

How Can Public Officials Protect the Rights of Prisoners with Mental Health Conditions?*

In the United States, state prisons and local jails house staggering numbers of people with mental illness. In March 2019, there were 1,306,000 people held in state prisons and 612,000 in local jails.¹ One third to one half of those prisoners have a mental illness.² In Massachusetts, in January 2019, 35% of men and 74% of women in state prisons had open mental health cases and 25% of men and 56% of women in those facilities were receiving psychotropic medication.³ Despite these numbers, appropriations for prison mental health care historically have been inadequate and access to treatment limited.⁴ Here, I'll describe the current situation in correctional mental health care and suggest what public officials should do to better serve prisoners with mental health conditions.

Federal and state constitutions and laws prohibit discrimination against prisoners with mental illness. Correctional officials must accommodate disability, maximize integration, and provide reasonable treatment for serious mental health conditions. (Additionally, the Eighth Amendment of the U.S. Constitution forbids cruel and unusual treatment; deficient mental health treatment may violate the Constitution.) Inadequate correctional mental health care not only constitutes disability discrimination, but it also exposes prisoners with psychiatric conditions to other discriminatory impacts. Compared with other prisoners, prisoners with mental illness have higher rates of segregated confinement (commonly defined as confinement to a cell for 22 or more hours daily),⁵ longer sentences,⁶ and a greater likelihood of recidivism.⁷

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¹ Prison Policy Initiative, *Mass Incarceration: The Whole Pie 2019* (Mar. 19, 2019), <https://www.prisonpolicy.org/reports/pie2019.html>.

² Olivia Kolodziejczak & Samuel Sinclair, *Barriers and Facilitators to Effective Mental Health Care in Correctional Settings*, *Journal of Correctional Health Care* (2018), at 253.

³ Mass. Department of Correction, *Quick Statistics*, <https://www.mass.gov/service-details/quick-statistics>.

⁴ *See, e.g.*, Doris J. James & Lauren E. Glaze, U.S. Department of Justice, *Mental Health Problems of Prison and Jail Inmates* (rev. Dec. 14, 2006), <https://www.bjs.gov/content/pub/pdf/mhppji.pdf> (there is only a 34% chance a state prisoner with a mental health problem has received any sort of mental health treatment since admission).

⁵ *See, e.g.*, Kolodziejczak and Sinclair, *supra* note 2, at 260. *See also* Garrett A. R. Yursza Warfield, *Managing Mentally Ill Inmates in Massachusetts: Risk Assessment, Classification, and Programming in a House of Correction: A Dissertation presented to the School of Criminology and Criminal Justice, Northeastern University* (Apr. 2012), <https://repository.library.northeastern.edu/files/neu:1031/fulltext.pdf>, at 109, 119, 135 (mental illness overrepresented in isolation and segregation units), and 135 (mental illness overrepresented in administrative segregation units).

These outcomes are predictable. Prisoners with mental illness may have trouble following rules or fitting in, resulting in segregation for punishment or protection. Once there, they cannot access rehabilitative programming that impresses parole boards or awards good time and they don't gain the skills-training that helps protect against reincarceration.⁸

The best approach is to divert people with mental health issues from the correctional system.⁹ Until workable diversion systems are widely available, however, persons with mental health issues will continue to arrive at correctional facilities in need of screening and care. Yet, "[t]he U.S. prison system often falls short of meeting acceptable standards of care."¹⁰

Even accessing psychiatric medication — the one type of treatment that correction agencies have routinely delivered¹¹ — can be challenging. A study of 14,499 state and 3686 federal prisoners found that more than 50% of those who reported taking medication for a mental health conditions at intake did not receive pharmacotherapy in prison.¹² In some cases, particular medications may not be available in prisons due to expense¹³ or concerns regarding abuse potential.¹⁴ The limitations can be significant. In Massachusetts, between 2010 and 2015, state prison mental health providers reduced the average number of prescriptions by 35%.¹⁵

⁶ See, e.g., James & Glaze, *supra* note 4 (state prisoners with a mental health problems stayed an average of 5 months longer than state prisoners without such problems); Samantha Hoke, Mental Illness and Prisoners: Concerns for Communities and Healthcare Providers, *The Online Journal of Issues in Nursing* (Jan. 2015), <http://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/Tab/eofContents/Vol-20-2015/No1-Jan-2015/Mental-Illness-and-Prisoners.html#James> (citing studies that found a 15 month differentiation).

⁷ Kolodziejczak and Sinclair, *supra* note 2, at 261.

⁸ For further discussion, see Hoke, *supra* note 6, at "Recidivism and Mental Health Concerns."

⁹ To do so, we must reduce entry not only into the juvenile delinquency and adult criminal justice systems, but also into the child welfare system, the beginning of "the cradle to prison pipeline." To accomplish those goals and keep people in their homes and with their families, we must direct more resources to community mental health care, which has been historically underfunded. See, e.g., MassLive, Mental Health Funding in Massachusetts Slashed While Prison Budgets Boosted, Attorney Says (updated Jan. 7, 2019), <https://www.masslive.com/news/2017/03/gov-charlie-bakers-budgets-str.html>.

¹⁰ Hoke, *supra* note 6, at "Brief Overview of Healthcare in Corrections."

¹¹ Kolodziejczak and Sinclair, *supra* note 2, at 258 (medication management considered less costly than regular psychotherapy).

¹² Jennifer M. Reingle Gonzalez & Nadine M. Connell, Mental Health of Prisoners: Identifying Barriers to Mental Health Treatment and Medication Continuity, *Am. J. Public Health* (Dec. 2014), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4232131/>.

¹³ See, e.g., Kolodziejczak and Sinclair, *supra* note 2, at 258.

¹⁴ See Hoke, *supra* note 6, at "Drug Abuse."

¹⁵ The Boston Globe Spotlight Team, "There may be no worse place for mentally ill people to receive treatment than prison yet a growing number end up in the 'new asylums,'" *The*

Raising new concerns, a recent report that pharmaceutical companies are marketing their drugs to correctional officials, sometimes including through the provision of free samples, could lead officials to select promoted medicines to the exclusion of potentially more appropriate ones.¹⁶

As the experiences of prisoners seeking medication suggest, it is imperative to monitor correctional mental health care for access and quality. Correction officials should welcome and encourage external oversight, which, as prisoner advocate Michelle Deitch argues, promotes the twin goals of transparency and accountability.¹⁷ Currently, public oversight of correctional facilities is sporadic and uneven at best. While some states have sophisticated citizen review,¹⁸ others have almost no regular, established, and empowered ways to shine public light on prison practices and conditions. One solution might be to utilize the kind of monitoring NAMI chapters have undertaken in psychiatric hospitals.¹⁹

Monitors face an initial hurdle of determining what resources facilities are devoting to mental health care. Correctional officials may not disaggregate mental and physical health expenditures. State dollars may not be distributed among counties in proportion to inmate population.²⁰ Even when mental health care spending is isolated and appears to be increasing,

Desperate and the Dead Series (Nov. 25, 2016), <https://apps.bostonglobe.com/spotlight/the-desperate-and-the-dead/series/prisons/>

¹⁶ Max Blau, Marketing Psychiatric Drugs to Jailers and Judges: Drug companies are courting jails and judges through sophisticated marketing efforts, *The Atlantic* (Dec. 31, 2019), <https://www.theatlantic.com/politics/archive/2019/12/pharmaceutical-companies-are-marketing-drugs-jailers/604264/>

¹⁷ Michelle Deitch, Special Populations and the Importance of Prison Oversight, *Am.J.Crim.L.* (2010), <https://www.equitasproject.org/wp-content/uploads/2018/01/Deitch-Special-Populations-and-the-Importance-of-Prison-Oversight.pdf>, at 104-105.

¹⁸ New York State has a good public monitoring program, run by the Correctional Association of New York and authorized by state law.

¹⁹ See, e.g., NAMI Michigan, A Resource Guide to Families Dealing with Mental Illness, https://www.michigan.gov/documents/MDCH-MentalIllness-10AUG04_102671_7.pdf, at 3 (one purpose of state chapter is to monitor existing health care facilities, staff, and programming for adequacy and accountability).

²⁰ For example, in Massachusetts in 2016, while Essex and Hampden counties each housed around 1,500 inmates, Essex has four mental health clinicians while Hampden employed more than 50, according to a survey conducted for *The Boston Globe* by the Massachusetts Sheriffs' Association. The Boston Globe Spotlight Team, *supra* note 15. Variation in health care spending across Massachusetts counties is routine. In FY 2016, Barnstable, Hampshire, and Middlesex each spent less than \$5,000 per inmate, while Bristol, Hampden, Norfolk and Suffolk each provided at least 40 percent more for health care services. Benjamin Forman & Michael Widmer, MassINC., Getting Tough on Spending: An Examination of Correctional Expenditure in Massachusetts (May 2017), <https://massinc.org/wp-content/uploads/2017/05/Getting-Tough-on-Spending-1.pdf>, at 14.

that may not necessarily mean increased resources for care.²¹ What appears as increased spending may reflect something else: inflation in medical costs, the concentration of funds on relatively more expensive programs that may not reach all prisoners with mental health needs, or privatization.

Many prisons and jails outsource their mental health services. A 2017 study found that over half the states have privatized at least some of their prisons and local jails, which suggests that mental health services would also be privatized.²² Likewise, a correctional accreditation agency estimates that about 70% of the jails that it certifies have privatized their medical services.²³ These trends extend to mental health care.

For example, in Massachusetts, the state correctional agency and multiple counties now contract with for-profit companies, including national entities, to provide their prisoners with mental health services. Only a few counties provide mental health services in-house or through contracts with local non-profits. It is difficult to undo these trends. When for-profit companies underbid community-based public or non-profit providers and put them out of the prison health care business, correctional officials are left with these corporate providers as their only choice.²⁴

As privatization becomes entrenched in correctional health care, officials should be wary. Private providers have a strong incentive to limit care in the interest of shareholders. And, corporate health care providers have faced numerous lawsuits across the country regarding quality of care in prisons.²⁵ Unfortunately, this private system that may not be as subject to external scrutiny as are public systems.

²¹ See, e.g., Wharton Public Policy Initiative, The Current State of Public and Private Prison Healthcare (Feb. 24, 2017), <https://publicpolicy.wharton.upenn.edu/live/news/1736-the-current-state-of-public-and-private-prison-for-students/blog/news.php>.

²² The Pew Charitable Trusts, Prison Health Care: Costs and Quality (Oct. 2017) at 14, https://www.pewtrusts.org/-/media/assets/2017/10/sfh_prison_health_care_costs_and_quality_final.pdf.

²³ Steve Coll, The Jail Health Care Crisis, *The New Yorker* (Feb. 25, 2019), <https://www.newyorker.com/magazine/2019/03/04/the-jail-health-care-crisis>.

²⁴ See Marsha McLeod, “The Private Option: One company has become the biggest provider of jail health care. Sheriffs are worried: “If you’re the only dance in town, you can pretty much call your own shots,” *The Atlantic* (Sept. 12, 2019), <https://www.theatlantic.com/politics/archive/2019/09/private-equitys-grip-on-jail-health-care/597871/>

²⁵ See Coll, *supra* note 22; Wharton Public Policy Initiative, The Current State of Public and Private Prison Healthcare (Feb. 24, 2017), <https://publicpolicy.wharton.upenn.edu/live/news/1736-the-current-state-of-public-and-private-prison-for-students/blog/news.php>.

To overcome these obstacles, corrections officials must allocate additional resources to formulating and managing their medical contracts. Particularly given the financial incentive to deliver minimal levels of care, contracts must include specific standards and penalties. Correction agencies should assign full-time, senior-level staff to rigorously monitor contract compliance and oversee service delivery.²⁶

External and internal monitors should look to the legal system for guidance when evaluating care. A growing body of case law requires that correctional mental health services include intake screening, assessment, staff training, adequate mental health staff, suicide prevention and response, treatment planning and service delivery (at the same levels as available in the community), exclusion from solitary, access to emergency care, hospitalization when inpatient care is needed, and adequate record keeping. Some courts have held that mental health must be factored in the disciplinary process. Monitors also should ensure compliance with National Commission on Correctional Health Care accreditation standards, although these provisions set only minimum benchmarks.²⁷

These authorities, while important, do not specify what mental health services should look like in corrections facilities. Unless states develop robust mental health care standards, corrections officials and their providers are left to create their own policies and practices. This can result in uneven, and potentially inadequate, levels of care.²⁸

Public officials can begin to remedy such deficiencies by offering instruction as to what prison and jail mental health care should include. Recent clinical research provides answers. For example, the most common diagnoses in correctional facilities – major depressive disorder, bipolar I, schizophrenia, and PTSD – can be effectively treated with a *combination* of medication and psychotherapy.²⁹ Specialized therapies, like cognitive-behavioral therapy and mindfulness-based therapies, have been shown to be effective in corrections.³⁰ Group therapies have also

²⁶ For a discussion of what types of professionals might provide this oversight, see Anthony Tamburello *et al.*, Correctional Mental Health Administration, *Int'l Rev. of Psychiatry* (2017), <https://www.tandfonline.com/doi/full/10.1080/09540261.2016.1248908>

²⁷ See, e.g., Josiah D. Rich *et al.*, The Need for Higher Standards in Correctional Healthcare to Improve Public Health, *J. Gen. Int. Med.* (Apr. 2015), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4371015/>.

²⁸ A lack of collaboration between state correctional agencies and their mental health counterparts – who may hold expertise in delivering mental health services – can also thwart the development of high standards. In Massachusetts, for example, the Department of Mental Health (DMH) has supported a statewide research center on mental health topics, promulgates clinical standards, and creates resource guides. However, cooperation between DMH and the Department of Correction has mostly been limited to DMH providing re-entry services.

²⁹ See Kolodziejczak & Sinclair, *supra* note 2, at 259.

³⁰ Isabel A. Yoon *et al.*, Outcomes of Psychological Therapies for Prisoners with Mental Health Problems: A Systemic Review and Meta-Analysis, *J. of Consulting and Clinical Psychology* (2017), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5518650/>.

been found to be as successful as individual therapy.³¹ Additionally, treatments used in the community should be imported, including for substance use.³² This array of services should be fully available.

Finally, correction officials must examine their own practices to ensure they are providing a safe and therapeutic environment. They should eliminate punitive mental health watches, make suicide resistant cells the norm, and provide individual and group therapy in comfortable environments, comparable to what one would experience in the community. A full-fledged paradigm shift is needed.

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³¹ Yoon *et al.*, *supra*.

³² Seena Fazel *et al.*, The Mental Health of Prisoners: A Review of Prevalence, Adverse Outcomes and Interventions, *Lancet Psychiatry* (2016), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5008459/>.