.6	6	50.0
Wisconsin Correctional Center System[5]	8	1.1	2	25.0
Chippewa Valley	3	0.4	1	33.3
Wisconsin Resource Center	114	15.1	102	89.5
Total	**755**	**100.0%**	**598**	79.2

[1] Does not include 30 assaults for which we could not determine the inmates' mental health status.

[2] Includes inmates identified as having mental health needs (MH-1) and inmates identified as seriously mentally ill (MH-2) before the assaults.

[3] Taycheedah Correctional Institution houses maximum and medium security female inmates.

[4] Fox Lake Correctional Institution houses medium and minimum security inmates.

[5] Includes inmates at both men's and women's correctional centers.

Table 40

Types of Inmate Assaults on Staff
FY 2005-06 through FY 2007-08

Description of Assault	Assaults[1]	Percentage of Total	Number Committed by Mentally Ill Inmates[2]	Percentage Committed by Mentally Ill Inmates[2]
Striking, Biting, or Stabbing	404	53.5%	303	75.0%
Spitting or Throwing Human Waste	270	35.8	235	87.0
Attempted Assault[3]	38	5.0	31	81.6
Throwing Object	28	3.7	24	85.7
Sexual Assault	15	2.0	5	33.3
Total	**755**	**100.0%**	**598**	79.2

[1] Does not include 30 assaults for which we could not determine the inmates' mental health status.

[2] Includes inmates identified as having mental health needs (MH-1) and inmates identified as seriously mentally ill (MH-2) before the assaults.

[3] Includes incidents in which an inmate attempted to assault a staff person but did not make contact.

From FY 2005-06 through FY 2007-08, assaults on staff by mentally ill inmates resulted in $874,200 in worker's compensation awards.

Staff who are assaulted by inmates may claim worker's compensation for the costs of medical care, lost wages, vocational rehabilitation, retraining, and compensation for permanent disabilities. Worker's compensation awards related to inmate assaults have declined significantly over the past three years, although the number of assaults has increased. As shown in Table 41, the number of awards increased from 56 in FY 2005-06 to 67 in FY 2007-08, but total awards declined from $546,200 in FY 2005-06 to $156,900 in FY 2007-08. Over the three-year period, $874,200, or 84.5 percent, of the total awarded resulted from assaults by mentally ill inmates. The average award was $5,600 for an assault by a mentally ill inmate and $4,300 for an assault by an inmate with no identified mental illness. Assaults involving inmates striking, biting, or stabbing staff accounted for 94.6 percent of all worker's compensation awards for inmate assaults.

Table 41

Worker's Compensation Awards Related to Inmate Assaults on Staff[1]

Inmate Mental Health Classification before Staff Assault	FY 2005-06		FY 2006-07		FY 2007-08	
	Awards	Amounts	Awards	Amounts	Awards	Amounts
Seriously Mentally Ill (MH-2)[2]	**23**	**$106,200**	**29**	**$263,800**	**32**	**$114,400**
Mental Health Need (MH-1)[2]	**20**	**320,900**	**24**	**43,100**	**27**	**25,800**
Developmentally Disabled (MH-3)	–	–	–	–	2	14,000
No Mental Health Needs (MH-0)	13	119,100	16	24,800	6	2,700
Total	**56**	**$546,200**	**69**	**$331,700**	**67**	**$156,900**

[1] Includes DOC personnel assigned to adult institutions and DOC and DHS personnel assigned to WRC. Excludes 5 awards totaling $61,632 for which we could not determine the inmates' mental health status.

[2] Inmates with mental illnesses.

From FY 2005-06 through FY 2007-08, WRC staff received $423,200, or 40.9 percent of total awards. We also note that a few incidents can account for the majority of compensation. For example, while WRC had 27 separate awards, three incidents accounted for 77.5 percent of all award costs, including $236,500 awarded in FY 2005-06 to a psychiatric care technician who received head injuries, $61,100 awarded to another technician injured while restraining an inmate, and $30,500 awarded to a clerical staff person stabbed by an inmate. Similarly, $179,400 awarded in FY 2006-07 to a correctional officer who suffered head injuries while preventing an inmate from assaulting library staff accounted for 85.6 percent of Racine Correctional Institution's awards. Appendix 6 lists amounts of worker's compensation awards related to inmate-on-staff assaults by institution.

Segregation

Inmates are placed in segregation for violations of prison rules.

Under section 302.10, Wis. Stats., inmates who violate prison rules "may be confined to a solitary cell, under the care and advice of the physician." Chapter DOC 303, Wis. Adm. Code, further describes segregation as a highly controlled environment within an institution in which inmates' property, privileges, and movement are further restricted. Segregation is one of the disciplinary options for major conduct violations such as assault, possession of weapons, and misuse of prescription medications. The maximum length of a segregation sentence is 360 days. All DOC medium and maximum security institutions have segregation units, and the Wisconsin Secure Program Facility consists primarily of segregation inmates.

Housing of mentally ill inmates in segregation has been an area of concern in recent years. The Supermax lawsuit filed in September 2000

alleged, in part, that confinement at the institution caused severe psychiatric suffering because of the isolation and restriction of the institution's segregated setting. As noted, the January 2002 settlement agreement disallowed the placement of seriously mentally ill inmates at Supermax (now the Wisconsin Secure Program Facility). Although the settlement agreement is no longer in effect, DOC still excludes seriously mentally ill inmates (MH-2) from placement at the Wisconsin Secure Program Facility. However, inmates with mental health needs (MH-1) may be housed there.

In 2005, DOC's Segregation Workgroup recommended modifications to the disciplinary process for mentally ill inmates.

In April 2003, DOC convened a workgroup to address treating mentally ill inmates in segregation settings. Members included DOC staff, WRC staff, and two attorneys for the Wisconsin Coalition for Advocacy (now known as Disability Rights Wisconsin). The January 2005 report of the Segregation Workgroup cited a "growing recognition among mental health professionals, correctional administrators, and accreditation organizations" across the country that the health of mentally ill inmates can deteriorate as a result of the isolation and inactivity of segregation. The Segregation Workgroup recommended that psychological services staff provide "formal input" into the disciplinary process for mentally ill inmates and developed a form that it recommended be used for seriously mentally ill (MH-2) and developmentally disabled (MH-3) inmates who commit conduct violations that could result in segregation placements.

DOC policy does not require use of the Segregation Workgroup's form because it is time-consuming to complete. However, the form is being used at Taycheedah Correctional Institution, and DOC officials indicated that a pilot program using the form in cases of inmate self-harm in maximum security institutions is planned for early in 2009. In addition, DOC officials indicated that its administrative code committee is considering changing administrative code to explicitly include mental illness as a mitigating factor to be considered by hearing officers involved in the disciplinary process, as recommended by the Segregation Workgroup.

Institution staff indicated that inmates' mental health is sometimes taken into consideration during the disciplinary process. As noted, special management units and informal special housing units often have more flexible disciplinary procedures, such as providing mentally ill inmates with additional warnings before taking disciplinary action. In addition, staff at some institutions reported that mental health staff may provide informal input to hearing officers. However, staff at two institutions reported that inmates' mental health has little or no impact on the disciplinary process.

Segregation Populations

DOC data systems do not allow for ongoing analysis of mentally ill inmates in segregation because inmate housing locations and mental health classifications are not recorded in the same data system. However, each January for the past several years, DOC has compiled data on segregation inmates with mental illnesses by manually matching data from two separate sources.

Mentally ill inmates have been overrepresented in segregation.

Table 42 shows that in each year from 2005 through 2008, mentally ill inmates (MH-1 and MH-2) were overrepresented in segregation. For example, in January 2008, 46.1 percent of inmates in segregation were mentally ill, compared to 33.0 percent of the population as a whole.

Table 42

Mentally Ill Inmates in Segregation and in the Total Population[1]

	Percentage of Segregation Inmates Who Are Mentally Ill[2]	Percentage of All Inmates Who Are Mentally Ill[2]
January 2005[3]	38.0%	26.8%
January 2006[4]	35.9	29.5
January 2007	40.3	31.5
January 2008	46.1	33.0

[1] Includes only institutions with segregation units.

[2] Includes inmates identified as having mental health needs (MH-1) and inmates identified as seriously mentally ill (MH-2).

[3] The mental health classification system was implemented in mid-2004; January 2005 data may understate the number of mentally ill inmates.

[4] Dodge Correctional Institution data were not included in the documents received from DOC for January 2006.

Institutions varied in their use of segregation for mentally ill inmates, as shown in Table 43. In January 2008, the percentage of inmates in segregation who were identified as mentally ill ranged from a low of 17.6 percent at Oakhill Correctional Institution to a high of 76.2 percent at Taycheedah Correctional Institution, reflecting differences in the overall percentages of mentally ill inmates at those institutions.

Table 43

Mentally Ill Inmates in Segregation at Individual Institutions
January 2008

Institution[1]	Mentally Ill Inmates in Segregration[2]	All Inmates in Segregation	Percentage in Segregation Who Are Mentally Ill	Percentage in Institution Who Are Mentally Ill[2]
Maximum Security				
Columbia	86	118	72.9%	48.0%
Dodge	35	75	46.7	32.6
Green Bay	79	143	55.2	40.4
Taycheedah[3]	48	63	76.2	74.8
Waupun	115	188	61.2	43.4
Wisconsin Secure Program Facility	100	339	29.5	26.1
Subtotal	463	926	50.0	43.4
Medium Security				
Fox Lake[4]	33	93	35.5	26.3
Jackson	22	42	52.4	34.5
Kettle Moraine	43	80	53.8	30.8
New Lisbon	18	45	40.0	26.2
Oshkosh	38	73	52.1	34.3
Prairie du Chien	5	16	31.3	21.7
Racine	56	108	51.9	31.2
Redgranite	22	44	50.0	30.1
Racine Youthful Offender	32	78	41.0	31.7
Stanley	24	115	20.9	18.9
Subtotal	293	694	42.2	28.8
Minimum Security				
Oakhill	6	34	17.6	11.0
Total	**762**	**1,654**	46.1	33.0

[1] No information was available for the Milwaukee Secure Detention Facility. The Wisconsin Correctional Center System centers, Chippewa Valley Correctional Treatment Facility, and Sturtevant Transitional Facility were excluded because they do not have segregation units. WRC was excluded because of differences in its definition and use of segregation.

[2] Includes inmates identified as having mental health needs (MH-1) and inmates identified as seriously mentally ill (MH-2).

[3] Taycheedah Correctional Institution houses maximum and medium security female inmates.

[4] Fox Lake Correctional Institution houses medium and minimum security inmates.

Monitoring and Treatment of Mentally Ill Inmates in Segregation

DOC's suicide prevention policy requires that psychological services staff conduct face-to-face interviews and file reviews for all seriously mentally ill (MH-2) and developmentally disabled (MH-3) inmates within one working day of segregation placement. We were unable to verify the extent to which this occurred because neither automated data systems nor paper-based inmate files clearly indicated dates and times of segregation placements or the required interview and file review.

Psychological services staff see inmates in segregation one or more times per week.

Psychological services staff also complete segregation rounds, which consist of brief encounters with inmates to determine their mental status and identify any problems resulting from placement in segregation. NCCHC standards state that inmates in segregation should be monitored three days per week by medical or mental health staff, and DOC's Segregation Workgroup identified the development of staffing plans to fulfill the NCCHC recommendations as a long-term goal. DOC policy does not specify how often rounds should be completed by psychological services staff. However, a list of psychological services unit priorities prepared in July 2006 and updated in June 2008 recommended weekly segregation rounds for mentally ill inmates, and among the institutions we visited:

- seven indicated that psychological services staff complete segregation rounds once per week;
- three indicated that psychological services staff complete rounds twice per week;
- Waupun Correctional Institution does not complete rounds, but has a psychologist present on the segregation unit each weekday; and
- Racine Correctional Institution indicated that it planned to hire a new psychologist who would conduct daily segregation rounds.

DOC policy requires each institution's Segregation Review Committee, which may include psychology, psychiatry, health services, and security staff, to review the status of inmates housed in segregation at least once every 30 days. The committee discusses inmates' psychological, medical, security, and housing issues. Based on recommendations from the review committee, psychological services staff, and the institution's security director, the warden decides to either remove the inmate from segregation or continue

the segregation placement. Of the 12 institutions we visited that have segregation units, 11 reported that these reviews are performed at 30-day intervals.

Most institutions do not offer mental health programming in segregation.

At all institutions, inmates are seen by psychological services or psychiatry staff for monitoring and medication management appointments regardless of their segregation placement, though these contacts may occur at the cell door while the inmate is in segregation. However, our interviews with staff indicated that most institutions offer limited or no programming in segregation. Taycheedah Correctional Institution reported offering several programs to inmates in segregation, including anger management and current events. Waupun Correctional Institution was the only institution for male inmates that indicated it is currently offering group programs to inmates in segregation, including a coping skills group focused on decision-making skills and a psychotherapy group focused on changing counterproductive beliefs and behaviors. Staff at Racine Correctional Institution stated that they have offered group segregation programs in the past but were not doing so at the time of our interview because of staff vacancies. Staff at Oshkosh Correctional Institution noted that out-of-cell group programs have been proposed but not implemented, and staff at Green Bay Correctional Institution indicated some program materials were available for inmates to complete in their cells.

Reasons cited by DOC staff for the relative lack of segregation programs include:

- the significant staff time required to move segregation inmates from their cells, because often they must be placed in restraints and require multiple staff escorts;
- insufficient psychological services staff time for group programs and individual therapy; and
- the lack of sufficient or appropriate space for individual therapy or group programs to be held.

Enhancing Information and Training

As noted, mentally ill inmates have a disproportionate effect on institution safety and discipline. While they accounted for fewer than one-third of inmates in DOC custody in recent years, they accounted for:

- more than 90.0 percent of self-harm observation placements;
- 80.0 percent of inmate suicides;
- nearly 80.0 percent of assaults on staff; and
- more than 40.0 percent of segregation placements.

DOC's management of information related to safety and discipline could be improved.

Although the implementation of the mental health classification system was a significant step in improving DOC's ability to identify and monitor mentally ill inmates, DOC does not yet have the ability to systematically integrate those data with data on self-harm incidents, assaults, or segregation placements. We also found other data limitations in DOC's information management. For example:

- Data on observation placements are maintained in a centralized database; however, we found examples of duplicative and inconsistent data.
- Inmate assaults are reported on text documents e-mailed to DOC central office from each individual institution, rather than recorded directly by each institution in a centralized database, which would improve reporting efficiency and facilitate routine analysis of the data.
- Data on inmate housing locations, including segregation placements, are maintained only in a data system that is not specifically designed for that purpose and cannot be readily used for analysis. DOC staff have indicated that a new data system implemented in June 2008 is expected to include inmate housing locations in the spring of 2010.

Addressing limitations in information management would improve DOC's ability to accurately monitor and analyze incidents related to safety and discipline, including special concerns involving inmates with mental illnesses, and could potentially identify trends or more effective practices for addressing these concerns.

☑ Recommendation

We recommend the Department of Corrections improve its collection and management of data related to inmate self-harm, assaults on staff, and segregation placements by:

- *developing data entry instructions that will reduce inconsistent data in the observation placement database;*
- *developing a centralized database for recording assaults;*
- *including inmate housing locations in its new data system; and*
- *developing methods for automated matching and analysis of inmate mental health classifications in conjunction with information on assaults, observation placements, and segregation.*

Correctional officers are typically not informed of inmates' mental health status.

Although psychological services and psychiatry staff are primarily responsible for monitoring and treating mentally ill inmates, correctional officers have the most day-to-day contact with inmates and are therefore most involved with safety and discipline. However, correctional officers are generally not aware of inmates' mental health classifications. We interviewed 15 correctional officers at six DOC institutions and found that only 2 were regularly aware of inmate mental health classifications: 1 because he is informed when the mental health status of inmates placed in the housing unit he supervises must be considered in cell assignments, and the other because he is a member of the institution's Segregation Review Committee. Some correctional officers reported that they can sometimes tell if an inmate is mentally ill based on his or her behavior, and correctional officers who deliver medications may be able to infer the type of mental health problem an inmate has. However, it is unclear whether these assessments are accurate.

As noted, correctional officers receive initial training on mental health issues. In addition to medication delivery training and annual suicide prevention training, all new officers receive eight hours of

training in correctional mental health issues during orientation. The training covers suicide prevention; descriptions, signs, and symptoms of various mental illnesses; when to refer inmates to the psychological services unit; and classes of psychotropic medications, including what they are designed to treat and potential side effects. However, we could not determine whether this training is either sufficient or effective in giving officers the tools and information they need to interact with mentally ill inmates, particularly because most training occurs before officers have actually begun working at institutions.

Increased mental health training for correctional officers could enhance security.

Advocacy groups with whom we spoke believe that mentally ill inmates sometimes need to be managed differently than other inmates because traditional approaches are not necessarily effective, and that in order to effectively manage mentally ill inmates, correctional officers need to know whether an inmate is mentally ill. Advocates cited the crisis intervention model as a promising approach in training correctional officers in how to work with mentally ill inmates, including strategies for deescalating potentially dangerous situations and using simulated auditory hallucinations as a way to increase officers' understanding and empathy for the mentally ill. A two-day version of this training was recently offered at the Milwaukee Secure Detention Facility, and officials there spoke positively of the training and reported that the response among officers who attended was positive. Advocates emphasized they believe that these more flexible approaches to handling mentally ill inmates enhance security rather than conflict with it.

Some DOC staff have expressed concerns that privacy and confidentiality issues could prevent disclosure of detailed mental health information to correctional officers, but knowledge of an inmate's mental health code without additional information on the specific illness or symptoms might not be very useful for correctional officers. However, given correctional officers' roles in interacting with mentally ill inmates, finding a way to resolve these concerns by providing appropriate information on inmate mental health, as well as training on how to effectively manage mentally ill inmates, could improve institution safety and discipline.

☑ Recommendation

We recommend the Department of Corrections report to the Joint Legislative Audit Committee by January 4, 2010, on its plans for providing correctional officers with more specific information on inmates' mental health needs and enhancing officer training in managing mentally ill inmates.

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Release Planning ■

Connecting inmates to community services through a pre-release planning process can support their successful reentry into the community. No state or federal laws require release planning or guide the provision of release-related services. However, DOC has in place a release planning program for all inmates, which includes release planning services of particular relevance to inmates with mental illnesses.

General Release Planning Initiatives

At 13 of 20 institutions, one or more social workers specialize in release planning.

In recent years, DOC has undertaken three sets of strategies to improve release planning services for all inmates. First, in 2004, it directed all correctional institutions to ensure release planning services were available to inmates. Several institutions responded by establishing specialized release planning social worker positions and assigning all inmates closest to release to those workers' caseloads. Other institutions developed pre-release housing units for inmates closest to release, which similarly allow social workers and other unit staff to focus their services to these inmates. As of December 2008, five institutions reported operating such units. Overall, 13 of 20 institutions, including the 5 with pre-release units, reported that one or more of their social workers maintained a specialized pre-release caseload, and specialists with whom we spoke believe they are able to provide more effective release planning assistance than nonspecialists because of their increased knowledge and experience.

Second, the Community Reintegration Services Initiative, which was enacted in 2005 Wisconsin Act 25, provided DOC $3.1 million to fund release planning services during the 2005-07 biennium and included $1.51 million to hire probation and parole agents who provide release planning assistance to inmates nearing release from maximum security institutions. Currently 11.5 FTE positions with these responsibilities are filled in DOC's Milwaukee, Fond du Lac, Green Bay, Racine, and Kenosha offices. The remaining funding—$1.6 million—was provided to fund release planning services for three target populations: female inmates, male inmates at medium security institutions, and inmates with mental illnesses. DOC was unable to provide complete information on the amount of funding or types of services directed to inmates with mental illnesses. However, officials indicated during the course of our fieldwork that their process for allocating FY 2009-10 and FY 2010-11 funds has prioritized proposals to provide services to inmates with mental illnesses.

DOC developed a release planning curriculum for all inmates in 2007.

DOC implemented its third general release planning strategy in 2007 with the development of a ten-module pre-release curriculum designed to provide standardized and comprehensive release planning assistance to all inmates. The curriculum guides inmates and staff through a formal release planning process to be conducted for every inmate beginning at least six months before release. As part of the process, each inmate completes an inventory of release-related needs—including housing, medication, and health care—and meets with an institution social worker and a probation and parole agent to review the inventory. The social worker and agent are then responsible for arranging to meet the inmate's identified needs. DOC directed all facilities to implement the curriculum by April 30, 2008; however, as of February 2009, DOC found only 9 of 20 institutions and 1 of 16 correctional centers reported full implementation of all modules of the pre-release curriculum. In our interviews, five facilities cited a lack of resources as a primary cause of their delays, and others expressed concern about the volume of additional responsibilities placed on existing staff by the initiative. DOC indicated that it has worked with institutions to establish formal time lines for achieving full implementation.

☑ Recommendation

We recommend the Department of Corrections report to the Joint Legislative Audit Committee by January 4, 2010, on:

- *the allocation of Community Reintegration Services Initiative funds for the 2009-11 biennium; and*
- *its progress in implementing the pre-release curriculum for all inmates.*

Release Planning for Inmates with Mental Illnesses

Standards published by the American Psychiatric Association and other professional organizations specify services that should be included in inmate release plans, including three that are particularly relevant to inmates with mental illnesses: provision of a short-term supply of medications upon release; assistance in obtaining benefits from government programs; and assistance in obtaining health treatment services in the community, including mental health treatment.

In FY 2007-08, 2,420 mentally ill inmates were released from prison.

Table 44 shows the number of inmates released from DOC facilities in FY 2007-08. Of the 9,123 inmates released that year, 815, or 8.9 percent, were classified as seriously mentally ill (MH-2) at the time of their release, and 1,605, or 17.6 percent, were classified as having mental health needs but not seriously mentally ill (MH-1).

Table 44

Inmates Released from DOC Facilities[1]
FY 2007-08

Mental Health Classification	Released Inmates	Percentage of Total
No Mental Health Needs (MH-0)	6,128	67.2%
Mental Health Needs (MH-1) [2]	**1,605**	**17.6**
Seriously Mentally Ill (MH-2) [2]	**815**	**8.9**
Developmentally Disabled (MH-3)	17	0.2
Code Missing	558	6.1
Total	**9,123**	**100.0%**

[1] Excludes inmates incarcerated on certain temporary holds, as well as those at the Milwaukee Secure Detention Facility, for whom limited mental health information was available.

[2] Inmates with mental illnesses.

To assess release planning services received by mentally ill inmates, we reviewed the files of 50 randomly selected inmates released between July 2007 and March 2008, including 24 classified as seriously mentally ill at the time of their release (MH-2) and 26 classified as having mental health needs (MH-1). Of the 50 inmates, 25 were male and 25 were female.

Release Medications

Upon release, inmates receive a two-week supply and a 30-day prescription for their psychotropic medications.

In order to ensure that inmates have a supply of medication sufficient to last until they can obtain treatment in the community, DOC policy requires they be provided with a two-week supply of all their prescription medications upon release, as well as a 30-day prescription for psychotropic medications. Inmates may also receive a 30-day prescription for non-psychotropic medications at the discretion of health care staff. DOC pharmacy data indicate 42 of the 50 inmates we reviewed were entitled to a supply of medication upon release, and 31 appear to have received those medications. It is not clear whether the remaining 11 inmates failed to receive medication or whether they did receive medication but its receipt was not documented by DOC.

Concerns were reported by DOC staff regarding recently released inmates' ability to fill their 30-day prescriptions, particularly if they have serious mental health needs or are prescribed multiple medications, in part because of cost. Institution social workers reported providing inmates with information on pharmacies and discount programs, but probation and parole agents indicated they try to arrange access to medications for released inmates before they exhaust their two-week supply, thereby avoiding the need to fill the prescription.

Some correctional systems provide inmates with more than a two-week supply of prescription medications upon release. For example, Iowa and Michigan provide all released inmates with a 30-day supply of medication, and Minnesota provides up to a 37-day supply in some cases. In addition, WRC provides a four-week supply to released inmates, but no prescription. DOC has considered modifying its policy to provide released inmates with a one-month supply of medication and no prescription. While doing so would provide released inmates a greater supply, some believe it could increase the likelihood of overdoses, and it increases concern by institution prescribers about providing medications without scheduled follow-up. The policy change would also increase DOC's pharmaceutical costs.

Benefits Assistance

DOC policy requires institution staff to help inmates apply for Social Security and Medical Assistance benefits.

In July 2004, DOC implemented a policy requiring institutions to help inmates apply for Social Security and Medical Assistance benefits. Because individuals are ineligible for those benefits while incarcerated, the goal of the policy is to permit inmates to begin receiving benefits upon or shortly after their release.

To support this goal, DOC has signed memoranda of understanding with the federal Social Security Administration (SSA) and DHS, which administers Wisconsin's Medical Assistance program, to permit inmates to submit applications before their release dates. The memorandum with SSA permits submission of disability benefit applications 90 days before release, and the memorandum with DHS permits submission of Medical Assistance applications 23 days before release. DOC's benefits assistance policy includes a time line that is summarized in Appendix 7.

Social workers help inmates prepare Social Security disability applications and work with treatment staff to obtain necessary supporting medical documentation. DOC policy requires that "potentially eligible" inmates be assisted but does not specify which inmates should be given priority. Institution staff reported they help all interested inmates classified as seriously mentally ill (MH-2) apply for Social Security disability benefits, because these inmates are most likely to qualify as disabled under program criteria. Staff note they also assist inmates with less-serious mental health needs (MH-1) when it appears they may be eligible for benefits.

Benefits application assistance often did not meet time lines set by DOC policy.

One-half of the inmates whose files we reviewed were documented as applying for Social Security disability benefits before release, including 19 inmates who were seriously mentally ill (MH-2) and 6 inmates who had mental health needs but were not seriously mentally ill (MH-1). However, the files suggest that DOC's application assistance often did not meet the time frames set forth in the benefits assistance policy. For example, according to policy, SSA should be contacted 150 days before release to determine the forms needed to complete the disability benefits application. We found that only 1 of the 16 files that documented the date of SSA contact met this requirement, and the average date of contact was 95 days before release. These delays may have prevented inmates from receiving their eligibility determinations before release; among the 22 inmates for whom determination dates were documented, only 3 received determinations before their release dates.

Table 45 shows Social Security disability benefit application status for the 50 inmates whose files we reviewed.

Table 45

Social Security Disability Application Status[1]
September 2008

Status	Inmates[2]
Approved[3]	13
Initially Denied, Appeals/Reapplications Pending	6
Denied, No Appeals/Reapplications Pending	6
Applied, Status Unclear	4
No Documented Application	21
Total	**50**

[1] For a sample of 50 inmates released from July 2007 through March 2008.

[2] 25 inmates applied for benefits before release and 4 applied after release.

[3] Two of the 13 re-offended near their date of approval and thus appear to have lost eligibility before benefit payments began.

Documentation of benefits application assistance was incomplete.

In an effort to facilitate the Social Security disability application process, DOC has developed a tracking form for staff to record each inmate's application status and progress through the process. However, the form was included in the files of only 13 of the 25 inmates who pursued benefits before release, and most of the forms were only partially complete. In addition, none of the forms were updated after the inmates' release dates, even though DOC policy directs probation and parole agents to continue updating the forms throughout the application and appeals process.

DOC cited several obstacles affecting its ability to comply with its benefits assistance policy, including resource constraints. DOC also noted that social workers lack expertise to effectively assist inmates with the process, including the ability to identify and obtain the medical documentation needed for the eligibility determination to be completed.

From 2004 through 2008, inmates in three DOC correctional institutions—Columbia, Oshkosh, and Oakhill—received assistance with Social Security disability benefit applications through Legal Action of Wisconsin's Prisoner Disability Assistance Project. The project, which was funded with approximately $500,000 in federal grant funding from SSA, employed attorneys to help inmates referred by institution social workers through the application process. During the course of the project, which stopped taking

referrals in March 2008 because of the anticipated expiration of project funding, attorneys helped 327 inmates submit applications and appeals. Of the 317 inmates who received initial application decisions as of August 2008, Legal Action reported that 44.2 percent were approved, compared to a national initial approval rate of 35 percent. In addition, of the 302 inmates who had completed both applications and appeals by August 2008, 55.3 percent were ultimately approved for benefits, partly because of appeal success rates that also exceeded national averages.

DOC is planning to implement a form to better document disability claims.

Legal Action and DOC staff believe project outcomes were positive because of project staff's expertise and time to devote to benefits assistance. However, project staff reported that their largest obstacle to providing effective benefits assistance was a lack of documentation by DOC institutions to support inmates' disability claims. Partly in response to project feedback, DOC is currently developing a standardized form for facility psychological services staff to complete in support of inmates' disability claims. Implementation is expected by mid-2009. Legal Action and others involved in the disability claims process believe that use of the form may improve applicants' chances of successful and timely claims.

Participation in Medical Assistance and other health care benefit programs can help ensure that released inmates have access to medications and treatment. Because 11 inmates included in our file review received Social Security disability payments, they were automatically enrolled in the Medical Assistance program. We found an additional seven released inmates were enrolled in other public health care programs: four in BadgerCare or other Medical Assistance programs, which require applications for receipt of benefits; two in the General Assistance Medical Program, a health coverage program for residents of Milwaukee County; and one in a tribal insurance program.

DOC's policy concerning Medical Assistance benefit applications could be improved.

DOC's policy for assisting inmates with Medical Assistance applications does not target the inmates most likely to benefit from application assistance. For example, the policy directs institution social workers to assist inmates who applied for Social Security disability benefits but were denied or have not yet been approved. However, DHS officials noted that when a person has already applied for Social Security disability benefits, submission of a separate Medical Assistance application will not expedite either application. In addition, the policy does not identify or assist other inmates, with or without mental illnesses, such as custodial parents of children who may be eligible for non–disability related Medical Assistance. None of the files we reviewed contained documentation indicating the inmate submitted a Medical Assistance application before release or received assistance in preparing one.

☑ Recommendation

We recommend the Department of Corrections report to the Joint Legislative Audit Committee by January 4, 2010, on its efforts to improve inmate benefits assistance, including:

- *an internal assessment of the use of tracking forms for Social Security benefits applications and provisions to ensure more consistent use of the forms;*
- *its efforts to improve documentation of inmate disabilities for use in applications for Social Security disability benefits; and*
- *steps to identify and assist inmates who may benefit from submitting Medical Assistance applications before release.*

Post-Release Treatment Appointments

Probation and parole agents are typically responsible for arranging post-release mental health treatment appointments.

DOC officials, institution staff, and probation and parole agents report that agents are typically responsible for arranging inmates' post-release treatment appointments, such as psychiatric appointments or mental health counseling. DOC employees at 9 of 13 institutions indicated that social workers occasionally make appointments but that agents are more commonly responsible. A release planning social worker reported that her specialization gives her a greater knowledge of available treatment providers than other, nonspecialized staff.

Some advocates and DOC officials with whom we spoke expressed concern that DOC's ability to link inmates to mental health treatment is constrained by a lack of community treatment resources, particularly the availability of county mental health services. For example, they note that Dane County's waiting list is more than one year long, and Milwaukee County's walk-in clinic serves only 15 clients per day on a first-come, first-served basis. However, other DOC staff, such as probation and parole agents and institution social workers, reported that they can usually arrange treatment appointments. DOC officials report that although counties are primarily responsible for providing mental health services to released inmates, DOC pays for some mental health services to released inmates. For example, from July 2008 through December 2008, DOC paid $38,400 for contracted psychiatric services in Madison, $46,600 for psychological services in the Racine/Kenosha area, and $25,000 for mental health services in

Outagamie County. In FY 2007-08, DOC also employed 4.5 FTE psychologists in the Milwaukee region and 4.5 FTE chief regional psychologists in other areas of the state.

Post-release treatment appointments were documented for 62.5 percent of the inmates in our sample.

Of the 50 inmates whose files we reviewed, 2 were released to jurisdictions outside of Wisconsin. Post-release treatment appointments were documented in 30, or 62.5 percent, of the remaining files. However, other inmates who were released in Wisconsin may have had appointments that were not documented in their files. Released inmates who had been classified as seriously mentally ill (MH-2) were more likely to have appointments than those who had been classified as having mental health needs (MH-1), 73.9 percent compared to 52.0 percent.

Of the 30 released inmates with documented treatment appointments, 14 had their first appointment within one month of release, but 4 did not have their first appointment until more than three months after release. Most of the 30 released inmates received treatment beyond their initial appointment, and as many as 20 could be described as receiving consistent, ongoing treatment following their initial post-release appointment through the date of our file reviews in fall 2008.

Based on our file reviews, the percentage of released inmates who obtained treatment appointments varied by the location to which they were released:

- 13 of the 21 inmates released to the Milwaukee area had treatment appointments;
- all 4 inmates released to Madison had appointments;
- 3 of the 4 inmates released to Green Bay had appointments; and
- 10 of the 19 inmates released to other locations had appointments.

The treatment provider also varied by location, as shown in Table 46. Most appointments in Milwaukee and Madison were with either DOC-funded mental health professionals or community providers. By contrast, appointments for offenders released to other locations were more likely to be with county or unspecified providers, which may support concerns about the limited availability of county treatment, particularly in areas without DOC-funded providers or numerous community providers.

Table 46

Initial Post-Release Treatment Appointments by Provider and Offender Location[1]

	Offender Location		
Provider	Milwaukee/Madison	Other Locations[2]	Total
DOC-Funded Mental Health Professionals[3]	8	0	8
County Agency	1	6	7
Community Provider	5	1	6
Other	1	2	3
Not Specified	2	4	6
Total	**17**	**13**	**30**

[1] For a sample of 50 inmates released from July 2007 through March 2008; 30 had documented post-release treatment appointments.

[2] Includes three offenders released to Green Bay, two offenders released to Kenosha, and one offender released to each of eight other locations: Balsam Lake, Burlington, Janesville, La Crosse, Manitowoc, Neenah, Portage, and Sheboygan.

[3] Includes psychiatrists and psychologists employed or contracted by DOC.

DOC is seeking to improve post-release appointment scheduling.

In an effort to improve its capacity to link inmates to county mental health treatment, DOC has developed a form for institution staff to record the mental health needs and conditions of inmates. The form is to be directed to county mental health agencies 90 days in advance of release. DOC officials intend for the form to provide counties time to schedule a treatment appointment near the inmate's release date. DOC plans to pilot use of the form early in 2009 with seriously mentally ill inmates released from Oakhill and Redgranite correctional institutions to the Milwaukee area.

As noted, 13 of 20 institutions have specialized social workers who assist inmates nearing release with benefits assistance, scheduling treatment appointments, and making other arrangements for post-release support and services. Given the reported advantages of such specialization, we believe DOC should consider whether other institutions could also benefit from reallocating social worker caseloads to allow for increased specialization in release planning.

☑ Recommendation

We recommend the Department of Corrections report to the Joint Legislative Audit Committee by January 4, 2010, on:

- *an analysis of efforts to improve access to specialized release planning staff; and*
- *results of its implementation of the treatment form in the Milwaukee area.*

Community Supervision of Inmates with Mental Illnesses

Upon release from incarceration, offenders are supervised by a DOC probation and parole agent. As noted, DOC directs all probation and parole agents to collaborate with facility social workers to provide release planning for the offenders they supervise as part of the pre-release curriculum.

Specialized Mental Health Agents

Probation and parole agents in Milwaukee and Madison specialize in supervising mentally ill offenders.

DOC's Milwaukee and Madison regions employ specialized mental health agents whose caseloads are limited to offenders with serious mental illnesses: a 10-agent Mental Health Unit operates in Milwaukee, and two agents serve as mental health specialists in Madison. Mental health agents' caseload responsibilities match those of other agents and include enforcement of the conditions of supervision and support with securing housing and employment. However, these specialized agents also direct offenders to mental health providers in the community and monitor and respond to offenders' mental health needs. Mental health agents receive offender referrals from courts, institution staff, and fellow agents and accept those with the most severe diagnoses and symptoms. The Milwaukee unit has written criteria that prioritize the acceptance of offenders with specific serious mental health diagnoses. However, we note these criteria do not correspond to the mental health codes used by DOC facilities.

Mental health agents and other DOC officials agree that supervision by specialized agents is beneficial for offenders with serious mental health needs, because those agents are more experienced in identifying the needs of mentally ill offenders and have established better working relationships with mental health providers. However, they expressed concern about the adequacy of existing specialized supervision. For example, mental health agents report that they supervise approximately the same number of offenders as nonspecialized agents, although they believe mentally ill offenders require more intensive supervision. The specialized agents also reported that they are unable to accept less severely ill offenders who could also benefit from specialized supervision.

DOC officials report that regions other than Milwaukee and Madison do not have designated mental health agents. All agents receive four hours of training in the supervision of offenders with mental illnesses, and DOC reports that agents may choose to informally specialize in supervising inmates with mental illnesses. While offenders are generally assigned to the eligible agent with the smallest caseload, DOC notes that individual units may make arrangements for inmates with mental illnesses to be placed on the caseload of an informal specialist.

☑ Recommendation

We recommend the Department of Corrections report to the Joint Legislative Audit Committee by January 4, 2010, on:

- *its efforts to ensure that offenders with mental illnesses are supervised by the probation and parole agents best equipped to meet their needs; and*

- *the feasibility of aligning policies for assigning offenders with mental illnesses to specialized agents with the mental health coding system used in correctional facilities.*

The Conditional Release Model

The Conditional Release Program supervises mentally ill individuals released from state mental health institutes.

Under s. 971.17, Wis. Stats., individuals charged with crimes but found not guilty by reason of mental disease or defect are committed to either Mendota Mental Health Institute or Winnebago Mental Health Institute. Such individuals may subsequently petition the committing court to authorize a conditional release from the Institute. With the court's approval, a plan for post-release

supervision and assistance is developed to address the individual's participation in the Conditional Release Program operated by DHS.

The Conditional Release Program serves approximately 400 participants each year. It is funded through a GPR appropriation to DHS, and expenditures totaled approximately $4.4 million in FY 2006-07. In addition, participants secure Medical Assistance benefits and help support themselves through any income they earn. Under contract with DHS, DOC assigns probation and parole agents to supervise program participants. The specialized mental health agents in Madison and Milwaukee supervise participants in their jurisdictions. In addition, DHS contracts with regional service providers, which usually are nonprofit organizations, for case management and support services.

DOC officials, advocacy groups, and DHS managers all believe the Conditional Release Program is a promising model for improving post-release assistance and outcomes for DOC inmates with mental illnesses. They also cite the low recidivism rates of program participants. For example, while DOC reports that 38.2 percent of released inmates return to DOC custody within three years of release because of new offenses, available data suggest that only about 5.0 percent of Conditional Release Program participants commit a new offense within three years. Some interviewees believe the program model could be transferable because the clinical condition and post-release needs of DOC inmates with serious mental illnesses are similar to those of existing participants. However, DOC notes that inmates have mandatory release dates, whereas current program participants are approved for conditional release only if their mental health conditions are stable, to increase their chances of successful reentry.

The Inmate Mental Health Services Pilot Program was created in 2005 Wisconsin Act 25 to provide services based on the Conditional Release Program model to 12 inmates released from WRC during FY 2006-07. To fund the program, Act 25 decreased a DOC GPR appropriation by $43,700 and increased the DHS Medical Assistance benefits appropriation by $104,000, which includes $60,300 in federal matching funds. However, DOC and DHS jointly decided not to implement the program because of concerns over the amount and availability of funds.

Neither DHS nor DOC report current efforts to pursue pilot program funding, but both expressed interest in pursuing future funding opportunities. The departments acknowledge that the program would involve substantial upfront costs, estimated by DOC at $16,000 per participant in a 2008 grant proposal. However, supporters note that the low demonstrated recidivism rate for

participants served by the existing program suggests the prospect of long-term cost savings. They also believe the Conditional Release Program model would be an efficient means to enhance assistance for DOC inmates, because of the opportunity to utilize and expand upon the existing program's infrastructure.

☑ Recommendation

We recommend the Department of Corrections report to the Joint Legislative Audit Committee by January 4, 2010, on the feasibility of incorporating elements of the Conditional Release Program model into its supervision of released inmates.

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Future Considerations ▪

In recent years, DOC has taken a number of actions in response to recent litigation, the federal Department of Justice investigation, and several independent evaluations. As a result, improvements to inmate mental health services have been made, including capital expenditures and increased staffing. Setting priorities for the future will be important as the State continues to seek to improve the provision of inmate mental health services at a time of significant budget constraints.

Recent Improvements in the Provision of Services

DOC has taken steps to improve the provision of mental health services.

DOC reports that improved procedures and training, additional staff, and new facilities have all helped to improve the provision of inmate mental health services. For example:

- DOC hired a mental health director in 2002, a psychology director in 2004, and a psychiatry director in 2008 to enhance central oversight and management of mental health care services.
- DOC opened a special management unit at Taycheedah Correctional Institution in 2002 to serve female inmates with serious mental health needs.

- In 2003 and 2004, DOC improved staff training by adding information on medication types and side effects to correctional officers' pre-employment training, and by developing additional training on suicide prevention and general mental health issues.

- DOC implemented a mental health classification system in 2004 to improve its ability to monitor the number of inmates with mental illnesses, inform staffing decisions, and make data collection and tracking easier and more uniform.

- In 2007, DOC achieved accreditation for the Psychology Internship Program.

DOC officials, as well as advocacy group representatives with whom we spoke, believe these changes represent significant improvements in DOC's capacity to provide mental health care services. However, they note that improving services to inmates at Taycheedah Correctional Institution has been the focus of DOC's recent attention and resources.

Changes at Taycheedah Correctional Institution

A 2008 settlement agreement requires improved mental health care services at Taycheedah by 2012.

As noted, the federal Department of Justice began an investigation of inmate mental health care at Taycheedah Correctional Institution in 2005. In May 2006, a findings report was issued, citing mental health care services that did not meet constitutional standards. A conditional settlement reached in September 2008 provides that the federal Department of Justice will dismiss its complaint if DOC ensures mental health care at Taycheedah complies with a set of negotiated standards by September 2012. If compliance cannot be demonstrated by that time, the federal Department of Justice reserves the right to reinstate its complaint in federal court.

The settlement sets specific standards for all major aspects of mental health care services at Taycheedah Correctional Institution, which are listed in Appendix 8. For example:

- all inmates with mental health needs or serious mental illnesses must have individualized treatment plans that are regularly updated;

- inmates housed in the special management unit must participate in at least ten hours per week of therapeutic activity, including one hour of individual contact with psychological services staff;

- psychiatry staffing levels must be sufficient for psychiatrists to see all inmates in need of care, prescribe and monitor medications, help develop treatment plans, and collaborate with psychological services staff; and

- psychological services staff must review disciplinary charges for inmates with serious mental illnesses and provide written information regarding mental health factors that may have influenced the inmates' behaviors.

The agreement also requires that a consultant jointly appointed by DOC and the federal Department of Justice be given full access to Taycheedah Correctional Institution in order to assess the State's progress in implementing the settlement agreement. The consultant is required to issue a report four months after the date of the settlement and every six months thereafter. In October 2008, the consultant was hired at an estimated annual cost of $27,000 to monitor DOC's progress and issue the necessary reports.

☑ Recommendation

We recommend the Department of Corrections report to the Joint Legislative Audit Committee by January 4, 2010, on the findings reported by the consultant regarding DOC's progress in implementing the settlement agreement with the federal Department of Justice.

The cost of improvements in mental health care for female inmates has been substantial. For example, 2007 Wisconsin Act 20, the 2007-09 Biennial Budget Act, authorized $11.1 million in general obligation bonding to construct a 45-bed addition to WRC specifically for female inmates. Currently, WRC houses only male inmates. The project is in the design phase, with groundbreaking anticipated in July 2009 and completion scheduled for February 2011. 2009 Assembly Bill 75, the Governor's 2009-11 biennial budget proposal, requests $4.7 million in GPR and 113.0 FTE positions to provide services to the female inmates at WRC once the addition is complete, as well as $881,500 in GPR and 15.1 FTE security staff positions.

The Governor's FY 2009-11 budget proposal includes additional treatment and security staff at Taycheedah.

Meanwhile, improvements continue at Taycheedah Correctional Institution. In addition to the opening of a special management unit in 2002, staffing and services increased in the 2007-09 biennium, and additional increases are requested for the 2009-11 biennium. For example, 2007 Act 20 appropriated $2.3 million and authorized an additional 38.0 FTE positions to improve prison health care, including 11.25 FTE positions specifically authorized to enhance mental health services at Taycheedah. 2009 Assembly Bill 75 proposes an additional $1.0 million and 20.90 FTE treatment and security staff for mental health services at Taycheedah. The Governor's 2009-11 capital budget request has not yet been submitted to the Legislature, but DOC has asked for an additional $7.6 million in GPR bonding to build additional space at Taycheedah to house enhanced treatment facilities.

Setting Priorities for Improving Inmate Mental Health Services

DOC's proposed budget for the 2009-11 biennium requested an additional $4.6 million in GPR and 31.05 FTE positions for other facilities in order to make incremental progress toward the level of care prescribed in the Taycheedah settlement agreement by, for example:

- creating a new medium security special management unit at Oshkosh Correctional Institution;
- adding psychological services staff to existing special housing units; and
- adding psychiatry staff to provide the equivalent of 1.0 FTE psychiatrist for every 250 male inmates on psychotropic medications, to move closer to the American Psychiatric Association's recommended ratio of 1:150.

These proposals were not included in the Governor's 2009-11 biennial budget proposal because of current budget constraints and other spending priorities.

Settlements or judgments against the State in 18 inmate health care lawsuits totaled $4.8 million.

If the Legislature appropriates additional funding for mental health services in the future, it may help to reduce costs in other areas. For example, although the majority of lawsuits are dismissed or result in judgments in the State's favor, 18 cases related to inmates' physical or mental health have resulted in $4.8 million in payments by the State since June 2003. These include:

- $1.4 million in attorneys' fees paid to the plaintiffs of the Supermax lawsuit, under the settlement that resulted in the removal of seriously mentally ill inmates from the institution;

- $475,000 in damages paid under a 2007 settlement with an inmate who alleged that his seclusion and harsh treatment by guards at Supermax in 2001 worsened his mental illness; and

- $735,000 in damages and attorneys' fees paid under a 2008 settlement with the family of an inmate who committed suicide at Taycheedah Correctional Institution in 2006.

In addition, the Wisconsin Department of Justice, which typically defends DOC and other state agencies against lawsuits, estimates that its staff costs for DOC inmate health care litigation total approximately $1.1 million annually, with an additional $372,400 in travel and expert witness expenses for the period from July 2004 through December 2008. DOJ notes that it is difficult to differentiate between cases pertaining to medical issues and those pertaining to mental health care issues, in part because many lawsuits address both. Nevertheless, DOJ has estimated that approximately one-half of all inmate health care cases relate specifically to mental health.

Improved management of mental illnesses among inmates may also reduce expenditures for worker's compensation claims or emergency room costs, although additional cost reductions are difficult to calculate. Similarly, recidivism may be reduced by improved management of mental illnesses and continued emphasis on release planning. Finally, we note the recommendations made in this report should improve DOC's ability to monitor and assess issues related to mentally ill inmates and provide more effective services.

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Appendix 1

Mental Health Care Expenditures by Institution

Department of Corrections

Institution	FY 2003-04	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08
Maximum					
Taycheedah[1]	$ 451,300	$ 603,200	$ 728,600	$ 950,500	$1,078,500
Dodge	623,400	681,500	785,300	911,200	930,900
Waupun	337,500	382,500	358,800	564,000	649,900
Columbia	449,300	487,100	551,500	573,600	635,100
Green Bay	302,400	391,000	399,500	480,700	493,300
Wisconsin Secure Program Facility	291,700	279,700	297,900	412,200	453,200
Subtotal[2]	2,455,700	2,824,900	3,121,400	3,892,200	4,240,900
Medium					
Oshkosh[3]	812,700	851,800	834,900	912,300	923,600
Racine[4]	533,600	620,300	653,200	790,500	803,400
Milwaukee Secure Detention Facility	448,200	575,400	670,800	760,700	711,300
Redgranite	300,600	355,800	446,600	471,000	501,500
Jackson	486,200	453,500	503,700	566,800	496,500
New Lisbon[5]	41,800	332,000	345,100	449,400	474,500
Stanley	278,800	301,900	461,900	500,700	450,600
Kettle Moraine	325,200	368,500	315,100	389,100	433,200
Racine Youthful Offender	323,000	419,100	363,100	306,600	366,000
Fox Lake[6]	274,800	298,000	270,500	327,400	340,000
Prairie du Chien[7]	60,400	61,800	0	70,900	110,100
Subtotal[2]	3,885,300	4,637,800	4,864,900	5,545,500	5,610,800
Minimum					
Oakhill	280,700	299,400	316,600	354,900	358,800
Chippewa Valley[8]	0	48,800	67,700	81,100	71,600
Women's Correctional Centers[9]	35,500	96,800	73,300	96,400	124,500
Wisconsin Correctional Center System	1,900	12,000	12,100	11,900	12,000
Subtotal[2]	318,100	457,100	469,700	544,500	566,900
Bureau of Health Services					
Psychotropic Medication[10]	5,409,500	5,364,600	4,601,500	5,011,400	6,067,500
LTE Psychiatry Expenditures[10]	1,828,000	2,128,700	2,035,100	2,769,400	3,194,600
Other[11]	359,100	498,800	534,600	595,900	604,900
Contract Costs[10]	93,500	84,800	321,500	188,900	264,600
Subtotal[2]	7,690,200	8,077,000	7,492,700	8,565,600	10,131,500

Institution	FY 2003-04	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08
DOC Security at WRC[12]	$ 5,201,000	$ 5,701,000	$ 5,608,300	$ 6,225,600	$ 6,436,600
Total[2]	**$19,550,300**	**$21,697,700**	**$21,557,100**	**$24,773,400**	**$26,986,700**

[1] Taycheedah Correctional Institution houses maximum and medium security female inmates. Expenditures at Taycheedah include amounts for the institution's dual diagnosis substance abuse and mental health treatment program, which totaled $219,000 in FY 2007-08.

[2] Totals may not sum because of rounding.

[3] Expenditures at Oshkosh Correctional Institution include amounts for the institution's dual diagnosis substance abuse and mental health treatment program, which totaled $406,200 in FY 2007-08.

[4] Includes expenditures for Sturtevant Transitional Facility.

[5] New Lisbon Correctional Institution opened in April 2004.

[6] Fox Lake Correctional Institution houses medium and minimum security inmates.

[7] Mental health staff from the Wisconsin Secure Program Facility provided treatment to inmates at Prairie du Chien Correctional Institution in FY 2005-06.

[8] Chippewa Valley Correctional Treatment Facility opened in April 2004.

[9] Includes three minimum security correctional centers that are part of the Wisconsin Women's Correctional System.

[10] These expenditures result from services provided at institutions. However, DOC records do not allow these expenditures to be accurately identified by institution.

[11] Includes costs associated with Bureau of Health Services mental health management staff.

[12] DOC correctional officers provide security services at the Wisconsin Resource Center.

Appendix 2

Prescription Drugs with Highest DOC Expenditures

FY 2007-08

Drug Name (Brand)[1]	Commonly Prescribed for[2]	Expenditures
Quetiapine (Seroquel)	Psychotic disorders	$ 1,676,600
Risperidone (Risperdal)	Psychotic disorders	1,504,800
Ziprasidone (Geodon)	Psychotic disorders	1,111,100
Fluticasone/Salmeterol (Advair)	Asthma	1,023,400
Venlafaxine (Effexor)	Depression	723,300
Interferon-Pegylated (Peg-Intron)	Hepatitis C	593,500
Olanzapine (Zyprexa)	Psychotic disorders	588,200
Emtricitabine/Tenofovir (Truvada)	HIV/AIDS	360,200
Insulin Glargine (Lantus)	Diabetes	355,500
Omeprazole (Prilosec)	Ulcers, acid reflux	351,700
Atorvastatin (Lipitor)	Cholesterol	350,000
Epoetin Alfa (Epogen, Procrit)	Anemia	320,900
Aripiprazole (Abilify)	Psychotic disorders	311,000
Efavirenz/Emtricitabine/Tenofovir (Atripla)	HIV/AIDS	310,400
Albuterol	Asthma	269,800
Atazanavir (Reyataz)	HIV/AIDS	249,800
Divalproex (Depakote)	Mood instability/Epilepsy	246,000
Glucometer Strips	Diabetes	234,400
Tamsulosin (Flomax)	Enlarged prostate	231,300
Losartan (Cozaar)	Hypertension	231,100
Total[3]		**$11,043,000**

[1] DOC reports using generic medications when available. Brand names are listed for reference.

[2] Some drugs may also be prescribed for uses other than those listed.

[3] Total estimated expenditures for the 20 drugs listed, based on the value of drugs dispensed from Central Pharmacy. Actual expenditures are lower because of repackaging of unused medications and cost savings from manufacturer refunds.

Appendix 3

Authorized Full-Time Equivalent Mental Health Positions by Institution[1]

Department of Corrections

Institution	FY 2003-04	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08
Bureau of Health Services[2]	2.00	2.00	2.00	2.00	3.00
Maximum Security					
Taycheedah[3]	10.00	10.00	11.50	11.50	14.00
Dodge	11.50	11.00	11.00	11.50	11.50
Green Bay	5.25	5.25	6.25	6.25	6.25
Columbia	7.00	7.00	7.00	7.00	7.00
Waupun	5.50	5.50	5.50	5.50	5.50
Wisconsin Secure Program Facility	5.50	5.50	5.50	5.50	5.50
Subtotal	44.75	44.25	46.75	47.25	49.75
Medium Security					
Oshkosh	13.50	13.50	13.50	13.50	13.50
Racine[4]	7.50	8.00	8.00	8.00	8.00
Milwaukee Secure Detention Facility	6.00	7.00	8.00	8.00	7.00
Jackson	6.00	6.00	6.00	6.00	6.00
Stanley	7.00	7.00	7.00	7.00	7.00
Racine Youthful Offender	6.00	6.00	5.00	5.00	5.00
Redgranite	6.00	6.00	6.00	6.00	6.00
New Lisbon	7.00	6.00	6.00	6.00	6.00
Kettle Moraine	4.50	4.50	4.50	4.50	5.00
Fox Lake[5]	3.60	3.60	3.60	3.60	3.60
Prairie du Chien[6]	1.00	1.00	1.00	1.00	1.00
Subtotal	68.10	68.60	68.60	68.60	68.10
Minimum Security					
Oakhill	3.50	3.50	3.50	3.50	3.50
Chippewa Valley[7]	1.00	1.00	1.00	1.00	1.00
Women's Correctional Centers[8]	1.00	3.00	1.50	1.50	2.00
Wisconsin Correctional Center System[9]	0.00	0.00	0.00	0.00	0.00
Subtotal	5.50	7.50	6.00	6.00	6.50
Total	**120.35**	**122.35**	**123.35**	**123.85**	**127.35**

[1] Taycheedah and Oshkosh Correctional Institutions include positions for each institution's dual diagnosis substance abuse and mental health treatment program. In FY 2007-08, Taycheedah employed 2.5 FTE dual treatment staff and Oshkosh employed 6.25 FTE dual treatment staff.

[2] Includes Bureau of Health Services mental health management staff.

[3] Taycheedah houses maximum and medium security female inmates. A psychologist supervisor at Taycheedah also provides clinical oversight to psychological services staff at three minimum security correctional centers that are part of the Wisconsin Women's Correctional System.

[4] Racine mental health staff also provide treatment for Sturtevant Transitional Facility inmates.

[5] Fox Lake Correctional Institution houses medium and minimum security inmates.

[6] A psychologist supervisor at the Wisconsin Secure Program Facility also provides mental health treatment for inmates at Prairie du Chien Correctional Institution.

[7] A psychologist supervisor from Stanley Correctional Institution also provides mental health treatment at Chippewa Valley Correctional Treatment Facility.

[8] Includes the three minimum security correctional centers that are part of the Wisconsin Women's Correctional System.

[9] Correctional center inmates typically receive mental health treatment at nearby DOC adult institutions.

Appendix 4

Limited-Term Employees Providing Mental Health Care[1]

Department of Corrections

Institution	FY 2003-04	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08
Bureau of Health Services[2]	2.21	2.36	3.87	4.38	4.00
Institution Psychiatrists[3]	7.23	8.41	8.05	10.72	11.49
Maximum Security					
Taycheedah[4]	0.00	0.00	0.00	1.23	1.36
Waupun	0.00	0.00	0.20	1.08	0.89
Columbia	0.00	0.00	0.00	0.35	0.34
Green Bay	0.15	0.48	0.10	0.00	0.16
Dodge	0.05	0.18	0.00	0.00	0.05
Wisconsin Secure Program Facility	0.00	0.43	0.48	0.15	0.00
Medium Security					
Milwaukee Secure Detention Facility	0.00	0.00	0.25	1.11	2.88
Racine Youthful Offender	0.00	0.00	0.00	0.10	0.14
Oshkosh	0.00	0.00	0.00	0.22	0.10
Kettle Moraine	0.18	0.32	0.28	0.31	0.00
Minimum Security					
Wisconsin Correctional Center System	0.02	0.10	0.10	0.10	0.10
Total[5]	**9.84**	**12.28**	**13.33**	**19.75**	**21.51**

[1] Estimates based on hours worked during the fiscal year.

[2] Includes primarily psychological interns who provide services at institutions.

[3] DOC records do not allow for accurate identification of psychiatrist hours by institution.

[4] Taycheedah Correctional Institution houses maximum and medium security female inmates. Includes 335 hours in FY 2006-07 and 548 hours in FY 2007-08 for Taycheedah's dual diagnosis substance abuse and mental health treatment program.

[5] Totals may not sum because of rounding.

Appendix 5

Descriptions of Selected Mental Health Disorders

Disorder	Description
Adjustment Disorder	A temporary disorder characterized by a severe emotional reaction to a stressful life event that impairs a person's ability to function in daily life.
Anxiety Disorders	Disorders characterized by persistent, excessive, and unrealistic worry.
Attention Deficit Hyperactivity Disorder	A disorder characterized by pervasive inattention and/or hyperactivity/impulsivity, which impairs a person's ability to function in daily life.
Bipolar Disorder	A severe mental illness characterized by dramatic mood swings that fluctuate between feelings of euphoria, extreme optimism, and inflated self-esteem and feelings of sadness, anxiety, guilt, and hopelessness.
Depressive Disorders	Depressive disorders, including major depressive disorder and dysthymia, are characterized by feelings of sadness and a loss of interest in one's usual activities, impairing the ability to function in daily life. Major depressive disorder, which is a severe mental illness, may include feelings of despair, hopelessness, and thoughts of suicide.
Impulse Control Disorders	Disorders in which an individual is unable to resist the urge to act on a certain potentially harmful impulse. Includes intermittent explosive disorder, which is characterized by repeated episodes of aggressive, violent behavior that are grossly out of proportion to the situation.
Personality Disorders	Personality disorders are characterized by a rigid, potentially self-destructive way of thinking, behaving, and relating to others. Includes borderline personality disorder, which is characterized by a lack of one's own identity, emotional instability, impulsivity, and intense, unstable interpersonal relationships.
Post-Traumatic Stress Disorder	An anxiety disorder that can result following exposure to a terrifying event in which physical harm occurred or was threatened. Individuals with this disorder may experience flashbacks, sleep problems, or may be easily startled.
Schizophrenia	A severe mental illness that may be characterized by a variety of symptoms, such as loss of contact with reality, disorganized thinking and speech, hallucinations, delusions, decreased emotional expressiveness, and social withdrawal. Individuals with this disorder may not be able to distinguish reality from imagination.
Substance Abuse Disorders	Disorders characterized by a maladaptive pattern of substance use resulting in a failure to fulfill obligations of daily life. Individuals with substance abuse disorders continue to use the offending substance despite persistent social or interpersonal problems caused or exacerbated by its effects. Substance abuse often co-occurs with other psychological disorders.

Appendix 6

Worker's Compensation Awards Related to Assaults by Mentally Ill Inmates[1]

FY 2005-06 through FY 2007-08

Institution	Amount Awarded[2]	Percentage of Total	Amount Related to Assaults by Mentally Ill Inmates[3]	Percentage Related to Assaults by Mentally Ill Inmates[3]
Maximum				
Columbia	$77,200	7.5%	$76,500	99.1%
Dodge	45,500	4.4	5,200	11.4
Green Bay	33,500	3.2	25,200	75.2
Waupun	16,000	1.5	14,700	91.9
Wisconsin Secure Program Facility	6,200	0.6	4,600	74.2
Taycheedah[4]	4,900	0.5	4,900	100.0
Subtotal	183,300	17.7	131,100	71.5
Medium				
Racine	209,700	20.3	208,100	99.2
New Lisbon	79,500	7.7	2,000	2.5
Kettle Moraine	45,800	4.4	43,000	93.9
Stanley	37,600	3.6	34,600	92.0
Milwaukee Secure Detention Facility	32,400	3.1	29,900	92.3
Racine Youthful Offender	5,100	0.5	4,900	96.1
Fox Lake[5]	3,900	0.4	3,900	100.0
Oshkosh	3,600	0.3	3,400	94.4
Redgranite	1,700	0.2	1,700	100.0
Subtotal	419,300	40.5	331,500	79.1
Minimum				
Oakhill	8,300	0.8	1,800	21.7
Chippewa Valley	600	0.1	600	100.0
Wisconsin Correctional Center System[6]	200	<0.1	–	–
Subtotal	9,100	0.9	2,400	26.4
Wisconsin Resource Center	423,200	40.9	409,200	96.7
Total	**$1,034,900**	**100.0%**	**$874,200**	84.5

[1] Includes DOC personnel assigned to adult institutions and DOC and DHS personnel assigned to WRC.

[2] Does not include five awards totaling $61,632 for which we could not determine the inmates' mental health status.

[3] Includes inmates identified as having a mental health need (MH-1) and inmates identified as seriously mentally ill (MH-2) before the assaults.

[4] Taycheedah Correctional Institution houses maximum and medium security female inmates.

[5] Fox Lake Correctional Institution houses medium and minimum security inmates.

[6] Includes inmates at both men's and women's correctional centers.

Appendix 7

DOC's Time Line for Benefits Application Assistance

Days before Release	Activity
180 days	Identify offenders who may be eligible for Social Security benefits. Initiate case tracking of Social Security application process.
150 days	Help offenders complete forms to authorize release of information to SSA. Contact SSA to determine forms needed for individual cases.
120 days	Assist eligible offenders in completing forms for disability assistance. Obtain medical/psychological documentation to support disability claims.
90 days	Submit disability claims and supporting documentation to SSA.
60 days	Contact local SSA office if eligibility determinations have not been made. Review denied claims. Determine whether Medical Assistance application should be made. Refer offenders to entities that assist with appeals.
45 days	Help offenders complete Social Security applications for nondisability benefits.
30 days	Submit nondisability Social Security applications to SSA. Help offenders complete Medical Assistance applications.
23 days	Submit Medical Assistance applications to the county/tribal agency where offender will be living.
10 days	Contact county/tribal agency to determine status of Medical Assistance applications. Review Medical Assistance denials. Assist offenders in filing appeals.
Day of Release	Notify SSA and county of offenders' release. Provide contact information for offenders and probation and parole agents.

Appendix 8

Standards of Mental Health Care at Taycheedah Correctional Institution[1]

Department of Corrections

	Title	Standard	Key Terms
1	Serious Mental Health Needs	The State shall provide services to address the serious mental health needs of all inmates.	▪ Refer to standards below.
2	Psychiatric Treatment	The State shall retain enough psychiatrists to ensure that the needs of inmates with serious mental illness are addressed, and that inmates on psychotropic medications are seen regularly for monitoring.	▪ The State shall hire psychiatrists for a sufficient number of hours per week to see patients, prescribe and monitor medications, help develop treatment plans, review and respond to test results, collaborate with psychological services staff, and communicate with institution staff.
3	Administration of Mental Health Medications	Policies, procedures, and practices shall be implemented to ensure psychotropic medications are prescribed, distributed, and monitored properly and safely.	▪ Qualified health care professionals shall administer medications to inmates in the special management unit and the segregation unit. ▪ Appropriately trained staff shall deliver medications to inmates in general population housing units. ▪ Corrections staff that administer medications shall receive training at orientation and annually thereafter.
4	Serious Mental Illness Training	The State shall conduct training for all security staff on recognizing and responding to symptoms of serious mental illness.	▪ Security staff shall be provided eight hours of training when they begin employment. ▪ Security staff shall be provided three additional hours of training annually.
5	Mental Health Screening	All inmates shall receive mental health screenings from trained staff upon entering the institution.	▪ Nursing staff shall conduct an initial mental health screening on the day an inmate enters the institution. ▪ Inmates taking psychotropic medications before intake shall be assessed no later than ten days after intake regarding their need to continue medications.
6	Mental Health Assessment and Referral	All inmates whose screenings or health histories indicate a need for mental health assessment shall receive an assessment and ongoing treatment from mental health staff.	▪ Psychological services staff shall conduct assessments within 72 hours of an inmate's intake from outside Department custody. ▪ Psychological services staff shall review the file of an inmate on the mental health caseload within 5 working days of transfer from another DOC facility. ▪ Inmates shall have access to a confidential system for requesting non-emergency mental health care. ▪ Inmate requests shall be processed within 24 hours, and urgent requests shall receive responses immediately. ▪ Non-urgent requests shall receive responses within 3 working days of receipt.

	Title	Standard	Key Terms
7	Mental Health Treatment Plans	All inmates who require mental health services shall have an individual treatment plan developed by a mental health professional and implemented.	▪ Comprehensive treatment plans shall be developed for all inmates requiring a special management unit level of care, and updated at least every six months. ▪ Outpatient treatment plans shall be developed for all inmates requiring outpatient-level care, and updated annually.
8	Crisis Services	Crisis services shall be available to inmates during psychiatric emergencies, and inpatient psychiatric care shall be available to inmates when appropriate.	▪ Inmates shall have access to crisis services that include staff contacts, observation placement, psychiatric intervention, emergency room care, and inpatient psychiatric care.
9	Treatment for Inmates with Serious Mental Illnesses	Therapy, counseling, and other mental health programming shall be available to all inmates with serious mental illnesses.	▪ Inmates with serious mental illnesses in the special management unit shall be provided at least ten hours per week of therapeutic activity, including one hour of individual contact with psychological services staff. ▪ Staffing shall be sufficient to provide inmates with serious mental illnesses in general population units with an average of one individual contact with psychological services staff every four weeks, and an average of four group therapy programs per year. ▪ Staffing shall be sufficient to provide inmates on the mental health caseload without serious mental illness with an average of one individual contact with psychological services staff every six weeks, and an average of two group therapy programs per year.
10	Review of Disciplinary Charges for Inmates with Serious Mental Illnesses	Disciplinary charges against inmates with serious mental illnesses shall be reviewed to ensure that inmates are not punished for behavior resulting from their illnesses, and to ensure that inmates' serious mental illnesses are a mitigating factor in punishments when appropriate.	▪ Disciplinary charges for inmates with serious mental illnesses will be reviewed by psychology staff. ▪ Reviewing staff will provide written input regarding mental health factors that may have influenced the behavior associated with the disciplinary charges.
11	Procedure for Inmates with Serious Mental Illnesses Who Are in Segregation or Observation Status	Inmates with serious mental illnesses in segregation shall receive treatment.	▪ All inmates on the mental health caseload shall be evaluated by psychological services staff within one working day of their placement in segregation. ▪ Inmates in segregation with a special management unit level of care shall be provided ten hours per week of therapeutic activity, including one hour of individual contact with psychological services staff. ▪ Inmates in segregation on the mental health caseload but without serious mental illnesses shall be provided at least two hours per week of therapeutic activity, and at least one weekly opportunity to request individual contact with psychological services staff. ▪ Inmates in segregation or the special management unit who require a special management unit level of care shall be provided ten hours per week of recreation.

	Title	Standard	Key Terms
12	Medical and Mental Health Record System	A record-keeping system shall be maintained that makes all documents relating to treatment of inmates with serious mental illnesses available to treatment staff.	▪ Psychological services files shall include a complete record of mental health care documentation. ▪ Psychiatry records and copies of psychological services documents shall be included in inmates' health services files.
13	Medication and Laboratory Orders	Orders for medications and laboratory tests related to mental health care shall be filled in a timely manner, and related policies and procedures shall be periodically evaluated to ensure delays are prevented.	▪ Psychotropic medication and laboratory test orders shall be processed within 24 hours of being written. ▪ Staff who administer medications shall notify health services staff if an inmate refuses or fails to take psychotropic medications for three consecutive days.

[1] Established under the terms of DOC's September 2008 settlement agreement with the federal Department of Justice.

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Janice Mueller, State Auditor
Legislative Audit Bureau
22 East Mifflin Street, Suite 500
Madison, WI 53703

Dear Ms. Mueller:

We have completed our review of the Legislative Audit Bureau's report on mental health services within the Department of Corrections and appreciate the opportunity to examine and comment on the content. We believe that such an audit will add value to the discussion of how we best meet the needs of inmates with mental illness. We appreciate the care and professionalism of the Legislative Audit Bureau staff while they conducted this audit.

There is a now a broad consensus among correctional administrators and mental health advocates that the number of mentally ill inmates who are in correctional settings is increasing. As your report indicates, we have seen a significant increase in mentally ill inmates within our department over the last several years. The challenges we face are significant. Providing effective mental health treatment in a prison environment requires that we prioritize needs, use our resources wisely, and increasingly value rehabilitation and treatment approaches as we strive to maintain safe and secure facilities.

In your report you include a brief description of how you employ the term "mental illness", defined as those inmates who are classified as either MH-1 (having a mental health need) or MH-2 (having serious mental illness). We believe that this definition deserves to be highlighted, since "mental illness" can have a variety of meanings depending on the source data and the definition of illness used. You correctly point out that your definition of mental illness is an inclusive one and meant to designate inmates who are on the mental health caseload at a given point in time. Note that under this definition, inmates who have mild or time-limited conditions, personality-based problems, or conditions that do not rise to the level of a formal diagnosis are still defined as mentally ill by virtue of being engaged in treatment at the time of data collection.

Your report correctly states that there are no Special Management Units for mentally ill inmates in medium security prisons. The Department has an interest in developing such units, although recognizes that additional staff resources would be required to make this a reality. Starting in 2007, the Department developed an alternative model, Special Housing Units, which are now present within at least five medium-security institutions. These Special Housing Units allow for more flexible disciplinary approaches as well as providing some programming without requiring a significant influx of staff resources. We believe that this direction begins to address the need for specialized housing for mentally ill and at the same time recognizes current fiscal realities.

Your report reviews the operations of the Wisconsin Resource Center and the processes that govern transfers between this facility and DOC institutions. We agree that clearer policies regarding transfers, admission criteria and bed utilization would be beneficial and look forward to collaborating with the Department of Health Services to develop these.

Your report correctly states that the suicide rate in Wisconsin prisons is significantly higher than the national average for prisons. This issue has been a cause of considerable concern for the Department and in recent years we have developed new policies, procedures and training to address this problem. Suicide numbers from the past two fiscal years show a trend towards lower rates and we are hopeful that this reduction will continue. Data not published in your report also shows a reduction in serious, but non-lethal attempts since 2005 when new policies started to be implemented.

Much of the data in your report regarding suicide rates and comparisons was gathered in 2001-2002. Due to the more remote time frame, we are concerned that such data may be misleading and not reflective of more current trends.

Your report outlines the amount spent by the Department on mental health treatment for released inmates, citing, for example, amounts spent for contracted psychiatric and psychological services in various counties. We note that these amounts reflect only a portion of the resources devoted to mentally ill inmates post release, and do not include services such as transitional housing or treatment for substance abuse programs or other recidivism-based programs.

Your report describes the Conditional release model employed by the Department of Health Services for individuals who are adjudicated Not Guilty by Reason of Mental Disease or Defect and court-ordered for release to the community from one of the state mental health institutes. We value such an intensive community treatment approach for individuals with serious mental illness and would welcome the opportunity and resources to develop this further.

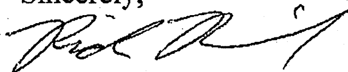
However, it is important to recognize that the inmates with serious mental illness who are currently in the Conditional Release Program represent a more stable population of individuals than inmates who would be served from the Department of Corrections. Current program participants who are released from DHS facilities need to navigate a process designed to enhance the chance for success, including stability on an inpatient unit, a positive evaluation from an outside mental health expert, and concurrence of the court. In contrast, inmates with serious mental illness who are released from the Department of Corrections generally do so on a pre-determined date regardless of symptoms, stability, motivation, or treatment compliance.

Although considerable work remains, the Department has taken many strides to improve mental health care to inmates. The following are highlights of ongoing efforts.

- Development of Special Handling Units to provide specialized housing for inmates with serious mental illness.
- Stricter oversight of the psychotropic medication formulary to improve quality of care and decrease costs.
- Greater time devoted to assisting mentally ill inmates with re-entry into the community.
- Development of Quality Improvement protocols to track treatment outcomes.
- Development of additional and more specific policies and procedures to govern mental health treatment.
- Developing additional training for correctional officers in the area of mental illness.

Thank you for the opportunity to provide comments. We look forward to implementing the recommendations in the report.

Sincerely,



Rick Raemisch
Secretary

State of Wisconsin
Department of Health Services

Jim Doyle, Governor
Karen E. Timberlake, Secretary

March 13, 2009

Janice Mueller, State Auditor
Legislative Audit Bureau
Suite 500
22 E. Mifflin Street
Madison, WI 53703

Dear Ms. Mueller:

Thank you for the opportunity to respond to the Audit Bureau's evaluation of mental health care services in adult correctional facilities. Audit Bureau staff did a good job collecting and analyzing an extensive amount of complex information on a subject of considerable importance to our department, which is meeting the mental health needs of patients we serve.

As the audit notes, the Wisconsin Resource Center (WRC) is the one department facility that exclusively provides inpatient services to adult inmates with complex mental health needs. We believe the audit accurately describes WRC resources and operations, and our working relationship with the Department of Corrections (DOC). We appreciate the Audit Bureau's recognition that WRC is functioning well, and that the department's Conditional Release program is widely acknowledged as an effective program for managing community placements.

In regard to the recommendation to clarify and document the process for transferring inmates between the WRC and DOC prisons, DHS will work collaboratively with DOC to address this recommendation and provide a report to the Committee by January 4, 2010.

Sincerely,

Karen E. Timberlake

Karen Timberlake
Secretary

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