

# Chapter 7

## Prison



What we've got here is failure to communicate. Some men you just can't reach. So you get what we had here last week, which is the way he wants it. Well, he gets it. I don't like it any more than you men.—Captain, Cool Hand Luke (Carroll & Rosenberg, 1967)

Prisons present a complex array of problems relating to mental health. Perhaps most notably, the prison environment is quintessentially *iatrogenic*—that is, the “treatment” for substance abuse and mental illness now comes commonly in the form of incarceration, and this treatment by incarceration is related to further sickness. In other words, the American prison environment is the antithesis of a therapeutic community. Argumentatively, this has resulted in part from a combination result of a recent “no-frills” movement (Finn, 1996) and a growing scarceness of resources. Regardless, prison is often awash in contraband (e.g., alcohol and drugs) and trauma-inducing situations (e.g., physical and sexual violence, administrative segregation and isolation, and missing the death of loved ones in the free world while incarcerated). The data provided in earlier sections of this text presented the daunting statistics behind these issues: just over half of state prisoners have a mental health problem; only one-third of state inmates with a mental illness receive treatment for their illness in prison; and a smaller proportion receives professional mental health therapy for their symptoms. It appears that change is occurring most slowly for prisons than any other segment of the criminal justice system, primarily due to persistent budgetary constraints dating back to at least 1998 (National Center on Addiction and Substance Abuse, 1998).

### 7.1 Know the Role

The seminal guide on substance abuse treatment in the criminal justice system disseminated by SAMHSA offers a handy section on treatment issues specific to prison (SAMHSA, 2014). While it relates to substance use and abuse, its content easily

applies to broadly treatment issues in prison. In its prison section, the guide spends a great deal of time discussing the issues of inmate culture. It explains that, compared to jail inmates, those in prison are more likely to learn to adopt prison cultural mores as a means of survival. This path to an inmate identity is also honed by the pressures of the institution and by the common interactions between inmates with one another and with prison staff. Of particular importance, “there are many more people who are accustomed to the setting and who take the attitude that it is ‘no big deal’ [in prisons, as opposed to jails]....The hardened demeanor and ‘macho’ attitude adopted as part of the inmate culture can discourage offenders from participating in treatment...as [it] is a sign of ‘weakness.’...[For example,] inmates who enroll in treatment are often characterized by other prisoners as too weak to ‘handle their drugs’ in the community” (SAMHSA, 2014, p. 193).

Thus, there often is a unique and complex dynamic in prisons that presents countervailing forces relating to mental health: (1) the prison environment is laden with the potential to develop mental health symptoms in otherwise healthy adults and, further, puts individuals with mental health diagnoses (particularly those with co-occurring disorders) at great risk of decompensating and falling deeper into their disease, and (2) the stigma of seeking help often becomes intensified in this setting, lending to a significant barrier to treatment. These forces become particularly significant when realizing that, after initial intake and medical screening and assessment, follow-up typically happens only when necessary—for example, upon a mental health crisis, overdose, contraband violation, or the like. Truly, in this setting, squeaky wheels (especially the loud ones) will get attended to, yet many prisoners become adept at hiding any signs that may raise suspicion that they need help. And further, if prison administrators sought to provide care to everyone who needs it, the cost of adequate care would quickly bankrupt all prison operations.

With this in mind, a prominent subsection in the guide is entitled “What treatment services can *reasonably* be provided in the prison setting” (emphasis added). The ideal program being advocated for is a “true” therapeutic community (TC) inside of the prison setting with complete segregation from the general population 24 h and 7 days a week for optimal success. TCs feature the integration of work (and/or educational or vocational programming), professional counseling, and a healthy (e.g., pro-social) community environment. Oftentimes, prison administrators must compromise by offering as many components of the TC as possible given the resources available. In many cases, TCs are composed of individuals who remain in general population who receive a schedule of programming to attend, which features the components of a TC—counseling, education classes, group therapy sessions, and so on. Further, self-help programming has become extremely popular in this framework due to its simplicity to set up and the few resources required to sustain them.

Yet, is it reasonable to assume that as long as prisons offer an array of services (such as these mentioned above) to their inmate population, regardless if they are driven to use them or not, that prisons are fulfilling their constitutional duties of inmate care? With often scarce resources and remote distancing from the community-based care system that can support jails and other forms of justice involvement (e.g., community corrections), the answer to “what treatment services can reasonably be provided in a prison setting?” is a pressing one.

### **7.1.1 Reaffirming Minimal Mental Health Care: The Epicenter (California) and the New Frontier (Alabama)**

In May 2017, experts at the Stanford Law School teamed up with a California State Senator to publish a study entitled “When did prisons become acceptable mental healthcare facilities?” (Steinberg et al., 2015). This work begins by focusing on the rapid increase of mentally ill people in the California prison system after deinstitutionalization and then brings to light the current conditions of incarceration for individuals with mental illness, which specifically tend to result in longer sentences than those who have not been diagnosed with a mental illness. Steinberg et al. (2015) offer some grim statistics about the California State Prison System to drive their points home: as of 2017, 45% of inmates had been treated for *severe* mental illness in the past year (vastly more by proportion than other states as indicated by the data provided earlier in this text); the number of prison inmates with mental illness has doubled in the 15 years prior to the report’s release (since 2000); and the average sentence for burglary is 30% longer for an individual with a mental health diagnosis compared to the average sentence for defendants without mental illness who are convicted of the same crime, leading the sentencing disparities among other crime types (e.g., robbery, assault, assault with a weapon, child molestation, second-degree murder, weapon charges, and drug sales—much like as seen within jails). Criminal justice reform in California was intended, in part, to ameliorate these issues—especially in light of *Coleman v. Wilson*. Yet, behavioral health disparities continue in California as evidenced by the number of inmates with mental illness gaining relief under new resentencing laws (e.g., Proposition 36) relative to inmates without mental health problems; that is, individuals with a mental health diagnosis have recently been denied resentencing relief relative to those who do not have a diagnosis.

These issues highlight the enduring nature of seeding institutional change. California has been at the forefront of a paradigm shift for prisoners with mental illness since 1994 with the formation of the California Department of Corrections and Rehabilitation Mental Health Services Delivery System (2009; see Table 7.1). Despite years of effort, defining model policies and procedures and promulgating them throughout the prison system, and engaging in best practices, significant slip-page is still commonplace. For example, in the most recent complaint in *Coleman v. Brown* (2017)—which was originally filed as *Coleman v. Wilson* as discussed earlier in this text—the Department of Corrections was found to have not provided prompt care for inmates experiencing life-threatening psychiatric crises. Small and Pickoff-White (2017) offer additional details in their expose on the facts of the case; according to their investigative journalist accounting on the matter, over 25% of individuals needing critical care for life-threatening mental health crises experienced longer than a 24-h wait in February of 2017. Further, some inmates were placed on a waitlist, resulting in death in extreme cases. With the federal judge in this most recent flare up of *Coleman v. Brown* deciding in favor of the defendants, as a matter of law, this means that the bar for the minimal constitutional level of care in California has been reified by the standards set forth in Table 7.1.

**Table 7.1** Summary of California Department of Corrections and Rehabilitation mental health program

Primary component	Program description
Crisis intervention	“A crisis is defined as a sudden or rapid onset or exacerbation of symptoms of mental illness, which may include suicidality or other aberrant behavior which requires immediate intervention. Crisis intervention is provided at all institutions to inmate suffering from a situational crisis or an acute episode of mental disorder. The first step in providing crisis intervention is adequate training for all institutional staff in the recognition of mental health crisis symptoms, a plan for immediate staff response, and procedures for referral to clinical staff. Custody and clinical staff cooperation is critical to ensure that an inmate in a mental health crisis is treated as soon as possible”
Comprehensive services	“The MHSDS (Mental Health Services Delivery System) offers comprehensive services and a continuum of treatment for all required levels of care. In addition to standardized screening and evaluation, all levels of care found in a county mental health system are represented in the CDCR MHSDS programs. All levels of care include treatment services provided by multiple clinical disciplines, and development and update of treatment plans by an Interdisciplinary Treatment Team (IDTT), which includes appropriate custody staff involvement”
Decentralized services	“Mental health services are geographically decentralized by making basic services widely available. All levels of care, except inpatient hospitalization, are available at most geographically-defined Service Areas. Case management and crisis intervention are provided at all institutions”
Clinical and administrative oversight	“In coordination with each institution, the CDCR Division of Correctional Health Care Services (DCHCS) and Division of Adult Institutions will continue to update standardized program policy and develop a system for monitoring delivery of program services. The CDCR shall develop an annual review schedule. A systemwide automated tracking and records system continues to evolve to support administrative and clinical oversight”
Standardized screening	“Access to mental health services is enhanced for all inmates through standardized screening of all admissions at Reception Centers. Standardized screening ensures that all inmates have equal and reliable access to services. The data generated by standardized screening provides the CDCR with necessary information to improve the assessment of mental health service needs. If screening reveals indicators of mental disorder, such as prior psychiatric hospitalization, current psychotropic medication, suicidality or seriously maladaptive behaviors, follow-up evaluation by a clinician shall determine the immediate treatment needs of the inmate. Early identification of an inmate’s mental health needs will provide an appropriate level of treatment and promote individual functioning within the clinically least restrictive environment consistent with the safety and security needs of both the inmate-patient and the institution. Avoiding the utilization of more expensive services will aid in budget containment”

(continued)

**Table 7.1** (continued)

Primary component	Program description
Prerelease planning	“This component of service, in conjunction with the Correctional Counselor’s preparation of the CDCR 611, Release Program Study, focuses on preparing the seriously mentally disordered inmate-patient for parole. Its objective is to maximize the individual’s potential for successful linkage and transition to the Parole Outpatient Clinic, or, if required, to inpatient services in the community or the Mentally Disordered Offender Program operated at the DMH facilities. In the case of paroling inmate-patients, this includes facilitating the work of the Parole and Community Services Division’s Transitional Case Management Program”

**Table 7.2** Summary of Steinburg, Mills, and Romano’s three modest but significant proposals

Reform the way we sentence the mentally ill	<ul style="list-style-type: none"> <li>• Take mental health into account at sentencing</li> <li>• Use the <i>preponderance of evidence</i> burden of proof when determining whether a defendant’s crime was likely committed as a result of his/her mental illness                             <ul style="list-style-type: none"> <li>– If proof positive, provide non-prison/noncustodial sentences, whenever possible, for nonserious and nonviolent offenses</li> </ul> </li> </ul> Note: the cost of such treatment is far less than the cost of incarceration
Provide meaningful treatment in prison	<ul style="list-style-type: none"> <li>• Sentencing judge should be able to order treatment in the terms and condition of an offender’s incarceration</li> <li>• Create an oversight court (consisting of judges and mental health professionals) to review cases to ensure proper and adequate services are being rendered to each inmate</li> <li>• Court continues to provide meaningful oversight of treatment throughout incarceration</li> </ul>
Continue meaningful treatment after prison	<ul style="list-style-type: none"> <li>• Provide evaluation before release of potential mental health needs in the community</li> <li>• Refer releasees to mental health centers with full access to health and treatment records</li> </ul>

These revelations have disheartened many but continue to drive reformers to press for possible solutions for change. While California has consistently been working in good faith toward improvements in their system, Steinberg, Mills, and Romano describe “three modest but significant proposals” to give the state some momentum to realize some *real* gains in improvement. First, “reform the way we sentence the mentally ill,” discusses taking a different look at crimes that are non-violent and nonserious that may have been committed as a result of the person’s mental illness. Rather than incarceration, a judge could then sentence the person to treatment which is much more cost-effective. Second, prisons must begin to provide *meaningful* treatment for inmates while they are incarcerated. Last, treatment should continue to the point of release, during release, and must connect with meaningful treatment in the community (Table 7.2).

To accomplish these aims, Steinberg, Mills, and Romano identify that California will still need to invest greatly in additional infrastructure, such as mental health case managers for parolees, transitional housing for inmates returning back to the community, and expanded alternatives like mental health court (see Chap. 6). These investments, it should be noted, should arguably save the public money in the long run as the cost of incarceration tends to be the most exorbitant relative to any alternative. Yet, the radical component of Steinberg, Mills, and Romano's proposition—judicial oversight of the mental health services of prison inmates—may just be the missing ingredient California needs for lasting change.

Judicial oversight is not new. Traditionally, this comes in the form of federal consent decrees, which places prison facilities into receivership of the court—meaning that the oversight of operations rests with judges and/or the individuals they designate. This has happened with Louisiana's prisons in 1969 and with California's prisons as described above. Consent decrees have historically been wrought with political conflict and have pitted local administrators against their external overseers in a plainly adversarial approach. Steinberg, Mills, and Romano's special Mental Health Prison Oversight Court may hold a distinct advantage over consent decrees if this model can approach oversight in a non-adversarial way. That is, instead of a top-down approach to ensure oversight and compliance, a team-based approach that includes correctional, mental health, and legal professionals (all led by a judge) in shaping decision-making may prove beneficial.

While California has been at the forefront of these issues, Alabama's prisons have only begun this cycle by revealing its institutional failures to serve individuals with mental illness in the case *Braggs et al., v. Dunn* (2017). At the conclusion of the dramatic trial, Federal Judge Myron H. Thompson issued a 302-page ruling featuring an order for immediate- and long-term relief of the violation of Eighth Amendment rights of a class comprised of mentally ill inmates and to the Alabama Disabilities Advocacy Program. Specifically, Judge Thompson found that the defendants were at fault for:

- (1) Failing to identify prisoners with serious mental-health needs and to classify their needs properly;
- (2) Failing to provide individualized treatment plans to prisoners with serious mental-health needs;
- (3) Failing to provide psychotherapy by qualified and properly supervised mental-health staff and with adequate frequency and sound confidentiality;
- (4) Providing insufficient out-of-cell time and treatment to those who need residential treatment; and failing to provide hospital-level care to those who need it;
- (5) Failing to identify suicide risks adequately and providing inadequate treatment and monitoring to those who are suicidal, engaging in self-harm, or otherwise undergoing a mental-health crisis;
- (6) Imposing disciplinary sanctions on mentally ill prisoners for symptoms of their mental illness, and imposing disciplinary sanctions without regard for the impact of sanctions on prisoners' mental health; and
- (7) Placing seriously mentally ill prisoners in segregation without extenuating circumstances and for prolonged periods of time; placing prisoners with serious mental-health needs in segregation without adequate consideration of the impact on mental health; and providing inadequate treatment and monitoring in segregation.

Further, Judge Thompson carefully articulated the “abundant evidence presented in support of the Eighth Amendment claim” throughout his decision. Starting with the basics, Judge Thompson opined on the scope of the Alabama Department of Corrections population—about 19,500 men and women spread

across 15 major facilities (one for women). Of this total population, evidence presented at trial suggested an approximate mental health caseload of 3400 inmates actively receiving some form of mental health treatment. A wealth of data from the Alabama Department of Corrections and its private (for-profit) mental health-care provider, MHM Correctional Services, Inc., would unveil minimal resources dedicated to providing mental health care when considering this level of need. Alabama's two mental health units providing treatment for its most severely ill have 346 male residential treatment beds and 30 stabilization unit beds (for acute mental health crises) and 30 female residential treatment beds and 8 stabilization unit beds for women—suggesting that the entire Alabama prison system can professionally handle only 38 mental health crises at any given time. Further, Alabama Department of Corrections only retains one governmental employee in a leadership position with mental health expertise; all other mental healthcare functions reside with the contracted service provider.

MHM Correctional Services, Inc., provided the following information to the court about their current staffing across the entire system: the Alabama contract includes a medical director (psychiatrist), mid-level managers (quality improvement manager and chief psychologist), 45 full-time mental health professional counselors/social workers, 4 psychiatrists and 8 certified registered nurse practitioners (who are qualified to diagnose, prescribe medication, and provide psychotherapy), 3 psychologists, and 3 registered nurses who supervise 40 licensed practical nurses (LPNs conduct mental health intake and monitor medication compliance and side effects). The testimony in conjunction with these scant resources led Judge Thompson to conclude that the low prevalence rates of mental illness in Alabama's prisons relative to other states were not due to high-quality mental health care in Alabama's prisons or that Alabama's prisons simply had fewer mentally ill inmates than other states. Many cases seemed to be slipping through the cracks at intake (poor supervision of minimally trained front-line staff) and evidence suggested that referrals for evaluation and treatment were often neglected. When mental illness is identified correctly, evidence suggested that follow-up care was haphazard with delays or cancellations of professional counseling largely due to a shortage of counselors or the correctional staff required to ensure safety. For inmates with severe mental illness, Judge Thompson found that the specialized mental health units operated as large segregation units with little evidence of counseling, programming, or time allotted for inmates to spend out of their cells. If hospitalization was deemed medically necessary, the Department of Corrections simply did not provide this level of care.

At trial, the Commissioner of the Alabama Department of Corrections candidly offered an explanation for these conditions—that the system is struggling with overcrowding in conjunction with understaffing. The dangerous effects of these shortcomings were on full display in court for 7 weeks. The trail began with a rousing start. A prisoner named Jamie Wallace shared painful testimony with the court, whose personal prison story was fraught with multiple suicide attempts with visible scars to show for it at trial. Mr. Wallace struggled to detail his experiences of not receiving any help from the system to the point when Judge Thompson had to order a recess and to continue testimony in chambers. After his story was detailed for the record, Judge Thompson excused Mr. Wallace and immediately ordered both sets of

attorneys to provide him with a report on Mr. Wallace's mental condition and what was being done about it. In a twist, Mr. Wallace would hang himself 10 days later, thus laying bare the exact basis of the litigation at hand—the system was not just failing, it was in failure.

Highlights of the system failures that were detailed in the weeks after Mr. Wallace's testimony were jarring. For example, Judge Thompson described that correctional staff tended to “gamble” with prisoners lives as they did not have a good method of determining suicidality and had such few suicide-watch cells to work with. Further, the suicide-watch cells available were far from suicide-proof: visibility was poor for direct monitoring, cells still included places where one could tie off ligatures, and dangerous items that could easily aid in self-injury were still easily available. In fact, before the trial could conclude, another inmate (not related to the trial) had committed suicide adding to the steep uptick of prison suicides that has occurred in the last 2 years:

[A]s explained earlier, the court had a close encounter with one of the tragic consequences of inadequate mental-health care during the trial. Over the course of the trial, two prisoners committed suicide, one of whom was named plaintiff Jamie Wallace. Prior to his suicide, defendants' expert, Dr. Patterson, concluded based on a review of Wallace's medical records that the care he received was inadequate. Dr. Haney, a correctional mental-health care expert, met Wallace months before his death, while he was housed in a residential treatment unit, and in his report expressed serious concerns about the care he was receiving. Wallace's case was emblematic of multiple systemic deficiencies. Wallace testified, and his records reflected, that mental-health staff did not provide much in the way of consistent psychotherapeutic treatment, which is distinct from medications administered by nurses and cursory 'check ins' with staff. MHM clinicians recommended that he be transferred to a mental-health hospital, but ADOC failed to do so. His psychiatrist at the time of this death testified that the medically appropriate combination of supervised out-of-cell time and close monitoring when he was in his cell was unavailable due to a shortage of correctional officers. As a result, Wallace was left alone for days in an isolated cell in a treatment unit, where he had enough time to tie a sheet unnoticed; because his cell was not suicide-proof, he was able to find a tie-off point from which to hang himself.

From all accounts, American prison systems are often at a near or full crisis of mental health services, and this segment of the criminal justice system seems least able to promote change. While California has seen decades of progressive reform, many of these reforms have not been fully actualized primarily due to what has come to be a repeated mantra—resources and money. The story of the California and of Alabama will, no doubt, repeat itself in the future with other straining and failing systems—often being sparked by litigation. Each case will only serve to reinforce new standards to be promulgated across the county.

### ***7.1.2 The Common Affront: Locking Someone in Ad Seg***

As alluded to in the case of Alabama above, prisons often maintain controversial facilities called administrative segregation, often called “ad seg” or solitary confinement. These facilities are used in instances when an inmate is violent or has some behavioral issues as punishment, for behavior modification, or, primarily, for security

reasons (e.g., an inmate is too dangerous for general population). In an article in the *National Prison Project Journal*, social psychologist Haney (1993; see also, Haney, 2003) describes the effects of administrative segregation as “psychologically destructive” and shown to produce social withdrawal, violence, and self-mutilation behaviors and suicidal ideation, leading to what he would later term a “social death.” Individuals with preexisting mental illness are, in fact, at a greater risk of negative consequences (Haney, 2003). A comprehensive review of the literature confirms this; Smith (2006) finds evidence to support that solitary confinement impacts many prisoners negatively and substantially so. These impacts are moderated by duration of confinement, environmental factors, and characteristics of the prisoner. Yet, the negative impact endures for many.

Administrative segregation often involves an inmate being locked up for, at times, 23 h a day. Any recreational time outside of this cell is often suspended, or if it is allowed, it is often of a minimal duration. Imagine that scenario, being locked in a tiny cell for 23 h a day for days or weeks at a time. Additionally, many of the items an inmate may have in general population are not allowed or taken away when put into administrative segregation. Until recently, California prison was said to have used administrative segregation more so than any other state prison system—that is, until litigation forced its ways. In 2015, *Ashker v. Brown* was settled with promises to minimize the use of solitary housing units (nearly 3000 cells at that time) and put into place policies to ensure its proper use. It now seems that Alabama may be at the brink of needing similar intervention.

What is clear is that the use of administrative segregation provides fertile ground for litigation. Of particular note, Supreme Court Justice Anthony Kennedy made clear mention of his concerns with solitary confinement in a separate opinion on a case questioning the procedural rules of a criminal trial of a death row inmate:

In response to a question, respondent’s counsel advised the Court that, since being sentenced to death in 1989, Ayala has served the great majority of his more than 25 years in custody in “administrative segregation” or, as it is better known, solitary confinement....if his solitary confinement follows the usual pattern, it is likely respondent has been held for all or most of the past 20 years or more in a windowless cell no larger than a typical parking spot for 23 hours a day; and in the one hour when he leaves it, he likely is allowed little or no opportunity for conversation or interaction with anyone....It is estimated that 25,000 inmates in the United States are currently serving their sentence in whole or substantial part in solitary confinement, many regardless of their conduct in prison.

The human toll wrought by extended terms of isolation long has been understood, and questioned, by writers and commenters. Eighteenth-century British prison reformer John Howard wrote “that criminals who had affected an air of boldness during their trial, and appeared quite unconcerned at the pronouncing sentence upon them, were struck with horror and shed tears when brought to these darksome solitary abodes.” In literature, Charles Dickens recounted the toil of Dr. Manette, whose 18 years of isolation in One Hundred and Five North Tower, caused him, even years after his release, to lapse in and out of mindless state with almost no awareness or appreciation for time or his surroundings....Yet despite scholarly discussion and some commentary from other sources, the condition in which prisoners are kept simply has not been a matter of public inquiry or interest. To be sure, cases on prison procedures and conditions do reach the courts. See e.g., *Brown v. Plata*.... Sentencing judges, moreover, devote considerable time and thought to their task. There is no accepted mechanism, however, for them to take into account, when sentencing a defendant, whether the time in prison will be or should be served in solitary. So in many cases, it

is as if a judge had no choice but to say: “In imposing this capital sentence, the court is well aware that during the many years you will serve in prison before your execution, the penal system has a solitary confinement regime that will bring you to the edge of madness, perhaps to madness itself.” Even if the law were to condone or permit this added punishment, so stark an outcome out not to be the result of society’s simple unawareness or indifference....Over 150 years ago, Dostoyevsky wrote, “The degree of civilization in a society can be judged by entering its prisons.” There is truth to this in our own time. (*Davis v. Ayala*, 135 S.Ct. 2187, 2205, 2015)

Thus, administrative segregation has been vaulted to the epicenter for mental health advocacy in recent years. Expect increased litigation forcing this issue, beginning in Alabama. Earlier efforts have resulted in settlements, not a summary judgment, which lacks the authority of case law. This absence of case may soon change as keenly noted by Justice Kennedy. While the Supreme Court has yet to hear a case specific to administrative segregation, the time for its review is becoming imminent.

### **7.1.3 A Local Case Study: Boston**

The Boston Globe (2016) published an article in late 2016 discussing the perils of the criminal justice system in Massachusetts for individuals with mental illness and substance abuse. The article uses the story of an inmate Nick Lynch to discuss the struggles experienced by an incarcerated person in Boston. The year before, approximately 15,000 inmates were released from prisons and jails in Massachusetts. As with many of these stories, the problems worsen, and here more than half of those released inmates had a history of addiction, and more than one-third suffered from mental illness. This is not unlike many other states with inmates being released with diagnoses of one or both mental illness and/or substance abuse. Even more complicated, these diagnoses increase the likelihood of them being incarcerated again within 3 years.

The article brings up another great point stating, “The prison environment itself is a major obstacle to treatment: In a culture ruled by aggression and fear, the trust and openness required for therapy are exponentially harder to achieve.” This statement is somewhat the epitome of the dilemma of crime and mental health. If prison is not the ideal environment for treatment and treatment is obviously needed, then why is the person being incarcerated? This is almost the exact same question posed by Steinberg, Mills, and Romano in California.

Further, as mentioned before, individuals are leaving prisons and jails in Massachusetts without the proper tools needed to be successful in society. Without medication, counseling, and support, those with mental illness and substance abuse issues are more likely to return to jail/prison. As one could imagine, the cost of incarceration can be expensive. Therefore, the idea of reducing recidivism would be beneficial to states and their Department of Corrections. In Massachusetts, the state would save \$50,000 by lessening incarceration by just one inmate. This begs the question—what is the state doing to help released inmates? In Massachusetts,

unfortunately, not much it seems. According to numbers from the state itself, more than 90% of the 6000 inmates who are estimated to have mental illness and released from prisons or jails received “little or no help” from the Department of Mental Health when trying to find treatment in the community.

Recently, the state has begun cutting the budget for mental health within the criminal justice system. This has largely come from reducing prescriptions provided to inmates by 35% between the years 2010 and 2015. The reduction of prescriptions can obviously be problematic for many reasons. The first group that was impacted was those receiving treatment for ADHD (attention-deficit hyperactive disorder); many others are slated to lose access to necessary treatment in the near future if these trends continue. The politics of prisons seem to be guided by crisis, as in until mental health reaches a critical mass; many systems seem to copasetic with the minimum effort needed to remain under the radar.

## **7.2 Example Progressive Programming and Program Elements**

A change that has developed as a result of the increasing rates of incarceration and the already overcrowded prison systems is unique prison programming. Different states have been developing new way to fight recidivism and help inmates prepare for success outside of prison. These programs can receive some skepticism and resistance; some also have not yet developed to produce conclusive results. The good news, not unlike entrepreneurship, with creativity come success. The odds are that at least some of these particular programs will result in success.

### **7.2.1 *Pen Pals, Inc.***

As discussed earlier, a diverse array of innovations and alternative programming have occurred in recent years to address mental health issues in prison settings. Many of these alternatives seek to develop vocational and life skills as well as lessen the impact of the prison setting to inspire hope. From this movement, animal care programs have emerged to help inmates in this capacity. Although many programs of this nature exist across the country (and in many others), Pen Pals was developed out of a major natural disaster—Hurricane Katrina—which caused many animals to be without care as families evacuated their devastated homes. Dixon Correctional Institute (DCI), in Louisiana, is a medium-sized, medium-security prison that first of its kind to house a full animal shelter and clinic called Pen Pals.

In addition, Pen Pals features a fully operational clinic inside of the prison. Thus, not only can the rescued animals receive care and training from trustee inmates, they can also receive the medical care they need without having to be transported off-site. This serves to provide the trustees with an immersion experience of operat-

ing an animal shelter in the free world with the added mental health benefits of caring for animals in this capacity. Most importantly, Pen Pals continues to serve an important function for the local region as a no-kill shelter and is likely to receive more difficult cases than many shelters in the free world—an inept analogy to how some prisoners view their own lives or, at least, have done so in the past.

*PEN PALS, INC. ANIMAL SHELTER AND ADOPTION CENTER*

*A NONPROFIT ORGANIZATION*

*ADOPTION GUARANTEED*

*TAX ID # 80-0646300*

In 2005 Hurricane Katrina hit the state of Louisiana as a category 5 storm with maximum force. A conservative estimate reveals that over 50,000 animals were abandoned by their owners in New Orleans as they fled to safety. While their intentions were to return within days to retrieve their beloved pets, the animals were left trapped in homes or chained to fences, braving toxic waters, and 105-degree heat with no food or water. Hours became days as they waited to be rescued and reunited with their owners.

Rescuers were understaffed and overwhelmed by the scope of the problem and the time-critical nature of their effort. But motivated by compassion, relief came in the form of these few dedicated volunteers. Along with those volunteers, the Louisiana Department of Public Safety and Corrections, Dixon Correctional Institute (DCI) assisted by housing many of these abandoned animals. A makeshift animal clinic was set up, and inmates were trained in caring for animals of all types, shapes, and sizes. A vision was born out of tragedy.

In response to the events of this tragic and horrific situation, an agreement was made between the Humane Society of the United States (HSUS), the Louisiana State University School of Veterinary Medicine, and DCI, to establish a permanent and emergency temporary animal shelter on the grounds of the prison. The HSUS obtained a grant in the amount of \$600,000 to fund the construction of the facilities. The permanent animal clinic (better known as Pen Pals, Inc., Dog and Cat Shelter and Adoption Center) provides comprehensive training for future veterinarians and promotes the rehabilitation of those incarcerated who are trained to assist.

Our belief is that tragedies will happen, but Pen Pals Inc. will be there with food and a leash in hand.

### **7.3 Pop Culture and Prison, New Links to Awareness**

In addition to celebrities and other influential people, the mainstream media has taken to discussing the criminal justice system and mental health. Podcasts, television, as well as magazines and newspapers are covering the subjects to shed light on the system, including the flaws.

One of the more popular and raw television shows is *Lockup* on MSNBC. *Lockup* brings cameras into jails and prisons across the country to show the reality behind the bars. This reality includes interviews and insight from everyone involved from the wardens, corrections officers, support staff, and even inmates. The show has traveled to different areas and levels of prisons to show how things vary at each

institution. Additionally, *Lockup* has specialty episodes to tackle some unique outliers like First Timers which covers individuals who are serving their first sentence in prison or jail, Special Investigation which covers the juvenile justice system, and Women Behind Bars which follows women in the system.

Despite the somewhat negative nature of the television show, the positive consequences are also very present. Each episode digs into the stories behind the inmates that make them human, rather than just a number. Background information, history, as well as interviews from staff and inmates create an overall picture of the tragedies that brought the person to jail or prison. This knowledge can be positive in that it helps to show the truth behind incarceration. Additionally, making the individual seem human allows for the compassion and empathy needed in some cases to aid in the rehabilitation of that person.

*Lockup* also provides footage and insight into the lives of mentally ill inmates. In the episode entitled Inside Wabash Valley Correctional Facility, the production staff interviews an inmate by the name of Joe Carr who is serving an 8-year sentence for robbery in this facility in Indiana. In this episode, the prison's psychologist is also interviewed where she discusses "shoe" or Special Housing Unit (SHU). At other facilities, this may be called administrative segregation. The brief interview with the psychologist and inmate paint the picture that mentally ill inmates are often put into the SHU after harming themselves. In Joe Carr's case, he swallowed ink pens in one incident and cut his leg open in another. He goes on to describe the feelings he experienced while cutting himself "when you're going through one of them phases, you don't even feel the pain...you don't even know you're doing it." Joe also describes his feelings of anger and using the acts of harming himself to "feel better." Joe was put into the SHU for hurting himself from we describe as being antisocial. After serving his time in the SHU, he was then put back into general population at the prison but describes the repeating cycle of self-harm. After several cycles of going to the SHU for harming himself, and then returning to general population with no success, Joe was then evaluated and diagnosed with bipolar disorder and transferred to the residential treatment unit (RTU). The interview concludes with Joe's own perspective about life after prison when he states "this is all you know...you're used to what, a population of 1200 people. Then, they turn you back into society of billions of people. Are you ready for it?"

The episode of *Lockup* featuring Joe Carr is just one of many that feature a person in the criminal justice system who is mentally ill. On a societal level, this leads to questions and controversy. What amount of harm is done to the individual for the repeated cycle of self-harm and punishment in the SHU? For those discussing the fiscal consequences, his repeated acts of self-harm resulted in many medical exams, most of which resulted in surgeries. How much of a burden does that put on the system? How could the burden and harm on the inmate be avoided? How could the burden on the system be avoided as well?

Another example of the portrayal of the criminal justice system and mentally ill inmates involves the controversy behind the 10-episode Netflix original *Making a Murderer*. *Making a Murderer* is dubbed a "real-life thriller" by Netflix and a true crime documentary by other sources. This series was filmed over a 10-year period

following Steven Avery, a man who had been recently released from prison after serving 18 years for rape. At the beginning of the series, he had just been released after being exonerated with DNA evidence from his original 32-year charge. Despite this happy outlook, the series quickly takes a turn to Steven then being accused of murder. He, along with his nephew, Brendan Dassey, was arrested for the rape and murder of Teresa Halbach and sentenced to life in prison.

The controversy infiltrates this story in many ways including police corruption, evidence tampering, and questionable ethics. As it relates here, the mental health of both men, Steven Avery and Brendan Dassey, was called into question. As this book is being written, there is still development in this case bringing to light relevant issues regarding the treatment of individuals with mental health concerns by the system. It appears that we are at a moment in which coverage of mental health issues is beginning to increase across platforms, medium, and by source.

## 7.4 Out-of-the-Box Innovations

There are some positive trends in regard to prisons in other parts of the world. In recent years, The Netherlands has seen such a decline in crime that they have actually been closing their prisons. The stereotype in the United States is that prisoners serve “hard time” while in prison and they will be remorseful of the crimes they committed. The assumption is that the tough times of prison create a situation in which the person learns to not want to return to prison. It is somewhat of a behavior modification process. If the conditions inside prison are worse than outside or home, the idea is that a person who commits crimes would then not want to return to prison. The person would then want to do all possible to avoid another sentence, like changing their behaviors and no longer committing crime. The problem with this assumption and argument is that it just does not work in America. If this were the case, most prisons would be useless and empty at this point. The view of using prison as a form of punishment has really only led to an increase of inmates currently in prison as well as an increase in those that return for repeated offenses.

Prisons around the world are trying different approaches within their prisons to show the possibility that the alternative to “hard time” works better to combat recidivism. Rather than using a prison and sentence as punishment, other countries are working toward a prison sentence as a time for change and reform where the person can learn other skills to use after time served as well as maintain their support system with family and their mental health. In Suomenlinna Prison, often referred to as the “open prison,” inmates in Finland do not see barbed wire and large fences around the grounds of the prison. The prison director Tapio Iinatti describes the thought process behind the way this prison is set up: “The main idea here is to prepare the inmates for release into the community. It doesn’t make sense for an inmate to be in a closed prison for, say, 6 years and to suddenly enter civilian life. We also offer rehabilitation for people who have had problems related to alcohol, drugs or mental illness. And in any case, it’s not so easy to be here.”

Another prison described as using a humane approach is Halden Prison in Norway. Halden Fængsel has been dubbed “the world’s most humane maximum-security prison.” This nickname was given for many reasons including the lack of a security fence. Halden does not have the typical razor wire, electric, or tall fence surrounding, and yet prisoners have not tried to escape. Much like Finland, Norway looks at the time inside the prison as preparation for life outside, and there are both no life sentences and death penalties. This is a stark contrast to most American prisons, including that the maximum sentence for crimes is 21 years. The Norwegian Correctional Service has the motto “better out than in” to say that they ensure a person leaves prison improved. In order to do this, the government uses resources to provide a social support system, a job, and housing. Additionally, Norway provides education, health care, and a pension for all citizens. The interesting part of this is that at the time of this article in 2015, Norway spent about \$93,000 per inmate per year on incarceration as compared to \$31,000 in the United States. Taking this into consideration, the United States incarcerates on average 700 people per 100,000, while Norway is about 75 per 100,000. The United States could save nearly \$45 billion per year if they were to also take on this practice.

Norway banned capital punishment for civilians in 1902, and life sentences were abolished in 1981. But Norwegian prisons operated much like their American counterparts until 1998. That was the year Norway’s Ministry of Justice reassessed the Correctional Service’s goals and methods, putting the explicit focus on rehabilitating prisoners through education, job training and therapy. A second wave of change in 2007 made a priority of reintegration, with a special emphasis on helping inmates find housing and work with a steady income before they are even released. Halden was the first prison built after this overhaul, and so rehabilitation became the underpinning of its design process. Every aspect of the facility was designed to ease psychological pressures, mitigate conflict and minimize interpersonal conflict.

It seems that cost is *the* impetus for change in the United States. In times of recession, the pressure to change seems to reach a tipping point. While there appear to be some radically progressive policies in countries such as Norway, it seems that there may be room to learn from other countries’ willingness to spend money lavishly on rehabilitative practices. In other words, countries such as Norway may offer the United States the ability to learn which rehabilitative processes and programs are promising, for which target population, and be able to consider cost-effectiveness before investing.

## 7.5 Conclusion

Prisons tend to get the least amount of attention in regard their mental health practices. When considering that near 95% of the American prison population will return back to the community at some point, this lack of attention is slowing changing. Currently, administrative segregation and intake are notable exceptions—there has been an array of interest in these two issues in recent years that have a growing

research base. Many other facets of inmate mental health remain unclear, ill-defined with aging data, and are given tacit attention relative to jail inmate and jail inmate reentry, in particular.

While research activity and programs begin to grow, it seems that litigation will continue to define the critical issues that prison administrators will need to address into the near and distant future. Expect an increase in litigation in the upcoming years to continue to refine the definition of constitutionally accepted levels of care in prisons, particularly as it relates to administrative segregation.

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