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Mental Health in U.S. Prisons: How Our System Is Set Up For Failure

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Claremont McKenna College

Mental Health in U.S. Prisons: How Our System Is Set Up For Failure

Submitted to
Professor Hwang

By
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Abstract

During the past 60 years, United States prisons have become one of the primary institutions caring for mentally ill individuals. Factors such as privatization of mental health care with a focus on profit-maximization, ineffective jail diversion programs, and unsuccessful mental health courts have contributed to prisons having an increased population of mentally ill inmates. In fact, about 20% of people who are currently incarcerated suffer from a major mental illness (Mason, 2007). Other elements outside of the justice system such as a lack of mental health awareness and a lack of resources have led to damaging interactions between the mentally ill and law enforcement and have added to this growing rate of mentally ill incarcerated. Given the harsh realities of prison, this overrepresentation of those suffering from mental illness is even more concerning and is worsened by aspects of prisons such as solitary confinement. This issue coupled with the lack of appropriate mental health care services being provided and the lack of support after release has led those suffering from mental illness to be potentially worse off than when they entered prison. This paper focuses on mental health care in prisons from admittance to post-release and provides evidence for the need to overhaul how those suffering from mental illness are treated. The responsibility of mental health care has been placed on prisons due to the escalation of inmates with mental illness, the failure of programs inside the justice system, and the lack of post-release follow-up. The physical setting, behavioral interactions, and personnel influences in prisons have led to worsening symptoms and have inhibited the ability to effectively treat these inmates. Given 95% of inmates will be released, these issues need to be addressed more comprehensively for the benefit of our society as a whole (Binswanger, Nowels, Corsi, Long, Booth, Jutner, & Steiner, 2011).

Keywords: mental health, mental illness, prisons, incarceration, inmates

Why Mental Health Issues Should Be a Primary Concern for Prisons

From Deinstitutionalization to Reinstitutionalization

As a collective society, we have attempted to care for mentally ill individuals in numerous ways. Most recently, we have favored psychiatric institutions, community centers, and prisons. The use of psychiatric institutions had been a common practice dating back to the 18th century (Ozarin, 2006). However, many of these institutions were not well maintained and were providing inadequate living conditions and rehabilitation for mentally ill individuals. In an effort to expose these circumstances, O’Keefe and Schnell (2008) found news sources publicized environments of “abuse, neglect, and unsanitary living conditions” to encourage a need for improvement (p. 82). In conjunction with these publications, “new psychotropic medications were [being] developed” with the intention of using these drugs in community mental health centers (p. 82). These changes stimulated a more compassionate approach to treating mental illness without the harmful effects of psychiatric hospitals. Additionally, moving to a more community-centered treatment was thought to reduce costs of treating mentally ill at inpatient hospitals, although later this was found not to be true.

During this time, legislation to close numerous state mental hospitals was passed. The Community Mental Health Act of 1963 was one such piece of legislation, which provided monetary support to community mental health centers and instigated deinstitutionalization (Kliwer, McNally, & Trippany, 2009). At this time, large numbers of individuals were released from mental health hospitals leaving a limited number of psychiatric hospital beds available (Lamb & Weinberger, 2005). Between 1955 and 1995, the number of inpatients decreased from 560,000 to 77,000 as cited by the Department of Health and Human Services (O’Keefe &

Schnell, 2008). This number continued to decrease over the years until most psychiatric hospitals closed (Lamb & Weinberger, 2005).

With the passage of the Act of 1963, O’Keefe and Schnell (2008) found individuals with mental illnesses were urged to move “closer to their families and live more normal lives” (p. 83). However, this reality was not always feasible. Additionally, the mental health reforms passed were largely “over-compensatory in nature” and many individuals with mental illnesses were suddenly not in hospitals to receive the care they required (p. 83). Given individuals needed treatment for their mental illnesses, funding was required to support these community programs. During this time, finances were tight “from the Vietnam War and the economic crisis in the 1970s” (p. 83). Because of these pressures, many mental health care programs could not be funded leaving individuals in the community without treatment.

The lack of community resources created a tremendous problem for the growing number of mentally ill individuals. The most immediate concern stemming from this issue was the lack of care. Outpatient clinics were under-resourced and were not able to provide adequate treatment. Meanwhile, a growing homeless population with mental illnesses continued to rise. To add to this concern, O’Keefe and Schnell learned individuals who were left untreated were likely to “experience survival difficulties that can elicit criminal activity” (p. 83). As a result, mentally ill individuals were homeless and committing crimes due to the lack of resources available to them. These circumstances led to reinstitutionalization, a process by which mentally ill entered prisons after carrying out crimes, many as a result of their illnesses (Dike, 2006). From deinstitutionalization of psychiatric hospitals to reinstitutionalization in prisons, mentally ill individuals moved from one confinement to the other, setting the stage for prisons’ mental health response.

How Prisons Came to Manage Mental Health Care

There are numerous reasons for prisons to have mental health care. Some inmates entering the prison system have a psychiatric history and have committed a crime either due to their illness or not. Others have a psychiatric disorder that gets re-triggered in prison because of the high stress environment and lack of sufficient treatment. Some prisoners have never had a mental health issue and develop one in prison such as depression, most often as a result of feeling guilty for their crimes. For these individuals especially, providing appropriate services is essential so they have a chance to rehabilitate and reduce their chance at reoffending. Regardless of how individuals develop or live with their illnesses, ensuring there is effective mental health care in prison is critical. The failure of mental health courts and a profit-driven mental health care model both contribute to a high percentage of inmates having a mental illness adding to prisons' responsibility for such treatment.

Ineffectiveness of Mental Health Courts

Lamb and Weinberger (2005) looked at the establishment of mental health courts, which is one program to deter the number of inmates with mental illness entering the prison system. These courts are designed to “hear cases of persons with mental illness who are charged with crimes” with the goal of reducing the criminalization of mental illness (p. 532). When going through this court system, a treatment plan is created including “medications, therapy, housing and social and vocational rehabilitation all in an effort to address the individuals’ mental illnesses and reduce their risk for recidivism” (p. 532). In theory, these courts would be beneficial because mentally ill individuals often commit crimes due to their illnesses. However, the “limited budgets of the Departments of Mental Health” and the already tight criminal justice

budget often prevent resources from being allocated to this program, therefore it is largely ineffective.

Increasing Privatization of Mental Health Care

With the increasing number of inmates with mental illnesses, prisons had to provide treatment for these individuals. Daniel (2007) analyzed the most popular approach, which was to hire personal staff for a prison and “directly administer mental health and medical care to offenders” (p. 407). However, rising costs of health care, personnel expenses, “lack of qualified health care professionals to work in prisons, lack of visionary correctional leadership, and increasing litigation” led to numerous states privatizing medical services including mental health care (p. 407). Furthermore, with the increasing number of mentally ill in prisons, more psychologists were needed to provide services. To incentivize working in a prison, higher salaries were required for prison psychologists, but still many prisons are understaffed. As of 10 years ago, about half of the states in the United States used private vendors for correctional health care services and this number has been steadily increasing. Some states such as Oklahoma, Connecticut, and Texas do not use private vendors and contract entirely with medical schools. Little research has been done to understand “which model is best suited to deliver adequate, reasonable, and cost-effective mental health and psychiatric services in correctional systems” (p. 407). However, the privatization of mental health encourages prisons to focus on profits, instead of the treatment being given leading to worse overall care. Inmates need and have a right to mental health treatment while in prison; therefore prisons should make this treatment a priority (Klein, 1978).

Factors Contributing to Rising Rates of Mentally Ill Inmates

As previously discussed, there was a substantial “lack of awareness of the needs of and support for people with manageable, or curable, mental illnesses in the community” (MacDonald, Hucker, & Hebert, 2010, p. 1399). Even if there was community awareness, the “lack of access to adequate treatment for mentally ill persons” was an insurmountable obstacle for many people (Lamb & Weinberger, 2005, p. 530). These issues led to homelessness and basic survival needs not being met, which resulted in criminal activity and increased interactions between mentally ill individuals and law enforcement.

Criminalization of Mental Illness Leading to Incarceration of the Mentally Ill

With reinstitutionalization, mentally ill individuals were becoming integral parts of the criminal justice system largely due to their higher propensity to commit crimes (Diamond, Wang, Holzer, Thomas, & Cruser, 2001). The greater number of people living in communities not receiving treatment increases “the likelihood that these individuals may come to the attention of law enforcement” (Lamb & Weinberger, 2005, p. 531). In fact, mentally ill people are “64-67% more likely to be arrested than those without a psychiatric condition” (Mason, 2007 and Soderstrom, 2008, p. 12). Furthermore, “42% of crimes committed by the mentally ill are related to symptomatic expression and 30% are related to survival” leaving a small percentage directly linked to criminal behavior (O’Keefe & Schnell, 2007, p. 83). Most mentally ill individuals are arrested for “minor crimes” that are explained by “their illness” rather than violence (Dike, 2006, p. 300). For example, individuals with schizophrenia “are more likely to be arrested for trespassing, theft, property destruction, assault, battery, drug possession and drugs sales” (Temporini, 2010, p. 121). Given these statistics, mentally ill individuals’ increased interaction with law enforcement can largely be explained by their illnesses.

Individuals with a mental illness are more likely to come into contact with law enforcement and have a negative result. When these individuals confront police, they may be “experiencing psychiatric symptoms or social disruptions related to their disability” causing them to act unlawfully (Borum, 2004, p. 293). Upon arrest, these people receive a police record, which criminalizes their mental illness. If a mentally ill person gets arrested again, police may develop a “tendency to choose the criminal justice system over the mental health system (Lamb & Weinberger, 2005). “Law enforcement, legal, and mental health professionals...are concerned that the criminal justice system has become a predominant disposition for many difficult-to-manage mentally ill persons in need of treatment” (Lamb & Weinberger, 2005, p. 531). This cycle has largely contributed to the increased number of incarcerated individuals with mental health issues.

To break this cycle with law enforcement, many measures could be in place to handle individuals with mental illness differently than other offenders. To begin with, police officers could be better trained and equipped to recognize symptoms of mental illnesses and be able to respond accordingly. Mental health training for police officers varies by community and is largely dependent on the city having a Crisis Intervention Team (CIT) to respond to situations with mentally ill individuals. Borum (2004) describes some examples for effective diversion. Police departments could have CIT programs and have officers specialize in handling mentally ill individuals. A more established screening process could be implemented to detect people suffering from mental illnesses. Lastly, having more accessible alternatives to jail or prison would allow for mentally ill people who are diverted to receive adequate care as a result.

Responsibility of Prisons to Manage Mental Health

“Correctional mental health services initially were developed primarily as a means of

suicide prevention and secondarily as a crisis intervention program, often in response to court-imposed mandates. Over the past several decades, in the context of deinstitutionalization, the public mental health system has deteriorated to the point that for many persons with mental illness, the correctional system has become the primary provider of assessment and care.” (Dlugacz & Roskes, 2010, p. 395-96).

One study described the continual incarceration of mentally ill individuals in this way: “jails have become the new mental hospitals” (Morrissey & Cuddeback, 2008, p. 524). This expression accurately describes the overrepresentation of mentally ill individuals in prison. Another researcher explained the “misuse of prison to address apparent public safety by incarcerating people with significant mental illness” as an “abuse of power, and an infringement of human rights” (Fraser, 2009, p. 139). This concern relates back to the transformation of using prisons as a way to protect the public versus a vehicle to treat mental illness.

Some argue, the criminal justice system should offer “mental health services only as a last resort to meet obligations concerning the conditions of safe confinement mandated by the U.S. Constitution (Morrissey & Cuddeback, 2008, p. 524). Others believe inmates have a constitutional right to health care services while incarcerated and efforts should extend beyond the minimum requirements for the sake of recidivism and the good of society. The Affordable Care Act and mental health parity laws have encouraged a move towards all people gaining access to appropriate mental and physical health care. Prisons and prisoners should not be exempt from these guidelines and should be held to the same standards. To complicate the issue, there is considerable debate around what services are necessary for mental health treatment. Some argue, “services should focus on assessment, crisis stabilization, and diversion – not on long-term treatment,” while others take a more inclusive service approach (Morrissey &

Cuddeback, 2008, p. 524). Little consensus has been reached on these important issues and prisons continue to bear responsibility for mental health care.

Overrepresentation of Mentally Ill Inmates in Prisons

What do the Statistics Say?

The United States incarcerates more people than any other country by far. In fact, the United States has the highest rate of incarceration among developed countries with 2.2 million currently in jails and prisons (Daniel, 2007). Among these individuals in prison, those with a mental illness are significantly overrepresented (Diamond et al., 2001). Estimating the prevalence of mental illness in prisons is challenging due to “prison populations, sub-groups, sampling techniques, sample sizes employed, type of psychiatric assessment instruments used, [and the] definition of mental illness applied” among other factors (Fries, Schmorrow, Lang, Margolis, Heany, Brown, Barbaree, & Hirdes, 2013, p. 317). To address some of these issues, this paper will report a range of statistics, while acknowledging all estimates are imperfect.

According to the National Epidemiologic Survey on Alcohol and Related Conditions, about 11% of the U.S. population, age 18 or older, meets the criteria for a mental health disorder (NESARC) (James & Glaze, 2006). Comparing that rate to the one in jails and prisons, according to the American Psychiatric Association, about 20% of inmates currently have a serious mental illness as of the last 12 months (Mason, 2007). Other studies suggest a current prevalence rate of 15-31% for inmates having a mental illness, but a higher lifetime rate of 24-70% (Fries et al., 2013). One study by the U.S. Department of Justice Bureau of Justice Statistics in 2006 surveyed state and federal prisoners and found 56% of state prisoners and 45% of federal prisoners had a potential mental illness (Fries et al., 2013). Other estimates by the Treatment Advocacy Center in a 2010 study found “there are three times as many seriously mentally ill persons in jail and

prisons than there are in hospitals” (Fries et al., 2013, p. 316). This number is to be expected given the decline of hospitals in recent decades.

Rates for specific mental health disorders are higher across the board for many illnesses. Temporini (2010) discussed such rates and found “major depressive disorder, bipolar disorder and other affective disorders are more prevalent in samples of incarcerated individuals than in general population samples” (p. 124). Other anxiety disorders such as posttraumatic stress disorders are “higher among incarcerated individuals than among their community counterparts” (p. 124). Finally, there are a higher “proportion of individuals in custody (with) [a] personality disorder” (p. 127). These rates further exemplify how the proportion of individuals with a mental illness is higher among inmates than the general population.

There is a fourth dimension to mental illness that is substance use. Given the high level of co-morbidity with substance use and mental illness, it is necessary to acknowledge one rarely exists without the other. Studies suggest that approximately 20% of inmates have a mental illness. Of that 20%, approximately “75% have a co-occurring substance use disorder” (Mason, 2007, p. 11). Another estimate reported the “overall percentage of prisoners who suffer from a mental health problem and/or drug dependency is estimated to be 60-65%” (Fraser, Gatherer, & Hayton, 2009, p. 411). As demonstrated, those inmates who suffer from a mental illness often have substance use problems as well, which adds to the complexity of diagnosing and treating these issues. However, given the complexities and uniqueness of substance use issues and its treatment, addressing substance use is beyond the scope of this thesis.

How Prisons Treat Mental Illness

Prisoners have a constitutional right to mental health treatment while incarcerated under the Eighth Amendment of the U.S. Constitution. Not only is this treatment a right, but it

mitigates the “unnecessary extremes of human suffering that can be caused by untreated mental illness (Soderstrom, 2008, p. 9). For these reasons, mental health treatment is of grave importance and can be delivered using a variety of techniques.

While incarcerated, prisoners suffering from mental illness must receive some level of care to avoid unnecessarily cruel punishment as defined in the Eighth Amendment. Temporini (2010) describes mental health care services and what prisoners are legally obligated to receive. Under the Eighth Amendment, prisoners are entitled to medical care including psychiatric and psychological care. Prisoners diagnosed with a mental illness are entitled to a screening and evaluation, a detailed treatment plan, staff to execute such plan, records of the mental health treatment, a suicide prevention and treatment program, and medication with supervision and evaluations. These expectations are guaranteed under the National Commission on Correctional Health Care and are systematic across U.S. jails and prisons. Yet, within each institution, the execution of these services has varied results. For example, the amount of therapy and level of post-release services are dependent upon the institution. Given such variation, these expectations are beneficial in attempting to maintain a standard of care, but in reality, fall short of meeting such goal.

Trencin Statement to Spur Discussion About Mental Health in Prisons

Fraser et al. (2009) provided background on the Trencin statement. To start the conversation about how mental health is conducted in prisons, this statement was delivered by the World Health Organizations’ Health in Prisons Project in 2007. In the declaration, they discussed how prisons are “becoming 21st century asylums for the mentally ill” and are “unsuitable places with limited help and treatment available” (p. 411). The following excerpt is regarding the declaration:

‘The ethos of prison is wrong. Resources, facilities and clinical skills are usually inadequate, the institutions are not geared to therapeutic environments. People with very high needs fail to thrive. Responding to the needs of people with severe and enduring mental illness who are acutely unwell is a complex matter – it is expensive for whichever system responds to their needs...as a great majority of prisoners will at some point return to the community, it is in the best interests of society that a prisoner’s health needs are met, that the prisoner is adequately prepared for re-settlement and that the causes of re-offending are addressed’ (p. 411).

This statement “places prisons and [the] mental health agenda in the context of broader health needs” (p. 412). By appealing to a wider audience and making the needs of prisoners pertinent to those outside of the criminal system, it legitimizes the problem and adds gravity to the situation. The Trencin statement encouraged thinking and a refresh of how mental health services are delivered in prison, which contributed to how our system is set up and run today.

Role of Mental Health Professionals in the Prison System

Management and care of mental health requires the work of numerous individuals to be done successfully in prison. For effective treatment, Temporini (2010) looked at “psychiatrists, psychologists, nursing staff, social workers, and correctional officers” and their important roles (p. 140). To begin with, prisoners first interact with psychologists during psychological evaluations upon entry into prison. Psychologists have played a growing role in serving mentally ill in prisons due to the higher proportion of the prison population having a mental illness. However, due to the untraditional work environment, many psychologists need further motivation such as higher pay or other benefits to work in such a place. Nonetheless, if an inmate does have a mental illness, they may be referred for “crisis, individual, and group

psychotherapy” offered by psychologists (p. 141). The amount of therapy and the manner it is delivered in are dependent upon the institution. Most often, therapy is delivered on an individual basis or in a group setting. Another vital role performed by psychologists is to “train correctional staff in the recognition and management of inmates who may require special management” or be in need of mental health services (p. 141).

Once a prisoner is receiving mental health treatment, they will encounter psychiatrists or other nursing staff. One of the primary roles of these individuals is to “distribute medications” and ensure inmates take the medication and do not “cheek” it for the purpose of “passing it to others or saving it for later use” (p. 141). If prisoners have undergone an evaluation and are determined to need medication, they are guaranteed that medication. Psychiatrists also track prisoners’ symptoms, conduct “assessments of suicidality,” and may direct therapy sessions (p. 141). Psychiatrists are critical to effective mental health treatment because often without medication, these inmates will not improve.

Correctional officers interact with prisoners most frequently and are therefore, essential for referring inmates for mental health treatment. Officers are “usually the first to observe changes in inmates’ behavior that correlate with the presence of psychiatric symptoms” (p. 143). For this reason, they “can encourage inmate participation in mental health programming and medication compliance” and can also signify to psychologists and psychiatrists if further intervention is needed (p. 143). By having an understanding of the symptoms of mental illness, correctional officers can be the eyes and ears to other mental health staff during or before the treatment process.

Finally, social workers operate on behalf of inmates to those outside of the prison system. When prisoners are released, they can work with social workers to connect “with outside

agencies” to continue their mental health care (p. 141). Social workers “can mobilize appropriate resources to aid inmates with community reinsertion” ensuring their progress made in prison does not get reversed (p. 142). By having social workers as the final connecting piece from treatment inside prisons to services outside of prison, this continuity ensures inmates are ideally set up for success when they are released. However, this practice is not always a reality, as we will see with recently released inmates and recidivism rates.

Physical Surroundings, Behavioral Interactions, and Prison Personnel Negatively Influence Mental Health in Prison Environments

Physical Surroundings Exacerbate Mental Health Symptoms

Prisons were designed to punish individuals who committed crimes and to keep the rest of society safe from dangerous individuals. Prisons were not built to treat mental illness and therefore, such treatment is unlikely to be beneficial in this environment due to numerous factors. One such factor is the physical setting of prisons. As the United States continues to incarcerate more and more people, we have not been expanding prisons, which has led to a major overcrowding issue. “Overcrowding has a negative influence on mental health” as inmates are often forced into contact with people and do not have any privacy to manage their illness (Fraser et al., 2009, p. 411). “Enforced solitude, lack of privacy, and isolation from social networks” are common complaints from prisoners who desire control in their life (Fraser et al., 2009, p. 412). Other concerns reported by prisoners have been “excessive noise and uncomfortable temperatures,” which have worsened their quality of life (O’Keefe & Schnell, 2008, p. 86).

Unhealthy Daily Routines Reduce Inmate Satisfaction

Inmates have highly structured days and do not make many choices for themselves in terms of their daily movement. Inmates are told when to be in their cells, when to eat, and when

to shower, among other demands and only occasionally choose how to spend their own time. These practices can make release from prison especially difficult, as inmates have not been making these choices for themselves. Fraser et al. (2009) found some common objections of prisoners are a “lack of meaningful activity and the monotony of the regime” (p. 412). Prisoners have little input into what they want to do on a daily basis, therefore being told what to do every day, particularly when the activities are not very engaging, can be tiresome. Other internal prison problems include, “poor diet, limited access to physical activity, and accessing health care and counseling services” (p. 412). Prisons were not designed with inmate comfort in-mind; therefore these issues though significant to inmates, are not of high importance to those running or funding the institutions.

Inmates are largely disconnected from the world outside of prisons so worries about “family, unresolved past life traumas and insecurities about the future” can be especially challenging to deal with (p. 412). Though some prisoners can communicate with family and friends via phone calls, notes or in-person visits, these methods are rarely satisfactory for keeping up with life outside of prison. All of these pressures and practices can worsen mental illness and be additional problems for inmates to address.

How Prison Personnel are Harmful to Inmates and Particularly the Mentally Ill

By far the most deleterious effects of prison come from the people on the inside. Inmates as a whole are considered to be a dangerous group of people. Prisoners frequently encounter “bullying, marginalization, stigma, and discrimination” and these experiences can “have a negative influence on mental health” (p. 412). “The abrasive atmosphere...when compounded with mental illness can easily trigger behavioral infractions (yelling, aggression) which [can] lead to punitive consequences” (O’Keefe & Schnell, 2007, p. 86). This cycle of negative

experiences leading to disciplinary actions keeps prisoners, and particularly mentally ill prisoners, in a constant state of fear and stress.

Other causes of anxiety in inmates' lives include the "lack of autonomy" as previously mentioned and "humiliation," which can come from prisoners or officers (O'Keefe and Schnell, 2008, p. 86). When prisoners experience these issues, they often cannot process them or trust anyone enough to talk to them about their problems (Fraser et al., 2009). If they do, this action could exacerbate tensions with cellmates and lead to conflict (Fraser et al., 2009).

Mentally ill "are often targets of predacious inmates in part because of their comprised mental functioning and also because their allegations may be taken less seriously by prison staff" (O'Keefe & Schnell, 2008, p. 87). "Limited behavioral control makes mentally ill appear mentally weak and vulnerable" leading them to be targets for "abuse and manipulation" by other inmates, particularly in the form of physical and sexual assaults (O'Keefe & Schnell, 2008, p. 87). Other concerns for mentally ill prisoners come from the prison staff. Prison staff "exacerbate their difficulties" by putting "disruptive inmates [into] disciplinary or administrative confinement settings" (Toch & Kupers, 2007, p. 1). A personal account recalled "guards and employees...call[ing] people 'crazies to their face and...dehumaniz[ing] them so they can justify their treatment of them" (Weaver, 2007, p. 51). Mentally ill are already at a great disadvantage while in prison and inmates and prison staff aggravate these challenges by their treatment.

How Solitary Confinement Exacerbates Mental Health Issues

Individuals who suffer from a mental illness are more likely "to be written up for breaking institutional rules" (Parker, 2009, p. 641) due to their unruly behavior. Maintaining a safe and secure prison is a top priority for correctional officers, therefore disruptive behavior, as a result of a mental illness, leads mentally ill prisoners to be found in violation of institutional

rules. For this reason, “offenders with mental illness are thus more likely to be housed in more restrictive settings” or “high-security solitary confinement units” (Parker, 2009, p. 641 and Soderstrom, 2008, p. 7). Being in a more restrictive or confined space can be triggering for those who are mentally ill. Due to the lack of human interaction, lack of privileges given, limited mental health care services provided, and other consequences, prisoners experience worse mental health symptoms.

Physical Confinement Conditions Damaging to Inmates

Solitary confinement is reserved for the most disruptive and/or dangerous criminals in prison. Beven (2005) described the goal of confinement as to remove inmates who cannot be controlled from the general prison population and to encourage inmates to “conform his or her actions to institutional standards of acceptable behavior” (p. 210). For these reasons, confinement is an intentionally unpleasant and emotionally damaging experience. This experience is even worse for individuals suffering from a mental illness.

Time Spent in Confinement Worsens Harm to Inmates

Though there are some recent restrictions on the amount of time an inmate can spend in confinement, it largely depends on the state and prison. Furthermore, any amount of time spent in confinement is purposely dreadful. Beven found inmates are locked in a cell “for as many as 23 hours per day” and this experience can “continue indefinitely” (p. 210). On average, prisoners spend about three months in solitary confinement, although it is contingent on the reason for being sent to confinement initially (p. 210). Spending an extended period of time in solitary confinement can exacerbate existing mental health symptoms or may trigger the onset of an illness.

Limited Privileges in Confinement Add to Punishment

Solitary confinement is intended to be a punishment for the most uncontrollable criminals. To serve as such, common restrictions are put in place to make the experience as miserable as possible. Some constraints include a lack of privileges or challenges getting the same resources as the general prison population. Examples include, “noncontact visitation, solitary recreation, no work, no religious programs, no group programs, no school (only self-study in cell), meals alone in cell, restricted shower schedule, clothing restriction, no (or restricted) access to television, radio and phone, no library/law library access, restricted commissary list, restricted list of personal items in cell, and no art or music programs” (p. 212). Physical movement is restricted by sheer nature of the cell and “incarcerates are shackled and restrained whenever they are in the presence of others” (Arrigo & Bullock, 2007, p. 626). Not having these freedoms would be largely unpleasant for any individual, but when suffering from a mental illness, these consequences can be even worse.

Another consequence of solitary confinement is the “diminished environmental stimulation” and lack of “social contact with other inmates” (Beven, 2005, p. 212). Humans are social creatures and need some stimulation to remain sane. This inadequate environment for human interaction causes individuals to lose their minds and if one has a mental illness, these conditions could be detrimental to one’s mental health.

Due to the nature of inmates who are in solitary confinement, officers may use excessive force to make an example of these prisoners to act as a deterrent for others. “Correctional officers frequently employ violent cell extractions in response to minor infractions” (Arrigo & Bullock, 2007, p. 626). This habit of violence continues with the use of “batons, shields, tasers, and rubber bullets” to remove prisoners from cells (Arrigo & Bullock, 2007, p. 626). There are many motivations not to be placed in solitary confinement, however when inmates have a mental

illness, they are at an increased chance of being sent there due to their symptoms and can experience harmful consequences as a result.

Development of Mental Illness Symptoms and Other Damaging Effects of Solitary Confinement

Being in an environment with limited stimulation and practically no human interaction can cause individuals to experience negative feelings and even develop a mental illness. How intense these symptoms are is determined by the “duration of segregation, the extent of isolation, the degree of environmental stimulation deprivation,” and the prisoner’s mental state (Beven, 2005, p. 213). Arrigo and Bullock (2007) reported inmates who spend long periods of time in solitary confinement “are at increased risk for developing symptoms of mental illness” (p. 628). For example, depression and impulse-control disorders are correlated with social isolation, the most extreme case being solitary confinement (p. 628). As previously discussed, prisoners with mental illnesses have an increased chance of being placed in confinement and being housed in such an environment can trigger “psychiatric symptoms” (p. 628).

While in solitary confinement, prisoners experience a multitude of symptoms. “Psychological effects can include anxiety, depression, anger, cognitive disturbances, perceptual distortions, obsessive thoughts, paranoia, and psychosis” (Metzner & Fellner, 2010, p. 104). Other health concerns include “appetite and sleep disturbance...social withdrawal, [and] cognitive impairment” (Morgan, Smith, Labrecque, Gendreau, Gray, MacLean, Van Horn, Bolanos, Batastini, Mills, 2016, p. 440). Indicators of psychological deterioration include, “restlessness and agitation, concentration and memory impairment, irritability...apathy...generalized anxiety and panic attacks, and irrational suspicion” (Beven,

2005, p. 213). Among the most severe effects include “suicidal behavior, and self-mutilation” (Arrigo & Bullock, 2007, p. 628).

All of these symptoms can be even worse if an inmate has a mental illness or could lead to the development of one in solitary confinement. “Stress, lack of meaningful social contact, and unstructured days can exacerbate symptoms of illness or provoke reoccurrence (Metzner & Fellner, 2010, p. 105). Other reports suggest, “lack of human interaction and limited stimulus” can worsen mentally ill inmates (Soderstrom, 2008, p. 7). Those with illnesses “will not get better as long as they are isolated” and often require “crisis care or psychiatric hospitalization” after confinement (Metzner & Fellner, 2010, p. 105). These effects lead to the deterioration of prisoners with or without mental illness, which calls into question the admissibility of this practice.

The longer a prisoner is held in solitary confinement, the worse symptoms they will likely experience. Inmates with a mental illness will have “a more damaging effect” with “lasting emotional” impairment (Beven, 2005, p. 214 and Morgan et al., 2016, p. 440). The result of this practice has led some to describe the prison system as a “warehouse for the mentally ill,” but also as “an incubator for worse illness and psychiatric breakdowns” (Soderstrom, 2008, p. 8).

Lack of Mental Health Care and Resource Limitations Contribute to Insufficient Treatment

Delivering mental health care services in prison is a challenge and in solitary confinement is even more difficult. The limitation of mental health services often includes “psychotropic medication, a healthcare clinician stopping at the cells front to ask how the prisoner is doing, and occasional meetings in private with a clinician (Metzner & Fellner, 2010, p. 105). Mental health treatment also varies by prison facility and staff and may include more or

less services. Lack of treatment can be a result of a variety of reasons including limited “office space for private interviews and counseling, absence of secure mental health group program facilities, segregation cells that afford inadequate observation, communication and ventilation” among other explanations (Beven, 2005, p. 215). Aspects of treatment that may be typically offered in prison are not always available in solitary confinement due to “insufficient resources and rules requiring prisoners to remain in their cells (Metzner & Fellner, 2010, p. 105). Examples include “individual therapy, group therapy, structured educational, recreational or life-skill-enhancing activities” (Metzner & Fellner, 2010, p. 105). Given these treatment limitations, alternative methods have become commonly practiced.

Temporini (2010) studied telepsychiatry, which is one kind of treatment that has become an increasingly popular option in solitary confinement. Telepsychiatry is the “use of electronic communication and information of technologies to provide or support clinical psychiatric care at a distance” (p. 139). Because prisons are such a unique setting for treatment, telepsychiatry has “played a significant role in psychiatric assessments and treatment in correctional settings” (p. 139). As of 2001, “26 states used some form of telemedicine” and this number has since risen (p. 139). This method is popular in the prison setting due to the improved safety and security that come along with it. Another benefit of the method is its success rate. “Studies of incarcerated populations show no difference between telepsychiatry and face-to-face therapy in measures of perceptions of the therapeutic relationship, postsession mood, or general satisfaction with services” (p. 140).

Though the benefits outweigh the drawbacks, there are a few downsides to telepsychiatry. Because clinicians are not in the physical presence of the inmates, there is the “possibility of individuals refusing the evaluation” (Temporini, 2010). Prisoners could also make “threats of

self-harm or harm to others” and “in those cases, presence of an on-site clinician becomes paramount” (p. 140). If a clinician needs to be there in case of extreme circumstances, telepsychiatry might not be the best method of treatment and an in-person approach could be better. Nonetheless, telepsychiatry remains a widespread and strong alternative for prisons treating mentally ill inmates.

You are Released, Now What?

Though the United States has a high rate of incarceration, we also have a high release rate. As of 2002, an estimated 650,000 adults are released from prisons every year (Dlugacz & Roskes, 2010). Another study suggests 95% of prisoners will ultimately be released (Binswanger et al., 2011). Given the vast majority of individuals sent to prison are released, as a country, we should care what inmates are doing while imprisoned and should provide opportunities for rehabilitation and self-improvement. As this paper details, there is ample room for progression in mental health care aspects of prison and this paper encourages this change to take place.

When an individual is released from prison, there are certain programs in place to assist with their transition. Outreach to community partners such as organizations and agencies ensure prisoners have a support system to aid them in not re-offending. Depending on the institution, quantities of medication are given to recently released inmates to hold them over until they can connect with a doctor outside of prison. Nurses, social workers, physicians, and other individuals work on behalf of recently released inmates to get them connected in the community. These services have varying levels of success and are described in more detailed below.

Going Home Reentry Initiative for Serious and Violent Ex-Offenders: Program to Aid Released Prisoners

Though there is progress to be made internally in prisons, this section will focus on released convicts and studies and programs to help these individuals succeed. One such program investigated by Flanagan (2004) to help offenders get the mental health support they need post-release is the Going Home Reentry Initiative for Serious and Violent Ex-offenders. This federal program “provides funding to support a variety of general transitional health-care models” (p. 43). The objective of this program is to decrease re-offense and “encourage individuals, government agencies, social service organizations, community organizations, and faith-based organizations to make re-entry of the offender population a priority” (p. 43). This program functions using three phases. The first, “Protect and Prepare,” starts in prisons themselves and provides “education, mental health treatment, substance abuse treatment, and assessment” (p. 43). The second and third phases entitled “Control and Restore” and “Sustain and Support” work conjunctionally in the community. These phases include “monitoring, mental health and substance abuse treatment, mentoring, and community service networking” (p. 43). Through these efforts, this program aims to reduce recidivism and provide necessary support for individuals in and outside of prison.

Effectiveness of Transitional Health Care in U.S. Prisons

Programs like the one described above have varying levels of breadth to their offerings. Flanagan (2004) continued to study such inclusions for transitional health care from prisons to communities. To do so, researchers sent surveys to the “chief medical officers at one of the 50 state corrections departments in the United States” (p. 46). Over half of the chief medical officers participated with a response rate of 31 corrections departments. The following were their results: 87% included a referral to community agencies, 77% aided in booking appointments with community mental health agencies, 71% gave referrals to state mental health agencies, and 61%

gave referrals to a community residence. One of the most important parts of transitional health care is the supply of medication post-release. 94% of agencies provided a supply of medication post-release and 52% gave printed instructions for these medications. However, varying amounts of medication were given to inmates. 43% of states provided a supply of two weeks or less, 36% provided a 30-day supply, and one prison provided a 60-day supply. Without these medications, individuals could digress or experience worse symptoms of their mental illness so this delivery of medication is vital.

The individuals who manage transitional health care depend on the prisons. About 55% of prisons used registered nurses, 39% used social workers, roughly 13% used physicians, 6% used case managers, and 6% used health service administrators. Another difference between prisons is who these individuals work with to provide these services. 71% coordinated with community mental health agencies, 55% worked with state parole agencies, 32% collaborated with community hospitals, and 16% used faith-based community organizations. Success of post-release treatment was conditional on who was coordinating inmates' health care and who they would be going to see when out of prison.

Though most institutions have transitional health care practices in place, recently released inmates are not guaranteed any services or medication as explored by Flanagan (2004). Ex-offenders already have many barriers to overcome; therefore lack of institutional support post-release can lead to high recidivism rates. Many ex-offenders have little income, unemployment or welfare benefits, and trouble finding housing and employment. Others also have little education and training making it even more challenging to survive in the community post-release. Without support via transitional services and medication, inmates are likely to fall back into the prison system. Furthermore, those suffering from a mental illness are likely to

experience worse symptoms with these basic needs not being met and could recidivate as a result. As a society, we should encourage such transitional measures to reduce the exceedingly high number of individuals in prison.

Studies on the Physical and Mental Health of Recently Released Inmates

So far, this thesis has examined a program and treatment coordination for post-release prisoners. Now, we will assess a study of recently released inmates' experiences in accessing health care and mental health treatment. This study by Binswanger et al. (2011) in Denver, Colorado, examined 29 inmates two months after they were released. To document their experiences, researchers coordinated interviews with participants asking about their health care and mental health post-release. Some of the major problems ex-convicts described were, "poor transitional preparation preceding release, inadequate or absent continuity of mental and physical health care in the context of significant emotional distress and anxiety, difficulty making appointments, lack of knowledge about how to engage available services, long waits, and inability to access providers who could refill their chronic medications" (p. 249).

Some inmates reported initial challenges immediately after they were released. This excerpt is from a "40-year old man describing his first day and night out of prison:"

It was terrible...I took a van from the facility to the bus station and they just kind of kicked you out of the van and said, 'Bye, have fun!'...[We] get into [the city] and it's too late to do anything. So...I couldn't get any shelters...of course the parole office is closed...I spent my first night just walking around...I had no idea where to go, I mean they don't tell you where to go or what to do. They don't tell you any of that (Binswanger et al., 2011, p. 251).

These challenges portrayed make it nearly impossible to succeed. Binswanger et al. found recently released inmates are already at a 12.7 times higher risk of death post-release and these logistical and environmental problems worsen those odds. Another obstacle faced by inmates is an insufficient amount of medication given post-release. Often the medication given does not allow for enough time to find and have an appointment with a doctor to continue treatment. Inmates also reported parole officers being of little help when searching for mental health services. All of these problems led to deteriorating symptoms of inmates with “increased paranoia and fear” (p. 253).

As this study suggests, there is need for improvement in the post-release transition for inmates. There must be better coordination between “mental health services agencies and criminal justice agencies” to ensure adequate treatment is continued for released prisoners (p. 254). “Structured transition plans” given to the providers of ex-convict’s care in the community could help with this move (p. 254). Medication use needs to be better monitored and controlled with a mechanism for receiving medication “in light of the difficulty establishing care with a new provider in the immediate post-released period” (p. 254). One way to help with this step would be for “on-site physicians and/or nurse practitioners [to be] at parole offices to facilitate continued medications” (p. 254). All of these alternatives could ensure released inmates continue with mental health treatment and have a higher chance of success after release.

Why Our Society Should Care

At first glance, mental health in prisons may not seem like a pressing or even important issue. However, given the vast population it effects and given many of these individuals will be released back into our society and are likely to commit crimes again, we should be interested in their treatment and programs in prison, particularly concerned with mental health.

Mental health in prisons is an issue beyond the scope of prison institutions themselves. This problem implicates police and policing practices, psychiatric and community mental health institutions, mental health professionals, our country at large, and numerous other stakeholders. Mentally ill individuals continue to suffer in prisons due to negative environmental and personnel influences, restricted confinement areas, and inadequate treatment. Once they are released, ex-convicts receive limited follow-up care, which is often ineffective. By providing better follow-up care, these individuals would be less likely to commit crimes due to their illness, which would reduce recidivism rates for the U.S. and lead to less crime overall. Furthermore, these individuals could become productive members of society and contribute to the progress of our country if the obstacles of their mental illness did not hinder them. Most importantly, taking these measures would move us in the direction of being a more compassionate society who values its members and takes care of them equally.

To combat mental health issues, reforms will have to come from several areas.

- ❖ **Police** will need better training to manage mentally ill individuals who have run-ins with the law.
- ❖ **Mental health institutions** will need to provide better care so prison is not the best option for treatment.
- ❖ **Mental health professionals** will need to be better staffed and equipped to meet the demand of mentally ill individuals in prisons.
- ❖ Finally, **our society** must recognize the importance of this issue and support initiatives to bring about these improvements.

Lastly, it is important to keep in mind when discussing mental health in prisons that having access to treatment is a constitutional right. Not only must we uphold this right for legal

reasons, but also for ethical and humanitarian reasons. In doing so, we directly benefit these individuals who cannot advocate for themselves and indirectly benefit our society as a whole. By discussing this issue and working to improve the inequalities in our justice system, we are ultimately bettering our country and world.

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