SELECTED ISSUES IN MENTAL HEALTH AND CORRECTIONS

A Collection and Summary of Research

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EXECUTIVE SUMMARY

Disability Rights Nebraska is the designated Protection and Advocacy organization for people with disabilities in Nebraska and continues to have interest in issues regarding people with disabilities in the criminal justice context. For the purposes of this report we have limited the scope of our research to four issues which, from our perspective, are of particular importance: 1) The use of solitary confinement; 2) in-house mental health treatment; 3) reentry and discharge planning; and 4) community-based mental and physical health services. This report represents a summary of our findings and provides some of the original research we collected. We intend this report to be a conversation-starter.

Summary of Findings

Solitary Confinement— A significant number of inmates with mental illness are placed in solitary confinement/extreme isolation/segregation programs. Once in segregation (whether long-term or short-term), their psychiatric symptoms and mental condition generally worsen (which can then be used to justify keeping them in segregation longer). Stuart Grassian, has identified a unique symptomology of inmates in solitary confinement, "SHU Syndrome", which includes irrational anger and rage, loss of impulse control, paranoia, and perceptual distortions/illusions/hallucinations. Serious symptoms can occur in even individuals without mental illness after being isolated for only a few days.

An association seems to exist between solitary confinement, diagnosis of serious mental illness, and self-harm or suicide—one study noted that although only 7% of inmates were in solitary confinement, they accounted for 53% of acts of self-harm. We also note one study that found a majority of male subjects preferred to administer electric shocks to themselves rather than being isolated.

In-House Treatment— Our research suggests that in Nebraska, mental health services available to individuals in segregation appear to be limited to face-to-face meetings with a mental health professional, the frequency of which is determined by apparent need. The Violence Reduction Program in Nebraska is not offered to individuals in segregation (who are some of the inmates most in need of such services). Funding levels for mental health services for inmates in segregation are reportedly inadequate.

We identified several other states that have made changes to the conditions of administrative segregation and the mental health services available to inmates. These reforms have had positive results: a decrease in "serious incidents" in the segregation unit; significant reductions in the use of segregation or return to segregation; and declines in 'use of force' incidents as well as inmate grievances.

Reentry/Discharge Planning— The vast majority of persons incarcerated in U.S. prisons and jails will eventually be released. The immediate period after release is an especially vulnerable time for released inmates: in the first two weeks of release, former inmates are over twelve times more likely to die from health problems than the general population as well as at a heightened risk to recidivate.

Navigating a successful transition is often uniquely difficult for former inmates with mental illness, especially without assistance in preparing for their release and figuring out what services are needed or how to access those services. Assisting inmates with mental illness with reentry planning (long-term, admissions) and discharge planning (short-term, imminent release) is a key component of a successful transition from corrections to the community.

Community-based Services— A released prisoner's unmet need for mental health care often precipitates arrest. Many former inmates with mental illness will need support to successfully make this transition, yet will often have few informal support systems (e.g., family or friends) or formal support systems (e.g., private or public health insurance, restrictions on federal housing benefits). They often face additional barriers unique to their mental illness (e.g., waiting for application approval for federal or other benefits, proving mental illness is their primary diagnosis for public benefits programs, and stigma associated with mental illness). An adequate and responsive public mental health system will work to prevent involvement with criminal justice by persons with mental illness, to treat and plan for release once in the system, and to maintain independent living for prisoners with mental illness upon release. Medicaid and the Affordable Care Act have been used by many states to finance reforms.

System collaboration is a necessary part of a successful transition to community. The corrections system and agencies, human service system and agencies, and other relevant or pertinent service systems need to work collaboratively to address the scope of needs of former prisoners with mental health conditions once living in the community and resist the temptation to operate as service "silos". Integrated services are essential.

SECTION 1: THE EFFECTS OF SOLITARY CONFINEMENT

The use of solitary confinement has a long history within the American prison context. Solitary confinement was used extensively in the design and operation of American penitentiary systems of the 19th Century as a means to reform prisoners. Consequently, "the earliest American penitentiaries were, generally systems of rigid solitary confinement. Extravagant attention was paid to the design of these institutions, to ensure the absolute and total isolation of the offender from any evil and corrupting influences".[1]

Despite early enthusiasm, concerns were raised over the psychological and health effects of solitary confinement as early as the 1820's. Seeing the effects of total isolation on inmates in a New York penitentiary was enough for the governor of the state to end it after a visit in 1821[2]. Reports in the 1840s from physicians in the New Jersey and Rhode Island state penitentiaries noted a decrease in psychotic behavior when inmates were removed from solitary confinement and were able to interact with each other[3].

In his 1847 study of American prisons, Francis Gray wrote:

"It appears that the system of constant separation as established here, even when administered with the utmost humanity, produces so many cases of insanity and of death as to indicate most clearly, that its general tendency is to enfeeble the body and the mind."[4]

> **"A considerable number of the prisoners fell, after even a short confinement, into a semifatuous condition, from which it was next to impossible to arouse them, and others became violently insane; others still, committed suicide; while those who stood the ordeal better were not generally reformed, and in most cases did not recover sufficient mental activity to be of any subsequent service to the community."**
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> --U.S. Supreme Court, *In Re Medley*, 134 U.S. 160 (1890)

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[1] Dr. Stuart Grassian, 2006, "Psychiatric Effects of Solitary Confinement", Washington University Journal of Law and Policy

[2] Smith, P. S. (2006). "The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature." *Crime and Justice*, *34*(1), 441–528.

[3] Ibid.

The use of solitary confinement in prisons had largely fallen out of favor as a broadly used method by the 20th century[5]. However, after 2 corrections officers were killed by inmates at the U.S. Penitentiary in Marion, IL on October 22, 1983, the call for extreme isolation was resurrected. As a consequence of the Marion, IL incident, the prison warden placed the entire facility on permanent lockdown status, making it the first super-maximum security prison. For the next 23 years, all prisoners at the Marion facility were confined to their cells for 23 hours a day. The Marion, IL penitentiary experience prompted many other states to either construct or repurpose freestanding facilities entirely devoted to the extreme isolation of prisoners[6]. As of 2012, at least 44 states have such freestanding facilities housing approximately 25,000 prisoners. Many states increased the number of these units within lower-security facilities[7]. The 2006 Commission on Safety and Abuse in America's Prisons reported that the number of prisoners held in extreme isolation numbered approximately 80,000 (using Bureau of Justice statistics from the year 2005), but warned that that figure only captures a fraction of the state and federal prisoners held in high-security control units and in Supermax prisons[8].

Modern prisons present some variation in the implementation of Administrative Segregation, but it typically involves restriction to the cell for at least 23 hours a day without meaningful social interaction. In his review of solitary confinement and 'Supermax' prisons, Dr. Craig Haney wrote, there is "an extensive empirical literature that clearly establishes their potential to inflict psychological pain and emotional damage."[9]

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[4] Ibid.
[5] Browne, Cambier, & Agha, 2011. "Prisons Within Prisons: The Use of Segregation in the United States", http://nicic.gov/library/026161
[6] Arrigo, B. A., & Bullock, J. L. (2008). "The Psychological Effects of Solitary Confinement on Prisoners in Supermax Units: Reviewing What We Know and Recommending What Should Change". *International Journal of Offender Therapy and Comparative Criminology*, *52*(6), 622–640
[7] American Civil Liberties Union, 2014. "The Dangerous Overuse of Solitary Confinement in the United States", https://www.aclu.org/dangerous-overuse-solitary-confinement-united-states
[8] See note 1
[9] Haney, C., 2003. "Mental Health Issues in Long-Term Solitary and "Supermax" Confinement", *Crime & Delinquency*, *49*(1), 124–156, http://cad.sagepub.com/content/49/1/124.abstract

In the mid-1980s, psychiatrist Stuart Grassian studied a group of prisoners living in conditions of extreme isolation in the "Special Housing Unit" (SHU) in the Walpole, Massachusetts prison. He identified a variety of physiological and psychological symptoms exhibited by these prisoners, which he called "SHU Syndrome". The symptoms included social withdrawal, anxiety, panic attacks, irrational anger and rage, loss of impulse control, paranoia, hypersensitivity to external stimuli, chronic depression, difficulties with concentration and memory, perceptual distortions and hallucinations. These same symptoms have been identified repeatedly in studies of solitary confinement. In his 1992 study, Hans Toch wrote, "the reaction to isolation is a panic state"[10].

While research is primarily focused on long-term segregation, some studies have found "serious symptoms can occur in healthy individuals after only a few days in isolation". More strikingly, a 2014 article published in the journal *Science*, reported results of 11 studies, including one that found a majority of male subjects preferred to administer electric shocks to themselves over the course of 15 minutes, rather than sitting alone with their thoughts[11]

Recent estimates – including one supported by the National Sheriff's Association – hold that at least 15% of all prisoners have a severe mental illness (SMI)[12]. Individuals with mental illness have more difficulty adjusting to prison conditions and are more likely to commit infractions.[13] Symptoms of mental illness may result in placement in Administrative Segregation[14] .

SHU Syndrome

Social withdrawal

Anxiety and nervousness

Panic attacks

Irrational anger and rage

Loss of impulse control

Paranoia

Hypersensitivity to external stimuli

Severe and chronic depression

Difficulties with thinking, concentration and memory

Perceptual distortions, illusions and hallucinations

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[10] See Toch, Hans. 1992. *Mosaic of Despair: Human Breakdowns in Prison.* Lawrenceville, NJ: Princeton University Press.

[11] Wilson, T. D., Reinhard, D. A., Westgate, E. C., Gilbert, D. T., Ellerbeck, N., Hahn, C., Shaked, A. (2014). "Just think: The Challenges of the Disengaged Mind". *Science*, *345* (6192), 75–77

[12] Lamb, H. R., Weinberger, L., Marsh, J., & Gross, B. (2007). "Treatment prospects for persons with severe mental illness in an urban county jail". *Psychiatric Services*, *58*(6) Torrey, E. F., Kennard, A. D., Eslinger, D., Lamb, R., Pavle, J., Association, N. S., others. (2010). *More mentally ill persons are in jails and prisons than hospitals: A survey of the states.* Treatment Advocacy Center Arlington, VA, pp. 782–786.

[13] See note 4

[14] See note 2

Consequently, studies have found some prisons with half of all inmates in segregation to be individuals with a diagnosable mental illness. Once in segregation, the conditions generally worsen an inmate's psychiatric symptoms, which can then be used to justify keeping them in segregation[15].

Social isolation is a known risk factor for suicide among people with SMI[16]. A 2014 study of the medical records of over 240,000 jail inmates found a significant association between solitary confinement, diagnosis of SMI, and self-harm or suicide[17]. More specifically, although only 7% of inmates were in solitary confinement, they accounted for 53% of acts of self-harm.

While the overwhelming majority of studies on solitary confinement have found negative consequences such as those named above, there are a few exceptions. Among the dozens of studies on solitary confinement, there appear to be fewer than five which found no serious negative consequences. Most notable is a 2010 longitudinal study of Administrative Segregation in the Colorado State Penitentiary[18]. The authors of the Colorado study - which tested 270 inmates over one year – concluded that individuals held in Administrative Segregation did not have worse psychological deterioration than individuals in the general prison population. A number of critiques and defenses of the study have been written, but there several arguments against the conclusions drawn the authors have either ignored or not adequately answered.

The Colorado study is not what it purports to be. Of the 270 participants, only 89 (one third) were actually in the same conditions for the entire year of the study. More specifically, 65 inmates were in solitary for the duration of the study, 24 in general population, and the other 181 were in Administrative Segregation for part of the time, and general population for part of the time. The authors gloss over this point as if it is a small detail, while it in fact puts the entire study into question.

The study data actually appears to show some psychological improvement for inmates in Administrative Segregation, but there are two possible explanations the authors neglect to explore. The trend may simply be a statistical phenomenon, a hypothesis bolstered by the study's graphs, which often show the same trend for the individuals in all conditions.

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[15] See note 2 and Metzner, J. L., & Fellner, J. (2010). "Solitary Confinement and Mental Illness in US Prisons: A Challenge for Medical Ethics". *Journal of the American Academy of Psychiatry and the Law Online*, *38*(1), 104–108.

[16] Fenton, W. S. (2000). Depression, suicide, and suicide prevention in schizophrenia. *Suicide and Life-Threatening Behavior*, *30*(1), 34–49.

[17] Kaba, F., Lewis, A., Glowa-Kollisch, S., Hadler, J., Lee, D., Alper, H., Parsons, A. (2014). "Solitary confinement and risk of self-harm among jail inmates". *American Journal of Public Health*, *104*(3), 442–447.

[18] O'Keefe, M. L., Klebe, K. J., Metzner, J., Dvoskin, J., Fellner, J., & Stucker, A. (2013)."A Longitudinal Study of Administrative Segregation". *Journal of the American Academy of Psychiatry and the Law Online*, *41*(1), 49–60.

However, another likely explanation is reflected in the fact that individuals in the Administrative Segregation setting had been in Punitive Segregation for an average of 30 days before the first test was administered. As the name implies, Punitive Segregation involves conditions more restrictive than Administrative Segregation. An improvement in psychological symptoms between the first and second time points may be the result of inmates being transferred to less harsh conditions.

While there are many criticisms that can be leveled against the Colorado study's methodology, a particularly important problem is the result of an omission. O'Keefe and colleagues declined to explore data on 'crisis events' because "the number of participants who experienced a crisis event was so small," the data was incomplete, and "the reason for the self-harming ideation/behavior is not captured in the graph data." A look at the graphs tells a different story. Although the numbers may be small, over 13 months, it appears that those with mental illness in the general population had two crises involving self-harm ideation or behavior, while for the group with mental illness in Administrative Segregation, the number appears to be twenty-eight. If this discrepancy is not statistically significant, the authors should say so. The argument that the data does not give the reason behind the self-harm behavior is a weak one. The authors note that one person in Administrative Segregation who engaged in self-harm did so because of family issues. It is unlikely that everyone who did not self-harm have ideal family circumstances. O'Keefe and colleagues seem to be suggesting that for an act of self-harm to be relevant, the inmate has to explicitly say it was due to being in solitary confinement, rather than noting the conditions might lead to more rumination and volatile emotional responses to circumstances.

Equally important as the effect Administrative Segregation has on inmates is the residual effect after release. While data on the long-term effects of solitary confinement are more limited, relevant studies indicate the damage can be long lasting. O'Keefe and colleagues noted, "inmates released directly from segregation to the streets had dramatically higher rates and severity of detected recidivism than AS [Administrative Segregation] inmates who first released to GP [General Population]."

SECTION 2: IN-HOUSE MENTAL HEALTH TREATMENT

A common argument used in justifying the use of administrative segregation is that the prisoners are too dangerous to be released into the general population. While this may be true in some cases, lowering the number of prisoners in segregation has actually been associated in some cases with a decrease in violence. According to a 2004 report by the National Institute of Corrections, Nebraska had 3,932 prisoners, 95% of whom were held in General Population[19]. A September, 2014 article in the Lincoln Journal Star said there are approximately 5,100 prisoners in Nebraska prisons, 81.4% of whom are in General Population[20]. Over the last decade there has been a gradual increase in both the total number of prisoners and the proportion of prisoners in segregation. The mental health services available to individuals in segregation appears to be limited to face-to-face meetings with a mental health professional, the frequency of which is determined by apparent need. While there is a Violence Reduction Program in Nebraska, it is not offered to individuals in segregation, who are some of the inmates most in need of such services[21]. In testimony given in August, 2014, former Director of the Department of Corrections in Nebraska, Robert Houston acknowledged that there was inadequate funding for mental health services for inmates in segregation. He did note however, that within the last year, Tecumseh State Correctional Institution has introduced group therapy for individuals in administrative segregation. Several other states have made changes to the conditions of administrative segregation and the mental health services available to inmates.

Mississippi

A 2009 study of the Mississippi State Penitentiary found that releasing approximately 80% of people in administrative segregation into general population did not result in an increase in violent incidents[22]. Significantly, the number of serious incidents in the segregation unit involving prisoner-on-staff and prisoner-on-prisoner "showed an almost 70% drop" over

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[19] Austin, J., & McGinnis, K. (2004). *Classification of high-risk and special management prisoners: A national assessment of current practices.* US Department of Justice, National Institute of Corrections. http://www.ncjrs.gov/App/abstractdb/AbstractDBDetails.aspx?id=252479

[20] Young, J. (2014, September 4). "Nebraska may be one of highest users of solitary confinement". *The Lincoln Journal Star.* http://journalstar.com/legislature/nebraska-may-be-one-of-highest-users-of-solitary-confinement/article

[21] Nebraska Ombudsman's report 2014, available at http://d1vmz9r13e2j4x.cloudfront.net/NET/misc/40161741.pdf

[22] Kupers, T. A., Dronet, T., Winter, M., Austin, J., Kelly, L., Cartier, W., Mcbride, J. (2009). "Beyond Supermax Administrative Segregation: Mississippi's Experience Rethinking Prison Classification and Creating Alternative Mental Health Programs". *Criminal Justice and Behavior*, *36*(10), 1037–1050.

the following 2 years. A 'step-down' segregation unit was developed as a treatment program for individuals with SMI. Prisoners are initially kept in segregation, but can move to an open unit after "exhibiting appropriate behavior". From the open unit, prisoners would then graduate into general population. However, inmates in the segregation unit receive mental health treatment and are not isolated in their cells at all times. There is a weekly therapy group for 4 prisoners at a time and the treatment program is based on Assertive Community Treatment[23]. An examination of 43 prisoners who completed the program found a large decrease in their number of Rule Violation Reports (RVR). In the 6 months before entering the program, the 43 received 253 RVRs, while in the 6 months following the program, the same prisoners received 30 RVRs.

Washington State

In cooperation with the Vera Institute of Justice, the Washington State Department of Corrections (WA DOC) engaged in a 'Segregation Reduction Project' in 2011[24] (Turner, 2014). The WA DOC expanded their programming aimed at reintegrating prisoners in segregation back into the general prison population. One of these programs "utilize[s] violence reduction cognitive-behavioral interventions (CBI). This program employs creative structures using high security chairs that allow maximum custody prisoners… to receive programming in a classroom-like environment"[25]. The WA DOC reported a "30% reduction in the use of segregation statewide from January 2011 to June 2013. We have also experienced a decline in 'use of force' incidents in the Washington State Penitentiary… and a decline in inmate grievances."

Virginia

In 2011, the Virginia Department of Corrections introduced its "Step Down Program for Administrative Segregation". The program was developed from Evidence-Based Practice research. According to the Southern Legislative Conference, no offender who has completed the program has returned to segregation. Since the program's introduction, the number of prisoners in segregation has gone down by 53%. Additionally, prison incidents were reduced by 56%, and offender grievances went down 23%.

Colorado

In December 2013, the Colorado Department of Corrections declared that individuals with "major mental illnesses" would no longer be sent to solitary confinement. In testimony

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[23] Dixon, L. (2000). "Assertive Community Treatment: Twenty-Five Years of Gold". *Psychiatric Services*, *51*(6), 759–765.; Drake, R. E. (1998). "Brief History, Current Status, and Future Place of Assertive Community Treatment". *American Journal of Orthopsychiatry*, 68(2), 172-175.

[24] Written Testimony of Nicholas Turner (2014), U.S. Senate hearing, available at http://www.vera.org/sites/default/files/resources/downloads/solitary-confinement-testimony-nicholas-turner-v2.pdf

[25] Ibid; for more on the program, see http://www.vera.org/project/segregation-reduction-project

given in February 2014[26], Rick Raemisch, the current Executive Director of the Colorado Department of Corrections spoke about recent changes made in his state. Mr. Raemisch said the current "goal is to get the number of offenders in Administrative Segregation as close to zero as possible."   He reported that the number of prisoners in Administrative Segregation went "from 1451 in January 2011 to 597 in January 2014." Mr. Raemish also said that one prisoner with serious mental illness remained in Administrative Segregation, while the rest had been transferred to Residential Treatment Programs.

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[26] Available at http://www.judiciary.senate.gov/meetings/reassessing-solitary-confinement-ii-the-human-rights-fiscal-and-public-safety-consequences

SECTION 3: RE-ENTRY AND DISCHARGE PLANNING

The American criminal justice system is housing a significant number of people with mental illness, either diagnosed or not, such that many authors have deemed U.S. prisons as "the new asylum"[27]. Research indicates that people with mental illness continue to be overrepresented within the criminal justice system (see table 1), inmates typically have significant and multiple health problems[28], and the incidence of co-occurring disorders (simultaneous substance abuse and mental illness) is common[29].   The increasing numbers of people with mental illness in the criminal justice system places additional strains on the corrections system which historically has had limited tools and resources to treat or manage this particular population.

Table 1 Estimated Proportion of Adults with Mental Health, Substance Use, and Co-occurring Disorders in U.S. Population and under Correctional Control and Supervision

	General Public	State Prisons	Jails	Probation and Parole
Serious Mental Disorders	5.4%	16%	17%	7-9%
Substance Use Disorders (Alcohol and Drugs) — Abuse and/or Dependence	16%	53%	68%	35-40%
A Co-occurring Substance Use Disorder When Serious Mental Disorder Is Diagnosed	25%	59%	72%	49%
A Co-occurring Serious Mental Disorder When Substance Use disorder Is Diagnosed	14.4%	59.7%	33.3%	21%

 Source: GAINS Center for Behavioral Health and Justice Transformation, 2013, available at: http://www.asca.net/system/assets/attachments/4908/9.27.12_Behavioral_Framework_v6_full.pdf?1348755628

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[27] See Frontline, "The New Asylums" (video), http://www.pbs.org/wgbh/pages/frontline/shows/asylums/

[28] Council of State Government 2013 "Health, Mental Health, and Substance Use Disorders FAQs" http://csgjusticecenter.org/substance-abuse/faqs/, at p. 2: "In a study of more than 800 individuals released from U.S. prisons, nearly all—eight in 10 men and nine in 10 women—had chronic health conditions requiring treatment or management…People in the study often had more than one type of health problem-conditions that they had when they entered the facility and that required ongoing attention upon release. Roughly four in 10 men and six in 10 women reported a combination of physical health, mental health, and substance use conditions."

[29] See note 2, at p.2: "Co-occurring mental health and substance use disorders are common. In prisons, approximately 30 percent of individuals with substance use disorders also have a major mental health disorder. Conversely, in jails, an estimated 72 percent of individuals with serious mental illnesses have a substance use disorder. In prisons, co-occurring disorder estimates range from 3 to 11 percent of the total incarcerated population."

The vast majority of persons incarcerated in U.S. prisons and jails will eventually be released, including those with mental illness. Former inmates with mental illness have significant recidivism rates and many individuals with behavioral health issues (if left without adequate support systems and treatment inside and outside the prison/jail setting) will cycle in and out of corrections. A released prisoner's unmet need for mental health care often precipitates arrest[30].

The transition from incarceration to the community is a crucial time period to address overarching needs and supports to released inmates:

> "A critical component of cross-system work occurs at the transition from jail or prison to the community. Reentry into the community is a vulnerable time, marked by difficulties adjusting…and a 12-fold increased risk of death in the first two weeks after release."[31]

Re-entry and discharge planning is important for inmates. Planning is especially important for those releasees who will encounter a unique set of obstacles upon release such as those with mental illness (or other chronic health conditions) and those released directly from maximum security. However, according to the Prisoner Reentry FAQ from the Nebraska Legislative Research Office, Nebraska has invested an insufficient amount of resources towards prisoner reentry: "a relatively small percentage of those resources are invested in parole supervision and prisoner reentry. In fact, there is no central clearinghouse for information relevant to inmates leaving prison."[32]

"Isolation during incarceration adds enormous barriers to the already difficult task of successful prisoner re-entry…there are long-lasting social and psychological impacts on people who are kept in isolation, even after they are released. These impacts have tangible outcomes that further limit one's ability to succeed once released from prison."

-- Arizona Friends Service Committee, 2012

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[30] Bazleon Center for Mental Health Law (2001), "Finding the Key to Successful Transition from Jail or Prison to the Community", http://www.bazelon.org/LinkClick.aspx?fileticket=Bd6LW9BVRhQ=&tabid=104

[31] *Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison*, November 2013, Council of State Governments Justice Center, http://gainscenter.samhsa.gov/cms-assets/documents/147845-318300.guidelines-document.pdf;

[32] "Prisoner reentry FAQ: Frequently Asked Questions about Nebraska's Post-Prison Policies", 2014, available at: http://nebraskalegislature.gov/pdf/reports/research/2014prFAQ.pdf

Access to healthcare (and other support services) is often limited or non-existent post-release. This is an especially pernicious situation for those prisoners who had treatment provision in prison, but lose that treatment once on their own in the community. A lack of health insurance complicates the ability of former inmates with mental illness to seek treatment or maintain their treatment regimen, providing an outlet for a replay of the issues that brought them into contact with the criminal justice system in the first place.

The lack of access to health care also has broader social costs:

> "The community will also suffer when releases go without health care, as citizens bear the costs of hospitalization and emergency room treatment. Indeed, one study found that although most recently-released prisoners lacked health insurance, one-third had used an emergency room and one-fifth had been hospitalized in the ten months following their release."[33]

The multiple problems faced by released inmates are inextricably linked. Releasees must make prioritization of competing immediate needs, and often accessing or maintaining health care is a secondary priority--jeopardizing their ability to realize reentry success:

> "Some of these obstacles may represent the releasee's prioritization of needs. As with their healthier counterparts, released prisoners with chronic health problems face a wide array of reentry challenges such as finding housing, obtaining a job, and attending to basic necessities. In the absence of appropriate support mechanisms, however, focusing on these care needs may distract them from adhering to treatment and medication plans. In a vicious circle, this lack of adherence hinders their ability to accomplish the reentry goals they value most."[34]

For example, homelessness itself functions as a barrier to accessing mental health services as homeless releasees with mental illness often will have "difficulty keeping appointments and are often unable to adhere to treatment regimens."[35]

A lack of institutional or financial support combined with a disconnected "silo" infrastructure between human service and correctional systems "create(s) a significant barrier to the successful reintegration into society for many returning prisoners."[36] An integrated and

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[33] *Release Planning for Successful Reentry: A Guide for Corrections, Service Providers, and Community Groups*, 2008, http://www.urban.org/UploadedPDF/411767_successful_reentry.pdf,

[34] Ibid, p. 18

[35] "Local Implementation of 10 Year Plans to End Homelessness (7.11.05 NAEH Conference) HomeBase/ Legal and Technical Services Supporting Shared Prosperity -- Training Institute", http://www.homebaseccc.org/PDFs/TenYearPlannng/NAEH%20Discharge%20Planning%20Key%20Concepts.pdf

[36] Luther et al (2011), "An Exploration Of
Community Reentry Needs And Services For Prisoners: A Focus On Care to Limit Return to

comprehensive plan for reentry is critical to the successful integration of released inmates into society. The development of both a "reentry plan" and a "discharge plan" for inmates scheduled for release is a key determinant of how successful reintegration will be. Reentry planning starts when the inmate is admitted into the correctional facility and helps prepare inmates for long-term successful social reintegration; discharge planning is a component of reentry planning, focused on the inmate's needs at the time of discharge and the days/weeks to follow.[37] Development and implementation of effective reentry and discharge plans can help minimize the risk of released inmates falling back on the activities that placed them in corrections in the first place and improve individual recovery outcomes. Luther et al argue that the absence of sufficient discharge planning and continuity of medical and mental health services leaves many prisoners without needed care[38]. Further, released prisoners with mental illness problems "require immediate and ongoing services to successfully reenter the community"[39]. Lavine et al continue:

> "These services not only refer to the obvious needs for medication, medical equipment, prescriptions and referrals, but also to assistance in accessing these key supports. Many individuals facing mental health challenges will require intensive support in order to navigate life outside of prison. This support is particularly critical given that mentally ill releasees tend to receive less support from family members relative to other former prisoners and rarely have private insurance or Medicaid benefits to fund medical treatment."[40]

High-Risk Behavior". *AIDS Patient Care and STDs,* 25(8).

[37] See note 7, at p.5. "…while the larger reentry plan may address long-term employment needs by providing in-prison training and education the release plan [discharge plan] would focus on the more short-term needs for transitional employment. Release planning [discharge planning] often draws upon the assessments, resources, and relationships developed during the course of a person's incarceration and in many respects, represents the bar minimum preparation that a DOC [Department of Corrections] should engage in prior to a prisoner's release…but discharge planning, or planning for release, essentially begins after an assessment and classification have been completed and after the behavior and programming issues have been outlined."

[38] Luther et al (2011), "An Exploration of Community Reentry Needs and Services For Prisoners: A Focus on Care to Limit Return to High-Risk Behavior", *AIDS Patient Care and STDs*, v. 25, no. 8, p. 475

[39] See note 7, p. 20

[40] Ibid, p. 20

For inmates with mental illness reentering society, and especially for those individuals who have been subjected to solitary confinement, the need to help them access necessary supports, especially mental health care, is extremely important and unlikely to happen on its own. A study of the effects of solitary confinement in Arizona reports that, for prisoners in solitary, "Rarely is there acknowledgement of the impact prison (and solitary confinement) has on inmates and the difficulties prison/solitary has on the ability for prisoners to reintegrate"[41].

Assisting inmates to plan for and build the key support networks and services is a critical determinant in their successful transition to the community. Many states have some form of discharge/re-entry planning. Whether or not the current state of planning is adequate is an important question. The Urban Institute and the Council on State Governments have produced some guides[42] for states, corrections officials, and other relevant stakeholders to develop a more robust and effective means of discharge/re-entry planning, preparing inmates for a more successful transition to society and a greater ability to break the cycle of recidivism.

Fundamental to any effective program for discharge/re-entry planning is a strong collaborative partnership between corrections and the agencies/organizations that provide the services necessary for community reintegration (e.g., housing, employment, health care). In order to maximize the odds for successful reintegration, a more holistic and coordinated approach must be utilized. The services provided post-release must recognize the interrelated nature of multiple needs (e.g.,

> **"Nebraska's nine prisons hold 4,782 men and women. Almost all of them will eventually be released. Although the [Nebraska] Department of Correctional Services annual budget is now over $160 million, a relatively small percentage of those resources are invested in parole supervision and prisoner reentry. In fact, there is no central clearinghouse for information relevant to inmates leaving prison."**
>
> -- "Prisoner Reentry FAQ: Frequently Asked Questions about Nebraska's Post-Prison Policies"

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[41] See American Friends Service Committee, 2012, "Lifetime Lockdown: How Isolation Conditions Impact Prisoner Reentry"

[42] See, *Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison*, November 2013, Council of State Governments Justice Center, http://gainscenter.samhsa.gov/cms-assets/documents/147845-318300.guidelines-document.pdf; *Adults with Behavioral Health Needs Under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery,* 2012, https://www.bja.gov/Publications/CSG_Behavioral_Framework.pdf; *Release Planning for Successful Reentry: A Guide for Corrections, Service Providers, and Community Groups*, 2008, http://www.urban.org/UploadedPDF/411767_successful_reentry.pdf

housing, employment, health care), and must utilize this broader perspective to provide appropriate services and supports to cover a releasee's multiple needs. The Council on State Governments puts it directly: "interventions to reduce recidivism among people with mental illnesses in the criminal justice system need to not only include traditional mental health treatment, but also incorporate new multifaceted strategies."[43] However, they warn that despite having shared outcomes and goals, the current services and supports systems often lack an integrated framework :

> "Returning prisoners often require considerable assistance with basic issues of daily life (i.e., obtaining housing, education, employment, transportation, and personal documentation). The lack of institutional support and infrastructure create a significant barrier to successful reintegration into society for many returning prisoners."
>
> -- Luther et al (2011)

> "The corrections, mental health, and substance use disorder systems share a commitment to help these individuals successfully address their needs and avoid criminal justice involvement, yet each system has its own screening and assessment tools and research-based practices…what has been lacking is a truly integrated framework that can help officials at the systems level direct limited resources to where they can be most effective in achieving both public safety and healthcare goals."[44]

The interrelated nature of the needs of released inmates "confounds the ability of single problem-focused systems, such as the criminal justice, social welfare, drug and alcohol, mental health, and physical health care systems, to provide comprehensive and integrated services."[45] However, Wilson argues further that a lack of formal collaboration between service systems hampers access to vital services and further diminishes prospects for successful reentry:

> "This silo approach to service delivery is created in part by the fact that these service delivery systems lack formal mechanisms to support intersystem collaboration or oversight. This approach to services also confounds individuals' ability to seek help for their different problems after release because each system

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[43] See "Adults with Behavioral Health Needs Under Correctional Supervision", p. 5
[44] See "Adults with Behavioral Health Needs Under Correctional Supervision", summary
[45] Ibid, at p. 1576

maintains separate service delivery mechanisms that individuals must engage separately when trying to obtain help after they get out of jail."[46]

Wilson concludes in her study that financial and housing decisions will take precedence over seeking treatment for many released inmates, reaffirming the need for supports to not only be present and accessible immediately (especially financial and housing supports), but also that those services and systems must work collaboratively to address the comprehensive spectrum of releasees' needs. Wilson states that meeting ancillary needs is a key determinant in the successful reentry of inmates with mental illness and were the "building blocks in individuals' other help-seeking efforts"[47]. She concludes:

> "Increasing access to evidence-based practices for people with serious mental illness involved in the criminal justice system and expanding the clinical focus of these practices to address the specific needs of this client population are important issues to consider when discussing how to improve these programs' effectiveness. However, these approaches to improving the effectiveness of mental health services for this client population will be effective only if mental health programs are able to engage and retain clients in their services. Findings from this study suggest that people with serious mental illness leaving jail are confronted with a host of needs that are not easily met by existing services. This resource gap presents a critical point of intervention that needs to be addressed for mental health treatment, whatever its form, to have a chance of working for these clients."[48]

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[46] See note 19 at p. 1576
[47] See note 19 at p. 1588
[48] See note 19 at p. 1588

SECTION 4: COMMUNITY-BASED SERVICES

Estimates report that as many as 70%-90% individuals released from prison each year are uninsured[49], which is "compounded by rates of mental illness, substance use disorders, infectious disease, and chronic health conditions that are as much as seven times higher than rates in the general population."[50] Individuals involved with the criminal justice system comprise as much as one-third of the uninsured population in the U.S.[51]

> **"Rarely is there acknowledgement of the impact prison (and solitary confinement) has on inmates and the difficulties prison/solitary has on the ability for prisoners to reintegrate."**
>
> -- American Friends Service Committee, 2012

Given that most people who are incarcerated in prisons and jails will be released inevitably and with severely limited resources or community/family supports, serious consideration must be given to identifying and providing supports, services, and resources they will need to ease their reintegration into society. As the research on reentry and discharge planning demonstrates, the first weeks after release is an especially vulnerable time for former inmates. Their immediate needs are particularly high and interrelated:

> "Adding to the complexity of the releases of people with serious mental illness is the wide array of interrelated problems that need to be addressed on release which include issues such as poverty, homelessness, drug and alcohol misuse, and chronic health problems"[52].

The lack of supports to meet an releasee's needs is a significant barrier which further compromises the ability to make an effective transition to community living[53]. This is

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[49] Council of State Governments 2013. "Medicaid and Financing Health Care for Individuals Involved with the Criminal Justice System", December, http://csgjusticecenter.org/wp-content/uploads/2013/12/ACA-Medicaid-Expansion-Policy-Brief.pdf

[50] Ibid.

[51] Ibid.

[52] Wilson, A. (2013). "How People with Serious Mental Illness Seek Help After Leaving Jail", *Qualitative Health Research*, v. 23, no. 12, p. 1575.

[53] Luther et al (2011), "An Exploration of Community Reentry Needs and Services For Prisoners: A Focus on Care to Limit Return to High-Risk Behavior", *AIDS Patient Care and STDs*, v. 25, no. 8, p. 475

especially true for former inmates with mental health needs: "Mental health services play a pivotal role in the reentry of people with serious mental illness leaving jail." [54]

In order to create a more successful transition to community living for former prisoners, and particularly those with mental illness, a thorough understanding and examination of the structure, policies, services, as well as access and delivery systems of community-based mental health services is critical. Investing in community-based mental health services can work to stem the *introduction* of individuals with mental illness to the criminal justice system, and to *maintain* access to healthcare which is the key to breaking the cycle of recidivism within this population:

> "By failing to provide early intervention and adequate ongoing treatment and supports, a mental health system's routine operation perpetuates the crisis cycle that places people at risk of police intervention."

If community-based services are not around to help, he knows he will see them again. 'We let them out the door only to crash and burn…We are setting them up for disaster.'

-- Sgt. Bernard Kelly, a supervisor in the Harris County Jail's mental health unit.

The Council of State Governments puts it even more bluntly: "With insufficient community treatment and supervision options, jails and prison are sometimes seen as more certain placements to ensure public safety".[55]

A recent study reports that consistent access to medication for persons is a key variable in determining likelihood of re-offending (and furthermore the study reports that providing medications for longer than 90 days to released inmates with mental illness even further reduced likelihood of re-offending)[56]. The Council of State Governments reaffirms the social costs associated with inaccessible health care and services for released inmates, the need for re-entry/discharge planning, and the need for inmates to be able to access healthcare and ancillary services upon release:

> "When an individual returns to the community after incarceration, disruptions in the continuity of medical care have been shown to increase rates of re-incarceration and lead to poorer and more costly health outcomes. Research shows that the first few weeks after release from incarceration are the most crucial in terms of connection people to treatment…for many the failure to provide a link to healthcare

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[54] See note 19 at p. 1576
[55] See Council of State Governments (2012), "Adults with Behavioral Health Needs Under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery", p. 9
[56] Van Dorn et al (2013), "Effects of Outpatient Treatment of Risk of Arrest of Adults with Serious Mental Illness and Associated Costs", *Psychiatric Services*, v. 64, no. 9, p.860

coverage and services upon release results in needless, potentially months-long gaps in their access to healthcare. If they access care at all, these individuals often rely upon hospital emergency room services, shifting much of the cost burden to hospitals and state, county, and city agencies."

Investing in community-based services and better enabling inmates to access health services post-release is cost-beneficial:

> "People who are released from jails and prisons without access to behavioral health services may decompensate unpredictably…Strategies to improve health status can be cost-effective for states and counties. Treatment for addiction reduces recidivism which, in turn, reduces the absolute number of incarcerated people, thereby reducing the cost of correctional facility operations. Some of these savings are shifted to community resources, but it is far less costly to manage and provide care in the community than in expensive correctional facilities."[57]

Some states have already begun to address the need to provide healthcare and other services and supports necessary to increase the odds of a successful reentry for former prisoners with and without mental illness (or other health conditions). Two tools some states have used to provide services to this population are Medicaid and the Affordable Care Act. Ignoring the linkages between reentry and recidivism and the interrelated nature of needs for former prisoners (especially those with mental illness) comes with a significant cost; Medicaid is often a more cost-effective alternative for states than simply financing through corrections budgets:

> ""Medicaid is also typically more cost-effective than other sources of health care coverage. This is particularly true in comparison with health care spending by corrections systems, which typically do not have the same negotiating power and cannot obtain similarly favorable rates for health care services."[58]

However, the Council of State Governments reports that on the whole states are not utilizing federal Medicaid to its fullest extent:

> "However, opportunities to maximize and maintain Medicaid enrollment for eligible individuals in this population and especially to make use of Medicaid to finance certain types of care provided to those who are incarcerated, have been largely underutilized by states."[59]

Some states are billing Medicaid for medical services and treatment for prisoners while incarcerated. The Medicaid program will allow billing for services for a prisoner if those
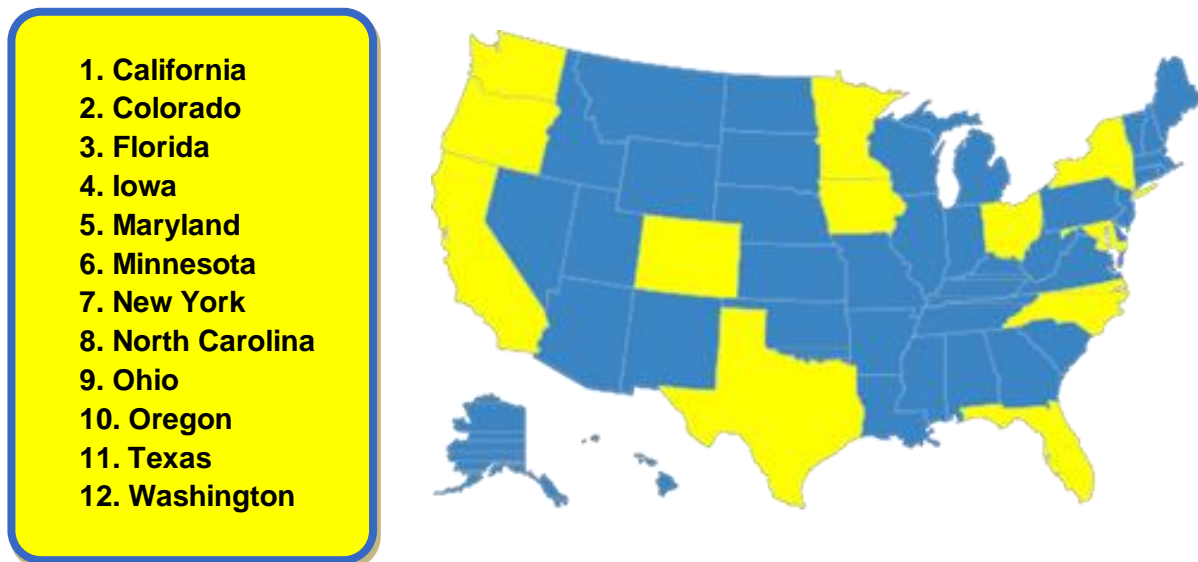
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[57] Ibid, p. 6
[58] See note 49, p.3
[59] Ibid., p. 1

services are provided in a facility other than the prison. So some states (Nebraska is one of them) are billing Medicaid for services/treatment for persons currently incarcerated if rendered in a hospital or other similar facility.

However, Nebraska is still one of many states that *terminates* an individual's Medicaid eligibility upon his/her incarceration. States and localities (including Nebraska) continue to misinterpret the provision of Medicaid that excludes coverage for treatment while in prison to mean that Medicaid requires termination of Medicaid coverage while incarcerated.[60] The practical implication for released inmates is stark: they are forced to re-apply for Medicaid. The application process and the eventual receipt of benefits can take over a month. Again, the first few weeks of release are critical to the reentry success for former inmates, especially those with mental illness.

In response, a few states have decided not to terminate Medicaid eligibility upon incarceration, but instead *suspend* eligibility for the duration of an eligible inmate's incarceration. This way Medicaid coverage is maintained (assuming the inmate remains eligible at time of release) for the former inmate and she/he can utilize that coverage immediately to access necessary health care.   As of December 2013, at least 12 states have laws or policies to suspend Medicaid benefits upon incarceration[61]:

Figure 1 States Suspending Medicaid Benefits upon Incarceration

1. **California**
2. **Colorado**
3. **Florida**
4. **Iowa**
5. **Maryland**
6. **Minnesota**
7. **New York**
8. **North Carolina**
9. **Ohio**
10. **Oregon**
11. **Texas**
12. **Washington**

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[60] Ibid., p.3
[61] Council of State Governments 2013. "Medicaid and Financing Health Care for Individuals Involved with the Criminal Justice System", December, http://csgjusticecenter.org/wp-content/uploads/2013/12/ACA-Medicaid-Expansion-Policy-Brief.pdf

New York suspends Medicaid enrollment indefinitely, allowing individuals who are incarcerated to remain enrolled. Other states including CA, FL, IA, MD, MN, NC, OH, OR, TX and WA suspend Medicaid for a certain period of time (usually until next Medicaid eligibility re-determination). Other states have policies that include enrolling eligible inmates in Medicaid as a part of their reentry/discharge plan.

States that suspend Medicaid "can more easily ensure that enrollment is reinstated when incarcerated individuals are released and that formerly incarcerated individuals can immediately access health care without gaps in coverage."[62]

The Centers for Medicare and Medicaid Services has encouraged states to suspend Medicaid enrollment rather than suspend it.

The implementation of the Affordable Care Act has provided opportunities for states to link uninsured individuals to health coverage. In their issue paper[63], Blair et al describe a variety of areas where the Affordable Care Act can be applied to individuals who are justice-involved and where states could leverage federal funds to maximize assistance and support, including suspending rather than terminating Medicaid eligibility and providing community-based services.

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[62] Ibid., p. 9

[63] Blair et al (2011), "Increasing Access to Health Insurance Coverage for Pre0trial Detainees and Individuals Transition from Correctional Facilities Under the Patient Protection and Affordable Care Act", http://www.cochs.org/files/ABA/aba_final.pdf

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