Ombudsman for Corrections
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PREFACE

In 1994 the Ombudsman for Corrections investigated the death of an inmate at a Minnesota Corrections Facility.[1] The investigation identified issues related to identification and treatment of seriously mentally ill inmates committed to the Department of Corrections.

During that initial investigation, other mentally ill inmates came to the attention of the Ombudsman, and additional questions were raised regarding the services that had or had not been provided them. Two of those inmates who were patients at the mental health unit are the subjects of this investigative report.

The Ombudsman is concerned that the problems are more pervasive than those discovered in this five month investigative period, and are beyond the scope of expertise and available resources of the Ombudsman for Corrections to investigate more extensively.

The number of inmates incarcerated in Minnesota's state correctional system is increasing. In 1982, when the twenty-two bed mental health unit was opened at the Minnesota Correctional Facility - Oak Park Heights (MCF-OPH),[2] there were 2278 adult males incarcerated. In July 1994, the Department of Corrections records indicates there were 4273 adult males incarcerated in the system.[3]

In 1993, Dr. Carlson, Health Services Director of the Oak Park Heights - Mental Health Unit (OPH-MHU) estimated that two to four percent of the inmate population is seriously mentally ill. Patricia Hughes, who was an Assistant State Public Defender then recalled that the DOC listed only twenty-five inmates with serious mental illness out of a total of 3,300 state inmates. She thought the numbers should probably

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[1]Ombudsman Investigative Report 94-1.

[2]The mental health unit at OPH-MHU is designated for use by the adult male inmates.

[3]Reports from July 1, 1994 - Minnesota Department of Corrections.

be closer to ten percent of the 1,350 - 1,400 inmates at the Minnesota Correctional Facility at Stillwater (MCF-STW), where she worked.[4]

Although it is difficult to reach consensus on the term, "mentally ill offender," it is something that has been studied on national and local levels.

> "Surveys of facility administrators suggest that six to eight percent of adjudicated felons are currently being designated as seriously mentally ill. Clinical studies; however, suggest that ten to fifteen percent of prison populations have a major DSM-III-R thought disorder or mood disorder and need the services usually associated with severe or chronic mental illness: medications, day treatment, case management and specialized housing . . . (James et.al 1980; Neighbors 1987).[5]"

> ". . . Steadman, Dvoskin and their colleagues . . . conducted a survey of the inmates in the New York State prison system to determine the extent of psychiatric disabilities among inmates. The results showed that five percent of inmates were 'severely psychiatrically disabled,' demonstrating psychopathology similar to that found in state psychiatric center acute inpatients. Another ten percent were 'significantly psychiatrically disabled' similar to patients in crisis beds in the community."[6]

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[4]Jennifer Vogel, Life in Hell - Warehousing the Mentally Ill in Minnesota Prisons, **City Pages**, February 24, 1993, pg.10.

[5]National Coalition for the Mentally Ill in the Criminal Justice System, "Mental Illness in America's Prisons," October, 1993.

[6]Ibid at pg. 61.

In March, the Ombudsman contacted the DOC institutions to survey the numbers of inmates prescribed psychotropic medications[7] to understand the numbers of mentally ill inmates in the Minnesota system. The results of this study are:

DOC ADULT MALE INSTITUTIONS

INSTITUTION	DATE	INMATE POPU-LATION	INMATES ON MEDICATION	PERCENT-AGE OF INMATES
Stillwater	3/14/94	1,350	222	.164
Oak Park Heights	3/15/94	395	64	.162
Red Wing (Adult)	3/16/94	94	4	.043
Lino Lakes	3/16/94	530	36	.068
Willow River	3/28/94	44	1	.023
Moose Lake	3/28/94	220	1	.005
Faribault	3/16/94	550	57	.104
St. Cloud	3/15/94	845	56	.066
TOTAL		4,028	441	.110

These figures indicate that 11% of the adult male inmate population were prescribed psychotropic medications in March 1994.[8]

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[7]Medications prescribed for serious psychiatric disorders.

[8]MCF - Red Wing (juveniles) - as of 3/16/94 had a population of 94 with 12 on medications for a percentage of .128.

MCF - Shakopee (adult females) - as of 3/15/94 had a population of 150 with 32 on medications for a percentage of .213.

The Ombudsman requested information regarding accreditation and/or licensing standards for the mental health unit. We were provided with a copy of the fifty-two American Correctional Association (ACA) standards that cover mental health services and a memo stating:

> "ACA does not give an "accreditation report"; it gives "% compliance". For the past two accreditation audits, the mental health unit (including Health Services) has received ratings of 100%.
>
> The only other accreditation or licensing is the annual inspection by the Department of Health of the infirmary and medical services."

Some prison's medical and mental health facilities, the Minnesota Security Hospital and many community hospitals seek JCAHO accreditation.[9] This is generally considered a rigorous accreditation of all aspects of medical services including evaluation methods regarding the quality of services provided. The DOC does not seek this accreditation.

Because of the concerns identified in these investigations, the Ombudsman is making the following recommendations:

> **1. That the Department of Corrections conduct an administrative review examining the policies and practices of the department that relate to the identification and treatment of the mentally ill inmates to ensure that the policies are adequate and the practices are in compliance with good mental health practices and constitutional standards.**

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[9]JCAHO - Joint Commission on Accreditation for Health Care Organizations.

2. That the Department of Corrections evaluates the psychiatric and mental health staff-to-inmate ratios to ensure that adequate numbers of staff are available to meet the needs of the growing inmate population. If additional staff resources are needed, they should be requested.

3. That the Department of Corrections conduct an evaluation to determine if the twenty-two mental health unit beds are sufficient to meet the needs of the department as an acute care unit and a stabilizing treatment unit for the adult male mental health population. Additional resources should be developed if recommended by the study.

4. That the Department of Corrections review the standards used for emergency holds and contacting the courts for judicial commitment of the seriously mentally ill in an appropriate and timely manner. If changes are needed, they should be implemented.

5. That the Department of Corrections establish an independent review board to provide a quality assurance review of the treatment provided to those inmates at the mental health unit and within the department's institutions to ensure that the treatment practices are in compliance with acceptable mental health treatment standards.

6. That the Department of Corrections establish a special needs unit to deal with the vulnerable, mentally ill and developmentally delayed inmates. That this unit be staffed with case managers and correctional officers specifically trained to deal with this special population.

CASE A

In 1994, the Ombudsman received a copy of a court petition that was filed for judicial commitment of this inmate to the mental health unit.

The Ombudsman attended that court hearing and was alarmed after seeing the inmate's physical and mental condition. The Ombudsman has attended the subsequent court hearings. In addition, the Ombudsman has discussed this case with the inmate's attorney for the commitment proceedings and the court appointed psychiatrist for purposes of the Jarvis hearing.[10] Both expressed their concern with his condition at the time he came to the attention of the court.

The attorney noted that he had a history with this inmate; he had been his attorney of record when the matter was before the court for judicial commitment several years earlier. The psychiatrist noted that she had been the court appointed psychiatrist in the past for some DOC inmates brought before the court for Jarvis hearings. She suggested we obtain a copy of the **City Pages** article cited in this report. She mentioned that she had been involved in some of these cases and had concerns at the time about the length of time it took to get these seriously mentally ill inmates treatment in the prisons.

FACTS OF THE CASE

This inmate was admitted the DOC in 1993. It was his second commitment.

The records indicate:

> ". . . since this admission to the DOC, the inmate has demonstrated odd behavior such as sitting and standing for long periods of time and urinating on his cell floor . . . he will not communicate; although it is not apparent if it is due to his deteriorated mental health

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[10] *Jarvis v. Levine*, 419 N.W. 2d 139 (Minnesota 1988). Court case which establishes judicial process to impose intrusive treatment of neuroleptic medications.

> condition or refusal to cooperate . . . During previous incarcerations, he was able to communicate very well in English."

This inmate was voluntarily admitted to the mental health unit from the general population. There was concern about his vulnerability in the general population. He was:

> ". . . posturing, staring at people in the cell hall."

Other notes indicate that when he was admitted to the unit, there was some edema present in his feet.

In the mental health unit, the inmate was:

> ". . . observed to be standing like a statue staring at people and refusing to respond when spoken to by others . . . There has been no significant change in his behavior . . . "

Other records indicate that medications were offered to the inmate, but he refused to take them. The possibility of commitment and a Jarvis hearing was documented.

Initial reports indicated that:

> ". . . since he has been back at Oak Park Heights he has been posturing, standing on his wash counter, standing on his bed, urinating on the floor and being intermittently mute. The staff observed him to abandon these postures when he is feeling that no one is watching him."

Notes from a six month period indicate:

> " - inmate continues to urinate in his room. <u>We may have to proceed a commitment and force medications if this continues.</u>
>
> - inmate has improved only to the point where he takes his shower alone now without having the squad scrub him down.

> - inmate has shown no improvement and he has shown a tendency to some threatening behavior.
>
> - inmate is reported by staff as doing a bit better in that he tends to his showers and other activities without a lot of prompting or having to get the squad involved. However, he still postures a lot and doesn't communicate very well.
>
> - . . . continues to posture, to be resistant, and sometimes threatening . . . The courts have established this man is feigning mental illness . . . think our willingness to keep him here under these circumstances indicates that we have some doubts about the accuracy of the court's judgment on this. We will have to start commitment proceedings of this man, I believe, in order to get him to take medications that are likely to be helpful to him.
>
> - The staff have reminded me that in the past, when we committed him and given him medications, he stayed on them for an extended period of time . . . It may be worth the trouble to take him to court at this time.
> - inmate continues to void on the floor. His posturing continues.
>
> - inmates legs are healing. His mental state has not changed. I have requested that the commitment procedure be accelerated."

A petition for judicial commitment was prepared. The pre-petition screening report states the presenting problems are:

> "Inmate stands for long periods of time in various postures, which is a symptom of his mental illness. He has recently developed edema and some stasis changes of the feet from this prolonged standing secondary to catatonic behavior.[11] He is now having some breakdown

[11]The Ombudsman notes that notes from his admission date indicate that there was edema present in his feet.

> of the skin and has a stasis ulcer on the medial aspect of his right ankle. He has not been compliant with medical treatment recommendations, including elevation of his feet. He also refuses to take psychotropic mediation for his mental illness."

At the judicial commitment hearing a psychologist testified that:

> "Respondents catatonic posturing has caused poor circulation in his feet, has led to edema, or swelling, of his feet and foot ulcers."

At this hearing a nurse testified on cross examination that:

> ". . . it would be a long time before symptoms would lead to amputation but that it was a possibility if respondent remained untreated for his mental illness."

The pre-petition screening report, indicates the tentative diagnosis as Schizophrenic Disorder - Catatonic Type. Previous diagnosis was - Paranoid Schizophrenia; Depression; Schizophrenia Disorder - Catatonic type; Schizophrenia Undifferentiated Type; Subchronic with Acute Exacerbation; Schizophrenia Undifferentiated in Type with Hebephrenic and Catatonic Features.

The District Court Judge signed an order committing the inmate to the mental health unit.

A month later, a petition was filed for authorization to impose intrusive treatment of a neuroleptic (a Jarvis Hearing). Before this hearing, Patricia Seleen, the Ombudsman, and Maxine Regguinti, Investigator with the Ombudsman, met with the inmate in his cell at the mental health unit. This was not a very productive interview. He didn't communicate in any logical way. He was staring, posturing and making non-sensical statements. He had a strong body odor of urine. After leaving the cell, we both noted that we had probably been standing in urine.

Medications were ordered by the court. Records indicate that the inmate suffers from schizophrenia, catatonic type.

Ms. Seleen and Ms. Regguinti met with the members of the inmate's treatment team to discuss the Ombudsman's concerns about the inmate's condition when they filed for judicial commitment and the course of treatment that had been provided before that time.

The Ombudsman questioned the mental health unit staff about their decision to allow the inmate to remain in an untreated, catatonic state for so long. The psychologist stated that she had been the "holdout" on the team for the decision to intervene; she thought that he had been "faking his illness." She said that they needed a consensus on the team before action would be taken.

The psychiatrist told us that "he was the one that makes the decision to proceed with a judicial commitment and that he wasn't going to take cases to court until he was certain that they would win those cases." He acknowledged the difficulty to treat an individual with such a prolonged illness and admitted that maybe they had waited too long to intervene.

At this meeting, the psychologist stated that she had not had any coherent discussions with the inmate during the 10 months he had been on the unit and the forced medications began. She also noted that he had participated in his latest treatment review. The psychiatrist also noted that he had difficulty in communicating with the inmate during his stay at the mental health unit.

Ms. Regguinti met with the inmate two months after the Jarvis hearing to evaluate how he was doing. She noted that his hygiene was much better. He communicated better with her, although he acknowledged that he did not speak English very well. He requested that she return with a translator and then he could speak easier with her. He said that he did remember her from her earlier visit. Ms. Regguinti concluded that the inmates condition had improved noticeably, this occurring in less than two months since he began receiving medications.

PRIOR HISTORY

In reviewing the inmate's prior DOC records, the Ombudsman learned that during his first incarceration, he had six admissions to the mental health unit. The psychiatrist of record was the same for each of these admissions. The records indicate, that at times, the inmate displayed behavior of being mute, posturing, vacillating between being angry and menacing, delusional thinking, head banging, poor hygiene and urinating on the floor and other places.

Throughout this period, medications had been prescribed for him. The records note that he did not always accept medications, but that there was improvement noted when there was compliance with medications.

During his first incarceration, judicial commitment was sought, and when granted, a subsequent order was requested and granted to force medications for treatment. The diagnosis was Schizophrenic Disorder-Catatonic or Undifferentiated.

Records from that period indicate that his behavior improved with medications, he no longer postured and could manage his own self-care. He was ultimately discharged from the mental health unit to the general population.

INVESTIGATION

Issue: Treatment

In reviewing this case, the Ombudsman questioned if it was reasonable given his history, and the prior treatment of this inmate to wait almost a year before approaching the courts to intervene to help with treatment? Was it reasonable to wait until he had developed ulcers on his feet from his posturing, to the extent that there was discussion regarding amputation, before approaching the courts to intervene?

The Ombudsman doesn't think that this was reasonable.

The American Psychiatric Association (APA) and the Washington State Psychiatric Association filed an *amici*

curiae brief with the U.S. Supreme Court in the case of, *Washington v. Harper*.[12] In this brief the APA argued inmates may benefit from psychotropic medications, even in a case where the inmate wished to refuse the medications. Further, the APA argued:

> ". . . it cannot be overemphasized that antipsychotic medication is prescribed to treat the most serious of psychiatric disorders. Even in those cases that could not be described as emergencies, a two to four month delays in administering treatment can cause harmful and irreversible deterioration of a prisoner's mental condition. (Footnote: See Gutheil, et.al., Legal Guardianship in Drug Refusal: Al Illusory Solution, 137 Am. J. Psychiatry 347 (1980 . . .)"

The Protection and Advocacy for Mentally Ill Individuals Act of 1986 define:

> "(4) The term neglect means a negligent act or omission by any individual responsible for providing services in a facility rendering care or treatment which caused or may have caused injury or death to a mentally ill individual or which placed a mentally ill individual at risk or injury or death and includes an act or omission such as the failure to establish or carry out an appropriate individual program plan or treatment plan for a mentally ill individual, the failure to provide adequate nutrition, clothing or health care to a mentally ill individual. . ."[13]

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[12]*Washington V. Harper* 494 U.S. 210,110 S. Ct. 1028, 108 L.Ed.2d 178 (1990).

[13]United States General Accounting Office, GGD-91-35, Mentally Ill Inmates, April, 1991.

The Ombudsman reviewed the Patient's Bill of Rights provided by the department:

"Inmates' Medical Rights and Responsibilities

At the mental health unit, every inmate has the right to and/or responsibility for . . .

1) considerate and respectful care . . .
14) be free from mental and physical abuse . . .
24) appropriate medical and personal care based on individual needs. Appropriate care means care designed to enable inmates to achieve their highest level of functioning . . .
31) be free from mental and physical abuse as defined in the Vulnerable Adults Protection Act . . . "

CONCLUSIONS

- The inmate's failure to receive appropriate treatment in a timely manner was, in the Ombudsman's opinion, due to negligence.

- Correction officials did not give valid consideration to the inmate's prior treatment and his prior responsiveness to medication.

- The care that the inmate received was not appropriate because it was not sufficient to enable him to achieve his highest level of physical and mental functioning, a violation of the Patient's Bill of Rights.

CASE B

FACTS OF THE CASE

This inmate was committed to the DOC in 1993. The records indicate that he had a history of Schizophrenia and had been taking Thorazine for about three years. This medication was continued following his initial psychiatric evaluation. The inmate indicated that the medication helped him.[14] The records also indicate that he has a full-scale IQ of sixty-five, indicating limited intellectual abilities.

The records indicate that over a three month period, referrals were made to psychological services regarding this inmate.

> " - Marked Urgent - cell is very unsanitary along with his person, he does not leave his cell to eat, sleeps all day and nite.
>
> - Marked Urgent - inmate refuses to keep clothes in his cell. He states that clothes smell moldy and make lights float all around.
>
> - Marked Urgent - Referral to psychiatrist - . . . continues on observation status with 1/2 hr. checks. Pattern is sleep/isolation except at meals. . . Remains on observation due to no opening at MHU. Refused meds and dumped meds in toilet.
>
> - Taken off observation status by psychological services. Remarks: I saw the inmate because he has been on observation for several days[15] . . . He was very appropriate. I saw no psychotic or bizarre behavior.
>
> - Marked Urgent - . . . has missed medication."

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[14]Psychological services report.

[15]The Ombudsman notes that he had been on Observation Status over two weeks.

The inmate was admitted to the mental health unit as a voluntary patient a month after being in segregation. The treatment problems were:

> "#1 - Schizophrenia
>
> Goal - Reduce Schizophrenic Symptoms
> Treatment Mode - Medication
>
> #2 - Hygiene
> Goal - To increase the cleanliness of both himself and his room."
> Treatment Mode - Individual Counseling

About a month later, the inmate was discharged to the general population. The records indicate that there was minimal to no progress:

> "The following aftercare plan is recommended. Since his admission the inmate has consistently refused to participate in unit activities, comes out of his room only for his meals, and requires prompting from staff to shower and clean his room. He shows no interest in benefiting from being on our unit and is not changing. Being in the general prison population again, he might be more motivated to improve his activity level. He ought to see the psychiatrist for continued monitoring of his need for psychiatric medication . . .".

Shortly after his return, more psychological referrals were being made regarding the inmate (these cover a three month period):

> - . . . He has had a problem with his hygiene both times in his stay in this unit. Seems to have a hard time understanding a cell block program. Tends to spend all his time in his cell and misses meals. He does get bread when it comes into the unit. Very slow in response to request to do things . . .
>
> - Marked Urgent - . . . Inmate walked to

H/S,[16] smells terrible and is "unresponsive" . . . Confused, denies thoughts of suicide or harming others. Does not want Rx[17] "makes me feel bad." Believes date to be different than it is.

- Marked urgent - . . . recently has become withdrawn and unresponsive

- while doing count inmate threatened to kill me. Because I closed his door (No notation other than seen by psychiatrist a month later.)

- appeared to be confused - couldn't find cell without assistance of officers . . . question his ability to follow through in rational manner.

- Marked routine - inmate is not showering or cleaning his cell . . . He is also urinating in his pants (Marked seen by psychiatrist two weeks later.)

- Marked Urgent - Refused to take medication this day, that is all medication including blood pressure mediation . . . flat affect . . . please evaluate for 72 hour hold

Other notes state: "It is obvious to this psychologist that inmate has a mental condition affect his perception of reality. He has such mental condition for quite some time. Even though he poses no threat to his own safety at this time, he needs a Treatment Plan for his chronic mental problem. Will refer to chief of psychological services."

- Inmate referred for refusing to take meds. Inmate refused to talk to me and told me "never to come back."

- . . .Inmate was rather placid. Mood was even. Affect was slightly swollen and

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[16]Health Services.

[17]Rx means medication.

uncooperative. Minimal cooperation with this examiner. Reality testing not observed.

- Previous trips to the mental health unit have only resulted in his return for noncompliance.

Does not appear to be suicidal.
Does not warrant 72 hour hold.

Health services should continue to monitor as compliance is a predominately medical issue."

The next record is that of a patient care monitoring conference two weeks later where a report was written. This report indicates only one person attended the conference. The recommendations of this report are:

"(1) Transfer to the mental health unit for 72 hour hold and eventual commitment.
* Continues to need close supervision and care which MHU can provide.
* Primary diagnosis is schizophrenia.
* Behavior continues and creates difficulties for cell hall staff which are not trained, have time for or resources for intervention.
* Attending medical needs are also important and require close supervision
* Limited IQ - not favorable for general population.
* Approximately one year until discharge"

About a week later, an Examiner's Statement in Support of Emergency Hospitalization was signed. The stated reasons for this hold are:

"Inmate is diagnosed as schizophrenic. Inmate is refusing both neuroleptic medications and blood pressure medications. Prison physician has attested that inmate's blood pressure has reached dangerous levels."

The record states:

"Inmate has a history of schizophrenia. He is suspicious and angry. He threatens staff.

> Emergency hold is based on his refusal of blood pressure medication . . . "

A referral was made to the physician requesting an opinion regarding the inmates blood pressure medication. The report indicates:

> ". . .it was difficult to tell if his resistance to answer questions was due to anger vs. mental illness. I basically stated . . . that a major issue would be the patient's competence. Hopefully his competence will be addressed."

Another record indicates:

> ". . . the inmate came to the cell door when I asked him to, but he did not come very close to the door and spoke in a soft voice which was difficult for me to hear . . . I asked him if he would like to stay here or go back to segregation. He said he would rather stay here. I asked him if he would then sign in. He said he refused to do so. Since he is here on a 72-hour hold, a release will have to be effected or a petition signed on Monday. At this time he is totally negative. When pressed to continue the conversation, he walked back to his bunk, lay down, and told me he was going to take me to court . . . I am hard pressed to determine the basis for commitment proceeding other than being unable to thrive . . . I support the hold order and the petition on the basis of his inability to care for self. He has been languishing in segregation. . . "

A petition was filed in support of prehearing confinement. The judge signed an order to continue his hospitalization in the mental health unit.

The records indicate that the inmate was placed on involuntary confinement status for having assaulted a staff person.[18]

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[18]The inmate was still on confinement status when the Ombudsman last inquired three months later.

The treatment problems identified were:

"# 1 - Elevated Blood Pressure.
Goal: Take blood pressure medications
Treatment mode: Medication

#2 - Schizophrenia.

. . .After being discharged and returned to his institution, the inmate rarely, if at all, took his psychiatric medication. Because of his refusal to take them, the psychiatrist has not prescribed medication for him since the start of his present admission. Staff hope that if his mental disorder is improved with medication, he will be more willing to comply with the treatment for his blood pressure problem.[19]

Goal: Reduce schizophrenic symptoms.
Treatment mode: Medication

#3 - Hygiene
Goal: Keep himself clean and his room clean.
Treatment mode: Management Plan

#4 - Threatening and Aggressive Behavior
Goal - Eliminate aggressive behavior and verbal threats.

Treatment mode: Medication
Confinement Status

Long-term goal - Return to general population

The inmate was committed to the mental health unit as mentally ill by the court.

The mental health unit filed a petition with the court for authorization to impose treatment of neuroleptic. The judge ordered medications to be administered to the inmate.

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[19]The Ombudsman notes that this is contradictory.

INVESTIGATION

Issue: Assessment and 72 hour holds

The stated reasons on the Examiner's Statement in Support of Emergency Hospitalization are:

> "Inmate is diagnosed as schizophrenic and is refusing both neuroleptic medications and blood pressure medications. Prison physician has attested that inmate's blood pressure has reached dangerous levels."

The Ombudsman is concerned that precedents are not set where inmates must have a physical problem such as high blood pressure in addition to a psychiatric emergency to obtain admission to the mental health unit on an involuntary basis.[20] There is evidence the inmate was confused, not taking care of himself and perhaps not competent to make adequate decisions for himself. As discussed in an earlier report,[21] factors such as these can be considered as criteria to justify an emergency hold in certain situations.

Issue: Treatment

While the inmate was in the mental health unit he made little, if any progress. For all practical purposes, he was discharged to the general population with the same problems that he had when he entered the mental health unit.

Given his limited intellectual abilities, his history of schizophrenia and his sporadic compliance with

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[20]In the Ombudsman Investigative Report 94-1, the Ombudsman noted problems with not taking blood pressure medication as the criteria that finally convinced the mental health unit to accept him.

[21]Ibid.

medications, the Ombudsman understands why he was in psychiatric distress shortly after returning to his institution.

This is a good example where better case management and the services of a Special Management Unit for offenders who are mentally ill or mentally retarded, like this inmate would be beneficial for both the inmates and staff.

The American Correctional Standard **C2-4146** states:

> "Inmates who are severely disturbed or mentally retarded are referred for placement in either non-correctional facilities or in specially designated units for the handling of this type of individual. (2-4296)
>
> DISCUSSION: It is inappropriate to place severely disturbed and mentally retarded individuals in a prison setting. They are vulnerable to abuse by other inmates and require an inordinate amount of personal attention. . . . "[22]

Many psychological referrals were made regarding this inmate. It is good to know that part of the system works, but the responses and results of the referrals are questionable.

The discharge plan from was not very developed; the only plan was to have a medication follow-up. From the records, it appears there were times when it took well over a month to have the psychiatrist see him, and during that time, he was in segregation for problems that were a result of his mental illness.

In the *amici curiae* brief filed by the APA in *Washington v. Harper*,[23] they argued:

> "Permitting a psychotic prisoner to remain unmedicated for months within the general

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[22] American Correctional Association Standards.

[23] *Washington v. Harper* 494 U.S. 210, 110 S. Ct. 1028, 108 L.Ed.2d 178 (1990).

> population presents a very real danger of violent confrontations resulting in serious physical injury to that prisoner, to other inmates or to prison officials. (Footnote: The alternative of unmedicated administrative segregation for a psychotic prisoner alleviates the threat his or her illness may present to others, but it cannot relieve and may likely aggravate the dysphoria that many psychotics experience before receiving proper treatment. In addition to subjecting the prisoner to the often intense discomfort of untreated psychosis, such a transfer to solitary confinement would likely deprive a prisoner of a significant measure of liberty enjoyed among the general population.)"

The Ombudsman is especially concerned that when he returned to the mental health unit the second time, the Treatment Plan developed for him there was not appropriate.

The Ombudsman is troubled by the statement that "since the inmate had rarely, if at all, taken his psychiatric medication, the psychiatrist was not going to prescribe them for him."

This sounds punitive to the Ombudsman.

It does not appear that medications were offered for about a month after his second admission to the unit and were not administered until they were ordered by the court. The Treatment Plan was formulated on the basis that he would improve in other areas if his medication was effective. There is no ability for any of this to occur without the psychiatrist prescribing the medication and giving the staff a chance to work with him to take his medication, which he has done at times.

The Ombudsman is also concerned that this inmates competency is not addressed in any of the treatment reports. It is interesting to the Ombudsman, however, that the medical doctor called in for a consultation regarding blood pressure medication immediately identified competency as an issue. Although the psychiatrist saw him the same day as the medical doctor, this issue was not addressed in his report.

This inmate has limitations. The additional complications from his schizophrenia require a very thorough and competent evaluation, diagnosis and Treatment Plan.

CONCLUSIONS

- The Treatment Plan for this inmate was not adequate when he was discharged from the mental health unit.

- The Treatment Plan developed for this inmate when he returned to the mental health unit was not adequate to address his treatment needs.

- The failure to prescribe and offer medication after his return to the mental health unit was inappropriate. Components of the treatment plan were directly correlated with his ability to improve with medications. The inmate's competency has not been adequately addressed. His continued confinement status is most likely related to his lack of capacity to understand and interact in an appropriate manner.

CONCERNS

Because of the review of these cases of mentally ill inmates, concerns have been raised about the attitude of various individuals within the DOC as to the identification, treatment and rights of the mentally ill inmates. While the Ombudsman wants to believe that these individuals are all well intentioned, the Ombudsman is concerned about some decisions that have been made regarding the care of these vulnerable individuals.

The Ombudsman is especially concerned about what happens with the seriously mentally ill population. For many reasons, such as their competency, they are the least likely to complain about what is/is not happening to them. They are the ones who get lost in the cracks. At times they are disruptive or unpleasant to deal with. However, these inmates have the right to appropriate treatment for their mental health conditions while they are incarcerated.

The Ombudsman is concerned that if the current practices at the DOC continue, the department will leave itself vulnerable to litigation claiming failure to provide appropriate treatment.

In *Estelle v. Gamble,*[24] the Supreme Court established that prisoners have an Eighth Amendment based right to treatment for serious medical conditions. The Court held that deliberate indifference to the serious medical needs of prisoners constitutes unnecessary and wanton infliction of pain.

In *Langley v. Coughlin,*[25] the court defined the type of problems that may well establish or negate deliberate indifference:

> " . . . 3. Failure to respond to inmates' prior psychiatric history . . . 5. Failure to properly diagnose mental conditions . . . 9.

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[24]*Estelle v. Gamble* 429 U.S. 7 (1989).

[25]*Langley v. Coughlin,* 715 F. Supp at 504-41 (2d cir. 1989).

> Seemingly cavalier refusals to consider bizarre behavior as mental illness even when a prior diagnosis existed."

The court also clarified:

> "While one isolated failure to treat without more is not ordinarily actionable, it may in fact rise to the level of a constitutional violation if the surrounding circumstances suggest a degree of deliberateness rather than inadvertence, in the failure to render meaningful treatment. Moreover, the inference of such indifference may be based upon proof of a series of individual failures by the prison even if each such failure -- viewed in isolation -- might only amount to simple negligence."[26]

Professor Fred Cohen[27] has developed an instrument to evaluate mental health services in prisons. He comments in his document:

> "Deliberate indifference refers to a mental state in the same fashion as the law refers to intent, recklessness, and negligence . . . While deliberate indifference is a mental state, its proof invariably will flow from persons' conduct. Deliberate indifference will apply to acts or omissions of individuals and as a standard for measuring the constitutional acceptability of an entire mental health system.

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[26]*Langley v. Coughlin,* 715 F. Supp at 537.

[27]Fred Cohen, JD, Professor, School of Criminal Justice, SUNY Albany, Albany, New York.

RECOMMENDATIONS

1. That the Department of Corrections conduct an administrative review examining the policies and practices of the department that relate to the identification and treatment of the mentally ill inmates. The Department of Corrections ensure that the policies are adequate and the practices are in compliance with good mental health practices and constitutional standards.

2. That the Department of Corrections evaluates the psychiatric and mental health staff-to-inmate ratios to ensure that adequate numbers of staff are available to meet the needs of the growing inmate population. If additional staff is needed, they should be requested.

3. That the Department of Corrections conduct an evaluation to determine if the twenty-two bed mental health unit is sufficient to meet the needs of the department as both an acute care unit and a stabilizing treatment unit for the adult male mental health population. Additional resources should be developed if recommended by the study.

4. That the Department of Corrections review the standards used for emergency holds and contacting the courts for judicial commitment of the seriously mentally ill in an appropriate and timely manner. If changes are needed that they are implemented.

5. That the Department of Corrections establish an independent review board to provide a quality assurance review of the treatment provided to those inmates at the mental health unit and within the department's institutions to ensure that the treatment practices are in compliance with acceptable mental health treatment standards.

6. That the Department of Corrections establish a special needs unit to deal with the vulnerable, mentally ill and mentally retarded inmates. That this unit be staffed with case managers and correctional counselors specifically trained to deal with this special population.

APPENDIX A

Included with this report is an article: Life in Hell - Warehousing the Mentally Ill in Minnesota prisons printed in the **CITY PAGES, An Alternative News & Arts Weekly of the Twin Cities,** dated February 24, 1993.[28]

The significance of including this article is it raises many of the same issues that are cited in the Ombudsman's reports:

- "If a mentally ill inmate doesn't draw attention, he usually doesn't get any help at all . . . The people who threaten suicide if they don't get their way are the ones that occupy the greater percentage of a physician's time. (page 10)

- The prison system isn't set up to deal with mentally ill people, so its practical solution is to define them out of existence. (page 10)

- Mentally ill inmates often end up in segregation for unwittingly breaking a prison's strict rules or causing trouble. (pages 10-11)

- Guards frequently complain that they don't know how to deal with a mentally ill inmates. (page 11)

- . . . mental illness can't be used as a defense in disciplinary hearings. (page 10)

- The problem seems less dramatic, at least to the public, if you don't admit it exists at all." (page 10)

Although the Ombudsman is not claiming to have substantiated the content of this entire article, the Ombudsman has substantiated enough of its content from multiple sources to consider that it strengthens the argument for review of the mental health system within Department of Corrections.

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[28]Reprinted with permission, Jennifer Vogel, **CITY PAGES.**

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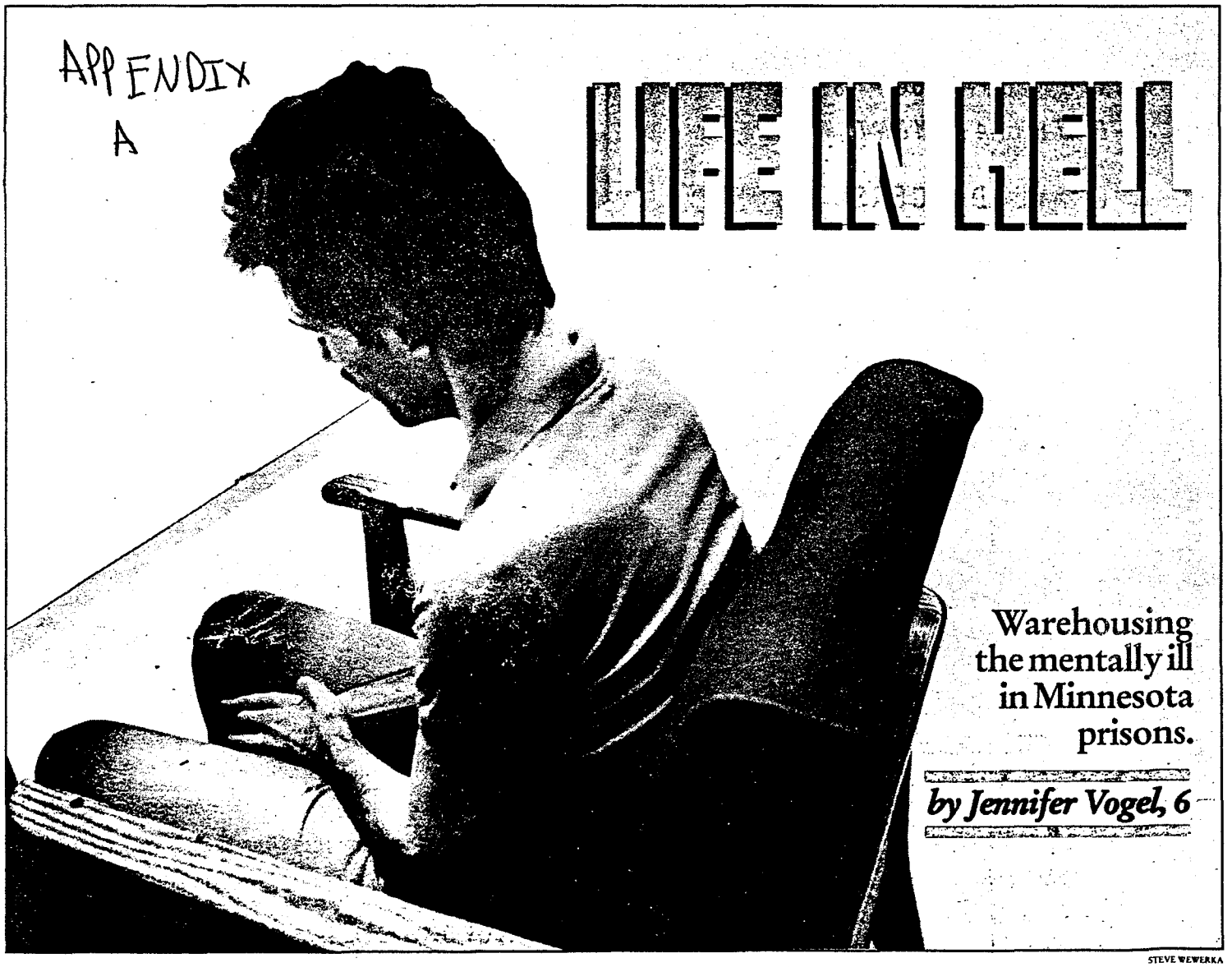
CITY PAGES



LIFE IN HELL

Warehousing the mentally ill in Minnesota prisons.

by Jennifer Vogel, 6

STEVE WEWERKA

PHOTOS BY STEVE WEWERKA

Robby Provost used to hear voices that said his wife and his best friend were plotting to drive him crazy.

by Jennifer Vogel

Robby Provost used to wear headphones to keep out the voices that tell him he's no good. He tries not to dwell on what they say; he never records their words in the daily logs he keeps faithfully. But sometimes they get him down. Sometimes he gets urges. Once, a little over a year ago in his old cell at St. Cloud state prison, he took a razor and slit his wrists four times each. Deeply. Then he sat down to watch television.

No one knows for sure when he started hearing the voices. But one day, while driving with his parents, he said they were telling him to kill his best friend since grade school, David—who, he believed, was having an affair with Provost's wife and plotting with her to drive him crazy or have him imprisoned. They could do this, he reasoned, because they were able to read his mind and control his thoughts. He was obsessed with his wife's supposed infidelity. Once he shaved her face in hopes that she would grow a beard. His parents took him to Golden Valley Mental Health Center, where doctors said he was psychotic and pronounced him dangerous to himself and his wife. But Provost didn't want help. According to the law, they had to let him go.

A few months later, after a drive to Taylors Falls, Provost and his wife stopped by his parents' house. He remembers his father saying that the two of them should split up and work on their individual problems. But that wasn't what Provost wanted. He went to the garage and put a can of gas in the trunk of his car. And the two then went for a drive. On a secluded road he pulled over and retrieved the can from the trunk. He told his wife to get out of the car, grabbing her by the arm. He doused her. He flicked his lighter. Then he drove to the police station to turn himself in and to get help. Later, as she lay charred in a melted circle of snow, he kept asking police how she was, which hospital she was in.

He just wanted to burn her enough to scar her, he would tell authorities later. So nobody would want her, and she could never leave him.

Now Provost lives in a bare cement cell on the Mental Health Unit at Oak Park Heights state prison. The two small windows in his cell look out over a snowy courtyard. Prison officials have stenciled a poster-sized square on the wall where he is allowed to hang pictures and cards.

Painfully shy, Provost would like to make friends with the inmates who live in the cells around him, but he says he can't. In group situations, he often sits with his head down. He generally keeps to himself except for the 15 minutes on the phone every night with his parents and visits with the doctors or prison chaplain. In our interview, his answers are usually three or four words. Sometimes a sentence will start and trail off into silence.

Oak Park Heights is built for security: It houses the most violent and desperate criminals with the longest sentences. It's mostly underground, with a large open recreational area in the middle. A guard with a high-powered rifle circles high above the courtyard. Inside, everything is controlled. Inmates are strip-searched when they go into the visiting room and when they go out. In the halls there's a muffled, hermetic feeling that's distinct even for a prison. "We've never had an escape attempt," brags assistant to the warden Lynn Dingle, who sits in on all the inmate interviews for this story—in case they started telling lies, she explains.

The Mental Health Unit is just one wing of the maximum-security prison. The cells are a little bigger than those in other units—about 10 by 15 feet. Some are equipped with cameras for 24-hour observation. Usually, you aren't put in a surveillance cell unless you've tried to kill yourself. Prison officials have tried to bring a little humanity to the MHU. In some areas, encouraging messages are tacked up on the walls. "When you're through changing, you're through," reads one.

Provost is one of the lucky ones. He's got his parents battling for his rights. They belong to a local chapter of the National Alliance for the Mentally Ill (NAMI), which meets monthly in Stillwater. There, they and parents of other mentally ill inmates share information, plan lobbying strategies, and give each other moral support to fight the good fight. One objective is more input into their children's treatment plans.

Provost's mother and father had to raise quite a ruckus before they were allowed to know what, if any, medical attention their son was getting. To help him better understand his illness, they sent him books on schizophrenia. They were then accused by prison officials of putting him up to faking his disease. Finally, persistence paid off. They were one of the first families ever to meet with prison doctors. And,

A PRISON of the MIND

COVER STORY

in part because of their diligence, he gets medication now—he was the first Minnesota inmate to get clozapine, a new schizophrenia drug that's had near-miraculous results in some cases.

If it were 20 years ago, Provost might have been sentenced to a mental institution instead of to a prison for 30 years to life. Or maybe his crime would have been prevented by early treatment. But Provost fell through a large and growing hole in mental health services in the United States. There are an estimated 100,000 seriously mentally ill people—including people with schizophrenia and manic depression—locked up in jails and prisons across the country. Many get no psychiatric help at all. They are simply warehoused.

"Not since the 1820s have so many mentally ill individuals lived untreated in public shelters, on the streets, and in jails," say the authors of a 1990 nationwide study of mental health systems sponsored in part by NAMI. "Countless more live in substandard boarding homes or rundown transient hotels, or pass their lives watching television or smoking cigarettes because no rehabilitation services are available. There are more people with schizophrenia and manic depressive psychosis in prisons and jails than in public mental hospitals."

And by most accounts the problem is steadily getting worse. Though it's hard to find definitive numbers because of differing definitions of serious mental illness and because most jurisdictions don't keep complete data, a 1989 study by three doctors at the University of Washington School of Medicine in Seattle found that between 1968 and 1978, "the proportion of men entering state prisons with a history of prior psychiatric hospitalizations increased from 7.9 percent to 10.4 percent."

And a 1992 NAMI study estimates that over the past 100 years, the number of mentally ill in this country's jails has increased tenfold. Even more startlingly, the study found that "29 percent of jails surveyed hold seriously mentally ill individuals without any criminal charges against them. These people are often jailed because no other facilities are available to respond to psychiatric emergencies."

Until the 1830s, when states started setting up mental hospitals, jails were the accepted answer when officials were looking for someplace to lock up people with serious mental illnesses. According to the 1992 study, "The practice of using psychiatric hospitals rather than jails to confine individuals with serious mental illnesses became standard practice throughout the United States for 150 years. In the past 25 years this trend has been reversed and we are moving steadily backwards toward the conditions which existed in the 1830s."

Between 1955 and 1984, the number of patients in public mental hospitals dropped from 552,150 to 118,647, a reduction of just under 80 percent. Most of the reduction reflected the rush toward deinstitutionalization in the 1970s and '80s. The idea then was to shift the focus of mental health services away from state institutions and toward community-based services. The federal government even provided some funding for the transition. But as inmates were released, community health centers didn't pick up the slack. The federal government made mentally ill people eligible for programs like food stamps, giving states an excuse to take even less responsibility for their care. As the 1990 NAMI study put it, "it is clear that whatever was supposed to happen did not happen, and that deinstitutionalization was a disaster."

Earl Karr, infamous in the early '80s as the Midwest Pipe Bomber, recently tried to electrocute himself using ketchup packets and wet towels.

While all this was going on, patients' rights advocates were fighting to make it more difficult to get people involuntarily committed. They were reacting to the perceived abuse of commitment laws—husbands locking up their wives just to get rid of them, and other such horror stories. But now it appears the laws may have gone too far the other way. As it stands, a mentally ill person has to be suicidal, dangerous, or want help in order to get treatment. The first two qualifications usually come too late. The third usually doesn't come at all. Between 60

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gation for unwittingly breaking a prison's strict rules or causing trouble. That means fewer privileges and personal effects. Less contact with the outside world. Less exercise. In Stillwater, it means solitary confinement, high bars, and metal doors. Recalls Hughes, "One guy, that was totally out to lunch, just sits back there and babbles. Some other person might be very quiet and not do much. Another might sit back there and cry. The people that I'm aware of that I believe are mentally ill often get in trouble in segregation and get more time." Spending extra days in segregation also counts against an inmate's release date. For every three days in segregation, an inmate loses one day of "good time."

Hughes says she walked into segregation one day about a year ago and found a mentally ill inmate strapped spread-eagle and naked to a board. He was in plain view of the other inmates and guards. "I don't know how long he was there. It could have been for a while. The cell this guy was in was a regular cell and so everybody could see. That's the staff frustration, dealing with somebody out of control and they're not trained." Hughes says she reported it to the warden and hasn't seen it happen again since.

A former prisoners' advocate at Stillwater says she walked into the segregation unit one day and found a mentally ill man stripped naked and strapped to a board in full view of guards and other inmates.

There is also the "quiet cell" for inmates who get out of hand. They go in without anything—no blanket, no clothes. There is nothing in the cell, not even a toilet. Just a hole in the floor and one small window.

Guards frequently complain that they don't know how to deal with mentally ill inmates, says Hughes. "They do the best they can, but they are frustrated. There are always going to be the guards that have their own personal problems and bring them to work and don't want to deal with a mentally ill person or have empathy."

Even taking into account shortcomings on a national level, Minnesota doesn't rank very well when it comes to providing mental health services. The 1990 NAMI study ranks Minnesota 16th (in a tie with nine other states) in the nation and says the policy in the state system is "going nowhere." The study says the state's six hospitals are "plagued by overcrowding and waiting lists of up to four weeks." The reasons include "grossly insufficient housing so patients who could be discharged have nowhere to go; minimal use of community

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beds for psychiatric admissions; virtually no screening of admissions by the Community Mental Health Centers; and an unusually dumb ruling by the State Supreme Court setting up a lengthy, unwieldy legal process for patients refusing medication, with the result that newly admitted patients may sit in the hospital for six weeks before medications can be started."

Minnesota's concern is clearly in protecting the public rather than in helping the mentally ill. It's almost impossible to get the insanity plea in this state, where defendants are judged according to the 100-year-old M'Naghten criteria. To be not guilty by reason of insanity, you must either not know what you were doing or not know it was wrong.

"By strict application of the M'Naghten criteria," says Turnquist, "most people who are psychotic when they commit a crime cannot be found not guilty by reason of insanity. They usually know what they are doing even if they have delusional reasons for it and they even know it's wrong a lot of the time. Robby Provost put gas in the trunk of his car and drove off in a secluded area. He knew what he was doing. The only people who wouldn't know those things must have severe, severe problems, like Alzheimer's or brain damage. If you kill someone because you think they are the devil or a traitor and they are not, I would say you are killing someone because you are insane."

In Provost's case, there was strong evidence that he was schizophrenic. A respected psychiatrist said so at his hearing. His symptoms were documented in records from Golden Valley Mental Health Center and in transcribed interviews with social workers. But despite his fifth-grade reading level, prosecutors insisted he was faking the subtle symptoms of his disease. So he was found guilty and sent to St. Cloud, where other inmates ridiculed him and threw food at him at dinner time. Once they smeared it on his glasses. Provost fell low in the prison pecking order; officials didn't take him seriously until he slit his wrists.

Bob and Nancy Provost talk to their son every night on the phone.

Some states use a standard called the American Law Institute Test. Turnquist says it's a much more accurate standard because it takes motive into account, saying a person can be not guilty by reason of insanity if "because of mental disease or mental defect he lacks the substantial capacity to appreciate the criminality of his conduct or to conform his conduct to the requirements of law."

Nationally, it became much more difficult to successfully plead insanity after the trial of John Hinckley Jr., who shot then-President Ronald Reagan in 1981. There was a huge public outcry after he was found insane—the feeling was that he was getting away with something. The crime package Reagan sent to Congress in 1984 included more restrictive federal guidelines for the insanity plea. It's hard to dig up statistics on the number of successful pleas in Minnesota each year, but Dr. William Erickson from St. Peter security hospital says it's "not more than a handful," maybe two or three.

The reluctance of courts to admit that a defendant is insane sometimes reaches absurd proportions. Tom Smith (not his real name) is at Oak Park Heights doing a combined state and federal sentence of 62 years for attempted murder of a peace officer. His mother says he was always an excellent student, never bringing home less than a B. He had been studying mechanical engineering at the University of Minnesota. But he started to change. He became paranoid. He left bizarre suicide notes.

Smith, at one point, was arrested in Wisconsin for a minor offense, was given the MMPI (Minnesota Multiphasic Personality Inventory), and was suspected to have paranoid schizophrenia. A doctor diagnosed him as having a "paranoid personality disorder." Recalls his mother: "But because he hadn't committed a crime and he didn't think he needed help, they wouldn't treat him. For the next two years, he held 23 jobs."

Smith was in Houston, Texas. He'd fled there out of fear his parents were trying to kidnap him. He wore a bulletproof vest and carried a gun. When police signaled him to pull over for a traffic violation, he was ready. He slowed his car down and picked up his semiautomatic. He fired 28 shots. They fired 40. Then, he says, "I took my gun to my head and pulled the trigger. It wouldn't work, so I recocked it and pulled the trigger again and it wouldn't click. I got really pissed off and threw it down and a cop came through my truck door playing T.J. Hooker with his gun in my face and I screamed at him to shoot me." Nobody was seriously hurt.

His mother says he later told her not to worry about him because bullets couldn't penetrate his body—he was the brother of Jesus.

Smith went through two trials, one in Texas courts and one in federal courts, since a federal agent had been at the scene of the shooting as well. "I just assumed we'd get

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and 70 percent of schizophrenics, for example, don't think there's anything wrong with them. Even if they do, they may refuse treatment, thinking doctors and family members are out to get them.

"I think we set these people up for failure," says Dr. Kevin Turnquist, head of psychiatry at Anoka state hospital. "In order for these people to tell they are sick, they would have to remember what it was like before they were sick. Then they would have to make an accurate picture of how they are and compare. That's exactly where a schizophrenic's mind fails. It's like a colorblind person trying to see green. It seems like the people who set up these laws mean well, but they set it up so people have to do something terrible to get treatment. So they end up in prison or on the streets with their rights intact.

"There are thousands of families in the community with schizophrenic children living in their basements or attics. But when they take them in for treatment, they can't get treatment. They are told they have to go home and wait for something bad to happen. If it's something illegal, they end up in jail and if it's something suicidal, you just hope they don't end up dead."

A person with schizophrenia lives somewhere between reality and a nightmare. Commonplace actions are sometimes invested with private meanings. Pull up a chair and a schizophrenic might take it as a sign that they are going to die. Scratch your ear, they might think it's time to go to sleep. Provost told Turnquist once that when people rub their noses it means he should "relax and enjoy the moment." Often schizophrenics have constructed elaborate paranoid fantasies about plots to kill, kidnap, or lock them up. They might see their best friends as devils. High-profile crimes by the mentally ill are uncommon. Usually, when they break the law, they commit minor offenses: public intoxication, theft, disorderly conduct, assault.

Karr: "This is the work of a curse. Or I'm in hell."

Once mentally ill people find their way into the nation's penal system, they often are preyed upon by other inmates, becoming the victims of physical abuse, rape, or extortion. Mentally ill inmates are also more likely to attempt suicide than other inmates —some jail and prison studies show that half to three-quarters of those who tried to kill themselves had a history of mental illness.

After Provost slit his wrists in his cell at St. Cloud prison, he was sent to the Minnesota Department of Corrections' only mental health facility, the 22-bed MHU at Oak Park Heights. He's been on the ward for more than a year, the longest stay for anyone there. The Unit itself is pretty well run—inmates sent there get psychiatric care, counseling, recreation, and individual attention. There are three full-time psychologists at the MHU and two psychiatrists who come in a couple of times a week.

But the MHU can handle only a small percentage of the state's nearly 4,000 prison inmates. It's mostly used as an outpatient facility—inmates are sent there from all over the state for short periods of time after a drastic episode, such as trying to kill themselves. Once they stabilize, it's back to the general prison population. Dr. Kenneth Carlson, who heads the unit, says sometimes he has no choice but to return them. Prisons have to follow the same rules as the outside world, he says. Unless an inmate is committed—which involves a court procedure—they don't have to stay.

A year and a half ago, for instance, a Stillwater inmate serving a six-year sentence for simple robbery became obsessed with the Bible, to the point where he was shouting verses down empty halls. Nobody did anything until one day he poked his eye out with a pencil to obey a biblical injunction: "If thine eye offends thee, pluck it out." The man, who had been in and out of institutions for most of his life, was committed to the MHU for six months. He got some medication and his mental health improved. After his eye healed, he was returned to the general population. He stopped taking his medication.

Back at Stillwater, he started writing hateful letters to his mother. One ended, "Burn Bitch! Burn Bitch!" and was signed "Honorable Judge and Executioner." Now she's terrified that if he doesn't get help before he gets out in two years, he'll come after her and her family. Prison officials refuse to tell her anything about his condition—because he's an adult, they say, and the information

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is confidential. But she says they did confirm that he's not getting treatment, because he doesn't want it.

If a mentally ill inmate doesn't draw attention, he usually doesn't get any help at all. According to Turnquist, "There are a lot of psychotic people in jails or prison that by virtue of their illness are quiet or withdrawn. They slip through the cracks and won't get any treatment. The people who don't have a mental illness but threaten suicide if they don't get their way are the ones that occupy the greater percentage of physicians' time."

By way of example, Turnquist recalls a case of a rapist who was sent to Stillwater for 10 years. "He's schizophrenic. But he's very quiet. The whole time he's sitting at Stillwater, he believes he's time-traveling and raping other women. He sits there fantasizing. When his sentence expires, they get worried and realize he's no better so they send him over to the county hospital for psychiatric evaluation. The day he gets released they send him to a hospital and he ends up at St. Peter [security hospital] as a psychopathic personality. If he needed treatment that bad, he should have gotten it before and not had to sit for 10 years."

The prison system isn't set up to deal with mentally ill people, so its practical solution is to define them out of existence. Official estimates on the percentage of seriously mentally ill inmates in the state are hard to come by—Carlson puts it at 2 to 4 percent. Patricia Hughes, who until recently worked as an assistant state public defender at Stillwater, where she represented inmates during disciplinary hearings, recalls that last year the DOC listed only 25 individuals with serious mental illnesses out of a total of 3,300 state inmates. She figures the numbers to be quite a bit higher. At Stillwater alone, she estimates that more than 10 percent of the total 1,350–1,400 inmates are mentally ill. Other estimates range from 10 to 20 percent.

The prison system isn't set up to deal with mentally ill people, so its practical solution is to define them out of existence.

But the problem seems less dramatic, at least to the public, if you don't admit it exists at all. At Stillwater, says Hughes, mental illness can't be used as a defense in disciplinary hearings. She cites the case of a mentally ill man who thought another inmate was talking about him in the food line. He turned on his imagined tormentor. "The other guy knew he had some problems and wanted to leave him alone," says Hughes. "The schizophrenic pushed the other guy into someone else. Both got wrote up. When it was my turn to cross-examine the guy who was mentally ill, it was clear he didn't know what was going on. He thinks people are picking on him all the time because of his illness. To get a rational answer was impossible. They found him guilty of disorderly conduct, but gave him a suspended sentence."

Mentally ill inmates often end up in segre-

insanity because there was so much evidence," says his mother. "We hired the best attorney. We paid for two doctors to testify that were supposed to be experts, for the first trial. I used to feel great shame about my son, but now I'm ashamed to be an American. We're not civilized in the way we treat the mentally ill."

Smith was found guilty in both jurisdictions. At his federal trial, the judge actually allowed him to fire his attorney and defend himself. His mother still remembers watching him before the jury—stroking the gun he used, cooing, "I bet you've never seen such an exotic weapon."

Robby Provost spends the time in his cell sleeping or writing detailed daily logs.

Earl Karr thinks Oak Park Heights might be hell. "It's the curse that put me here," he says in his hushed, manic tone. "Because it knows that I am going to die here." He's in prison because back in 1983 he planted pipe bombs in various cities in Iowa, Wisconsin, Illinois, and Minnesota. He was famous then, dubbed by the press "the Midwest Pipe Bomber." Karr served the first five years of his up-to-25-year sentence at St. Peter. But he made trouble. He started telling the press of alleged abuses there, rankling the hospital's higher-ups. He was transferred to Stillwater prison—allegedly because he refused to follow the treatment program laid out for him. He didn't stay in Stillwater long, though. After being accused of telling someone how to make a bomb, he was sent to Oak Park Heights.

"Number one, is either I am totally sane and on earth; I'm in hell and died in 1984 or in transport from St. Peter to Stillwater and I'm in hell; or I'm on Earth and I'm cursed," says Karr. "These are three things that I'm not completely sure about so during our interview you're going to find that there's a few contradictions to what I'm saying because I haven't totally sorted out all these things yet in my mind."

Karr isn't on any medication. He refuses it because he doesn't trust the prison staff. Doctors have never been able to agree on a diagnosis, but they suspect everything from schizophrenia to depression. He's been to psychologists since he was six years old, says his mother. And he's got an eating disorder. Much of the time he'll only eat brownies and chips, but as a prison staffer put it, this is a prison, not his mother's home. So he wastes away. He's about 40 pounds underweight and his head looks too big for his body. His mother says sometimes he hoards food in his cell like a chipmunk because he's afraid he won't have enough. Then he gets in trouble.

Carlson insists Karr is sane: "He's dysfunctional, not delusional. He has his own peculiar way of interpreting the world, but he certainly knows reality. He's a fascinating character."

Karr's cell gets searched a lot. About every three weeks, he claims, guards come in and tear everything apart looking for bomb fodder. He says sometimes they strip and search him as well. The process gives him nightmares. "Terrorizing with the green gloves," he says, his voice becoming more urgent. "Strip!" he cries out abruptly. "I don't sleep very good at night because I have constant nightmares about being shaken down and having the squad come in the night."

He blames the cell searches for his suicide attempt last spring. "We had a federal inmate. He'd come in to me after these shakedowns and he'd say Earl, sympathizing. He'd try to comfort me. But in return he wanted knowledge and I had no reason not to share that knowledge with him. That drove me to my suicide attempt. Because when he got busted, they held me responsible for teaching him. They put me in seg."

In segregation, Karr wired himself up to an electrical socket using tinfoil from ketchup packets and wet towels wrapped with plastic from potato chip bags. He used dried fruit with a cup of salt water as a timer. As the fruit absorbed water, it caused the cup to tip, completing the circuit. "I just sat on the floor one Friday night in seg and waited for the dried fruit to dissolve and the cup to tip." He still has marks on his arms and ankles from the jolt.

"I know my existence is over," he says. Not long after our interview, Karr tries to commit suicide again by thrusting himself backwards off a cement bookcase in an effort to break his neck. There is talk of finally having him committed. "This is the work of a curse or I'm in hell and this is the hell game against me," Karr pleads. "It's the curse. The curse knows. It knows I'm going to die here." **CP**

For more information on the forensic network of the National Alliance for the Mentally Ill, contact Millie Martineau at 450-1284.

Minnesota Department of Corrections

Office of the Commissioner

November 15, 1994

Patricia Seleen
Ombudsman for Corrections
1885 University Avenue, Suite 295
St. Paul, Minnesota 55104

Dear Ms. Seleen:

This letter is the Minnesota Department of Corrections' response to "Critical Report 94-2 Investigation of Systemic Issues of Mentally Ill Inmates." While your office's perspective and observations on the treatment needs for mentally ill inmates are appreciated, this is a complex issue that requires considerably more study. Our reactions to this report will be brief because we do not believe that we currently have sufficient information yet to respond to any specific points made in the report. Overall, the report does not reflect a comprehensive or objective analysis of the treatment available to this segment of our prison population. Our specific concerns, however, are related to the nature of the report's conclusions and the lack of factual support for them.

The information upon which the conclusions are based is far from comprehensive. Although in discussions with department staff you have indicated that the report is based upon a long history of complaints from inmates, the only information which the report cites explicitly is comments and opinions of a few individuals, data we provided about the number of inmates for whom psychotropic drugs were prescribed at a particular time, three individual cases, an observation that some prisons seek accreditation from organizations other than the American Correctional Association, and excerpts or quotes from books and legal decisions. This type and limited amount of information is simply not a sufficient basis for the broad conclusion that services provided are inadequate.

The report also includes legal conclusions which are beyond the scope of the ombudsman's authority. It is the role of the courts to determine whether a party is negligent or has violated constitutional standards, and a court only does so after hearing testimony from both the accusing and defending parties and studying thoroughly existing law on the issue. It is inappropriate for the ombudsman's office to issue a report which concludes that the department was "negligent" or "acted with deliberate indifference."

Notwithstanding our concern about and disagreement with the substance and form of the report, and in fact prior to the issuance of the report, our agency has begun a review of the policies and practices dealing with mental health services in our institutions. As we do whenever we review department and institution policies, we consult with the attorney general's office to be sure that the policies comport with constitutional and other legal standards. We fully anticipate that within a year the various policies about which the ombudsman has expressed concern will have been reviewed and revised to comply with corrections mental health standards.

Sincerely,

Frank W. Wood

Frank W. Wood
Commissioner

FWW:jw

On September 14, 1995 the Commissioner of Corrections released the following report:

MENTAL HEALTH SERVICES
FOR ADULT INMATES
IN MINNESOTA CORRECTIONAL FACILITIES

In a letter to the Ombudsman dated August 23, 1995, Deputy Commissioner Bruton indicated that this report is the Department of Corrections reponse to the Ombudsman's investigative reports.

A copy of this report is available upon request.

STATE OF MINNESOTA
OMBUDSMAN for CORRECTIONS
1885 UNIVERSITY AVENUE, SUITE 395
SAINT PAUL, MINNESOTA 55104
(612) 643-3656

September 27, 1995

Commissioner Wood
Department of Corrections
1450 Energy Park Drive, Suite 200
St. Paul, MN 55104

Dear Commissioner Wood:

I have had a chance to review the *MENTAL HEALTH SERVICES FOR ADULT INMATES IN MINNESOTA CORRECTIONAL FACILTIES* Report. It is my understanding that this report is your response to my investigative reports 94-1 and 94-2 issued to you on August 9, 1994.

Thank you for your attention to the many issues I raised in my reports. I am satisfied that you and your staff have taken the concerns seriously and are addressing the problems related to inmates with mental illness in the correctional facilities. I look forward to information on the implementation of the recommendations made in this report.

After receiving your final response to my draft investigative reports I finalized the reports. I have enclosed the final reports.

Sincerely,

Patricia Seleen

Patricia Seleen
Ombudsman for Corrections

Enclosures

cc: Chief of Staff, Morrie Anderson
Deputy Commissioner Bruton

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