malingering. The authors reported that one-third of psychiatric emergency department (ED) patients were suspected of malingering, with the majority "strongly or definitely suspected of malingering." This finding is unsurprising to me, having practiced emergency and crisis psychiatry for several years in a large urban setting. Many of our patients were known or suspected to be feigning acute psychiatric symptoms in the service of obtaining admission to treat their substance use disorders, for which they otherwise could not find care. Given the dearth of options available to them, they found themselves in crisis, with nowhere to turn other than the hospital ED. Although care may have improved since I last practiced in the emergency setting, there still is no "treatment on demand" for substance use disorders, at least where I currently practice.

Given the high prevalence of substance use disorders in the psychiatric emergency setting (2), one would think that consideration of substance use as a motivator for seeking psychiatric admission would have been high on the differential diagnosis for such a setting. Yet the terms "drug use," "substance use," and "addiction" appear nowhere in the article. More surprising to readers of *Psychiatric Services* might be the bizarre and counterintuitive position taken for many years by the American College of Emergency Physicians that "routine urine toxicology screens for drugs of abuse in patients who are awake, alert and cooperative do not affect ED management and should not be performed as a part of the ED assessment" (3). It is hard to imagine that any medical condition with an incidence as high as 1 in 3 would be ignored by our colleagues in emergency medicine, yet that is what this policy position does.

Until substance use disorders are treated as medical problems on par with schizophrenia and mood disorders, and as no different from poorly managed diabetes or acute chest pain, patients with behavioral emergencies may continue to suffer inadequate care at the hands of ED physicians.

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Repeal of Medicaid's IMD Exclusion

TO THE EDITOR: The National Association of State Mental Health Program Directors (NASMHPD) represents the state executives responsible for the public mental health service delivery systems in the states and territories. We read with interest the recent debate in *Psychiatric Services* on whether the Medicaid's institutions for mental diseases (IMD) exclusion should be repealed. Both sides in the debate made important points in their well-written position statements (1, 2).

We found it interesting that both debaters cited the same August 2016 Mathematica Medicaid Emergency Psychiatric Services Demonstration evaluation (3) to support opposing positions. That this citation was used by both parties is indicative of the scarcity of data available regarding the potential impact of the IMD exclusion and its repeal. The Centers for Medicare and Medicaid Services (CMS) recently proposed revising the Medicaid managed care rule. CMS leadership expressed reluctance to increase the limit on IMD services beyond 15 days per month under those rules because it had "conducted a literature and data review since publication of the [original] rule, but could not identify any new data sources other than those [it] relied upon in the 2016 final rule that supported 15 days" (4). CMS invited public comment on any data sources it may have missed supporting longer stays.

One week after CMS published the proposed Medicaid managed care rules revision, it issued State Medicaid Director Letter 18–011 authorizing state §1115(a) Medicaid waivers that would allow individuals with serious mental illness or serious emotional disturbance to be covered under Medicaid for IMD services for average stays of no more than 30 days. Those waivers will be conditioned on each participating state's maintaining its efforts in providing community-based services, especially crisis stabilization services, and reporting the full array of services offered by the state—a condition designed to ensure a comprehensive continuum of care. The waivers would require the reporting of data and measures to help ensure that future evaluations of the IMD exclusion would be evidence based.

NASMHPD strongly supports the need for a comprehensive continuum of care for individuals with serious mental illness, as illustrated by its *Beyond Beds* series of white papers (https://www.nasmhpd.org/content/tac-assessment-papers). One of the papers, written by the NASMHPD Research Institute, reviews the number of inpatient and community residential beds, including crisis beds (5).

The final decision on an IMD exclusion repeal must be evidence based. NASMHPD welcomes the waivers proposed by CMS as a way of quantifying the need for inpatient services and the effectiveness of providing those services as part of a continuum of care.

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Limited Availability and Use of Clozapine in State Prisons

TO THE EDITOR: Clozapine is a Food and Drug Administration–approved antipsychotic medication for both treatment-resistant schizophrenia and reduction in risk of recurrent suicidal behavior by persons with schizophrenia or schizoaffective disorder. Up to 30% of patients with schizophrenia that has not responded to other antipsychotics may benefit from clozapine (1). Furthermore, there is increasing evidence that clozapine may have benefits beyond these two indications, with an emerging literature suggesting efficacy in reducing impulsive, aggressive behaviors for patients with or without a psychotic disorder. Despite clozapine's benefits, this treatment is underutilized (2), likely because 1% of clozapine users may develop severe neutropenia, which requires both ongoing hematological monitoring and reporting to a national program.

The past few decades have seen a shift in where people with severe mental illness receive treatment. Estimates indicate that compared with a few decades earlier, ten times more people with severe mental illness are now treated in jails and prisons than in state psychiatric hospitals (3). The prevalence of severe mental illness in the general population is 4% (4), compared with three to four times that in incarcerated populations (5).

Although data exist for clozapine utilization in community settings across the United States, we were not able to find any reports of the frequency of clozapine use in jails or prisons. This letter aims to provide the first survey of clozapine utilization in state prison systems.

The Coalition of Correctional Health Authorities (CCHA) administered a national survey to each state correctional entity. The CCHA, a subgroup of the American Correctional Association and designed to promote excellence in correctional health care, represents each state prison system along with the Federal Bureau of Prisons. State representatives were informed that data would be reported only in aggregate in order to ensure privacy and confidentiality.

Data collection was approved by the University of North Carolina Office of Human Research Ethics. Twenty-one states (42%) responded, with one state unable to provide data. A total of 504,645 inmates were being held by the 20 states that responded (39% of the total state prison population). Of these 20 states, 13 (65%) reported that clozapine was available on their formulary, and seven (35%) reported that it was not. In states where clozapine was available, 191 inmates were receiving it (range 0–40 individuals, mdn=8 inmates per state).

These data from state prisons appear consistent with those from the nonincacerated population with severe mental illness in that clozapine is underused. Nevertheless, it was somewhat unexpected that one-third of states did not include clozapine on their formulary. Due to the shifting of treatment of individuals with severe mental illness from hospitals to state correctional facilities, the correctional facilities now have an additional responsibility to care for these inmates with evidence-based treatments. A recent white paper issued by the Substance Abuse and Mental Health Services Administration suggests that all correctional facilities should have the capacity to offer clozapine to inmates (6). Consideration needs to be given to help support correctional facilities with the additional resources and expertise needed to help adequately manage this vulnerable population.

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