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State Prisons Turning into De Facto Mental Health Institutes: A Comparative Look at the Illinois and Nebraska State Prison Systems

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State Prisons Turning into De Facto Mental Health Institutes:

A Comparative Look at the Illinois and Nebraska State Prison Systems

MARGARET KRAMER*

This Comment discusses the systems of approaching mental health in Nebraska and Illinois state prison systems. Starting with how prison systems became some of the largest de facto mental health institutes in the country after deinstitutionalization happened on a national scale. It will then provide the guidelines and regulations in place for both Nebraska and Illinois. This Comment will then discuss what regulations would be most beneficial and how some of these can help in continuing after an individual is released from prison.

INTRODUCTION.....	2
I. DEINSTITUTIONALIZATION OF PSYCHIATRIC HOSPITALS IN THE UNITED STATES.....	3
II. NEBRASKA’S APPROACH TO MENTAL HEALTH CARE IN PRISONS	10
III. ILLINOIS’S APPROACH TO MENTAL HEALTH CARE IN PRISONS.....	19
IV. PROCEDURES IN FAVOR OF TREATING MENTALLY ILL INMATES	23
A. INTAKE SCREENING OF INMATES ON ARRIVAL TO PRISON	24
B. REDUCTION OF OVERCROWDING IN PRISONS OR ADDITION OF EQUIVALENT STAFFING	26
C. ACCESS TO MENTAL HEALTH TREATMENT, MENTAL HEALTH PROFESSIONALS, AND PROPERLY TRAINED STAFF	27
D. RESTRICTIONS ON MENTALLY ILL INMATES IN RESTRICTIVE HOUSING	29
E. PREPARATION AND GUIDANCE FOR REINTEGRATION BACK INTO SOCIETY	31
CONCLUSION.....	33

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INTRODUCTION

Prisons across the country have had to deal with the increasing need for mental health services within their prison systems. More and more inmates enter the criminal justice system with mental health problems. The United States, along with the United Kingdom and Australia, has a dramatically higher rate of mental illness among prisoners than that of the general population.¹ In the United States, the largest mental health institute is not a hospital, but instead the Cook County Jail in Chicago, Illinois, where about one-third of the inmates have been diagnosed with a mental illness.² Part I of this article will discuss the deinstitutionalization of mental health facilities, how that has led to an increase of inmates having some form of mental health problem, the cases that have brought such problems to light, and stories from individuals. The deinstitutionalization of psychiatric hospitals across the United States has netted disastrous results.³ Many of the individuals who were in these facilities were released, which led to an increased use of community resources that were not funded to handle such an influx of individuals, many of whom were at risk of being homeless. This influx ultimately led many of the mentally ill to prisons.⁴ Many prisons are not prepared to handle this influx of individuals with mental health problems.

Parts II and III will discuss how two states, Nebraska and Illinois, are handling the issue of mental health in prisons. These are two states that are struggling but trying to make a change in their state prison systems. These two states differ in their political leanings, one being more conservative with the death penalty still in place, while the other is more liberal without the death penalty in place. Nebraska is implementing a change by adding ten additional mission-specific housing units, including one specifically for those with mental health needs.⁵ Illinois is similarly planning to build a new mental health facility that will contain two hundred mental health beds along

1. Kim P. Turner, *Raising the Bars: A Comparative Look at Treatment Standards for Mentally Ill Prisoners in the United States, United Kingdom, and Australia*, 16 *CARDOZO J. INT'L & COMPAR. L.* 409, 411 (2008).

2. Samantha Michaels, *Chicago's Jail Is One of the Country's Biggest Mental Health Care Providers. Here's a Look Inside.*, *MOTHER JONES* (Jan. 8, 2019), <https://www.motherjones.com/crime-justice/2019/01/chicagos-jail-is-the-one-of-the-countys-biggest-mental-health-care-providers-heres-a-look-inside/> [<https://perma.cc/8YJ9-EST5>].

3. Catherine Ryan Gawron, *Funding Mental Healthcare in the Wake of Deinstitutionalization: How the United States and the United Kingdom Diverged in Mental Health Policy After Deinstitutionalization, and What We Can Learn from Their Differing Approaches to Funding Mental Healthcare*, 9 *NOTRE DAME J. INT'L & COMPAR. L.* 84, 92 (2019).

4. Dae-Young Kim, *Psychiatric Deinstitutionalization and Prison Population Growth: A Critical Literature Review and Its Implications*, 27 *CRIM. JUST. POL'Y REV.* 3 (2016).

5. NEBRASKA DEPARTMENT OF CORRECTIONAL SERVICES 2019 – 2023 STRATEGIC PLAN 7 (2018) [hereinafter *NDCS 2019-2023 STRATEGIC PLAN*].

with fifty medical beds.⁶ However, while both states are implementing these new plans, both are currently lacking in the provision of mental health care to prisoners now. Further, their policies seem to be more reactive instead of proactive.

Part IV will address which plans and procedures are working within the two states, which are not, and suggest plans and procedures that might help. This part looks at how to create a system that will help treat and care for inmates with mental health problems. The goal is to provide these individuals with a level of care that will help them towards rehabilitation and assist them with addressing these mental health issues outside of prison.

I. DEINSTITUTIONALIZATION OF PSYCHIATRIC HOSPITALS IN THE UNITED STATES

Psychiatric hospitals became a popular notion during the early nineteenth century when Dorothea Dix, a retired schoolteacher, noticed an ongoing problem with the care that mentally ill individuals were receiving.⁷ Ms. Dix began advocating for the establishment of state-funded hospitals that cared for mentally ill patients, instead of incarceration.⁸ During her crusade, Ms. Dix brought to light the inhumane conditions that many individuals experienced and showed that, though these individuals were mentally ill, they could be helped.⁹ She helped to change the perception that many people had for mental health and advocated for treatment as the proper course of action, as opposed to confining the mentally ill to prisons.¹⁰ Sadly, this change did not last long for, soon after, psychiatric hospitals became overrun with issues such as sanitation, overcrowding, and conditions that were jail-like in nature.¹¹

In the 1960s and 1970s, many of the state-run psychiatric hospitals began to close, releasing involuntarily kept, mentally ill patients back into the community at large.¹² The deinstitutionalization process came about due to deteriorating and overcrowded conditions¹³ in the psychiatric hospitals and the realization that mentally ill individuals housed in these facilities were receiving substandard care. Many of the medical treatments used in these fa-

6. ILLINOIS DEPARTMENT OF CORRECTIONS FISCAL YEAR 2018 ANNUAL REPORT 18 (2018) [hereinafter IDOC 2018 REPORT].

7. Joanmarie Ilaria Davoli, *No Room at the Inn: How the Federal Medicaid Program Created Inequities in Psychiatric Hospital Access for the Indigent Mentally Ill*, 29 AM. J.L. & MED. 159, 168 (2003).

8. *Id.*

9. Gawron, *supra* note 4, at 89.

10. *Id.*

11. *Id.*

12. *Id.* at 86.

13. Gawron, *supra* note 4, at 89.

cilities became obsolete, such as lobotomies which were used to “treat uncontrollably emotional or violent patients.”¹⁴ Lobotomies consisted of cutting or disconnecting the prefrontal cortex, which was seen as a way to stunt and block conditions associated with depression, nervousness, and anxiety. Once psychoactive drugs became available, however, lobotomies fell out of fashion for treating severely mentally ill individuals.¹⁵ Instead, these new drugs were seen as a way to treat mental health outside of the psychiatric hospital environment. This realization helped to change the way many people saw these institutions, which was akin to another form of prison.

When many of the psychiatric institutions began to close, this opened another door that many states did not expect. “Deinstitutionalization was the mass reduction and elimination of large state-run mental hospitals and the release of patients back into the community.”¹⁶ The many patients who were released experienced risks of being homeless, poor, victims of crime, involved in perpetrating crime, and possibly put into different institutions, such as jails or nursing homes.¹⁷ Much of this was due to community centers that were underfunded and could not handle the influx of people being released from the psychiatric institutions.¹⁸ To address this, a piece of legislation called the Community Mental Health Centers Act was proposed to help with funding of community-based mental health centers to provide care when these patients were released. However, due to President John F. Kennedy’s death, the program never received proper funding and many localities blocked its establishment.¹⁹ Without this community-based treatment, many individuals with mental health problems fell victim to the above-mentioned risks. There is evidence to suggest there is a correlation between deinstitutionalization and the increasing number of mentally ill inmates in the United States prison systems.²⁰ Individuals with mental illness were motivated by homelessness and hunger after being released from the psychiatric institutions, which led many to commit crimes such as loitering, trespassing, and theft.²¹ It was this process of deinstitutionalization that “created the cultural, social, and political environment out of which mental health legislation and programming stemmed.”²²

These societal and political changes came about as more and more mentally ill inmates entered the prison system, which led to prison overcrowding

14. *Id.* at 90.

15. *Id.*

16. *Id.* at 90-91.

17. Kim, *supra* note 5, at 7.

18. *Id.*

19. Risdon N. Slate, *Deinstitutionalization, Criminalization of Mental Illness, and the Principle of Therapeutic Jurisprudence*, 26 S. CAL. INTERDISC. L.J. 341, 342 (2017).

20. *Id.* at 347.

21. *Id.* at 348.

22. Gawron, *supra* note 4, at 87.

and poor conditions for individuals who seriously needed help. This has persisted as the lack of community-based services has led to the high rate of mentally ill people in the prison system.²³ Although legislation has been created to increase insurance coverage for mental health services, because many of the “most severely mentally ill are also extremely poor, forcing private insurance to cover psychiatric illnesses does nothing to assist those who cannot afford insurance in the first place.”²⁴ The result is that, due to the influx of mentally ill inmates, many prisons have become de facto mental health facilities.²⁵

In Nebraska, for example, due to the shortage of community mental health services, long waiting times for services, and shortage of beds at hospitals, the Nebraska Department of Correctional Services (NDCS) has the best resources.²⁶ One example of how inmates can benefit from prison treatment can be found in the experiences of two former inmates, Amie Jackson and Tessa Demers, who both battled mental illnesses most of their lives but received the most help for those illnesses in jail or prison.²⁷ Amie and Tessa each landed in the Nebraska women’s prison in York after years of struggling with addiction that led to charges for possession or distribution of methamphetamine.²⁸ In prison, they learned to control their mental illnesses and positively benefited from receiving treatment for mental health problems in prison. As of June 2018, both women were out of prison and working as peer support specialists for the Mental Health Association in Lincoln, Nebraska.²⁹ Many are not as fortunate as Amie and Tessa, however, and struggle to receive the care that they need while they are in prison.

An example of a negative outcome is documented in *Goodenow v. State of Nebraska Department of Correctional Services*. In that case, Kenneth Goodenow was ordered to receive inpatient mental health treatment and was subsequently placed at Lincoln Correctional Center (LCC), which housed inmates rated medium or maximum security.³⁰ Mr. Goodenow was graded as a minimum level security inmate, but his classification was overridden to medium/maximum security in order for him to receive the inpatient mental

23. *Id.* at 96.

24. Davoli, *supra* note 8, at 162.

25. Melissa Kong, *Cook County Jail: A De Facto Hospital for the Mentally Ill*, 19 LOY. PUB. INT. L. REP. 141, 142 (2014). Cook County Jail became the largest mental health provider in Illinois around 2008 and “delivers treatment to an estimated 1,100 inmates on a daily basis.” *Id.*

26. See generally JoAnne Young, *Nebraska Prisons Playing Major Role in Mental Health Care*, LINCOLN J. STAR (June 20, 2018), https://journalstar.com/news/state-and-regional/govt-and-politics/nebraska-prisons-playing-major-role-in-mental-health-care/article_f28ed282-de63-5bf5-89f4-5669b157e17b.html [https://perma.cc/JB86-7CKQ].

27. *Id.*

28. *Id.*

29. *Id.*

30. *Goodenow v. Neb. Dep’t of Corr. Servs.*, 610 N.W.2d 19, 20-21 (Neb. 2000).

health care that was available at LCC, as it was the only location for male inmates to receive such a mental health program.³¹ While at LCC, Mr. Goodenow was terminated from the mental health treatment due to his non-compliance, after which he was placed in general population at LCC and deemed not to need a transfer to a minimum security prison.³² This determination was based on Mr. Goodenow not needing protective custody or an immediate transfer. Further, his classification was set for review in December 1993, since these reviews occur every six to twelve months.³³ He got into a “drug-debt” with some other inmates and on October 13, 1993, he was stabbed several times in his cell by two inmates.³⁴ Goodenow’s personal representative brought a tort claim against the Nebraska Department of Correctional Services (NDCS), where the district court found no negligence. On appeal, this decision was affirmed.³⁵ The court reasoned that the initial classification and overriding of the classification was reasonable on the part of the NDCS, stating there was no evidence to suggest the contrary.³⁶

Similarly, Ashoor Rasho of Illinois “spent most of his 26-year prison sentence in restrictive housing, or solitary confinement, where he had hallucinations, engaged in self-mutilation and tried to kill himself” multiple times.³⁷ Rasho was placed at Pontiac Correctional Center in 2003, after already having been in the custody of the Illinois Department of Corrections (IDOC) since 1996.³⁸ He was in prison for robbery and burglary, but his sentence was extended multiple times due to altercations with prison staff.³⁹ He was usually alone in his small prison cell, where he spent most of the day, and was typically permitted only one to three hours outside of the cell.⁴⁰ Rasho’s history of mental illness included “auditory hallucinations, severe depression, agitation, self-mutilation, and suicide attempts—for which he [was] prescribed psychotropic medications.”⁴¹ While at Pontiac, Rasho was housed in the Mental Health Unit until 2006, when he was transferred to the North Segregation Unit upon the recommendation of the staff psychiatrist.⁴² According to Rasho, this transfer was a punishment and was due to Rasho

31. *Id.* at 377.

32. *Id.*

33. *Id.*

34. *Id.* at 378.

35. *Goodenow*, 610 N.W.2d at 23.

36. *Id.* at 380.

37. Christine Herman, *Prisoners with Mental Illness Still Waiting for Treatment*, WILLRADIO (Jan. 23, 2019), <https://will.illinois.edu/news/story/prisoners-with-mental-illness-still-waiting-for-treatment> [<https://perma.cc/888V-JCMY>] [hereinafter Herman, *Prisoners with Mental Illness*].

38. *Rasho v. Elyea*, 856 F.3d 469, 472 (7th Cir. 2017).

39. Herman, *Prisoners with Mental Illness*, *supra* note 38.

40. *Id.*

41. *Rasho*, 856 F.3d at 472.

42. *Id.* at 473.

not receiving the benefits of the Mental Health Unit by the staff psychiatrist.⁴³ During his time in the segregation unit, Rasho's conditions worsened, but he was not given the care he needed and deserved due to the isolation techniques and treatment by Pontiac staff.⁴⁴ As a result of this, Rasho brought a civil suit against doctors at Pontiac Correctional Center for his placement in the segregation unit.⁴⁵ Further, his experience was echoed by other inmates with mental illness.⁴⁶ The civil suit brought against IDOC, by Rasho and other inmates, helped to bring some change in how Illinois prisons are to react and work with inmates that have a mental illness or illnesses. In *Rasho v. Baldwin*, the Amended Settlement Agreement that was approved on May 23, 2016, set out that IDOC would correct and deal with a huge range of practices that affect inmates, including: (1) policies and procedures; (2) intake screening; (3) medication continuity on arrival; (4) psychiatric evaluations; and (5) suicide prevention.⁴⁷

Despite these planned changes, another lawsuit against the IDOC was brought by Anthony Gay, a young man whose mental health issues were aggravated by solitary confinement in an Illinois prison.⁴⁸ Gay was sentenced to the IDOC in 1994, when he was just a young man, for robbery that occurred after a fight with another teen who reported to police that Gay stole a dollar and his hat.⁴⁹ Gay's initial sentence was to be three and a half years.⁵⁰

43. *Id.*

44. *See generally id.*

45. *See generally id.*

46. Herman, *Prisoners with Mental Illness*, *supra* note 38.

47. Midyear Report of Monitor Pablo Stewart, MD at 4-5, *Rasho v. Baldwin*, No. 1:07-CV-1298-MMM-JEH (C.D. Ill. Nov. 30, 2018), <https://www.documentcloud.org/documents/5411031-2018-12-3-IDOC-Prison-Mental-Health-Monitor-Mid.html> [<https://perma.cc/Y6A4-N2UL>]. The Amended Settlement Agreement further covered areas in referrals; mental health evaluations; crisis intervention team; licensure; inmate orientation; treatment plans and updates; follow-up after discharge from specialized treatment settings; staffing plans and hiring; bed, programming, and office space for residential treatment units, inpatient facilities, and crisis beds; administrative staffing; medication administration, documentation, evaluations, lab work, side effects monitoring, informed consent, non-compliance follow-up; enforced medication; housing assignment notice and recommendations; treatment, housing conditions, and out-of-cell time in segregation and investigative status; review of segregation terms length; restraints for mental health purposes; mental health care records and forms; confidentiality; change of seriously mentally ill designation; staff training; nondiscrimination in program participation; records and medication continuity on inter-facility transfers; use of force and verbal abuse; mental health input into discipline; continuous quality improvement; terms of monitoring this settlement; and IDOC reporting. *Id.* at 4-5.

48. *See generally* Jeff Coen & Stacy St. Clair, *How Solitary Confinement Drove a Young Inmate to the Brink of Insanity*, CHI. TRIB. (Jan. 2, 2019), <https://www.chicagotribune.com/news/ct-met-anthony-gay-solitary-confinement-suit-20181206-story.html> [<https://perma.cc/64X3-EM82>] [hereinafter Coen & St. Clair, *How Solitary Confinement Drove a Young Inmate to the Brink of Insanity*].

49. *Id.*

50. *Id.*

However, due to multiple fights, his sentence was gradually increased to twenty-two years.⁵¹ Much of the twenty-two years that Gay was in prison, he spent it in solitary confinement with only the occasional visit from therapists, who were only permitted to speak to him through a hole in the door.⁵² During these years, his mental health deteriorated, resulting in suicidal ideations and multiple attempts at taking his own life.⁵³ Gay learned that attention was given to inmates who harmed themselves when another inmate on his level cut himself, causing staff and nurses to rush to that inmate's aid.⁵⁴ Gay's suicide attempts were the only way for Gay to get contact with other humans instead of being isolated from others,⁵⁵ a cry for help that was not being addressed through any other measures. During Gay's incarceration, he was diagnosed with having "antisocial personality disorder and narcissistic personality disorder," with therapist notes describing him as "manipulative and anxious."⁵⁶ Once diagnosed, the IDOC put Gay on medication and provided the occasional therapy. However, despite this, Gay still continued to self-harm. The IDOC saw this solely as a manipulative gesture, however, and kept him

51. *Id.* When Gay was at the Pontiac Correctional Center: [T]he state's attorney's office lodged a series of 21 indictments against Gay between 2000 and 2004 for the many times he threw his own excrement at guards. In what some call 'picket fencing,' the cases were often stacked separately as the statute of limitations for each charge was about to expire, so the convictions led to consecutive sentences.

Id.

52. Coen & St. Clair, *How Solitary Confinement Drove a Young Inmate to the Brink of Insanity*, *supra* note 49.

53. *Id.*

54. *Id.*

55. *Id.*

56. *Id.*

Antisocial personality disorder, sometimes called sociopathy, is a mental disorder in which a person consistently shows no regard for right and wrong and ignores the rights and feelings of others. People with antisocial personality disorder tend to antagonize, manipulate or treat others harshly or with callous indifference. They show no guilt or remorse for their behavior.

Antisocial Personality Disorder, MAYO CLINIC (Dec. 10, 2019), <https://www.mayoclinic.org/diseases-conditions/antisocial-personality-disorder/symptoms-causes/syc-20353928> [<https://perma.cc/2JK7-WU2G>].

Narcissistic personality disorder – one of several types of personality disorders – is a mental condition in which people have an inflated sense of their own importance, a deep need for excessive attention and admiration, troubled relationships, and a lack of empathy for others. But behind this mask of extreme confidence lies a fragile self-esteem that's vulnerable to the slightest criticism.

Narcissistic Personality Disorder, MAYO CLINIC (Nov. 18, 2017), <https://www.mayoclinic.org/diseases-conditions/narcissistic-personality-disorder/symptoms-causes/syc-20366662> [<https://perma.cc/HC5A-LQ4Z>].

in solitary confinement.⁵⁷ Gay's release on August 27, 2018, came as the result of writing letters to lawyers and asking for assistance in his case.⁵⁸ These letters led to Scott Main of the Bluhm Legal Clinic at Northwestern University assisting in Gay's release by challenging how the sentence was structured, arguing that Gay's sentences should have been running concurrently.⁵⁹ Then "on October 28, 2018, the MacArthur Justice Center joined with co-counsel Stephen H. Weil and Alexis G. Chardon at Weil & Chardon in Chicago, and Antonio Romanucci and Nicolette Wart with Romanucci & Blandin in Chicago, to file a lawsuit in U.S. District Court."⁶⁰ The four-count complaint filed with the U.S. District Court for the Northern District of Illinois, Eastern Division, included allegations that IDOC violated Gay's Eighth Amendment rights by placing him in extended solitary confinement, failed to provide proper treatment for his mental health illness in violation of his rights under the Americans with Disabilities Act and Rehabilitation Act, failed to provide reasonable accommodations for his disability, and violated his rights under the Fourteenth Amendment by not allowing Gay to challenge his solitary confinement.⁶¹

The civil suit brought against IDOC by Rasho and multiple inmates ended in a settlement agreement that required IDOC to enact improvements to how inmates' mental health is handled while they are incarcerated.⁶² This civil suit, along with Gay's civil suit, are two cases challenging and trying to improve the way the IDOC handles the mental health of their inmates. In the multi-inmate suit, the court monitor's report filed in December 2018 from the Court Monitor, Pablo Stewart, MD, goes through each subsection of the Settlement Agreement and determines whether the IDOC has complied with

57. Coen & St. Clair, *How Solitary Confinement Drove a Young Inmate to the Brink of Insanity*, *supra* note 49. The self-mutilation that Gay committed on himself is laid out in his complaint against the State of Illinois including: multiple times of cutting his scrotum to either bleed out or insert items into it; multiple times of cutting his arm or thigh to hide items such as nails, plastic forks, pens, and metal; and cutting himself bad enough to require surgery. *Gay v. Illinois*, No. 1:18-cv-07196, 2018 WL 5456434, at *12 (N.D. Ill. Oct. 28, 2018).

58. Coen & St. Clair, *How Solitary Confinement Drove a Young Inmate to the Brink of Insanity*, *supra* note 49.

59. *Id.*

60. Maggie Filler & Daniel M. Greenfield, *Gay v. State of Illinois*, MACARTHUR JUST. CTR. (Oct. 28, 2018), <https://www.macarthurjustice.org/case/gay-v-state-of-illinois/> [<https://perma.cc/H6MR-U365>] [hereinafter MACARTHUR JUST. CTR.].

61. *Gay v. Illinois*, No. 1:18-cv-07196, 2018 WL 5456434, at *4-5 (N.D. Ill. Oct. 28, 2018).

62. See generally Christine Herman, *Court Monitor 'Absolutely Convinced' Mentally Ill Inmates Abused, Inadequately Treated in Illinois*, WILLRADIO (Dec. 5, 2018), <https://will-illinois.edu/news/story/report-illinois-prisons-failing-to-provide-adequate-treatment-to-inmates-wi> [<https://perma.cc/64QR-D5CT>] [hereinafter Herman, *Court Monitor 'Absolutely Convinced'*]; see also Midyear Report of Monitor Pablo Stewart, MD *supra* note 48, at 5-7

that area.⁶³ Generally, the report shows that in the two years since the Settlement Agreement was approved, IDOC has not substantially complied with many of the Agreement's requirements.⁶⁴ In the Pontiac Correctional Center, the court monitor personally observed staff using force on inmates, improper use of restraints by staff, and regular physical abuse of mentally ill inmates by staff.⁶⁵ This culture of violence is also seen in the allegations made in Anthony Gay's civil suit, where he was subjected to solitary confinement at Pontiac and is also suing some of the doctors there in their individual capacities for assisting in the harm that befell him, due to their inability to properly treat him.⁶⁶ Both cases deal with the improper monitoring and handling of inmates with mental health, but have they helped to change the way the IDOC works? Until all the portions of the *Rasho* settlement are complied with and cases like Mr. Gay's no longer occur, we won't know that this change has occurred.

These accounts highlight the idea that because many individuals do not have the resources they need in their communities to help with mental health, this leads some to lives of crime where the only help they receive is in prison.⁶⁷ However, other inmates find no solace for their mental health in prison and must face their demons alone.⁶⁸ Overall, the way that many states handle the mental health of inmates in prison needs changing. Incarcerated individuals deal with an overcrowded system where it may take months to receive treatment for their mental health needs. As a result of these and other suits, changes are happening in both Nebraska and Illinois, albeit slowly.

II. NEBRASKA'S APPROACH TO MENTAL HEALTH CARE IN PRISONS

Over the last few years, Nebraska has implemented procedures for dealing with mental health in its prison systems. This includes additions to the administrative code regarding restrictive housing; mental health screening, risk assessment, and discharge review team procedures; NDCS administrative regulations regarding mental health; NDCS 2019-2023 Strategic Plan;

63. Midyear Report of Monitor Pablo Stewart, MD *supra* note 48, at 5-7. Pablo Stewart received his Doctor of Medicine from University of California San Francisco in 1982. Mr. Stewart has specialized in the needs of severely mentally ill individuals, especially ones located in the Mental Health Units of prisons. Throughout the years he has had "experience managing, monitoring, and reforming correctional mental health systems." Further Mr. Stewart has served as the psychiatric expert or consultant on multiple federal court cases across the country. *Parsons v. Ryan*, No. CV 12-00601-PHX-DKD, at *1-3 (D. Ariz. Apr. 1, 2016).

64. *See generally* Midyear Report of Monitor Pablo Stewart, MD *supra* note 48, at 5-7.

65. *Id.* at 10.

66. *Gay v. Illinois*, No. 1:18-cv-07196, 2018 WL 5456434 (N.D. Ill. Oct. 28, 2018).

67. *See generally* Young, *supra* note 27.

68. *See generally* Coen & St. Clair, *How Solitary Confinement Drove a Young Inmate to the Brink of Insanity*, *supra* note 49; Herman, *Prisoners with Mental Illness*, *supra* note 38.

and numerous statutes. The reason for this legislation is because, “[i]n Nebraska, ninety-three percent of the people” contained within NDCS will “reenter the community.”⁶⁹ Currently the Nebraska prison system is overcrowded, which leads to a decline in medical and mental health services available to inmates, most of whom will be released into the community. For the 2019 Fiscal Year, the NDCS prisons had an average daily population of 5,369.6, the operational capacity total is only 4,807, and the design capacity total is only 3,535.⁷⁰ This has resulted in individuals housed in Nebraska prisons waiting months for treatment or to receive medication for serious mental health conditions.⁷¹

Despite what actually happens in practice, the Nebraska Revised Statute provides that upon arrival to prison, an inmate is to “receive a full mental health screening within the first two weeks of intake to determine if they are mentally ill,” which is done by intake staff.⁷² The information taken from this screening aids in creating a treatment plan, if needed, and is placed with the inmate’s file.⁷³ Treatment recommendations are made by licensed behavioral health professionals based on their professional judgment, and this treatment is to be provided before the inmate becomes eligible for parole.⁷⁴ From these treatment plans,⁷⁵ the NDCS then can determine the level of confinement required for that inmate.⁷⁶ Outside of general population, the levels of housing, or confinement, include, “immediate segregation housing, longer-term restrictive housing, and secure mental health housing.”⁷⁷ The different types of housing include general population, restrictive housing, immediate segregation, longer-term restrictive housing, mission-specific housing, protective custody, protective management unit, secure mental health housing (SMH),

69. NDCS 2019-2023 STRATEGIC PLAN, *supra* note 6, at 2.

70. *Average Daily Population*, NEB. DEP’T CORR. SERVS. (2019), <https://www.corrections.nebraska.gov/public-information/ndcs-research-division> [<https://perma.cc/KQY8-F4CG>] [hereinafter NDCS Population by Facility (2019)].

Design capacity is the number of inmates that planners or architects intended for the facility. Operational Capacity is the number of inmates that can be accommodated based on a facility’s staff, existing programs, and services. *Terms & Definitions: Corrections*, BUREAU JUST. STAT., <https://www.bjs.gov/index.cfm?ty=tdtp&tid=1> [<https://perma.cc/6DZP-QBFR>].

71. Amy Miller, *Overcrowding in Nebraska’s Prisons Is Causing a Medical and Mental Health Care Crisis*, ACLU NEB.: SPEAK FREELY (Aug. 16, 2017), <https://www.aclu.org/blog/prisoners-rights/cruel-inhuman-and-degrading-conditions/overcrowding-nebraskas-prisons-causing> [<https://perma.cc/QP25-YQR9>].

72. 72 NEB. ADMIN. CODE § 4-002 (2019).

73. *Id.*

74. 72 NEB. ADMIN. CODE § 4-003 (2019).

75. “A document used by mental health professionals to establish a patient’s mental health treatment plan.” 72 NEB. ADMIN. CODE § 1-002.02 (2019).

76. 72 NEB. ADMIN. CODE § 1-001.02 (2019).

77. 72 NEB. ADMIN. CODE § 1-002.01 (2019).

and solitary confinement.⁷⁸ Secure mental health housing consists of “units used to house inmates with serious mental illness who present a high risk to others or to self and who require residential mental health treatment.”⁷⁹ To be considered seriously mentally ill, NDCS must find that a prisoner has a mental health condition caused by a biological disorder and that substantially limits activities of living for that person.⁸⁰ A mental health program through NDCS is to include at a minimum: screening on intake; outpatient services for detection, diagnosis, and treatment; crisis intervention and management; stabilization and monitoring; elective therapy and preventive treatment; pro-

78. See generally 72 NEB. ADMIN. CODE § 1-002 (2019).

The definitions for the above housing are as follows:

(1) General Population: all inmate housing areas that allow out-of-cell movement without the use of restraints, a minimum of six hours per day of out-of-cell time, and regular access to programming areas outside of the living unit; (2) Restrictive Housing: conditions of confinement that provide limited contact with other inmates, strictly controlled movement while out of cell, and out-of-cell time less than twenty-four hours per week; (3) Immediate Segregation: a short-term restrictive housing assignment of not more than thirty days in response to behavior that creates a risk to the inmate, others, or the security of the institution; (4) Longer-Term Restrictive Housing: a classification-based restrictive housing assignment of over thirty days [and] . . . is used as a behavior management intervention for inmates whose behavior continues to pose a risk to the safety of themselves or others and includes participation in the development of a plan for transition back to general population or mission based housing; (5) Mission Specific Housing: housing focused on individual needs and demographics to provide effective living conditions and programming for specific populations; (6) Protective Custody: the status of an inmate who is housed in a safe location to reduce the risk of harm by others while having privileges similar to general population housing; (7) Protective Management Unit: units used to house inmates who cannot be safely housed in other general population units; (8) Secure Mental Health Housing: units used to house inmates with serious mental illness who present a high risk to others or to self and who require residential mental health treatment; and . . . (14) Solitary Confinement: the status of confinement of an inmate in an individual cell with solid, soundproof doors and which deprives the inmate of all visual and auditory contact with other persons (the definition states that NDCS does not utilize solitary confinement).

Id.

79. 72 NEB. ADMIN. CODE § 1-002.12 (2019).

80. 72 NEB. ADMIN. CODE § 1-002.13 (2019).

“Serious mental illness includes, but not limited to (i) schizophrenia, (ii) schizoaffective disorder, (iii) delusional disorder, (iv) bipolar affective disorder, (v) major depression, and (vi) obsessive compulsive disorder.” *Id.*

vision for referral and admission to a licensed mental health facility; procedures for informed consent; even if services are rendered unwillingly, they must comply with state law; and mental health meetings and the like are done in private.⁸¹

Once a prisoner is identified as having a mental illness or severe mental illness, NDCS implements the treatment plan and has strategies in place to reduce the issues an inmate with mental health issues has from being put into some kind of solitary confinement or restrictive housing.⁸² Even when an inmate is transferred intersystem, that inmate will receive an initial mental health evaluation performed by trained or qualified mental health care personnel at the time that inmate arrives at that new facility.⁸³ This mental health evaluation must include but is not limited to: (1) inquiry into: inmate's suicidal ideation; history of suicide attempts; prescribed psychotropic medication; any current mental health complaint; treatment for mental health problems; history of inpatient or outpatient treatment for mental health; and history of treatment for drug abuse; (2) observation of: "general appearance and behavior; evidence of abuse and/or trauma; and current symptoms of psychosis, depression, anxiety, and/or aggression;" and (3) "disposition of inmate: to the general population; to the general population with appropriate referral to mental health care services; and referral to appropriate mental health care services for emergency treatment."⁸⁴ If it is determined that an inmate was receiving medication for mental health issues or treatment for mental health prior to incarceration, the inmate is to sign a release for prior treatment records.⁸⁵ This inmate is then kept on the medications they were on prior to incarceration, although the prescriptions can be changed as they are evaluated

81. NEB. DEP'T OF CORR. SERVS., MENTAL HEALTH SERVICES 2-3 (Sept. 30, 2017) https://www.corrections.nebraska.gov/system/files/rules_reg_files/ar_115.23_2017_0.pdf [<https://perma.cc/EU2J-QX6N>] [hereinafter NDCS, MENTAL HEALTH SERVICES].

82. *Id.* at 3.

Major mental illness is defined as one of the following: A. A DSM 5 diagnosis of one or more of the following: Schizophrenia, Delusional Disorder, Schizophreniform Disorder, Schizoaffective Disorder, Brief Psychotic Disorder, Substance-Induced Psychotic Disorder (excluding intoxication and withdrawal), Other Specified Schizophrenia Spectrum and Other Psychotic Disorder, Major Depressive Disorder, and Bipolar Disorder I and II. B. A DSM 5 diagnosis of one or more of the following and meeting the threshold for high severity Depressive Disorder, other Mood Disorder, Posttraumatic Stress Disorder, Obsessive Compulsive Disorder, Panic Disorder, or other Anxiety Disorder.

Id.

83. *Id.*

84. *Id.* at 3-4.

85. NDCS, MENTAL HEALTH SERVICES, *supra* note 82, at 4.

throughout completion of their sentence.⁸⁶ When an intersystem transfer occurs, the transferring inmate undergoes an appraisal, like above, within fourteen days of transfer, unless that inmate had received a mental health evaluation within the past ninety days.⁸⁷ This appraisal includes, but is not limited to, a review of the inmate's current mental status, suicidal potential, violence potential, any inpatient or outpatient treatment for mental health, any treatment with psychotropic medication, any history of drug abuse, any educational history, history of sexual and predatory behavior, dependence on either alcohol or drugs, referrals to treatment, and development of a treatment plan if needed.⁸⁸

The Code also provides guidance on when and how inmates with mental health issues can be placed in restrictive housing by setting out that the only way an inmate will be placed in restrictive housing is if they show a certain amount of risk to themselves, staff, or other inmates around them.⁸⁹ NDCS lists out actions that could result in a mentally ill inmate being placed in restrictive housing (they first place the inmate in the least restrictive housing they can given the circumstances).⁹⁰ Actions that an inmate can take that cause placement in restrictive housing include: a serious act of violent behavior against either a staff member and/or other inmates; recent escape or attempted escape; threats or actions of violence that destabilize the prison environment; activity in a prison gang; incitement or threats to incite a disturbance; or presence that creates risk of harm to staff, themselves, and/or inmates.⁹¹ Prior to placement in restrictive housing, the shift supervisor initiates a medical assessment of the inmate.⁹² Health services staff must then conduct a face-to-face assessment of the inmate to identify any physical injuries, any urgent mental health needs, or any other emergent or urgent conditions.⁹³ If the evaluating staff has any concerns about the inmate but the inmate is still placed in segregation or other restrictive housing, the inmate is to be reevaluated by the shift supervisor twenty-four hours after being placed in segregation or other restrictive housing.⁹⁴ Title 72, Chapter One of the NDCS Code under Nebraska Administrative Code is labeled "Restrictive Housing."⁹⁵ This section establishes policies for the use of restrictive housing

86. *Id.*

87. *Id.* at 5.

88. *Id.*

89. 72 NEB. ADMIN. CODE § 1-003.02 (2019); 72 NEB. ADMIN. CODE § 1-004.03(A) (2019).

90. 72 NEB. ADMIN. CODE § 1-003.01 (2019).

91. 72 NEB. ADMIN. CODE § 1-003.02(A)-(F) (2019).

92. NDCS, MENTAL HEALTH SERVICES, *supra* note 82, at 6.

93. *Id.*

94. *Id.* "If the mental health needs are deemed to be emergent, the inmate shall be held in a location other than restrictive housing until a mental health screening can be completed by mental health staff." *Id.*

95. 72 NEB. ADMIN. CODE § 1-001 (2019).

in the NDCS to help ensure that restrictive housing is only utilized in the “least restrictive manner for the least amount of time consistent with the safety and security of staff, inmates and the facility.”⁹⁶ Another section of the Code sets forth strategies that help in reducing the use of and duration of restrictive housing for mentally ill inmates.⁹⁷ This reduction in restrictive housing use is to take place by establishing correct behavior through “programming, initiatives, incentives, and mission specific housing, rather than relying primarily on sanctions.”⁹⁸ When an inmate has been deemed to have a mental illness, there are greater procedures for staff when placing such an inmate into a type of restrictive housing. These inmates receive assessments to see if they have a need for mental health help, then, if so, they will be seen by NDCS mental health staff for a one-on-one, out-of-cell assessment within twenty-four hours of the initial assessment.⁹⁹ After this mental health assessment, if the inmate is deemed to be in need of more help, he or she will be held in a location that is not restrictive housing for a more in-depth mental health assessment.¹⁰⁰ “All inmates in restrictive housing shall receive a mental health screening within 14 days or less. This screening will be done in a location outside of the inmate’s cell.”¹⁰¹

Beyond taking steps towards reducing ways an individual with mental health can be put into housing that is too restrictive for their needs, NDCS also puts forth other alternatives that might be used. The Code states: “[a]lternatives to restrictive housing shall be used in every case possible” to reduce inmates with mental illness from being placed in too restrictive of housing.¹⁰² When dealing with mentally ill inmates, NDCS would rather use standards of short-term restrictive housing, programs, work, and restitution assignments to not further aggravate an inmate’s mental illness.¹⁰³ Longer-term restrictive housing is said to be used only for “risk-and needs-based intervention,” rather than for punishment of the inmate for any wrongdoing.¹⁰⁴ “The guiding focus of restrictive housing shall be on individualized goal planning, behavior change, and treatment as needed that will facilitate the inmate’s capacity to live successfully in general population and return successfully to the community.”¹⁰⁵ When an inmate is placed in restrictive housing, there are certain procedures that NDCS staff needs to follow. These include following up with the inmate’s progress toward reintegration, assessment of inmate’s

96. 72 NEB. ADMIN. CODE § 1-001 (2019).

97. *See generally* 72 NEB. ADMIN. CODE § 1-003 (2019).

98. 72 NEB. ADMIN. CODE § 1-003.01 (2019).

99. 72 NEB. ADMIN. CODE § 1-006.02 (2019).

100. *Id.*

101. 72 NEB. ADMIN. CODE § 1-006.03 (2019).

102. 72 NEB. ADMIN. CODE § 1-004.01 (2019).

103. *Id.*

104. 72 NEB. ADMIN. CODE § 1-004.02 (2019).

105. 72 NEB. ADMIN. CODE § 1-004.03 (2019).

compliance with rules, review of the inmate every thirty days, and documentation of any changes.¹⁰⁶ Additionally, the NDCS implemented a peer mentor program for individuals that are assigned to longer-term restrictive housing, so that the peer mentor may support the inmate, offer guidance to the inmate, and help the inmate accomplish their behavior and programming plan.¹⁰⁷ The last option for NDCS is to place inmates in longer-term restrictive housing and secure mental health housing where the “overarching goal shall be risk reduction and transition to the least restrictive environment as soon as possible.”¹⁰⁸

When an inmate’s conditions require a greater need for care, he or she can be placed in a secure mental health housing unit.¹⁰⁹ Here, the inmate will have a greater level of treatment and intervention for his mental health needs, which includes a treatment plan and not being put into long-term restrictive housing.¹¹⁰ The secure mental health housing unit focuses on providing inmates with serious mental illnesses with a therapeutic environment, daily contact with mental health staff, a private yard for time outside, and a secure classroom.¹¹¹ Guidelines for staff include checking on the inmates in this type of housing at irregular thirty-minute intervals every day, special programming, assignment review every thirty days, multidisciplinary review team review of inmates there more than ninety consecutive days, and status of being in this unit will keep the inmate out of other restrictive housing.¹¹² For inmates housed in secure mental health units, they receive specialized reentry plans to help with reentry back into the community once their sentence has come to an end or they are paroled.¹¹³ These reentry plans include finding the inmate a suitable mental health contact once released to aid in the transition back into society.¹¹⁴

Further, to help with determining appropriate care and keeping inmates with mental health issues out of restrictive housing, the Behavioral Health Assistant Administrator for Mental Health is to maintain a care record for each inmate “that provides complete and accurate information on all mental health contacts during course of his/her incarceration.”¹¹⁵ These records are to be confidential and are seen only by those with the responsibility of collecting and maintaining the information and include the following: “(1) Summary of what the inmate states is the problem; (2) Observation of the inmate’s

106. *See generally* 72 NEB. ADMIN. CODE § 1-004.03(B) (2019).

107. 72 NEB. ADMIN. CODE § 1-004.03(D) (2019).

108. 72 NEB. ADMIN. CODE § 1-004.05 (2019).

109. 72 NEB. ADMIN. CODE § 1-006.09 (2019).

110. 72 NEB. ADMIN. CODE § 1-006.07 (2019).

111. 72 NEB. ADMIN. CODE § 1-006.09 (2019).

112. *See generally* 72 NEB. ADMIN. CODE § 1-006.09 (2019).

113. 72 NEB. ADMIN. CODE § 1-008.02(A) (2019).

114. 72 NEB. ADMIN. CODE § 1-008.02(C) (2019).

115. NDCS, MENTAL HEALTH SERVICES, *supra* note 82, at 6.

behavior; (3) Assessment of the inmate's problem; (4) Plan of action.”¹¹⁶ These records follow the inmate if they are transferred to a new facility and are used upon intake when the staff interviews and evaluates the inmate.¹¹⁷ Even after discharge NDCS keeps the records and stores them in a secure location and maintains their confidentiality.¹¹⁸ Inmates may request access to their records, but, ultimately, the treating physician determines if they are allowed to see them.¹¹⁹

Staff training has become an essential part of moving towards better mental health for inmates. Overall, the staff at NDCS, according to the Nebraska Administrative Code as of 2018, is to receive training regarding “basic communication techniques, Motivational Interviewing¹²⁰, working with mentally ill and special needs populations, working with inmates with behavioral disorders, cognitive behavioral interventions, and trauma training, as well as core correctional practice, crisis de-escalation, and intervention.”¹²¹ Additionally, if the staff is to work with inmates in restrictive housing or secure mental health housing, they are to receive special training and an annual refresher training.¹²² Also, each year the NDCS is required to release a report on the number of individuals throughout that year who were put into restrictive housing, including: mean and median length of time held in restrictive housing; race, gender, age, protective custody inmates in restrictive housing, number of inmates released from restrictive housing, number of inmates placed in restrictive housing with a mental illness, and comparable statistics nationwide.¹²³ The purpose here is to be more transparent with the data associated with the NDCS system.

A showing of transparency is somewhat seen with the report regarding restrictive housing. The most current report shows data for the use of restrictive housing from July 1, 2018, to June 30, 2019.¹²⁴ The introduction further

116. *Id.* at 6-7.

117. *Id.* at 7.

118. *Id.* at 8.

119. *Id.* at 9.

120. “Motivational interviewing is a counseling method that helps people resolve ambivalent feelings and insecurities to find the internal motivation they need to change their behavior. It is a practical, empathetic, and short-term process that takes into consideration how difficult it is to make life changes.” This technique is usually used for individuals that are dealing with addiction or permanent health conditions. It is used to help the individual through the emotional stages and lead them to the change their life deserves. *Motivational Interviewing*, PSYCH. TODAY, <https://www.psychologytoday.com/us/therapy-types/motivational-interviewing> [<https://perma.cc/743Z-8C6F>].

121. 72 NEB. ADMIN. CODE § 1-009.02 (2019).

122. 72 NEB. ADMIN. CODE § 1-009.01 (2019).

123. *See generally* 72 NEB. ADMIN. CODE § 1-010 (2019).

124. NEB. DEP'T OF CORR. SERV., 2019 RESTRICTIVE HOUSING ANNUAL REPORT 3 (2019), https://www.corrections.nebraska.gov/sites/default/files/files/463/fy2019_rh_report.pdf [<https://perma.cc/WW7T-B68C>] [hereinafter NDCS, 2019 RESTRICTIVE HOUSING ANNUAL REPORT].

states that as of 2016, NDCS no longer uses restrictive housing as a disciplinary tool, but, instead, for assessing and helping to protect the inmate for their own safety and the safety of others.¹²⁵ To that end, a portion of the report is dedicated towards the special needs populations within the NDCS system, including “individuals needing protective management housing and inmates with diagnosed mental illnesses.”¹²⁶ Additionally, as NDCS wants to make sure that individuals with mental illnesses receive a therapeutic environment,¹²⁷ in January 2019, NDCS changed its system so that restrictive housing is now labeled “mental health housing unit,” where there is a three-tiered level of care.¹²⁸ These levels consist of: (1) acute care, designed for inmates with “serious, immediate, mental health care needs” and for a short term; (2) subacute care, designed for inmates with “serious issues in need of clinical treatment and intervention for emergent needs”; and (3) chronic care, for “inmates who are clinically determined to be chronically and persistently mentally ill and unable to reside in a more open housing environment.”¹²⁹ During the time period covered in this report, 695 of the 1,820 inmates placed in restrictive housing had a serious mental illness as defined by Nebraska statute.¹³⁰ The types of mental illnesses with which inmates were diagnosed included: bipolar disorder; major depressive disorder; psychotic disorder; schizoaffective disorder; schizophrenia; intellectual disability; delusional disorder; obsessive compulsive disorder; traumatic brain injury; schizophreniform disorder; and unspecified neurocognitive disorder.¹³¹ This list

125. *Id.* This is difficult to believe given the incident involving the double bunking of two inmates in April 2017 in a single occupancy restrictive housing cell. One inmate was days away from a parole date and in prison for forgery, while the other inmate was serving a life sentence for murder. This situation ended tragically with the death of the inmate with a lesser sentence, where he was strangled to death by the other inmate. The inmate with the life sentence stated he did so because of the other inmate being too “talkative.” Paul Hammel, *Death of Tecumseh Inmate Raises Questions About Why He Was Bunked with Murderer in Cell Built for 1*, OMAHA WORLD HERALD (May 2, 2017), https://www.omaha.com/news/state_and_regional/death-of-tecumseh-inmate-raises-questions-about-why-he-was/article_ec0dd9f6-0408-5948-b62e-c8d1a18a49e7.html [<https://perma.cc/R7VQ-95TM>].

126. NDCS, 2019 RESTRICTIVE HOUSING ANNUAL REPORT, *supra* note 125, at 19.

127. *Id.*

128. *Id.*

129. *Id.* at 19-20.

130. *Id.* at 20.

Serious mental illness means, on and after January 1, 2002, any mental health condition that current medical science affirms is caused by a biological disorder of the brain and that substantially limits the life activities of the person with the serious mental illness. Serious mental illness includes, but is not limited to (i) schizophrenia, (ii) schizoaffective disorder, (iii) delusional disorder, (iv) bipolar affective disorder, (v) major depression, and (vi) obsessive compulsive disorder.

NEB. REV. STAT. § 44-792(5)(b) (2019).

131. NDCS, 2019 RESTRICTIVE HOUSING ANNUAL REPORT, *supra* note 125, at 22.

shows the broad expanse of mental illnesses that inmates have while serving their sentence in prison and what staff at prisons are dealing with on a daily basis.

Much of Nebraska's guidelines and codes are aimed at helping inmates with mental illnesses, serious or not, receive treatment and be able to rejoin society with little difficulty. This is easy to say, but have those words turned into actions by NDCS staff at the many state prisons across the state of Nebraska? Incidents show that low staffing and over-population of the prison system makes it difficult for all procedures to be followed.¹³² The desire to help inmates with mental illnesses is there, but the question is, is that desire enough to make the drastic change needed in the Nebraska prison systems?

III. ILLINOIS'S APPROACH TO MENTAL HEALTH CARE IN PRISONS

Like Nebraska, the state of Illinois has also made changes to how they handle inmates with mental health problems in the recent years. Some were made due to a better societal understanding of mental illness, but many others were made due to recent lawsuits against the state, as discussed above. Regardless of the reason, the Illinois Department of Corrections (IDOC) is in the process of building a mental health facility that will add 200 beds for inmates with mental illnesses.¹³³ Further, IDOC has an Office of Mental Health and Addiction and Recovery Management, along with regulations pertaining to mental health of inmates. Unlike the NDCS's website where the information for the specific regulations was easy to find, much of IDOC's existing and planned new regulations are contained in a settlement agreement that was mentioned in Section II, and thus are not centrally located.

When a mentally ill inmate enters the prison system, the first step that IDOC completes is an initial screening of the inmate.¹³⁴ This initial intake screening for mental health is to ordinarily take place in the first twenty-four hours of the inmate's admission, but no later than forty-eight hours after admission.¹³⁵ The screening is done by a trained "Mental Health Professional"¹³⁶ and takes place within a private room to keep confidentiality.¹³⁷ During these screenings, inmates are evaluated for any "neurodevelopmental disabilities, suicidal ideation or intent, current or past self-injurious behavior, the presence or history of symptoms of mental illness, current or past use of

132. Hammel, *supra* note 126.

133. IDOC 2018 REPORT, *supra* note 7, at 18.

134. Midyear Report of Monitor Pablo Stewart, MD, *supra* note 48, at 16.

135. *Id.* at 16-17; *see also* ILL. ADMIN. CODE tit. 20, § 415.40 (2019).

136. "'Mental health professional' means a psychiatrist, physician, psychiatric nurse, clinically trained psychologist, or an individual who has clinical training and a master's degree in social work or psychology." ILL. ADMIN. CODE tit. 20, § 415.20(i) (2019).

137. Midyear Report of Monitor Pablo Stewart, MD, *supra* note 48, at 17.

psychotropic medications, or the presence of conditions that require immediate intervention.”¹³⁸ These screenings are to be kept in the inmate’s records and follow them if they are to be transferred to a different facility.¹³⁹ If an inmate is being transferred to a new facility, they are to be evaluated for any suicidal ideations, but do not receive this screening again.¹⁴⁰ Further, IDOC has procedures in place that allow an inmate to keep taking the prescriptions that the inmate was taking prior to incarceration, until a review can be made by a Mental Health Professional and medications changed if need be.¹⁴¹

The screening will also determine whether that inmate is to be placed into general population or into a specialized mental health setting.¹⁴² According to the code, “[inmates] placed in a specialized mental health setting shall remain as long as determined to be clinically necessary.”¹⁴³ If an inmate is in need of mental health care at any time, staff is to make a referral and an evaluation is to be done within fourteen days of the referral. However, this process seems to be an area that IDOC is currently working on.¹⁴⁴ An inmate “requiring on-going outpatient, inpatient or residential mental health services shall have a mental health treatment plan.”¹⁴⁵ The plan is recorded with the inmate’s records, including how the treatment is to be brought about, the type of treatment, frequency of the treatment, and which staff are to be conducting the treatment.¹⁴⁶ Once the plans are in place, they are to be reviewed and updated given the situation of the inmate, especially more often if the inmate has a serious mental illness.¹⁴⁷ When an inmate is prescribed a psychotropic medication they are to “be evaluated by a psychiatrist at least every thirty (30) days,” which is subject to certain considerations: (1) stable inmates in outpatient level of care are to receive appointments every thirty to ninety days; (2) stable inmates at residential level of care receive appointments every thirty to sixty days; and (3) inmates with inpatient care are evaluated

138. *Id.* at 19.

139. *Id.*

140. *Id.* at 17.

141. *Id.* at 18.

142. “‘Specialized mental health setting’ means a Department of Corrections facility or unit that specializes in mental health care.”

ILL. ADMIN. CODE tit. 20, § 415.20(k) (2019).

143. ILL. ADMIN. CODE tit. 20, § 415.50(b)(1) (2019).

144. Midyear Report of Monitor Pablo Stewart, MD, *supra* note 48, at 22. At the time of the making of the report by the Court Monitor the system was backlogged by 231 inmates that needed a mental health evaluation and were still waiting. *Id.* at 20.

145. *Id.* at 25.

146. Midyear Report of Monitor Pablo Stewart, MD, *supra* note 48, at 26 (explaining though that IDOC has not substantially complied with this requirement and many of the treatment plans were “incomplete, not individualized, contained generic boiler plate language and were of overall poor quality.”).

147. *Id.* at 26.

at least every thirty days.¹⁴⁸ In the situations of serious, emergent need, the facility's Crisis Intervention Team is to be contacted to help the inmate, though this is also still a work in progress.¹⁴⁹

However, one proposal that Illinois has put into action is the increase in mental health beds in both old and new facilities. The Settlement Agreement required IDOC to implement "renovations, upgrades, and retrofits" to provide more mental health beds to accommodate inmates with serious mental illnesses who can be treated at these sites as well.¹⁵⁰ These changes were to take place at Dixon Correctional Center, Pontiac Correctional Center, Logan Correctional Center, and the Joliet facility.¹⁵¹ At the time of the Court Monitor's report, IDOC reported having a total of 1,150 beds for residential treatment units specifically for male inmates, and eighty beds for female inmates.¹⁵² According to the settlement, crisis beds, which are for inmates who need an aggressive mental health intervention, are also to be made available and are not to be located in the segregation units in the prison facilities.¹⁵³ However, some of the challenges that IDOC is facing in updating some of its facilities to meet the settlement terms include: an increase in the amounts of inmates with mental illness who require a higher standard of care; a system in place that does not properly identify and intervene with mentally ill inmates when needed; inmates placed on crisis watch receive inadequate treatment and care and are not transferred to higher levels of care when needed; and the lack of crisis beds in these facilities to meet the demand.¹⁵⁴ In the pending crisis centers there will be space for therapy sessions, private screenings on intake, meetings with Mental Health Professionals, therapeutic environment, and procedures in place to care for these inmates.¹⁵⁵ Overall, IDOC has completed some of the actions required by the settlement, but also still has far to go to adequately house and treat inmates with serious mental illnesses.

One of the still unmet areas of improvement identified in the settlement agreement is segregation.¹⁵⁶ Prior to the settlement, and something that is still occurring, is the practice of placing two inmates to a segregation cell that is usually made for one due to overcrowding and lack of facility space.¹⁵⁷ This

148. *Id.* at 30 (stating that the IDOC had substantial difficulty with complying with this requirement and records indicated a backlog of psychiatric appointments).

149. *Id.* at 23 (stating that staff members will at times get in the way of the Crisis Intervention Team trying to help the inmate).

150. *Id.* at 35.

151. Midyear Report of Monitor Pablo Stewart, MD, *supra* note 48, at 35.

152. *Id.* at 36.

153. *Id.* at 41-43 (reporting that Pontiac Correctional Center had 62% of its crisis watches be contained in its segregation housing).

154. *Id.* at 42-43.

155. *Id.* at 43.

156. Midyear Report of Monitor Pablo Stewart, MD, *supra* note 48, at 55.

157. *Id.*

is especially troublesome when one of the individuals is suffering from a mental illness and is paired with another person who aggravates those symptoms. The problem, as stated by the Court Monitor, is that “[p]lacement in segregation will result in a worsening of their underlying mental illness and a creation of new psychiatric pathology.”¹⁵⁸ Once the settlement terms are implemented completely, before an individual is to be put into segregation, there are a variety of factors that need to be considered. These factors include compatibility of inmates, the differences in their ages or sizes, whether the inmate is affiliated with any groups in prison, the inmate’s history of violence with others, the reason for the segregation, the inmate’s mental health history, racial bias issues, any medical concerns, and any other factors that may be important to placement in segregation.¹⁵⁹ Further, before a mentally ill inmate is placed into segregation, staff is to consult with that inmate’s treatment team.¹⁶⁰ Along with calculation in placement of inmates into segregation, IDOC is to keep a standard regarding living conditions in these cells and resolve any issues in a timely matter.¹⁶¹ While in segregation, a mentally ill inmate is still to receive the treatment they were receiving before being put into segregation.¹⁶² After initial placement in segregation, they are also to receive a review by a Mental Health Professional within forty-eight hours and documentation needs to be made of this review.¹⁶³ At a minimum, inmates who are in segregation for sixteen days are to receive continuation of their treatment plan, rounds by a Mental Health Professional every seven days, continuation of medication(s), counseling per their treatment plan, documentation regarding clinical contacts, participation with a multidisciplinary team in a type of group therapy, and out-of-cell time.¹⁶⁴ Sadly, many of the changes that have been required of IDOC in the settlement agreement have not been implemented in the segregation area. Much of this is due to lack of mental health and custody staff, coupled with IDOC’s outdated notions.¹⁶⁵

158. *Id.*

159. *Id.*

160. *Id.*

161. Midyear Report of Monitor Pablo Stewart, MD, *supra* note 48, at 56. These conditions include:

double ceiling, secure fastening of the bed, clean bedding, running water, lighting, placement above ground with adequate heat and ventilation, food passage and visual observation, use of restraints inside the cell, cleaning materials, showers and shaves, toiletries, clothing and laundry, dentures, glasses and other hygienic items, property and commissary, food, visits, medical, chaplain and correctional counselor visits, programs, exercise, phone calls, mail privileges and reading materials.

Id.

162. *Id.* at 56.

163. *Id.* at 57.

164. *Id.* at 58.

165. Midyear Report of Monitor Pablo Stewart, MD, *supra* note 48, at 55.

IDOC still has a long way to go in keeping individuals with a mental illness out of segregation.¹⁶⁶

Two other areas that IDOC still has a way to go on are suicide prevention and the use of physical restraints on mentally ill inmates.¹⁶⁷ For suicide prevention, much of the concern centers on inmates who are in crisis not receiving adequate mental health care.¹⁶⁸ In many cases, the Crisis Intervention Team is sometimes blocked by regular staff, who thought the inmate was either faking the need or being dramatic.¹⁶⁹ As for physical restraints, their use is to be under medical supervision, especially if being used on an inmate with a mental illness.¹⁷⁰ Regardless of mental health, restraints are to never be used in a disciplinary matter.¹⁷¹ If restraints are used, their use is not to exceed four hours unless further stated by a healthcare professional to leave them on, in which the limit is sixteen hours.¹⁷² Also, restraints are to be used only in a crisis care area, where staff can keep a watch on the individual being restrained and keep accurate documentation of the use of the restraints.¹⁷³ The main provision for restraints is that they not be used at all on an inmate who is on the mental health caseload due to high possibility of aggravating the inmate's symptoms, or worse, causing them to develop a new mental illness.¹⁷⁴

As it stands now, Illinois has leaps and bounds to go before its take on the mental health of inmates is where it should be. Illinois has the necessary provisions in some areas but fails to meet them in other areas. However, with the prison system changes being court ordered and court supervised, the change is happening steadily, if not quickly. Illinois is still learning that the mental health of inmates is important to the goals of rehabilitation and being able to have these men and women re-enter society. Further, Illinois is still learning how to accomplish those goals.

IV. PROCEDURES IN FAVOR OF TREATING MENTALLY ILL INMATES

The Department of Justice has noted that, "a number of court rulings affirm that prison inmates are entitled to mental health care equal to that available in the community. Yet, few if any prisons are able to offer a comprehensive array of mental health services for all inmates who may require

166. *Id.*

167. *Id.* at 67.

168. *Id.*

169. *Id.*

170. Midyear Report of Monitor Pablo Stewart, MD, *supra* note 48, at 75.

171. *Id.*

172. *Id.*

173. *Id.* at 76.

174. *Id.* at 79.

or request them.”¹⁷⁵ As seen by the changes being made in Nebraska and Illinois, most policies and procedures that are implemented to help treat mentally ill inmates are enacted retroactively. They are put in place due to a tragic event, such as an inmate committing suicide or being murdered by another inmate, or by court order. To keep up with society’s understanding of mental health, prisons should be adapting along with new knowledge. As a nation with many incarcerated individuals who will reintegrate back into society at large, many of whom are mentally ill, we need a better system of helping these individuals when we can. Many instances have shown that in the absence of appropriate treatment and care, mentally ill individuals are more apt to recidivate.¹⁷⁶ These individuals also do not have many options when it comes to treatment they can seek when out of prison. With the closure of many psychiatric institutions, mentally ill individuals have to rely on community run and funded centers for their treatment, which, sadly, are few and far between.¹⁷⁷ Given the realities of mental health treatment for this population, prisons should act accordingly and implement procedures that are favorable in treating and caring for inmates that have mental health issues. This section will run through procedures that should be implemented in state prisons as a whole.

A. INTAKE SCREENING OF INMATES ON ARRIVAL TO PRISON

The first change that needs to be implemented is the provision of reliable and consistent mental health screenings for inmates. An inmate’s right to receive a mental health screening and treatment for any mental health issues is backed by legal precedent.¹⁷⁸ Courts have found “that prisoners are entitled to psychological or psychiatric treatment if a physician or other health care provider concludes that the inmate has a serious mental disease . . . that, without treatment, he or she would suffer some harm.”¹⁷⁹ Three types of screenings should be given to an inmate: (1) mental health screening, which is done upon admission, covering a wide range of information; (2) intake screening, which is a more extensive evaluation by trained staff; and (3) evaluation, which is a full examination by a mental health professional.¹⁸⁰

175. U.S. DEP’T OF JUST., EFFECTIVE PRISON MENTAL HEALTH SERVICES: GUIDELINES TO EXPAND & IMPROVE TREATMENT 25 (2004), <https://info.nicic.gov/nicrp/system/files/018604.pdf> [<https://perma.cc/ASP3-H8ZW>] [hereinafter EFFECTIVE PRISON MENTAL HEALTH SERVICES].

176. Gawron, *supra* note 4, at 97.

177. *See generally id.* at 86.

178. EFFECTIVE PRISON MENTAL HEALTH SERVICES, *supra* note 176, at 13 (“The U.S. Supreme Court established that it is unconstitutional under the eight amendment to show deliberate indifference to the serious medical needs of prisoners.”).

179. *Id.*

180. Fred Cohen, *Correctional Mental Health Law: Origins, Status, Future*, CRIM. L. BULL., Fall 2013.

Screening upon intake of an inmate is vital to mental health procedures.¹⁸¹ During this process, a trained prison official receives and documents any current conditions or past conditions that an inmate is dealing or has dealt with. An evaluation of the new inmate's mental health is crucial upon intake and starts the process of him or her receiving treatment and care.¹⁸² The evaluation and screening should focus on "security, self-harm information, and medical care, including mental health care."¹⁸³ The initial screening is used to gather wide swathes of information from the inmate when they arrive at the prison.¹⁸⁴ The information gathered here can indicate whether an individual is suffering from a mental illness or not. It is from here that the inmate can start to receive individualized treatment and be seen by either a trained mental health staff member or mental health professional. This process should not end after an initial intake screening but should continue with staff that has knowledge and experience with individuals having a mental illness.

The next step in the screening process is for the inmate to be seen by trained staff, who can further inquire into the inmate's mental health issues. "This is more extensive than the receiving stage," where staff can indicate the trouble areas for the inmate. By going more in depth into facts about the inmate, trained mental health¹⁸⁵ staff might pick up on something that the screening staff missed or the inmate was not willing to talk about with the intake staff. This stage should be completed within fourteen days of the inmate's arrival at the prison. The mental health evaluation should cover:

psychiatric history, including hospitalizations and outpatient treatment; current use of psychotropic medications, if any; current suicidal ideation; history of suicidal behavior; current and prior drug and alcohol usage; history of sex offenses; history of violent behavior; history of being victimized by criminal violence; history of special education placement; history of seizures or cerebral trauma; emotional response to being incarcerated; and intelligence testing for mental retardation.¹⁸⁶

By covering all of these areas, proper diagnosis and treatment can be determined, if needed. Once this is completed then the inmate should be seen for one more evaluation.

181. *See generally id.*

182. *See id.* (reasoning that finding the correct treatment and care for an inmate begins upon reception of that inmate); *see also* EFFECTIVE PRISON MENTAL HEALTH SERVICES, *supra* note 176, at 16 ("An APA task force report on psychiatric services in jails and prisons recommends that a mental health screening be conducted at the time of admission to the prison.")

183. Cohen, *supra* note 181.

184. *Id.*

185. "Qualified mental health personnel include psychiatrists, physicians, psychologists, nurses, physician assistants, psychiatric social workers, and others who are permitted by law to care for the mental health needs of patients." EFFECTIVE PRISON MENTAL HEALTH SERVICES, *supra* note 176, at 16.

186. *Id.*

The third, and final, evaluation, if needed to further diagnose, will delve deeper into what type of mental illness a prisoner could be experiencing. This evaluation should be conducted by a mental health professional, preferably one with experience in dealing with inmates. The evaluation should consist of “clinical interviews, histories, psychological testing, and clinical judgement.”¹⁸⁷ This is only done if the first two steps are positive and the inmate is exhibiting signs of a major mental illness.¹⁸⁸ Once complete, a treatment and care plan for the inmate can be implemented with the requisite medication, if needed. This stage is crucial for an inmate to see that they are being cared for and that someone is on their side; this gives them hope. The final evaluation should be completed at least within a period of five to fourteen days after the second evaluation.

These three screenings and evaluations help to begin the process of treating and caring for the inmate who has mental health issues, otherwise the process breaks down and is often difficult to institute later on in the inmate’s sentence.¹⁸⁹ By starting as soon as possible, the inmate can receive the appropriate amount of care and hopefully keep them on track to feeling better. The first few weeks an inmate is in prison is crucial, for that inmate is going through a drastic change, regardless of whether this is their first time incarcerated or their fifth. No matter who you are, especially as an inmate, mental health care and treatment is pivotal.

B. REDUCTION OF OVERCROWDING IN PRISONS OR ADDITION OF EQUIVALENT STAFFING

Many prisons blame much of their problems on prison overcrowding or inadequate staff members.¹⁹⁰ However, “adequate staff, bed space, and access,” has been referred to as the “spinal column of correctional mental health care,” by Fred Cohen.¹⁹¹ Fred Cohen is an expert in American correctional law and recognized as “the leading scholar and practitioner in correctional mental health law.”¹⁹² By reducing overcrowding and adding staff that understands mental health, inmates with mental illnesses will have a better chance at prospering.¹⁹³ As noted above, many individuals get the help they sorely need for their mental health in prison. However, others who look for that help do not receive it due to overcrowding and inadequate staffing.¹⁹⁴

187. Cohen, *supra* note 181.

188. *Id.*

189. *Id.*

190. *See generally* Midyear Report of Monitor Pablo Stewart, MD, *supra* note 48.

191. Cohen, *supra* note 181.

192. *Practical Guide to Correctional Mental Health and the Law*, CIVIC RSCH. INST., <https://www.civiresearchinstitute.com/pgcm.html> [perma.cc/79J6-JAVG].

193. *See generally* EFFECTIVE PRISON MENTAL HEALTH SERVICES, *supra* note 176, at 6.

194. *See generally* Midyear Report of Monitor Pablo Stewart, MD, *supra* note 48.

By increasing the number of beds, especially mental health beds, prisons could handle and care for a variety of mental illnesses.¹⁹⁵ Most state prison systems are overcrowded and lack space designed specifically for mentally ill inmates. As seen in both Nebraska and Illinois, some states have made strides toward adding more beds, but it has been a slow and retroactively done process. The addition of these beds is not enough by far. Unfortunately, it is difficult to put an exact number on any of items listed here, but if a prison wants to succeed in caring for mentally ill inmates then it can look to possible ratios, such as number of inmates dealing with mental illness, access to mental health beds, and number of trained staff.¹⁹⁶ Overcrowding also lends to aggravating the conditions and symptoms of mentally ill inmates. By reducing the number of prisoners in an area, this would help the general well-being of all the inmates being held in that prison.¹⁹⁷

C. ACCESS TO MENTAL HEALTH TREATMENT, MENTAL HEALTH PROFESSIONALS, AND PROPERLY TRAINED STAFF

Many states have created their own procedures and guidelines to cover how an inmate has access to psychiatric services, deeming who can be labeled mental health professionals, and how staff shall be trained. This leads to an array of varied procedures and results in treatment inequities for mentally ill inmates. A national standard should be set for all state and federal prisons to follow, to ensure uniform treatment for all mentally ill inmates.

Two of the most nationally recognized lines of standards are those created by the American Psychiatric Association (APA) and the National Commission on Correctional Health Care (NCCHC), which focus on the health and treatment of mentally ill inmates.¹⁹⁸ The common theme for both of them is that inmates must receive care as quickly as possible. The APA recommends “that a variety of biological and psychological therapies be available to treat mental health disorders that significantly interfere with an inmate’s ability to function in prison.”¹⁹⁹ Its standards require that these components be available to inmates: “[a] crisis intervention program with infirmary beds available for short-term treatment[,] . . . [a]n acute care program[,] . . . [a] chronic care program[,] . . . [o]utpatient treatment services[,] [c]onsultation services[,] . . . [and] [d]ischarge/transfer planning.”²⁰⁰ Many of the rules set

195. See generally Cohen, *supra* note 181.

196. Cohen, *supra* note 181.

197. See generally EFFECTIVE PRISON MENTAL HEALTH SERVICES, *supra* note 176, at 6.

198. *Id.* at 25-26.

199. *Id.* at 25.

200. *Id.* at 25. An acute care program would consist of “inpatient treatment for inmates with significant psychiatric symptoms that interfere with their ability to care for themselves,” while a chronic care program would be “a special housing unit for inmates with a chronic

forth by the APA focus on more of the treatment aspect of a mentally ill inmate and not the broader picture involved.

The NCCHC's standards similarly address issues of care and treatment, but also "administrative and personnel issues, support services, special needs and services, health records, and medical-legal issues."²⁰¹ Its plan for care and treatment include initial screening upon admission, information for inmates on how to access mental health care within the prison, a health appraisal that should be done within seven days of arriving at the prison, a mental health evaluation within fourteen days, personal treatment plans for inmates, access to a mental health professional within forty-eight hours of requesting, prison procedures, and private mental health treatment.²⁰² This standard seems to be more catered to a prison system, as a whole, and should be adhered to within all state and federal prisons. By allowing inmates access to adequate mental health treatment and care, including the applicable policies and procedures above, their rehabilitation will be much smoother for all parties involved.

Because it is important for mentally ill inmates to have access to mental health care, this also necessarily includes access to a mental health professional. A mental health professional is usually defined as someone having a state license, certification, and registration requirements for the area in which they are treating.²⁰³ This would preferably be someone who has experience dealing with inmates and has the requisite education and training to counsel inmates and possibly prescribe psychotropic medication, when needed. By having a professional with the requisite experience, prisons can ensure mentally ill inmates are appropriately medicated and treated. Mentally ill inmates should have the chance to meet with such mental health professionals in private and as frequently as needed to further help them. When to see a mental health professional would depend on the type of treatment plan for that individual inmate, but private counseling can benefit an individual who is dealing with illnesses. Regardless of whether private or not, "therapy can benefit the overall mental health and coping ability of individuals with mental illness in prison setting, and supportive individual psychotherapy for those with serious mental illness should be available."²⁰⁴ Other avenues for treatment could be sets of group counseling for inmates dealing with the same type of mental illnesses.²⁰⁵ This is the most cost-effective maneuver for prisons but can also help inmates realize they are not alone in their struggle with mental illness,

mental illness who do not need acute inpatient care but cannot function adequately within the general population." Consultation services should include "consultation with other prison officials and departments and the training of officers and program staff." *Id.*

201. EFFECTIVE PRISON MENTAL HEALTH SERVICES, *supra* note 176, at 26.
202. *Id.* at 26.
203. *Id.* at 29.
204. *Id.* at 28.
205. *Id.* at 27.

help them develop communication and interpersonal skills, assist with anger management, teach inmates how to cope with drug and alcohol abuse, and educate them about their mental illness and options available for it.²⁰⁶ Both of these, individual and group therapies, should be conducted by a mental health professional to ensure that treatment is going accordingly.

Finally, the importance of staff who are trained to work with and identify inmates with mental illness cannot be stressed enough. Training should be given to any staff member who is going to work with an inmate with a mental illness, including correctional officers and other prison staff positions regardless of whether they have the words “mental health” in their title. This is necessary because “[s]tudies suggest that staff who are most likely to succeed with correctional or mentally disordered offender populations are those who use authority to enforce rules but in a nonconfrontational manner, who model prosocial (and anticriminal) attitudes and behaviors, and who are at the same time empathetic and interpersonally skilled.”²⁰⁷ This means staff should be able to listen and speak with inmates that may be having mental health issues, keep in contact with inmates who have exhibited certain behaviors, provide inmates with information on how to request mental health care, observe and record inmate behavior, relay requests from inmates to mental health professionals, consult with mental health staff, monitor inmates who are taking certain psychotropic medications, and be able to identify the signs of a mental illness.²⁰⁸ Much of staff training should include acknowledgment of mental health issues with inmates and help staff to identify their occurrences.

Allowing easier access to mental health treatment and care can help inmates rehabilitate much more quickly and easily. This can be accomplished by allowing individuals to see mental health professionals on a regular basis and training staff to be able to properly identify an inmate with mental illness. The standards set forth by NCCHC are an excellent place for state prison systems to start.²⁰⁹

D. RESTRICTIONS ON MENTALLY ILL INMATES IN RESTRICTIVE HOUSING

Next, better disciplinary procedures need to be in place to assist mentally ill prisoners. “Finding safe, humane, and nonpunitive methods for han-

206. EFFECTIVE PRISON MENTAL HEALTH SERVICES, *supra* note 176, at 29.

207. *Id.* at 33 (quoting Marnie E. Rice & Grant T. Harris, *Treatment for Prisoners with Mental Disorders*, in PROVIDING SERVICES FOR OFFENDERS WITH MENTAL ILLNESS AND RELATED DISORDERS IN PRISONS 91, 110 (H. J. Steadman & J. J. Cocozza eds., 1993)).

208. *Id.* at 33.

209. *Id.* at 25.

ding inmates who are experiencing the symptoms of mental illness is an ongoing challenge for prison administrators.²¹⁰ Some inmates with mental illnesses commit infractions due to their mental illness.²¹¹ This causes problems for prisons regarding how to address these infractions in a safe manner, so as not to aggravate the mental health of the inmate. Main aggravations include solitary confinement and the use of restraints. Solitary confinement and even extended segregation have been found to cause mentally ill inmates extreme stress and possibly exacerbate their illness.²¹²

Because of this, the use of segregation on mentally ill inmates should be used sparingly or not at all. Segregation can cause anxiety in some and lead to suicidal ideations.²¹³ If an inmate with a mental illness is placed in some kind of segregation due to disciplinary matters, mental health staff should be readily available “to provide an adequate level of services” to that inmate.²¹⁴ Staff that is on duty in a segregation unit should administer rounds routinely, which will help them observe inmates who may be having difficulty. The NCCHC suggests that these rounds be made by mental health staff “at least three times a week for inmates in administrative segregation and daily for inmates in disciplinary segregation.”²¹⁵ If an inmate is deemed to need attention, he or she should receive it as soon as possible, rather than waiting.

Further, too many prisoners are put into penal isolation and restraints for long periods of time and for the wrong reasons.²¹⁶ “Both seclusion and mechanical devices that restrain are used at times to protect mentally ill offenders from harming themselves and others.”²¹⁷ However, use of restraints and seclusion methods can lead to dire consequences, such as an inmate developing suicidal ideations or another form of mental illness. These methods should be used sparingly and especially with the use of restraints, not for disciplinary matters.²¹⁸ As such, “specific and well-articulated policies and procedures must be in place to govern who can use them and under what conditions.”²¹⁹ The NCCHC standards stipulate that certain requirements should be followed when using restraints on a mentally ill inmate. These include strict policies and procedures at the prison, only the use of soft restraints, the use of restraints can only be ordered by a health provider, use of the restraints only at the direction of health staff, restraints and seclusion

210. *Id.* at 41.

211. EFFECTIVE PRISON MENTAL HEALTH SERVICES, *supra* note 176, at 41.

212. *Id.*

213. *Id.*

214. *Id.*

215. *Id.*

216. Cohen, *supra* note 181.

217. EFFECTIVE PRISON MENTAL HEALTH SERVICES, *supra* note 176, at 42.

218. *Id.* There is a high potential for misuse of these methods, such as for control or a use to punish the inmate, rather than keeping them from harming themselves or others. *Id.*

219. *Id.*

should not exceed twelve hours, and inmates in restraints should be checked every fifteen minutes by health staff.²²⁰

As seen above, prisons should use seclusion and restraints very sparingly, or not at all, as these types of methods cause a variety of short- and long-term consequences for individuals dealing with mental health issues. To avoid these consequences, highly regulated procedures and policies should be in place for these methods and should be followed strictly by all prison staff to ensure that seclusion and restraints are only used sparingly.

E. PREPARATION AND GUIDANCE FOR REINTEGRATION BACK INTO SOCIETY

These reforms are needed because the ultimate end game for most inmates is to be reintegrated back into society at large and be able to function normally.²²¹ The preparation and guidance for this transition begins in prison and is especially important for individuals who have mental health issues. These transitions can cause inmates with mental illnesses to become stressed and, depending on how their mental illness manifests, that stress can exacerbate their symptoms.²²² By preparing and guiding mentally ill inmates while they are in prison for the transition back into society, prisons can help them not recidivate.²²³

Before an inmate with a mental illness returns to his community, mental health staff in prisons should set up an appointment for the inmate with a community mental health professional.²²⁴ Continuity of care is crucial because for released inmates, “[a] successful reentry is the result of thorough assessment and planning.”²²⁵ A referral should be made by the prison health staff to community-based mental health services, and there should be communication between the community and the prison regarding that particular inmate.²²⁶ This communication should include exchanging of records to help with the continuity of treatment for that individual because²²⁷ “[w]ithout good coordination between institutional and community programs, the offender’s disorder, anxiety, or both are likely to weaken the gains made in treatment and trigger a relapse.”²²⁸ The reason for coordination is because when an inmate is going from a highly structured environment to one where

220. *Id.*

221. EFFECTIVE PRISON MENTAL HEALTH SERVICES, *supra* note 176, at 68.

222. *Id.* at 67.

223. *Id.* at 70.

224. *See generally id.* at 71.

225. EFFECTIVE PRISON MENTAL HEALTH SERVICES, *supra* note 176, at 68.

226. *Id.*

227. *See generally id.*

228. *Id.* (citing Gary Field, *From the Institution to the Community*, CORRECTIONS TODAY, Oct. 1, 1998, at 94–97).

the former inmate is back in complete control, without support they might forego the treatment they should continue.²²⁹

Unfortunately, many communities lack the requisite treatment and care centers for individuals transitioning from prison to society. In these communities an integrated system should be designed to help with continuity of care for mentally ill inmates.²³⁰ “One of the most significant issues facing people, with serious mental illness, when they are released from prison is their ability to continue their psychotropic medication.”²³¹ By having an integrated system between prisons and the communities, mentally ill individuals can continue their medications, which add a sense of regularity for them. The legal system also adds an incentive for more coordinated community care since “courts have ruled that the state must provide an outgoing prisoner who continues to require psychotropic medication with a supply sufficient to ensure the availability of the medication during the time reasonably necessary to consult a doctor and obtain a new supply.”²³²

Aftercare for mentally ill individuals released from prison can also mean the difference between a mentally ill former inmate being homeless and having a place to live. Much like the transition from a long hospital stay to home, the transition from prison to society needs a series of steps.²³³ These steps include: “assessment of need; development of a case plan; referral and linkage to available services; monitoring or continued services; and evaluation as to whether services are achieving the intended goals,” preferably implemented by a mental health professional.²³⁴ By having someone, acting sort of like a parole officer to ensure continuity of care, the newly released inmate can have this kind of necessary support. This support can help former inmates achieve the steps they need for treatment and care of their mental illness. These steps can be part of a conditional release to help keep the former inmate on track towards receiving mental health care, staying away from drugs, obtaining housing, obtaining employment, and other areas that might need to be added.²³⁵ The ultimate goal is for the inmate to receive treatment even after being released from prison and to have as seamless a transition as possible.²³⁶ This is helped by treatment providers who act as agents for the released inmate and help them stabilize any symptoms they may have.²³⁷

By assisting newly released inmates who have a mental illness, prison systems can foster their overall wellbeing. This is done by preparing and

229. EFFECTIVE PRISON MENTAL HEALTH SERVICES, *supra* note 176, at 68.

230. *See generally id.* at 69.

231. *Id.*

232. *Id.*

233. *Id.* at 71.

234. EFFECTIVE PRISON MENTAL HEALTH SERVICES, *supra* note 176, at 71.

235. *Id.* at 72.

236. *Id.*

237. *Id.*

guiding these inmates through the process of release and giving them a jumpstart to handling their own care. Courts and prisons can also have quite a bit of leverage with conditional releases and types of post-release supervision to aid these individuals towards a healthy lifestyle.

CONCLUSION

Although there are some who would argue that inmates do not deserve this standard of care, the truth remains that most mentally ill inmates will reintegrate back into our communities. By helping mentally ill individuals while they are in prison, this gives them a jumpstart for a life outside of prison. As this article has demonstrated, prisons are the main source of mental health services in this country, many individuals finally receive mental health treatment and care in prisons, and some individuals do not receive the treatment and care they need. Given the role prisons play in mental health treatment, and as a result of these varying outcomes, our mental health systems in prison need nationwide standards. Ensuring this not only aids the health and safety of mentally ill inmates, but of the communities to which they return as well.