



SCHOOL *of* LAW

BEAZLEY INSTITUTE FOR HEALTH LAW AND POLICY

Volume 29 | Issue 1  
FALL 2019

# Annals OF Health Law

ADVANCE DIRECTIVE

The Student Health Policy and Law Review of  
LOYOLA UNIVERSITY CHICAGO SCHOOL *of* LAW

**ANNALS OF HEALTH LAW AND LIFE SCIENCES**  
*Advance Directive*

**THE *STUDENT* HEALTH POLICY AND LAW REVIEW OF  
LOYOLA UNIVERSITY CHICAGO SCHOOL OF LAW**

**BRINGING YOU THE LATEST DEVELOPMENTS IN HEALTH LAW**

Beazley Institute for Health Law and Policy

VOLUME 29, STUDENT ISSUE 1

FALL 2020

**CONTENTS**

**Editor's Note**

*Hannah Lehmann and Jacalyn Smith*

**ARTICLES**

**H.R. 3239/S. 2135 – Humanitarian Standards for Individuals in Customs and Border Protection Custody Act: Analysis and Criticisms**

Krystal Tysdal ..... 101

**Healthcare for Justice-Involved Individuals: The Difference by State**

Juliano Florio ..... 119

**Prison Time is Not Treatment: An Argument to Exclude Drug Offenses From Illinois' Three Strikes Law**

Lauren Koch..... 131

**Evaluating the Effectiveness of Diversion Programs for Justice Involved Populations with Mental Illness**

Nicole Harris ..... 145

**Recidivism in Former Mentally Ill Prisoners Connected to Lower Funded Mental Health Programs in Prisons**

Michael Manganelli ..... 163

**Female Inmates and Access to Feminine Hygiene Products**

Milea Moye ..... 177

**Using Nature to Improve and Challenge Solitary Confinement**

Victoria ("Peggy") Frazier ..... 191

**The Need for Universal Adoption of the Medicaid Expansion**

Jessica Lubin ..... 207

<b>A Case Against Medicaid Work Requirements for Prisoners Re-Entering Society</b>	
Raminta Kizyte .....	219
<b>Advocating for Access: How the Eighth Amendment and Americans With Disabilities Act Open a Pathway for Opioid Addicted Inmates to Receive Medication-Assisted Treatment</b>	
Emily Mann .....	231

ANNALS OF HEALTH LAW  
*Advance Directive*

Editor's Note

The *Annals of Health Law and Life Sciences* is proud to present the twenty-third issue of our online, student-written publication, *Advance Directive*. As in past publications, this Issue's articles coincide with the Beazley Institute for Health Law and Policy and *Annals of Health Law and Life Sciences*, Thirteenth Annual Health Law Symposium topic: "Addressing the Needs of Justice Involved Populations."

The *Fall 2019 Advance Directive* Issue will dive into a broad spectrum of topics within the current conversation taking place in the United States surrounding the health care needs of justice involved populations. Justice involved populations often have a more difficult time accessing care due to the numerous barriers in place and lack of support that many involved in the United States justice system face.

Justice involved populations encompass a wide population in the United States. Not only does this population consist of people currently in jail or prison, it also includes people on probation, juveniles in juvenile detention centers, people in immigrant detention centers, and individuals who are otherwise involved with the U.S. justice system.

Immigrants in detention centers frequently have a difficult time accessing adequate living conditions and health care, leading to poor health outcomes for many immigrants. This Issue first explores the treatment of detainees at immigration detention centers, focusing on the Humanitarian Standards to Individuals in Customs Border Protection Custody Act, which was passed in 2019 in an effort to improve the provision of health care and treatment of immigrant detainees.

This Issue then explores how state laws affect healthcare for justice involved populations. This Issue assesses how differences state penal healthcare systems lead to differences in health outcomes for incarcerated individuals. Next, this issue analyzes how Illinois Habitual Criminal Act punishes non-violent drug offenders, thus failing to provide many of these incarcerated individuals with proper treatment for their drug addiction.

Mental health has a big impact on justice involved populations. The discussion on mental health issues for justice involved populations begins with a pre-incarceration analysis by exploring the effectiveness of diversion programs in reducing the recidivism rates for individuals with mental disorders. This discussion then shifts to an analysis of how funding for mental health programs in prisons affects recidivism rates for prisoners with mental health disorders.

This Issue then explores specifics of how life in prison can affect health outcomes for incarcerated individuals. This discussion begins with an analysis of how many female prisoners are often limited in their access to feminine hygiene products. Next, this discussion shifts to an analysis of how courts should consider a prisoner's access to nature when determining if a solitary confinement punishment violated the Eighth Amendment.

Access to health care for former prisoners is often overlooked. This Issue analyzes various barriers to health care that people often face after incarceration, beginning with an argument that all states should expand Medicaid so that post-incarcerated individuals can access the healthcare system. This discussion shifts to an examination of Medicaid work requirements and the hardships that newly freed individuals have in accessing health care due to Medicaid work requirements. This Issue then explores how access to medication-assisted treatment should be expanded for individuals who were recently released from prison.

We would like to thank Alesandra Hlaing, our Technical Production Editor. Without her knowledge and commitment, this Issue would not have been possible. We would also like to give a special thanks to Isabella Masini, our *Annals* Editor-in-Chief, for her leadership and support. We would also like to thank and acknowledge our *Annals* Executive Board Members: Christina Perez-Tineo, Nicolette Taber, and Raquel Boton, as well as the *Annals* Senior Editors: Haley Comella, Liz Heredia, Rachel Kemel, and Jan Dervish for providing invaluable editorial assistance with this Issue. The members of *Annals* deserve recognition for their hard work, dedication and well-thought articles. Lastly, we must thank the Beazley Institute for Health Law and Policy and our faculty advisors, Professor Larry Singer and Kristin Finn for their guidance and support.

We hope you enjoy this Issue of *Advance Directive*.

Sincerely,

Hannah Lehmann  
Advance Directive Editor  
*Annals of Health Law*  
Loyola University Chicago School of Law

Jacalyn Smith  
Advance Directive Editor  
*Annals of Health Law*  
Loyola University Chicago School of Law

# H.R. 3239/S. 2135 – Humanitarian Standards for Individuals in Customs and Border Protection Custody Act: Analysis and Criticisms

Krystal L. Tysdal

## I. INTRODUCTION

The U.S. immigration system is on the brink of collapse.<sup>1</sup> Between September 2018 and November 2019, twelve people, “including three children,” died while in U.S. Customs and Border Protection (“CBP”) custody.<sup>2</sup> Described as “the stuff of nightmares”, the CBP facility conditions in which immigrants are held are inextricably linked to this humanitarian crisis.<sup>3</sup> One pediatrician even compared the CBP station in Clint, Texas to a “torture facilit[y][.]”<sup>4</sup> Further, the Inspector-General of the Department of Homeland Security (“DHS”) recently called overcrowded CBP facilities “a ticking time bomb.”<sup>5</sup> Policy experts and officials agree that several distinct

---

1. Rick Jervis et al., *One Deadly Week Reveals Where the Immigration Crisis Begins—And Where It Ends*, USA TODAY (Oct. 1, 2019, 2:21 PM), [www.usatoday.com/in-depth/news/2019/09/23/immigration-crisis-migrants-us-mexico-border/2022670001/](http://www.usatoday.com/in-depth/news/2019/09/23/immigration-crisis-migrants-us-mexico-border/2022670001/).

2. *Humanitarian Standards to Individuals in Customs and Border Protection Custody Act of 2019: Hearing on H.R. 3239 Markup Before the H. Comm. on the Judiciary*, 116th Cong. 4 (2019) [hereinafter *Markup Hearing*] (statement of Rep. Jerrold Nadler, Chairman, H. Judiciary Comm.); Raquel Reichard, *In One Week Two People Have Died in Arizona While in Border Patrol Custody*, REMEZCLA.COM (Oct. 30, 2019, 11:21 AM), <https://remezcla.com/culture/mexican-woman-dies-dehydration-border-patrol-custody-arizona/>.

3. Simon Romero et al., *The Stuff of Nightmares: Inside the Migrant Detention Center In Clint Texas*, USA TODAY: IMMIGR. (July 6, 2019, 1:00 PM), [www.usatoday.com/story/news/immigration/2019/07/06/border-patrol-el-paso-sector-migrant-detention-center-clint-immigration/1663750001/](http://www.usatoday.com/story/news/immigration/2019/07/06/border-patrol-el-paso-sector-migrant-detention-center-clint-immigration/1663750001/).

4. Cindy Carcamo, *Lawsuit Accuses U.S. Government of Holding Migrant Children in ‘Deplorable’ Conditions*, L.A. TIMES (June 26, 2019, 11:06 PM), [www.latimes.com/local/california/la-me-lawsuit-children-immigration-detention-20190626-story.html](http://www.latimes.com/local/california/la-me-lawsuit-children-immigration-detention-20190626-story.html).

5. OFF. INSPECTOR GEN., DEP’T HOMELAND SEC., OIG-19-51, MANAGEMENT ALERT – DHS NEEDS TO ADDRESS DANGEROUS OVERCROWDING AND PROLONGED DETENTION OF

factors generated this crisis.<sup>6</sup> First, CBP facilities are short-term processing administrative centers—not long-term detention facilities.<sup>7</sup> Second, “harsh conditions in Central America” provoked a sharp influx of a new demographic of immigrants—families and unaccompanied minors<sup>8</sup>—to the U.S. in the last three to four years.<sup>9</sup> Third, the Trump administration’s anti-immigration agenda has expanded the number of people subject to detention.<sup>10</sup> Fourth, CBP facilities are “more restrictive and closed to outsiders than almost any other detention facility in the U.S. (including jails and prisons).”<sup>11</sup> Finally, CBP internal guidelines are unenforceable as they

---

CHILDREN AND ADULTS IN THE RIO GRANDE VALLEY (REDACTED) 8 (2019).

6. Nicole Acevedo, *Migrant Children Face More Serious Health Risks with Longer Detentions, Groups Warn*, NBC NEWS: NBC LATINO (Aug. 21, 2019, 5:13 PM), [www.nbcnews.com/news/latino/migrant-children-face-more-serious-health-risks-longer-detentions-groups-n1045031](http://www.nbcnews.com/news/latino/migrant-children-face-more-serious-health-risks-longer-detentions-groups-n1045031).

7. Abigail Hauslohner & Maria Sacchetti, *Hundreds of Minors Held at U.S. Border Facilities Are There beyond Legal Time Limits*, WASH. POST (May 30, 2019, 4:23 PM), [www.washingtonpost.com/immigration/hundreds-of-minors-held-at-us-border-facilities-are-there-beyond-legal-time-limits/2019/05/30/381cf6da-8235-11e9-bce7-40b4105f7ca0\\_story.html](http://www.washingtonpost.com/immigration/hundreds-of-minors-held-at-us-border-facilities-are-there-beyond-legal-time-limits/2019/05/30/381cf6da-8235-11e9-bce7-40b4105f7ca0_story.html); *see id.*

8. Astrid Galvan, *By the Numbers: Migration to the US-Mexico Border*, AP NEWS (July 25, 2019), [www.apnews.com/cbba8ede5436460ab4f792f981ee32e2](http://www.apnews.com/cbba8ede5436460ab4f792f981ee32e2); *see* John Gramlich & Luis Noe-Bustamante, *What’s Happening at the U.S.-Mexico Border In 6 Charts*, PEW RES.: FACTTANK (April 10, 2019), [www.pewresearch.org/fact-tank/2019/04/10/whats-happening-at-the-u-s-mexico-border-in-6-charts/](http://www.pewresearch.org/fact-tank/2019/04/10/whats-happening-at-the-u-s-mexico-border-in-6-charts/).

9. Catherine E. Shoichet & Geneva Sands, *What’s Behind the Spike In Immigrants At the Border?*, CNN: POLITICS (June 7, 2019, 2:17 PM), [www.cnn.com/2019/06/07/politics/reasons-behind-immigration-spike-at-the-border/index.html](http://www.cnn.com/2019/06/07/politics/reasons-behind-immigration-spike-at-the-border/index.html); *see* GRAMLICH & NOE-BUSTAMANTE, *supra* note 8; *see also* Andrew Meehan, Assistant Commissioner for Public Affairs: U.S. Customs & Border Protection, *Public Statement* (March 30, 2019), [www.cbp.gov/newsroom/speeches-and-statements/statement-us-customs-and-border-protection](http://www.cbp.gov/newsroom/speeches-and-statements/statement-us-customs-and-border-protection).

10. Neena Satija et al., *A Trump Administration Strategy Led to the Child Migrant Backup Crisis at the Border*, WASH. POST (Nov. 12, 2019, 11:13 AM), [www.washingtonpost.com/immigration/a-trump-administration-strategy-led-to-the-child-migrant-backup-crisis-at-the-border/2019/11/12/85d4f18c-c9ac-11e9-a1fe-ca46e8d573c0\\_story.html](http://www.washingtonpost.com/immigration/a-trump-administration-strategy-led-to-the-child-migrant-backup-crisis-at-the-border/2019/11/12/85d4f18c-c9ac-11e9-a1fe-ca46e8d573c0_story.html). There are even credible allegations that, although the administration knew certain policies would exacerbate already strained conditions at CBP facilities and lead to overcrowding, officials implemented them anyway, *id.*

11. *Behind Closed Doors: An Overview of DHS Restrictions on Access to Counsel*, PENN. ST. L. 1, 3 (May 2012) (noting that “CBP routinely bars access to counsel” from detainees); *see* Jack Herrera, *If Conditions for Detained Migrant Children Got Worse, How Would We Know?*, PAC. STANDARD: NEWS IN BRIEF (June 25, 2019), <https://psmag.com/news/if-conditions-for-detained-migrant-children-got-worse-how-would-we-know>.

are not legally binding.<sup>12</sup>

In response to the heinous conditions in CBP facilities, the U.S. House of Representatives passed the Humanitarian Standards to Individuals in Customs and Border Protection Custody Act (“H. R. 3239”) on July 24, 2019; it was referred to the Senate Judiciary Committee on July 25, 2019, where it is currently being reviewed.<sup>13</sup> H.R. 3239 requires CBP to conduct timely initial health screenings of immigrants, enlist qualified child welfare and health care professionals, and provide detainees appropriate hygienic care.<sup>14</sup> H.R. 3239 further mandates that CBP provide suitable living quarters as well as interpreters and chaperones as warranted for all detainees.<sup>15</sup> Finally, H.R. 3239 directs DHS to conduct unannounced inspections of CBP facilities and subsequently distribute public reports to Congress.<sup>16</sup> To combat the ongoing, and rapidly deteriorating, humanitarian crisis at the U.S. Southern border, Congress should enact H.R. 3239.<sup>17</sup> Chiefly, the bill would protect the health of immigrant children and families in the custody of the CBP by codifying a legally enforceable, uniform policy which requires prompt health screenings upon intake and appropriate follow-up medical care when necessary.<sup>18</sup> Further, because the bill mandates third-party oversight of CBP facilities, it would ensure compliance with the health and safety standards.<sup>19</sup> This

---

12. ACEVEDO, *supra* note 6; *see generally* Bureau of Customs and Border Protection, *National Standards on Transport, Escort, Detention, and Search*, DEP’T HOMELAND SEC. (Oct. 2015) [hereinafter *CBP TEDS Standards*].

13. ACEVEDO, *supra* note 6; Humanitarian Standards to Individuals in Customs and Border Protection Custody Act, H.R. 3239, [hereinafter *H.R. 3239*] 116th Cong. (2019).

14. H.R. 3239, 116th Cong. §§ 2, 3 (2019).

15. H.R. 3239, §§ 5, 8.

16. H.R. 3239, § 11.

17. Annalisa Merelli, *US Immigrant Detention Centers Are So Crowded Border Patrol Is Running Out of Storage Space*, QUARTZ (Sept. 18, 2019), <https://qz.com/1709887/detention-centers-are-so-crowded-border-patrol-ran-out-of-storage/>; Jordan Fabian, *Trump Says ‘Catch and Release’ Border Policy to End in Two Weeks*, ORLANDO SENTINEL (Sept. 20, 2019), [www.orlandosentinel.com/sns-tns-bc-immigration-catch-release-20190920-story.html](http://www.orlandosentinel.com/sns-tns-bc-immigration-catch-release-20190920-story.html).

18. H.R. 3239, 116th Cong. § 2 (2019).

19. H.R. 3239, §§ 11, 12.



compliance would allow for the rectification of legal and moral wrongs currently being perpetrated in CBP facilities.<sup>20</sup> Although the bill does not directly address the root causes of the border crisis, it is a necessary piece of legislation.

## II. ANALYSIS

### *The Powerful Effect of Mandated Third-Party Oversight of CBP Facilities*

H.R. 3239 would ensure that CBP facilities comply with minimum health and safety standards by not only guaranteeing access to CBP facilities for members of Congress, but also by mandating unannounced investigations of CBP facilities by the U.S. Government Accountability Office (“GAO”) as well as the DHS Inspector General. In turn, such third-party oversight would help alleviate the deadly conditions in CBP facilities which have, thus far, been permitted to flourish.<sup>21</sup> Advocates and journalists say that CBP detention facilities “are like ‘black boxes,’ . . . little information gets out [about them]. . . [and] [t]hey do not permit people to enter as a general matter.”<sup>22</sup> Except in extremely narrow circumstances, “detainees can’t make phone calls, and attorneys are not permitted to visit [detainees] within CBP facilities.”<sup>23</sup> In fact, “CBP has no obligation to let third-party, non-government investigators enter, and no laws exist that give journalists access to CBP facilities.”<sup>24</sup> Similarly, internal oversight by CBP officials is nearly

---

20. *Id.*

21. Suzanne Gamboa, *From Bad to ‘Sheer Inhumanity’: Detention Conditions for Migrants Worse Under Trump Advocates Say*, NBC NEWS (July 2, 2019, 4:40 PM), [www.nbcnews.com/news/latino/bad-sheer-inhumanity-detention-conditions-migrants-worse-under-trump-advocates-n1025961](http://www.nbcnews.com/news/latino/bad-sheer-inhumanity-detention-conditions-migrants-worse-under-trump-advocates-n1025961).

22. HERRERA, *supra* note 11 (commenting by a policy analyst for the American Immigration Council).

23. *Id.*

24. *Id.* In contrast, the Supreme Court has held that restrictions on journalists’ access to a prison may only be justified based on security considerations if the restrictions are content-neutral, and reasonable alternative means of communication, by mail or through a family or friend visitation, are available to the prisoners, *Pell v. Procunier*, 417 U.S. 817, 827-28

non-existent.<sup>25</sup> Notably, the GAO released a report on July 11, 2019, which noted that CBP only conducted assessments at four of the forty facilities it owns between 2016 and 2018.<sup>26</sup> Hence, CBP failed to conduct assessments of over *ninety percent* of the forty facilities it owns as of last year.<sup>27</sup> As a consequence, “conditions. . .have worsened [and] flourish because there is and has been little third-party oversight over CBP[.]”<sup>28</sup>

For these reasons, H.R. 3239 contains critical oversight provisions which would ensure that CBP facilities comply with minimum safety and health standards regarding detainees.<sup>29</sup> Specifically, Section 11(c) of H.R. 3239 states: “The Commissioner may not deny a Member of Congress entrance to any facility or building used, owned, or operated by CBP.”<sup>30</sup> Further, Section 12 requires the GAO to conduct an investigation starting no later than six months after the date of enactment of H.R. 3239.<sup>31</sup> Within a year of enactment, the GAO would produce a report to Congress regarding CBP’s compliance with the standards.<sup>32</sup> In turn, members of Congress specifically would be able to prevent unnecessary deaths and illness of detainees in CBP

---

(1974); Jonathan Peters, *For Journalists Covering Prisons the First Amendment Is Little Help*, Columbia Journalism Rev. (July 3, 2018), [www.cjr.org/united\\_states\\_project/first-amendment-reporters-jail.php](http://www.cjr.org/united_states_project/first-amendment-reporters-jail.php) (discussing the ability of journalists to access prisons, jails, and other detention centers in the U.S.).

25. Nicole Narea, *GAO Urges CBP to Conduct Better Facility Oversight*, L. 360 (July 12, 2019, 8:25 PM), [www.law360.com/articles/1177550/gao-urges-cbp-to-conduct-better-facility-oversight](http://www.law360.com/articles/1177550/gao-urges-cbp-to-conduct-better-facility-oversight).

26. U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-19-534, BORDER INFRASTRUCTURE: ACTIONS NEEDED TO IMPROVE INFORMATION ON FACILITIES AND CAPITAL PLANNING AT LAND BORDER CROSSINGS 2 (2019).

27. *Id.*

28. Gamboa, *supra* note 21.

29. H.R. 3239, 116th Cong. §§ 2-7 (2019).

30. H.R. 3239, § 11(c).

31. H.R. 3239, § 12(a). This investigation would study specific issues such as “management and oversight by CBP ports of entry, border patrol stations, and other detention facilities” and whether “CBP personnel, in carrying out this Act, make abusive, derisive, profane, or harassing statements or gestures, or engage in any other conduct evidencing hatred or invidious prejudice to or about one person or group on account of race, color, religion, national origin, sex, sexual orientation, age, or disability”, H.R. 3239, § 12(b).

32. H.R. 3239, § 12(a).

facilities because “[o]versight by Congress tends to remind agencies. . .that they are being watched, and the accompanying press coverage reinforces that point.”<sup>33</sup> Moreover, “[o]versight and publicity. . .tend to make issues. . .receive priority attention from agencies or others.”<sup>34</sup> For example, more than a dozen lawmakers visited two CBP facilities in Clint and El Paso, Texas<sup>35</sup> on July 1, 2019 after receiving reports that immigrant children were being neglected in such facilities.<sup>36</sup> Immediately following the visits, the members of Congress released public statements on social media, interviews, and press conferences about the horrific conditions in CBP facilities.<sup>37</sup> Shaw Drake, a policy counsel at the American Civil Liberties Union Border Rights Center, emphasized that such visits and statements made by members of Congress are “vitally important” in overseeing CBP.<sup>38</sup> Therefore, because

33. *Id.*; Reid P. F. Stuntz, *Congressional Oversight and Investigations 101*, 20 HEALTH L. 24, 25 (2008) (“And, depending on the vigor and depth of the work, behavior or outcomes can be changed.”); see Julia Conley, *House Democrats Denounce DHS for Blocking Lawmakers’ Access to Detention Centers Amid Reports of Rampant Abuse*, COMMON DREAMS (Aug. 30, 2019), [www.commondreams.org/news/2019/08/30/house-democrats-denounce-dhs-blocking-lawmakers-access-detention-centers-amid](http://www.commondreams.org/news/2019/08/30/house-democrats-denounce-dhs-blocking-lawmakers-access-detention-centers-amid).

34. STUNTZ, *supra* note 33, at 25.

35. Catherine Kim, “*People Drinking Out of Toilets’: AOC and Other Democrats Share Details from Their Texas Border Facility Tour*,” VOX (July 2, 2019, 2:30 PM), [www.vox.com/2019/7/2/20678806/aoc-democrat-texas-border-facility-tour](http://www.vox.com/2019/7/2/20678806/aoc-democrat-texas-border-facility-tour).

36. *Id.*

37. Katie Mettler et al., *Border Agents Confiscated Lawmakers’ Phones Joaquin Castro Captured Photo and Video Anyway*, WASH. POST: POL. (July 2, 2019, 8:23 PM), [www.washingtonpost.com/politics/2019/07/02/ocasio-cortez-says-dispute-with-border-patrol-agents-started-after-one-tried-take-stealth-selfie/](http://www.washingtonpost.com/politics/2019/07/02/ocasio-cortez-says-dispute-with-border-patrol-agents-started-after-one-tried-take-stealth-selfie/). Democratic Representative Madeline Dean of Pennsylvania stated in a tweet that, she observed “[Fifteen] women in their 50s-60s sleeping in a small concrete cell, [with] no running water[,] [having gone] [w]eeks without showers”, Priscilla Alvarez, *Lawmakers Including Ocasio-Cortez Lash Out Over Conditions Following Border Facility Tours*, CNN: POLITICS (July 2, 2019, 8:33 AM), [www.cnn.com/2019/07/01/politics/alexandria-ocasio-cortez-clint-texas-facility/index.html](http://www.cnn.com/2019/07/01/politics/alexandria-ocasio-cortez-clint-texas-facility/index.html) (citing Madeleine Dean (@MadeleineDean), TWITTER (July 1, 2019, 2:37 PM), <https://twitter.com/RepDean/status/1145778546998202368>). Also, New York Representative Alexandria Ocasio-Cortez wrote on Twitter that she observed “systemic cruelty [with] a dehumanizing culture that treats [detainees] like animals”, Camilo Montoya-Galvez, *Alexandria Ocasio-Cortez Decries “Systemic Cruelty” After Visiting Migrant Detention Center*, CBS NEWS (July 1, 2019, 5:38 PM), [www.cbsnews.com/news/alexandria-ocasio-cortez-details-grim-condition-at-migrant-detention-centers/](http://www.cbsnews.com/news/alexandria-ocasio-cortez-details-grim-condition-at-migrant-detention-centers/) (citing Alexandria Ocasio-Cortez (@AOC), TWITTER (July 1, 2019, 11:57 AM), <https://twitter.com/AOC/status/1145768510783668232>).

38. METTLER ET AL., *supra* note 37.

H.R. 3239 guarantees access, lawmakers will be able to pull back the veil that CBP facilities are hidden behind and hold CBP responsible for any failure to comply with standards.<sup>39</sup>

Congressional oversight in this case is especially necessary because the Trump administration is not a reliable or trustworthy source—particularly regarding CBP facilities.<sup>40</sup> Despite numerous eyewitness reports and the DHS Inspector General’s report about the crisis at the border, the Trump administration pushed back by claiming that the descriptions were “mischaracterizations or sensationalizing.”<sup>41</sup> Three days prior to the aforementioned congressional visit to CBP facilities in Texas, Kevin McAleenan, the then-acting secretary of DHS, asserted that the conditions in one facility were “clean and well managed” and that claims that “children were housed with filthy clothes, dirty diapers and inadequate food” were “unsubstantiated allegations.”<sup>42</sup> Trump himself *praised* conditions in CBP

---

39. Paul Farhi, *Migrant Children Are Suffering at the Border but Reporters Are Kept Away from the Story*, WASH. POST (June 25, 2019, 5:00 AM), [www.washingtonpost.com/lifestyle/style/migrant-children-are-suffering-at-the-border-but-reporters-are-kept-away-from-the-story/2019/06/24/500313a2-9693-11e9-8d0a-5edd7e2025b1\\_story.html](http://www.washingtonpost.com/lifestyle/style/migrant-children-are-suffering-at-the-border-but-reporters-are-kept-away-from-the-story/2019/06/24/500313a2-9693-11e9-8d0a-5edd7e2025b1_story.html) (“If videos were released there would be massive changes” because the public outcry would be enormous.”).

40. Adam Harris, *An Astonishing Government Report on Conditions at the Border*, THE ATL. (July 3, 2019), [www.theatlantic.com/family/archive/2019/07/government-report-details-inhumane-conditions-migrant-facilities/593242/](http://www.theatlantic.com/family/archive/2019/07/government-report-details-inhumane-conditions-migrant-facilities/593242/); Zolan Kanno-Youngs, *McAleenan Says Arrests of Migrants on Border Expected to Decline by 25 Percent in June*, N.Y. TIMES (June 28, 2019), [www.nytimes.com/2019/06/28/us/politics/homeland-security-border-arrests.html](http://www.nytimes.com/2019/06/28/us/politics/homeland-security-border-arrests.html); NEENA SATIJA ET AL., *supra* at note, 11 (“According to current and former government officials, and emails and memos detailing the Trump administration’s strategy, it is clear they knew that without enough beds in government shelters, children would languish in Border Patrol stations not equipped to care for them, making the government a target of lawsuits and public criticism—both of which occurred.”); *see also* Peter Castagno, *Trump Administration Intentionally Worsened Conditions for Migrant Children*, CITIZEN TRUTH (Nov. 16, 2019), <https://citizentruth.org/trump-administration-intentionally-worsened-conditions-for-migrant-children/> (“The report comes as new government data shows that an unprecedented 69,550 migrant children were held in U.S. government custody over the past year, more than any other country in the world, according to the Associated Press.”).

41. HARRIS, *supra* note 40.

42. KANNO-YOUNGS, *supra* note 40; *see also* ALVAREZ, *supra* note 37. President Trump appointed Kevin McAleenan acting secretary of homeland security in April 2019, Jake Tapper, *Kevin McAleenan Resigns as Acting Homeland Security Secretary*, CNN: POLITICS (October 11, 2019, 8:17 PM), [www.cnn.com/2019/10/11/politics/mcaleenan-resigns-](http://www.cnn.com/2019/10/11/politics/mcaleenan-resigns-)

facilities.<sup>43</sup> In a statement made from the White House on July 5, 2019, Trump boasted, “I’ve seen some of those places, and they are run beautifully. . . They’re clean. They’re good. [CBP agents] do a great job.”<sup>44</sup> Vice President Mike Pence also downplayed reports of overcrowding and unsanitary conditions in CBP facilities.<sup>45</sup> After visiting the CBP facility in McAllen, Texas—just eleven days after the congressional visit—Pence publicly remarked, “[W]hat we saw today was a facility that is providing care that every American would be proud of[.]”<sup>46</sup> Likewise, in a press briefing on November 14, 2019, Acting CBP Commissioner Mark Morgan claimed near-complete “success [in] addressing the humanitarian crisis” at the border.<sup>47</sup> Notwithstanding this claim, “the conditions in detention centers remain substandard and dangerous.”<sup>48</sup>

In light of the conflicting statements and reports regarding conditions in CBP facilities, it is clear that third-party oversight is necessary in order to

---

homeland-security-secretary/index.html. Mr. McAleenan resigned from this position on October 11, 2019, *id.*

43. Michael Collins & David Jackson, *Trump Says Detention Facilities ‘Beautifully Run’ After Report Describes Dangerous Conditions*, USA TODAY (July 5, 2019, 5:05 PM), [www.usatoday.com/story/news/politics/2019/07/05/immigration-trump-defends-beautifully-run-detention-facilities/1660455001/](http://www.usatoday.com/story/news/politics/2019/07/05/immigration-trump-defends-beautifully-run-detention-facilities/1660455001/).

44. *Id.*

45. Neil Vigdor, *Pence Defends Conditions at Migrant Detention Centers in Texas*, N.Y. TIMES (July 13, 2019), [www.nytimes.com/2019/07/13/us/mike-pence-border.html](http://www.nytimes.com/2019/07/13/us/mike-pence-border.html).

46. *Id.* In contrast, “[o]ne [press] pool reporter described the stench [in the facility] as ‘horrendous’ — some of the agents wore face masks — and said it was sweltering inside the detention center”, *id.*

47. Press Briefing, Customs & Border Protection, Press Briefing by Acting CBP Commissioner Mark Morgan (Nov. 14, 2019, 10:32 AM), [www.whitehouse.gov/briefings-statements/press-briefing-acting-cbp-commissioner-mark-morgan-2/](http://www.whitehouse.gov/briefings-statements/press-briefing-acting-cbp-commissioner-mark-morgan-2/). Mr. Morgan emphasized the success of the Migrant Protection Protocols, otherwise known as the “Remain in Mexico” program, which requires immigrants to wait in Mexico while their asylum claims are processed in the U.S., *id.*; Camilo Montoya-Galvez, *Immigration Courts Fast-Tracking Hearings for Controversial “Remain in Mexico” Policy*, CBS NEWS (Aug. 23, 2019, 7:53 PM), [www.cbsnews.com/news/remain-in-mexico-immigration-courts-are-fast-tracking-hearings-for-controversial-trump-border-policy/](http://www.cbsnews.com/news/remain-in-mexico-immigration-courts-are-fast-tracking-hearings-for-controversial-trump-border-policy/).

48. Nicole Narea, *The Demise of America’s Asylum System Under Trump Explained*, VOX (Nov. 5, 2019, 12:00 PM), [www.vox.com/2019/11/5/20947938/asylum-system-trump-demise-mexico-el-salvador-honduras-guatemala-immigration-court-border-ice-cbp](http://www.vox.com/2019/11/5/20947938/asylum-system-trump-demise-mexico-el-salvador-honduras-guatemala-immigration-court-border-ice-cbp) (“[M]igrants remain in dangerously overcrowded facilities that were never designed to hold them for days and weeks at a time, sleeping on concrete floors with nothing but mylar blankets.”).

“increase oversight, transparency, and accountability” of CBP and ensure that accurate reports regarding the conditions in CBP facilities are made public.<sup>49</sup> This oversight will spur Congress into action—just as it did when lawmakers visited CBP facilities on July 1, 2019.<sup>50</sup> Just over three weeks after the visits, the U.S. House of Representatives passed H.R. 3239.<sup>51</sup> The speed with which Congress acted thus demonstrates how crucial congressional oversight is to effect change. In turn, this oversight will hold CBP accountable to the minimum health and safety standards laid out in H.R. 3239—ultimately saving lives and preventing illness among detainees.<sup>52</sup> Specifically, the bill “would require all individuals in CBP custody to receive an initial medical screening and would set certain minimum standards of hygiene, nutrition and shelter that CBP must meet.”<sup>53</sup> Furthermore, it “requires written documentation concerning health screenings, medical care, and medications so that upon arrival at an Immigration and Customs Enforcement [“ICE”] or Health and Human Services [“HHS”] facility, and immigrant’s health status is already known, and staff can prepare appropriately.”<sup>54</sup> Perhaps most importantly, H.R. 3239 “requires that each CBP facility include at least one medical professional. . .to conduct health screenings for individuals upon arrival. . .[and] mandates that other

---

49. *Markup Hearing, supra* note 2, at 84-85 (statement of Rep. Sheila Jackson Lee, Member, Comm. on Homeland Sec.); H.R. 3239, §§ 11, 12.

50. ACEVEDO, *supra* note 6.

51. H.R. 3239, 116th Cong. (2019).

52. *See Markup Hearing, supra* note 2, at 12 (statement of Rep. Zoe Lofgren, Chairwoman, H. Subcomm. Immigr. & Citizenship); *see also* Thomas M. Susman, *Congressional Oversight of Homeland Security*, 30 ADMIN & REG. L. NEWS 2, 3 (2004) (“[T]he consequences of failed congressional oversight of homeland security are likely to include not only poorer performance by the agency, increased opportunities for waste, priorities that may be less likely to have public imprimatur, and conflicting or at best uncoordinated signals from Congress[.]”).

53. *Markup Hearing, supra* note 2, at 4 (statement of Rep. Jerrold Nadler, Chairman, H. Judiciary Comm.); *see generally* H.R. 3239.

54. *Markup Hearing, supra* note 2, at 6 (statement of Rep. Jerrold Nadler, Chairman, H. Judiciary Comm.); *see generally* H.R. 3239; *see also* Ron Nixon & Linda Qiu, *What Is ICE and Why Do Critics Want to Abolish It?*, N.Y. TIMES, July 3, 2018, at A18 (stating that ICE takes custody of immigrants after they’re processed by CBP).

emergency care professionals be immediately available so that if a life-threatening situation arises, it can be addressed quickly instead of hours later at a hospital.”<sup>55</sup>

As former U.S. Representative for California’s thirty-third congressional district Henry Waxman once wrote “[A]bsence of oversight invites corruption and mistakes. The Founders correctly perceived that concentration of power leads to abuse of power if unchecked.”<sup>56</sup> In the case of CBP, a complete lack of oversight and transparency has turned deadly.<sup>57</sup> H.R. 3239 “will help make certain that no other child or parent dies for lack of an appropriate medical screening or access to medical care” by laying out uniform, ethical standards.<sup>58</sup> In combination with these standards, mandatory congressional oversight and subsequent investigations by the GAO and DHS Inspector General will ensure that CBP can no longer hide in the shadows and cover up misconduct. This assured accountability will thus improve conditions in CBP facilities.

*H.R. 3239 Will Provide A Uniform, Judicially Enforceable Policy*

H.R. 3239 provides a judicially enforceable cause of action which individuals may choose to pursue should CBP fail to comply with enumerated standards—an option which does not currently exist in the legal landscape today. The only guidelines CBP has in place—the “National Standards on Transport, Escort, Detention, and Search” Standards (“TEDS

---

55. *Markup Hearing, supra* note 2, at 13 (statement of Rep. Zoe Lofgren, Chairwoman, H. Subcomm. Immigr. & Citizenship); H.R. 3239, § 2.

56. SUSMAN, *supra* note 52, at 3 (citing Letter from Henry A. Waxman (D-CA), Ranking Minority Member, House Comm. on Gov’t Reform, to Tom Davis, Chairman (R-VA), House Comm. on Gov’t Reform (May 4, 2004)); *see generally* Jonathan Weisman, *Henry Waxman Key Democrat and Force for Health Care Law Is to Retire*, N.Y. TIMES, Jan. 30, 2014, at A16 (“Representative Henry A. Waxman of California, [was] a diminutive Democratic giant whose 40 years in the House produced some of the most important legislation of the era[.]”).

57. *See Markup Hearing, supra* note 2, at 4 (statement of Rep. Jerrold Nadler, Chairman, H. Judiciary Comm.).

58. *See id.*; *see also* H.R. 3239.

Standards”) —were published in October 2015.<sup>59</sup> The TEDS Standards purport to govern the conditions, resources, and medical treatment which CBP provides to children and other immigrants while in the agency’s custody.<sup>60</sup> Although CBP has this internal policy in place relating to detention conditions to protect detainees in detention facilities, “[CBP] was not previously—nor is it now—in compliance with its own guidance[.]”<sup>61</sup> This noncompliance stems from one critical loophole regarding the TEDS Standards—they are *not binding* on CBP.<sup>62</sup> That is to say, the TEDS Standards are not judicially enforceable against CBP.<sup>63</sup>

This shortcoming is most recently addressed in Rosa v. McAleenan.<sup>64</sup> In Rosa, petitioners alleged “that CBP violated the [Administrative Procedure Act (“APA”)] by holding detained aliens in CBP holding rooms for longer than 72 hours, and by maintaining substandard conditions in violation of CBP’s own TEDS Standards.”<sup>65</sup> Specifically, petitioners alleged defendants

---

59. See *CBP TEDS Standards*, *supra* note 12, at 1.

60. See *id.* at 3.

61. Guillermo Cantor, *Detained Beyond the Limit: Prolonged Confinement by U.S. Customs and Border Protection Along the Southwest Border*, AM. IMMIGR. COUNCIL (Aug. 18, 2016), [www.americanimmigrationcouncil.org/research/prolonged-detention-us-customs-border-protection](http://www.americanimmigrationcouncil.org/research/prolonged-detention-us-customs-border-protection).

62. *Rosa v. McAleenan*, No. 1:19-CV-00138, 2019 WL 5191095, at \*20 (S.D. Tex., Oct. 15, 2019) (“[T]he TEDS Standards on which Petitioners rely [do] not resemble the binding directives.”).

63. *Id.*

64. *Id.* at \*16-17.

65. *Id.* at \*19.



violated the [m]edical [c]are<sup>66</sup> . . . [t]emperature<sup>67</sup> . . . [h]ygiene<sup>68</sup> . . . [f]ood<sup>69</sup> . . . [w]ater<sup>70</sup> . . . [and] [c]leanliness<sup>71</sup>“ provisions of the TEDS Standards. The Court concurred and noted that, in the first half of 2019, “the conditions at CBP [facilities] deteriorated and reached levels that did not comply with the TEDS Standards.”<sup>72</sup> However, the Court found that “the TEDS Standards [do] not have the force of law or create legal rights or obligations between CBP and the public and, as a result, represent[] a policy statement.”<sup>73</sup> Further, the Court specifically noted that “the ‘only agency action that can be compelled under the APA is action legally required.’”<sup>74</sup> In making its finding, the Court noted that the TEDS Standards explicitly include language which foresees that “goal[s] may not always be met.”<sup>75</sup> For this reason, the Court dismissed the petitioners’ claim.<sup>76</sup> Accordingly, because CBP’s own standards are not judicially enforceable as demonstrated in Rosa, H.R. 3239

66. *Id.* at \*4 (“[I]f officers/agents suspect that a detainee has an observed or reported medical condition, such as a contagious disease, appropriate protective precautions must be taken.”) (citing CBP TEDS Standards, *supra* note 12, at § 4.3). However, in regards to other “observed or reported injuries or illnesses”, the policy states only that “appropriate medical care should be provided or sought in a *timely manner*”, *id.* (emphasis added).

67. *Id.* at \*5 (citing CBP TEDS Standards, *supra* note 12, at § 4.7). Notably, the policy gives a vague description of CBP facility temperature requirements, stating only that “officers/agents should maintain hold room temperature within a reasonable and comfortable range”, *id.*

68. *Id.* (citing CBP TEDS Standards, *supra* note 12, at § 4.11). Only “*reasonable efforts*” are required to be made in providing detainees “who are approaching 72 hours in detention” with “showers, soap, and . . . clean towel[s]”, *id.* (emphasis added). No requirements are given for providing such materials to detainees who are held in CBP facilities for less than seventy-two hours, *id.*

69. *Id.* (citing CBP TEDS Standards, *supra* note 12, at § 4.13). Detainees are to receive “food at regularly scheduled meal times” and “snacks between regularly scheduled meal times”, but there are no dietary guidelines for what food they are to be provided with, *id.*

70. *Id.* (citing CBP TEDS Standards, *supra* note 12, at § 4.14) (“Functioning drinking fountains *or* clean drinking water along with clean drinking cups must always be available to detainees.”) (emphasis added).

71. *Id.* (citing CBP TEDS Standards, *supra* note 12, at § 4.7). The facilities or hold rooms are to be “regularly and professionally cleaned and sanitized”, but the terms “regularly” and “professionally” are not defined, *id.*

72. *Rosa*, No. 1:19-CV-00138, 2019 WL 5191095, at \*7 (S.D. Tex., Oct. 15, 2019).

73. *Id.*

74. *Id.*

75. *Id.*

76. *Id.*

is necessary to protect immigrants detained in CBP facilities.<sup>77</sup>

Not only are CBP’s internal guidelines judicially unenforceable, there also appears to be no effective legal remedy to alleviate the issues in CBP facilities—even via traditional legal routes.<sup>78</sup> As demonstrated in Doe v. Kelly, this is particularly true for adult detainees in CBP facilities.<sup>79</sup> In Doe, plaintiffs—two women who were detained in the Tucson Border Patrol Station as well as a Tucson man detained twice in that facility—filed a class-action lawsuit challenging detention conditions in CBP detention facilities in the Tucson sector.<sup>80</sup> On November 18, 2016, the district court granted plaintiffs’ motion for preliminary injunction and ordered defendants to “provide all *class members* detained for 12 or more hours with a mat to sleep on, supply sufficient toiletries and bathing wipes to all *class members*, and ensure that all were provided meals at regular intervals and clean drinking water.”<sup>81</sup> On appeal, plaintiffs argued that “the district court should have required Defendants to provide detainees with beds, showers, and medical treatment provided by medical professionals.”<sup>82</sup> Unpersuaded by this argument, the appellate court affirmed the district court’s ruling on appeal.<sup>83</sup> The case remains active as of December 2019, but the district court denied plaintiffs’ motion for partial summary judgment which argued that “degrading and unsanitary conditions” in CBP facilities “deprive [c]lass

---

77. *Id.*

78. Nomaan Merchant, *Border Patrol Detains Adults with No End – Until Lawyers Sue*, AP NEWS (July 30, 2019), <https://apnews.com/4a7225271a03434db2634c3ac95fdc60>.

79. *Id.*

80. *Doe v. Kelly*, 878 F.3d 710, 725 (9th Cir. 2017); *Challenging Unconstitutional Conditions in CBP Detention Facilities*, AM. IMMIGR. COUNCIL: LITIG., <https://americanimmigrationcouncil.org/litigation/challenging-unconstitutional-conditions-cbp-detention-facilities> (“The complaint allege[d] that Tucson Sector Border Patrol holds men, women, and children in freezing, overcrowded, and filthy cells for days at a time in violation of the U.S. Constitution.”).

81. *Challenging Unconstitutional Conditions in CBP Detention Facilities*, *supra* note 80 (emphasis added).

82. *Doe*, 878 F.3d at 725.

83. *Id.*

[m]embers of their constitutional right to sleep.”<sup>84</sup> Doe demonstrates what limited judicial relief is available to adult detainees who are forced to endure CBP conditions.<sup>85</sup>

In comparison, immigrant children in CBP custody are provided *slightly* more protections—for now at least.<sup>86</sup> On August 15, 2019, a three-judge panel in the Ninth Circuit affirmed the lower court’s decision and held that “[CBP] must provide basic hygiene products, nutrition and adequate sleeping accommodations to immigrant children in its custody[.]”<sup>87</sup> Both courts relied on a specific provision of “the 1997 Flores settlement agreement [(“Flores settlement”)], which. . .requir[es] that immigrant children be held in ‘facilities that are safe and sanitary.’”<sup>88</sup> The Flores settlement stems from a class action suit in California federal court which was appealed to the Supreme Court.<sup>89</sup> In 1997, the parties signed the settlement agreement which “has governed the treatment of [im]migrant children in detention ever since.”<sup>90</sup> However, the Trump administration has recently taken active steps to end the long-standing agreement.<sup>91</sup> As a result the Flores settlement seems

---

84. Unknown Parties v. Nielsen, No. CV-15-00250-TUC-DCB, 2019 WL 1227217, at \*1 (D. Ariz. Mar. 15, 2019).

85. *See id.*

86. *See* Emma Cueto, *Feds Will Appeal Block of Migrant Child Detention Regulations*, L. 360 (Nov. 15, 2019, 2:07 PM), [www.law360.com/california/articles/1220178/feds-will-appeal-block-of-migrant-child-detention-regulations](http://www.law360.com/california/articles/1220178/feds-will-appeal-block-of-migrant-child-detention-regulations); *see also* Nicole Narea, *Detained Migrant Kids Must Get Basic Amenities: 9th Circ.*, L. 360 (Aug. 15, 2019, 2:13 PM), [www.law360.com/articles/1189205](http://www.law360.com/articles/1189205).

87. Nicole Narea, *Detained Migrant Kids Must Get Basic Amenities: 9th Circ.*, L. 360 (Aug. 15, 2019, 2:13 PM), [www.law360.com/articles/1189205](http://www.law360.com/articles/1189205).

88. *Id.*

89. Audie Cornish, *The History of the Flores Settlement and Its Effects On Immigration*, NPR (June 22, 2018, 4:24 PM), [www.npr.org/2018/06/22/622678753/the-history-of-the-flores-settlement-and-its-effects-on-immigration](http://www.npr.org/2018/06/22/622678753/the-history-of-the-flores-settlement-and-its-effects-on-immigration); Ken White, *Why a Government Lawyer Argued Against Giving Immigrant Kids Toothbrushes*, THE ATL. (June 23, 2019), [www.theatlantic.com/ideas/archive/2019/06/why-sarah-fabian-argued-against-giving-kids-toothbrushes/592366/](http://www.theatlantic.com/ideas/archive/2019/06/why-sarah-fabian-argued-against-giving-kids-toothbrushes/592366/) (“[Ken White is an] [a]ttorney and former federal prosecutor.”).

90. White, *supra* note 89 (outlining the conditions and length of time immigrant children are permitted to be detained in facilities by the government). The Flores settlement has been revisited multiple times since 1997, *id.*

91. *Id.*; *see also* Daniel González, *What Exactly Is the Flores Settlement? How Is the Trump Administration Trying to End It?*, ARIZ. REPUBLIC (Aug. 26, 2019, 9:00 AM), [www.azcentral.com/story/news/politics/immigration/2019/08/26/what-exactly-flores-](http://www.azcentral.com/story/news/politics/immigration/2019/08/26/what-exactly-flores-)

to be hanging on by a thread—U.S. District Judge Dolly Gee and the appellate judges in the Ninth Circuit appear to be the only ones preventing the Trump administration from eliminating those minimum standards of care for immigrant children in government custody.<sup>92</sup>

Accordingly, Congress should enact H.R. 3239 as it would supply individuals with a judicially enforceable cause of action for which they could obtain relief should CBP fail to comply with the minimum health and safety standards. Further, because it would require congressional action to change, rather than the decision of a judge, the bill would provide stable protection to immigrants in custody. As H.R. 3239 applies to all detainees in CBP custody, it would provide both adults and children the comprehensive set of protections that they need.<sup>93</sup>

#### *Opposition to H.R. 3239*

Opponents of H.R. 3239 contend that the bill “will do absolutely nothing to address the root causes of the crisis [at the southern border].”<sup>94</sup> This argument fails, however, because it does not take into consideration the underlying motivation for the bill, nor the limited nature of the standards which the bill actually sets.<sup>95</sup> For over a decade, advocacy organizations have reported that the medical care provided to people in CBP custody is inadequate or nonexistent.<sup>96</sup> In the span of a year, CBP’s failure to provide

---

settlement-what-you-need-know-asylum-immigration-migrant-children/2088464001/.

92. Cueto, *supra* note 86.

93. Cornish, *supra* note 89; Sarah Martinson, *CBP Denying Medical Care to Sick Children Advocates Say*, L. 360 (Sept. 4, 2019, 9:07 PM), [www.law360.com/articles/1195368/cbp-denying-medical-care-to-sick-children-advocates-say](http://www.law360.com/articles/1195368/cbp-denying-medical-care-to-sick-children-advocates-say).

94. *Markup Hearing*, *supra* note 2, at 8 (statement of Rep. Doug Collins, Ranking Member, H. Judiciary Comm. Republicans).

95. Dara Lind, *The Crisis of Children Dying in Custody at the Border, Explained*, VOX (May 22, 2019, 10:40 AM), [www.vox.com/2019/5/22/18632936/child-died-border-toddler-patrol-three-five](http://www.vox.com/2019/5/22/18632936/child-died-border-toddler-patrol-three-five).

96. Sheri Fink & Caitlin Dickerson, *Border Patrol Facilities Put Detainees with Medical Conditions at Risk*, N.Y. TIMES, Mar. 5, 2019, at A1. Only about six percent of CBP

proper medical care to its detainees has turned from unethical to deadly to a full-blown humanitarian crisis.<sup>97</sup> Indeed, “[t]his isn’t a problem in the future. It is a problem *right now*. And if we don’t act now. . .our failure risks the deaths of more innocent children.”<sup>98</sup> The urgency of this crisis is precisely the catalyst which prompted lawmakers to propose H.R. 3239.<sup>99</sup> Thus, although H.R. 3239 does not cure the undoubtedly broken U.S. immigration system, it “is the *first step* in preventing additional deaths by ensuring that individuals are held in humane conditions and have access to basic medical care when circumstances warrant.”<sup>100</sup> Moreover, the bill does not mandate CBP to provide frivolous or unnecessary medical treatment.<sup>101</sup> It merely sets bare minimum standards regarding health screenings, medical care, and medications in order address the *emergent* medical needs of detainees in CBP custody.<sup>102</sup> Finally, the additional provisions regarding basic water,

---

agents can act as emergency medical services providers while the vast majority only have “basic training.”

97. Lucas Guttentag, *Crisis at the Border? An Update on Immigration Policy with Stanford’s Lucas Guttentag: Q&A with Sharon Driscoli*, STAN. L. SCH. (April 22, 2019), <https://law.stanford.edu/2019/04/22/crisis-at-the-border-an-update-on-immigration-policy-with-stanfords-lucas-guttentag/>. As professor Lucas Guttentag, a U.S. immigration expert, said in an interview on April 22, 2019, “[t]he ‘crisis’ at the border is not the numbers who are arriving but the system’s failure to respond in a humane, efficient, and orderly way in light of the government’s legal obligations and the number of immigrants who are seeking protection”, *id.* Professor Guttentag was the founder and former national director of the American Civil Liberties Union Immigrants’ Rights Project who served as a senior immigration advisor at the DHS from 2014 to 2016, *id.*

98. *Markup Hearing*, *supra* note 2, at 28 (statement of Rep. Lucy McBath, Member, H. Judiciary Comm.) (emphasis added); FINK & DICKERSON, *supra* note 96, at A1 (“[Imm]igrants crossing the border from Mexico may be injured. . .They may be suffering from dehydration, heat exhaustion or communicable illnesses. . .that often spread in conditions of close confinement. . .Some require medications for chronic diseases such as asthma, diabetes and high blood pressure.”).

99. H.R. 3239, 116th Cong. (2019).

100. *Markup Hearing*, *supra* note 2, at 6 (statement of Rep. Jerrold Nadler, Chairman, H. Judiciary Comm.) (emphasis added).

101. H.R. 3239, 116th Cong. (2019).

102. *Markup Hearing*, *supra* note 2, at 4 (statement of Rep. Jerrold Nadler, Chairman, H. Judiciary Comm.). H.R. 3239 only requires an initial screening and medical assessment of all detainees to be performed for three clear objectives: (1) to assess and identify any illness, condition, or . . .symptoms that may have resulted from. . .traumatic experiences; (2) to identify acute conditions and high-risk vulnerabilities; and (3) to ensure that appropriate healthcare is provided. . .as needed”, H.R. 3239, 116th Cong. (2019) §§ 2(b), 2(c).

sanitation, hygiene, food, nutrition, and shelter standards are not only incontrovertibly minimum ethical requirements, but also, they are required pursuant to international treaty obligations.<sup>103</sup>

### III. CONCLUSION

Numerous sources including Human Rights Watch, physicians, attorneys, lawmakers, journalists, a federal government watchdog, and even CBP agents themselves, describe the conditions in CBP immigrant detention facilities as deeply inadequate and dangerous.<sup>104</sup> Complaints filed in recent years include a mother describing how she gave birth prematurely and was later forced to stay with the baby in a “dirty hold room,” a detainee who was refused access to prescribed medication, and a woman who was suffering from injuries following a sexual assault but did not receive any medical attention.<sup>105</sup> The inability to house an adapting immigrant population has caused CBP facilities to become dangerously overcrowded.<sup>106</sup> Although H.R. 3239 does not correct the factors which contributed to the influx of immigrant families in recent years, it does set minimum health and safety standards and employ third-party oversight mechanisms to ensure CBP cooperation. Accordingly, Congress should enact the

---

103. Felice D. Gaer, *Top Expert Backgrounder: Children in Immigration Detention – What Are the International Norms?*, JUST SEC. (July 1, 2019), [www.justsecurity.org/64765/top-expert-backgrounder-children-in-immigration-detention-what-are-the-international-norms/](http://www.justsecurity.org/64765/top-expert-backgrounder-children-in-immigration-detention-what-are-the-international-norms/). The U.S. has ratified two international human rights treaties which specify that the state must treat all persons who have lost their liberty, and are in the state’s custody, humanely, *id.* Both the International Covenant on Civil and Political Rights and the Convention against Torture and Other Forms of Cruel, Inhuman and Degrading Treatment or Punishment set out guidance on minimal conditions for persons who have been detained or imprisoned including the need to provide for their personal hygiene, clothing, food, water, accommodations, and more, *id.*

104. *Id.*; Ariana Sawyer, *Trump Administration Blocks Needed Oversight of Immigration Detention*, HUM. RTS. WATCH (Sept. 4, 2019, 9:03 AM), [www.hrw.org/news/2019/09/04/trump-administration-blocks-needed-oversight-immigration-detention](http://www.hrw.org/news/2019/09/04/trump-administration-blocks-needed-oversight-immigration-detention).

105. FINK & DICKERSON, *supra* note 96, at A1.

106. GALVAN, *supra* note 8.

Humanitarian Standards to Individuals in Customs and Border Protection Custody Act without delay or risk more unnecessary fatalities in CBP detention centers.

# Healthcare for Justice-Involved Individuals: The Difference by State

*Juliano Florio*

Over 2.3 million individuals are currently incarcerated in the United States of America, but in comparison to each other, these individuals do not receive equal, or even similar, health care services.<sup>1</sup> The Supreme Court in *Estelle v. Gamble* guaranteed healthcare for all incarcerated individuals; however, the extent of that healthcare is at the discretion of the state in which the individual is incarcerated.<sup>2</sup> This is because *Estelle v. Gamble* simply states that, “[i] a state elects to impose imprisonment as a punishment for crime . . . it has an obligation to provide the persons in its custody with a health care system which meets minimal standards of adequacy.”<sup>3</sup> Currently, each state varies on the amount that they spend on healthcare for justice-involved individuals.<sup>4</sup> In 2015, California spent an average of \$19,796 per justice-involved individual, while Louisiana’s average spending was only \$2,173.<sup>5</sup> In addition to differences in healthcare spending: wait times, copayments, and adequacy of medical staff also vary by state.<sup>6</sup>

The principle of equivalence is the idea that prisoners are entitled to the

---

1. Wendy Sawyer & Peter Wagner, *Mass Incarceration: The Whole Pie 2019*, PRISON POLICY INITIATIVE (Mar. 19, 2019) [www.prisonpolicy.org/reports/pie2019.html](http://www.prisonpolicy.org/reports/pie2019.html).

2. Joao F. Gomes et al., *The Current State of Public and Private Prison Healthcare*, WHARTON PUBLIC POLICY INITIATIVE (Feb. 24, 2017) [www.publicpolicy.wharton.upenn.edu/live/news/1736-the-current-state-of-public-and-private-prison](http://www.publicpolicy.wharton.upenn.edu/live/news/1736-the-current-state-of-public-and-private-prison).

3. *Estelle, Corrections Director v. Gamble*, 429 U.S. 97, 116 (1976).

4. Matt McKillop, *Prison Health Care Spending Varies Dramatically by State*, PEW (Dec. 15, 2017) [www.pewtrusts.org/en/research-and-analysis/articles/2017/12/15/prison-health-care-spending-varies-dramatically-by-state](http://www.pewtrusts.org/en/research-and-analysis/articles/2017/12/15/prison-health-care-spending-varies-dramatically-by-state).

5. *Id.*

6. *Id.*



same standard of healthcare as the general public without discrimination.<sup>7</sup> Although it is not referred to specifically as the principle of equivalence, it appears that this principle is applied in a few of the states' incarceration programs.<sup>8</sup> Applying the principle of equivalence, in addition to more uniform healthcare coverage for justice-involved individuals regardless of their location, would be beneficial to our country as a whole. For example, studies on recidivism show that justice-involved individuals that receive mental health treatment, which is included in some states' penal healthcare systems, during and after their sentences are less likely to re-offend.<sup>9</sup> The United States' recidivism rate is forty-three percent; which is an issue worth addressing.<sup>10</sup> Improving the healthcare standards used in prisons is also very important because upon return to the community, previously incarcerated individuals are capable of spreading untreated medical conditions, such as HIV/AIDS, tuberculosis, and others, to the general public.<sup>11</sup>

The aim of my article is to examine what factors have caused the massive differential in states' penal healthcare systems in an attempt to narrow it. California is a key state to focus on because not only does California spend the most on their inmates' healthcare, but California has recently made changes to their penal system's healthcare in response to it being deemed unconstitutional in 2006.<sup>12</sup> Louisiana is a key state to contrast because

---

7. *Id.*

8. *Id.*

9. Jo Sahlin, *The Prison Problem: Recidivism Rates and Mental Health*, GOODTHERAPY (May 20, 2018) [www.goodtherapy.org/blog/prison-problem-recidivism-rates-mental-health-0520187](http://www.goodtherapy.org/blog/prison-problem-recidivism-rates-mental-health-0520187).

10. Jeremiah Agenyi, *Recidivism in the United States – An Overview*, ATLAS CORPS, (May 31, 2017) [www.atlascorps.org/recidivism-united-states-overview/](http://www.atlascorps.org/recidivism-united-states-overview/).

11. McKillop, *supra* note 4.

12. Christopher Wayne McGuinness, *Captive Patient: Medical Care in California's Prisons and Jails*, USC ANNENBERG CENTER FOR HEALTH JOURNALISM (Oct. 19, 2017) (explaining that medical care for inmates was placed into receivership after a federal court ruled it unconstitutional).

Louisiana spends the least on their inmates' healthcare.<sup>13</sup> Louisiana's penal system is also known for having various issues including poor-quality healthcare and disproportionately high incarceration rates.<sup>14</sup> Shockingly, Louisiana's incarceration rate is nearly five times that of Iran's, thirteen times that of China's, and twenty times that of Germany's.<sup>15</sup> The major differences in California and Louisiana's penal healthcare systems can be attributed to three main factors: overcrowding, staffing, and financial budgets.<sup>16</sup> Removing copayments, reducing the overall number of inmates in each prison, and providing an adequate level of staffing are three changes that Louisiana's penal system can take to be more on par with California's penal system.

Although the median amount of per-inmate healthcare spending by state is \$5,720, some states, such as Louisiana, fall far below this threshold while some states, such as California, greatly exceed it.<sup>17</sup> California's spending for justice-involved individuals healthcare is \$14,076 above the country's median whereas Louisiana's is \$3,547 below the country's median.<sup>18</sup> Subsequently, California spends \$17,623 more than Louisiana does on healthcare per inmate.<sup>19</sup> Because of the different budgets allocated to prisons in these two states, the prison systems in California and Louisiana differ

---

13. McKillop, *supra* note 4.

14. Cindy Chang, *Louisiana is the World's Prison Capital*, THE NEW ORLEANS ADVOCATE (May 13, 2012) [www.nola.com/news/crime\\_police/article\\_8feef59a-1196-5988-9128-1e8e7c9aefda.html](http://www.nola.com/news/crime_police/article_8feef59a-1196-5988-9128-1e8e7c9aefda.html).

15. McKillop, *supra* note 4.

16. *Recent Report Compares California Inmate Health Care Costs to Rest of Nation*, LEGISLATIVE ANALYST'S OFFICE (Jan 18, 2018) [www.lao.ca.gov/Publications/Report/3733](http://www.lao.ca.gov/Publications/Report/3733); Gabby Galvin, *Underfunded, Overcrowded State Prisons Struggle with Reform*, US NEWS (July 26, 2017) [www.usnews.com/news/best-states/articles/2017-07-26/understaffed-and-overcrowded-state-prisons-crippled-by-budget-constraints-bad-leadership](http://www.usnews.com/news/best-states/articles/2017-07-26/understaffed-and-overcrowded-state-prisons-crippled-by-budget-constraints-bad-leadership).

17. *Prison Health Care Costs and Quality: How and why states strive for high-performing systems* PEW (Oct. 18, 2017) [www.pewtrusts.org/en/research-and-analysis/reports/2017/10/prison-health-care-costs-and-quality](http://www.pewtrusts.org/en/research-and-analysis/reports/2017/10/prison-health-care-costs-and-quality).

18. *Id.*

19. *Id.*

greatly. California's 35 penal facilities are home to over 183,000 individuals.<sup>20</sup> In comparison, Louisiana maintains only 9 penal facilities,<sup>21</sup> but Louisiana's penal facilities are home to over 40,000 individuals.<sup>22</sup> The overpopulation of prisons can have a devastating effect on the quality of health care provided, but smaller aspects such as copayments can have a larger impact than most people think.<sup>23</sup>

#### REMOVING COPAYMENTS WILL GREATLY IMPROVE ACCESS TO HEALTHCARE

One factor that affects the quality and accessibility of health care in prisons is copayments. While California has eliminated medical copayments for justice-involved individuals, Louisiana still requires them.<sup>24</sup> The California Correctional Health Care Services department stated that, "copayments may hinder patients from seeking care for health issues which, without early detection and intervention, may become exacerbated, resulting in decreased treatment efficacy and/or increased treatment cost."<sup>25</sup> An internal review of California's prisons found that these copayments amounted to nearly \$460,000 in the 2018 fiscal year.<sup>26</sup> In order to pay these copayments, a fee is added to the individual inmate's account, but if the inmate has no available finances, there is no charge assessed.<sup>27</sup> Removing these copayments will not only reduce financial strain on California's justice-involved population but will also make individuals more likely to seek necessary health care services

---

20. McGuinness, *supra* note 12.

21. *List of Louisiana State Prisons*, REVOLVY [www.revolv.com/page/List-of-Louisiana-state-prisons](http://www.revolv.com/page/List-of-Louisiana-state-prisons) (last visited Oct. 19, 2019).

22. Chang, *supra* note 14.

23. Bryan Anderson, *Medical Visits to be Free for California Prison Inmates as \$5 Copays are Dropped*, THE SACRAMENTO BEE (Feb. 21, 2019, 12:06 PM) [www.sacbee.com/news/politics-government/capitol-alert/article226572054.html](http://www.sacbee.com/news/politics-government/capitol-alert/article226572054.html).

24. *Id.*

25. *Id.*

26. *Id.*

27. *Id.*

and decrease the amount that the state would inevitably spend treating persistent medical conditions in the long-term.<sup>28</sup>

Even when copayments are not an issue, an inmate's request for medical attention may be delayed or denied.<sup>29</sup> In an attempt to provide necessary and timely health care, California has created an algorithm to identify at-risk patients and has assigned these specific inmates registered nurses that are required to check in with them on a regular basis.<sup>30</sup> California has also placed great emphasis on providing mental health care for inmates that are struggling with a serious mental disorder.<sup>31</sup> More than thirty percent of the individuals that were in California's penal system in 2014 received care for mental disorders.<sup>32</sup> In April of 2013, twenty-five percent of California's incarcerated population received care for mental disorders.<sup>33</sup> This demonstrates a five percent increase in less than one year, proving that California is currently improving their penal system's healthcare availability.<sup>34</sup>

Conversely, individuals in Louisiana's penal system must wait to receive vital medical attention while some of them never receive it at all.<sup>35</sup> The

---

28. *Id.*

29. Christie Thompson & Taylor Elizabeth Eldridge, *Treatment Denied: The Mental Health Crisis in Federal Prisons*, THE MARSHALL PROJECT (Nov. 11, 2018) [www.themarshallproject.org/2018/11/21/treatment-denied-the-mental-health-crisis-in-federal-prisons](http://www.themarshallproject.org/2018/11/21/treatment-denied-the-mental-health-crisis-in-federal-prisons).

30. *State Prisons and the Delivery of Hospital Care: How states set up and finance off-site care for incarcerated individuals*, PEW (July 19, 2018) [www.pewtrusts.org/en/research-and-analysis/reports/2018/07/19/state-prisons-and-the-delivery-of-hospital-care](http://www.pewtrusts.org/en/research-and-analysis/reports/2018/07/19/state-prisons-and-the-delivery-of-hospital-care).

31. Thompson & Eldridge, *supra* note 29.

32. Thompson & Eldridge, *supra* note 29.

33. Scott Graves, *Most State Corrections Spending Supports Prison Operations or Health-Related Services, Including Mental Health Care*, CALIFORNIA BUDGET & POLICY CENTER (April 2019) [www.calbudgetcenter.org/resources/most-state-corrections-spending-supports-prison-operations-or-health-related-services-including-mental-health-care/](http://www.calbudgetcenter.org/resources/most-state-corrections-spending-supports-prison-operations-or-health-related-services-including-mental-health-care/).

34. *Id.*

35. Arvind Dilawar, 'Cruel and Unusual Punishment': *The Questionable State of Medical Care at Louisiana State Penitentiary*, PACIFIC STANDARD (Oct. 19, 2018) [www.psmag.com/social-justice/the-questionable-state-of-medical-care-at-louisiana-state-penitentiary](http://www.psmag.com/social-justice/the-questionable-state-of-medical-care-at-louisiana-state-penitentiary) (the prison's nickname, Angola, is supposedly a reference to the area in Africa).

Louisiana State Penitentiary, better known as Angola, is currently fighting a class action lawsuit which purports that conditions are so bad in this specific prison that it constitutes a violation of the Eight Amendment's prohibition against cruel and unusual punishment.<sup>36</sup> Some of the most heinous allegations against Angola, and in turn against the Louisiana Department of Public Safety and Corrections, include refusing medical attention to an inmate experiencing a stroke, preventing an inmate with cancer from seeing an oncologist for over four years, and refusing to provide a cane to a blind inmate for almost two decades.<sup>37</sup> Mercedes Montagnes, the executive director of The Promise of Justice Network, stated that, "people incarcerated at Angola have suffered from permanent injury and death as a result of prison officials."<sup>38</sup> When reviewing 28 deaths that occurred at Angola, experts determined that that all but two of those deaths were "preceded by serious medical negligence".<sup>39</sup> This medical negligence includes, but is not limited to delays in medical diagnosis, failures to provide treatment, and denial of timely hospital transport.<sup>40</sup> Inmates at Angola that have access to doctors did not receive basic diagnostic checks such as physicals, medical history reviews, or testing.<sup>41</sup> Many of these requests were simply ignored.<sup>42</sup> Treating inmates' mental health problems does not seem to be a focus of Louisiana's penal system either.<sup>43</sup> The current warden of Angola, Dennis Grimes, has

---

where its former slaves came from).

36. *Id.*

37. *Id.*

38. *Id.*

39. Dilawar, *supra* note 35; *see also* Chang, *supra* note 14 (explaining that the suit claims that the medical care at Angola became significantly worse upon the closing of Earl K. Long Medical Center).

40. Dilawar, *supra* note 35; Chang, *supra* note 14.

41. Dilawar, *supra* note 35; Chang, *supra* note 14.

42. Dilawar, *supra* note 35; Chang, *supra* note 14.

43. Melissa Fares & Charles Levinson, *Special Report: In Louisiana Jail, Deaths Mount as Mental Health Pleas Unheeded*, REUTERS (May 31, 2018) [www.reuters.com/article/us-usa-jails-louisiana-specialreport/special-report-in-louisiana-jail-deaths-mount-as-mental-health-pleas-unheeded-idUSKCN1IW1G4](http://www.reuters.com/article/us-usa-jails-louisiana-specialreport/special-report-in-louisiana-jail-deaths-mount-as-mental-health-pleas-unheeded-idUSKCN1IW1G4).

stated, “the prison is equipped to deal with disciplinary behavior, not mental health patients. It doesn’t have the things that it really needs in order to function for those who have a mental health problem.”<sup>44</sup> While the mental well-being of inmates should be a major focus, it seems that it is simply being ignored due to underfunding.

REDUCING OVERCROWDING IN PRISONS IS ESSENTIAL TO A SUCCESSFUL  
PENAL SYSTEM

The United States prison population as a whole increased at an astounding rate between the 1970s and 1990s due to America’s “war on drugs”.<sup>45</sup> Jurisdictions that abolished parole while keeping life sentences have experienced a particularly high increase in prison populations as well.<sup>46</sup> Of the 2.3 million plus individuals that are currently incarcerated in the United States, approximately 1.36 million are incarcerated in state prisons.<sup>47</sup> Overcrowded conditions in America’s prisons has led to reduced medical attention for inmates and less spending for inmates’ wellbeing, and has also put the lives of correctional officers at risk.<sup>48</sup> Overcrowded prisons make inmate riots and hostage situations much more likely to occur.<sup>49</sup> This is important to note because the most recent major incident occurred at a Louisiana state prison.<sup>50</sup> These incidents are mainly attributed to

---

44. *Id.*

45. Gabby Galvin, *Underfunded, Overcrowded State Prisons Struggle with Reform*, US NEWS (July 26, 2017) [www.usnews.com/news/best-states/articles/2017-07-26/understaffed-and-overcrowded-state-prisons-crippled-by-budget-constraints-bad-leadership](http://www.usnews.com/news/best-states/articles/2017-07-26/understaffed-and-overcrowded-state-prisons-crippled-by-budget-constraints-bad-leadership) (describing how the war on drugs is a campaign focused on discouraging and punishing the use and sale of drugs in the United States).

46. *Overcrowding and Overuse of Imprisonment in the United States*, AMERICAN Civil Liberties Union (May 2015) [www.ohchr.org/Documents/Issues/RuleOfLaw/OverIncarceration/ACLU.pdf](http://www.ohchr.org/Documents/Issues/RuleOfLaw/OverIncarceration/ACLU.pdf).

47. Audrey Williams, *Prison Overcrowding Threatens Public Safety and State Budgets*, AMERICAN LEGISLATIVE EXCHANGE COUNCIL (Apr. 8, 2014) [www.alec.org/article/prison-overcrowding-threatens-public-safety-state-budgets](http://www.alec.org/article/prison-overcrowding-threatens-public-safety-state-budgets).

48. Galvin, *supra* note 45.

49. Galvin, *supra* note 45.

50. Galvin, *supra* note 45.

overcrowding but experts also believe that a lack of overall healthcare plays a role as well.<sup>51</sup> Stephen Hampton, an attorney who has been defending inmates' rights for over fifteen years, stated that "it isn't enough to increase funding for correctional officers".<sup>52</sup> Hampton believes that in order to change the culture of prisons, inmates need access to quality health care and programming, in addition to consistency in how they are treated.<sup>53</sup>

California has recently made an attempt to improve both inmates' access to health care and the overcrowding of prisons.<sup>54</sup> Following a Supreme Court mandate in 2011, California transferred 33,000 nonviolent inmates from state prisons to county prisons.<sup>55</sup> This relocation created less crowded prisons and allowed for more individualistic medical treatment of inmates.<sup>56</sup> Prior to this relocation effort, California's inmate suicide rate was eighty percent higher than the national average and the lack of access to basic health care was cause for approximately one unnecessary death each week.<sup>57</sup> Additionally, the living conditions became so deteriorated in California's prisons that there was even a shortage of beds available for inmates.<sup>58</sup>

---

51. Galvin, *supra* note 45; Fares & Levinson, *supra* note 43.

52. Galvin, *supra* note 45; Fares & Levinson, *supra* note 43.

53. Galvin, *supra* note 45; Shannon Price, *The Problem with Overpopulation in Prisons*, PENN STATE UNIV. (Feb. 3, 2016) [www.sites.psu.edu/ciblog16/2016/02/03/the-problem-with-overpopulation-in-prisons](http://www.sites.psu.edu/ciblog16/2016/02/03/the-problem-with-overpopulation-in-prisons).

54. Galvin, *supra* note 45; Shannon Price, *The Problem with Overpopulation in Prisons*, PENN STATE UNIV. (Feb. 3, 2016) [www.sites.psu.edu/ciblog16/2016/02/03/the-problem-with-overpopulation-in-prisons](http://www.sites.psu.edu/ciblog16/2016/02/03/the-problem-with-overpopulation-in-prisons).

55. Galvin, *supra* note 45; Shannon Price, *The Problem with Overpopulation in Prisons*, PENN STATE UNIV. (Feb. 3, 2016) [www.sites.psu.edu/ciblog16/2016/02/03/the-problem-with-overpopulation-in-prisons](http://www.sites.psu.edu/ciblog16/2016/02/03/the-problem-with-overpopulation-in-prisons).

56. Galvin, *supra* note 45; Shannon Price, *The Problem with Overpopulation in Prisons*, PENN STATE UNIV. (Feb. 3, 2016) [www.sites.psu.edu/ciblog16/2016/02/03/the-problem-with-overpopulation-in-prisons](http://www.sites.psu.edu/ciblog16/2016/02/03/the-problem-with-overpopulation-in-prisons).

57. Galvin, *supra* note 45; Shannon Price, *The Problem with Overpopulation in Prisons*, PENN STATE UNIV. (Feb. 3, 2016) [www.sites.psu.edu/ciblog16/2016/02/03/the-problem-with-overpopulation-in-prisons](http://www.sites.psu.edu/ciblog16/2016/02/03/the-problem-with-overpopulation-in-prisons).

58. Shannon Price, *The Problem with Overpopulation in Prisons*, PENN STATE UNIV. (Feb. 3, 2016) [www.sites.psu.edu/ciblog16/2016/02/03/the-problem-with-overpopulation-in-prisons](http://www.sites.psu.edu/ciblog16/2016/02/03/the-problem-with-overpopulation-in-prisons).

Louisiana has acknowledged that overcrowding of prisons is a serious issue as well and has begun taking action to combat it.<sup>59</sup> In 2017, the Louisiana legislature discussed the state's reputation as the "incarceration capital of the world".<sup>60</sup> In response, ten pieces of legislation were drafted and approved to address this issue.<sup>61</sup> The newly implemented laws will focus on expanding probation and parole opportunities in addition to lessening sentences for nonviolent offenders.<sup>62</sup> The effect of these changes will result in fewer individuals incarcerated in total, which will allow greater accessibility to health care for those individuals that are incarcerated.<sup>63</sup> Louisiana's governor, John Bel Edwards, predicts that the overall prison population in Louisiana will drop by around ten percent over the next decade.<sup>64</sup> Edwards has also stated that the capital saved by implementing these laws will be reinvested in treatment and training programs for inmates.<sup>65</sup> While overcrowding in prisons is a serious issue that can take away from the health care that the justice-involved population receives, it is assuring to see that both California and Louisiana are creating ways to combat it.<sup>66</sup>

#### UNDERSTAFFING AND INADEQUATE STAFFING LEADS TO DIMINISHED HEALTHCARE FOR INMATES

Understaffing and inadequate staffing are also factors that contribute to poor-quality penal healthcare in various states.<sup>67</sup> Lower state budgets for

---

59. R.J. Rico, *Louisiana Lawmakers United on Criminal Justice Overhaul*, U.S. NEWS (June 15, 2017) [www.usnews.com/news/best-states/louisiana/articles/2017-06-15/edwards-to-sign-louisiana-criminal-justice-overhaul-into-law](http://www.usnews.com/news/best-states/louisiana/articles/2017-06-15/edwards-to-sign-louisiana-criminal-justice-overhaul-into-law).

60. *Id.*

61. *Id.*

62. *Id.*

63. Galvin, *supra* note 45; Rico, *supra* note 59.

64. Rico, *supra* note 59.

65. Rico, *supra* note 59.

66. Galvin, *supra* note 45; Rico, *supra* note 59.

67. Price, *supra* note 58.



inmates' healthcare usually equate to less medical staff and/or poorly-trained medical staff.<sup>68</sup> Complaints of poor-quality staffing in the American penal system is nothing new.<sup>69</sup> Experts believe that complaints regarding lack of adequate medical staff in United States prisons can be traced all the way back to 1971 and potentially even earlier.<sup>70</sup> American courts have recently begun taking action to ensure that states are properly, or at least adequately, staffing their prisons with health care personnel.<sup>71</sup>

Following a recent federal mandate, the state of California has been required to increase the number of health care staff at its prisons.<sup>72</sup> Additionally, a separate court order has also required California to make other penal healthcare improvements such as improving most of the medical equipment used in its prisons.<sup>73</sup> These changes have significantly improved the medical staffing and equipment that California's inmates are afforded.<sup>74</sup> In 2015, California employed 69.9 full-time medical staff for every 1,000 individuals in the state's penal system.<sup>75</sup> This ranks the fourth highest of any state.<sup>76</sup> In comparison, Louisiana ranks the third lowest of any state at 23.4 full-time medical staff for every 1,000 justice-involved individuals.<sup>77</sup> A lack of available staffing can impact inmates' wait times as well as the quality of

---

68. Dilawar, *supra* note 35; Legislative Analyst's Office, *supra* note 16; Fares & Levinson, *supra* note 43.

69. Dilawar, *supra* note 35 (during the Attica Prison Uprising in 1971, inmates made multiple complaints about the current prison conditions; some of the most voiced complaints were "inadequate, understaffed, and prejudiced" health care in these prisons).

70. Dilawar, *supra* note 35.

71. Legislative Analyst's Office, *supra* note 16; Price, *supra* note 58.

72. Legislative Analyst's Office, *supra* note 16 (while California has increased the number of healthcare workers in their prisons, we see no evidence that Louisiana has attempted to do the same).

73. Legislative Analyst's Office, *supra* note 16.

74. Legislative Analyst's Office, *supra* note 16. Price, *supra* note 58.

75. Legislative Analyst's Office, *supra* note 16.

76. *Id.*

77. *Id.*

medical attention they receive.<sup>78</sup> When Dennis Grimes, a Louisiana prison warden, was asked about the lack of medical staff in Louisiana’s penal system, he stated, “[they] burn out, they don’t know what to do, they need some relief – and there are no mental health hospitals out there.”<sup>79</sup> One way to fix the apparent fatigue of Louisiana’s healthcare workers would be to hire more; however, this would require more financial investment into the penal system.<sup>80</sup> Given the amount that Louisiana currently allocates to their penal health care system, it would be difficult to hire more employees.

The availability of medical staff and quality of care for inmates correlates with the finances that each particular state allocates to their penal system’s healthcare.<sup>81</sup> Simply put “the more prisoners, the more staff a prison needs, which increases the amount spent on employees.”<sup>82</sup> Therefore, states that allocate little to no money to their inmates’ healthcare typically have significantly worse penal healthcare systems in comparison to those that allocated reasonable amounts.<sup>83</sup> The \$19,796 that California spends each year per inmate’s health care covers the medical staff’s salary, prescription drugs, transportation costs, mental health services, and more.<sup>84</sup> Louisiana only spends an average of \$2,173 per inmate, meaning they have approximately \$17,500 less per inmate to apply to these various healthcare aspects in comparison to California.<sup>85</sup>

#### CONCLUSION

California has taken many progressive steps, some by choice and some by

---

78. Fares & Levinson, *supra* note 43.

79. *Id.*

80. *Id.*

81. Legislative Analyst’s Office, *supra* note 16.

82. Price, *supra* note 58.

83. *Id.*

84. *Id.*

85. *Id.*

mandate, to better their penal healthcare system over the last decade.<sup>86</sup> Louisiana has taken a few steps, such as drafting legislation, to decrease their incarceration rate but they have failed to address many other issues that continue to plague their penal system.<sup>87</sup> Louisiana's penal healthcare system would benefit from observing the changes that California has made over the last decade and attempting to implement similar changes in their own state's prisons.<sup>88</sup> Louisiana investing more capital into their penal system would allow the state to hire more medical personnel, provide better quality-medical care, and fund other penal healthcare programs. Additionally, Louisiana needs to focus on mental health programs for incarcerated individuals. Mental health is a major issue because mental illness can hinder individuals from successfully integrating into the general population upon release from prison.<sup>89</sup> It may not be reasonable for Louisiana to spend an average of \$19,796 per inmate each year; however, strives could be made to be more on par with the current median of \$5,720.<sup>90</sup> An increase of \$3,547 per inmate, the difference between Louisiana's current spending and the national median, would greatly improve Louisiana's penal healthcare system.<sup>91</sup>

---

86. Galvin, *supra* note 45.

87. Rico, *supra* note 59; Dilawar, *supra* note 35.

88. Galvin, *supra* note 45.

89. Sahlin, *supra* note 9.

90. PEW, *supra* note 17.

91. PEW, *supra* note 17.

## Prison Time is Not Treatment: An Argument to Exclude Drug Offenses from Illinois' Three Strikes Law

*Lauren Koch*

The Illinois Habitual Criminal Act (“Act”)<sup>1</sup> dictates that individuals with multiple previous convictions should receive life sentences for subsequent crimes. When Illinois state legislature passed the original habitual offender statute in the 1970’s, the intent was to create a separate sentencing scheme for criminal defendants who have previously demonstrated a propensity to commit “violent crimes.”<sup>2</sup> The legislature sought to appropriately punish criminal defendants who have demonstrated that their prior imprisonment was not effective in deterring them from a life of crime.<sup>3</sup> The Act’s prescribed list of Class X felonies that qualify repeat offenders for a life sentence are largely violent crimes, such as armed robbery and aggravated criminal sexual assault.<sup>4</sup> The singular non-violent offense included in the Act’s sentencing mandate is possession of a controlled substance with the intent to deliver.<sup>5</sup>

Drug felonies should be excluded from the sentencing scheme created by the Act. Drug addiction relapse is incredibly common.<sup>6</sup> In practice, the Act punishes non-violent, drug offenders with life sentences, and fails to provide

---

1. 730 ILL. COMP. STAT. ANN. 5/5-4.5-95 (2019).

2. *People v. Palmer*, 843 N.E.2d 292, 298 (Ill. 2006) (explaining the intent of the state legislature was to consider both the seriousness of the offense, and the assumed rehabilitative potential of offenders).

3. *Id.*

4. 730 ILL. COMP. STAT. ANN. 5/5-4.5-95 (2019).

5. 730 ILL. COMP. STAT. ANN. 5/5-4.5-95 (2019).

6. *See infra* note 65.

treatment options or resources to prevent recidivism.<sup>7</sup> First, I will define “substance use disorder” and explain how substance use relates to the incarcerated population. Then, I will analyze other states’ habitual criminal offender laws and provide some historical context for the creation of these laws within the United States’ “war on drugs.” The shared framework of habitual offender laws fails to rehabilitate offenders with substance use problems going through the process of recovery. Next, I will provide support in favor of a “rehabilitation” approach to drug offenders, rather than continuing to waste taxpayer dollars by funding the failing deterrence approach of increased sentences for these crimes, and harshly penalizing individuals struggling with chronic substance use.

SUBSTANCE USE DISORDER IS ACQUIRED OVER A LIFETIME, NOT A RESULT  
OF POOR LIFESTYLE CHOICE

Substance use disorder is the most prevalent mental illness in the United States with roughly 21.5 million Americans using substances, including tobacco, alcohol or illegal drugs in a harmful way.<sup>8</sup> These harms are significant, deteriorating the quality of our health, educational, and social systems, and debilitating and killing individuals and families through overdoses, impaired accidents, or involvement with the criminal justice system.<sup>9</sup> Unfortunately, it is still common for the general public to consider a substance use disorder as a “bad lifestyle choice” rather than a legitimate

---

7. See *infra* note 30; compare Austin Berg, *What You Need To Know About Marijuana Legalization In Illinois*, ILLINOIS POLICY (June 1, 2019), <http://www.illinoispolicy.org/what-you-need-to-know-about-marijuana-legalization-in-illinois/> (explaining the new Illinois legislation decriminalizing marijuana, including the pardons to be granted for non-violent drug-related criminal offenders).

8. Zili Sloboda et al., PREVENTION OF SUBSTANCE USE, 75 (Zili Sloboda et al. eds. 2019) (citing a 2015 Center for Behavioral Health Statistics and Quality study examining Americans over the age of 12 warranting a substance use disorder diagnosis); see also *infra* note 9.

9. A. Thomas McLellan, *Substance Misuse and Substance Use Disorders*, 128 *Transactions Of The American Clinical & Climatological Assoc.*, 112, 114 (2017).

mental illness.<sup>10</sup> However, recent neurobiological, genetic, and psychological science suggest that substance use disorder is more like an acquired illness, similarly to type 2 diabetes – an illness that can be managed, but not yet completely cured.<sup>11</sup>

The American Psychiatric Association clinically defines a substance use disorder as “a cluster of cognitive, behavioral, and physiological symptoms indicating an individual continues using a substance despite significant substance-related problems.”<sup>12</sup> A mental-health professional will assess a number of criteria when making a substance use disorder diagnosis including the individuals’ unsuccessful efforts to control their problematic use of a substance, social problems resulting because of the substance use, risky use of the substances, and physiologic dependence (withdrawal).<sup>13</sup> Like with other chronic illnesses, the likelihood of an individual developing a substance use disorder depends on a combination of personal and environmental risk factors.<sup>14</sup> Significant environmental risk factors include easy access to inexpensive alcohol, heavy advertising of tobacco and alcohol in the individual’s neighborhood, low levels of parental supervision while growing up, and high levels of family conflict.<sup>15</sup> Major personal risk factors include a family history of substance use or mental health problems, a lack of involvement in school, abuse or neglect, and family conflict and violence.<sup>16</sup> While no single environmental or personal risk factor determines whether an individual will have a substance use problem, individuals are most vulnerable

---

10. *Id.* at 113.

11. *Id.*

12. See Sloboda et al., *supra* note 6, at 76 (citing the Diagnostic and Statistical Manual of Mental Disorders (DSM-5)).

13. Sloboda et al., *supra* note 8, at 76.

14. McLellan, *supra* note 9, at 119.

15. McLellan, *supra* note 9, at 119.

16. McLellan, *supra* note 9, at 119.

during adolescence and young adulthood.<sup>17</sup>

According to data released by the Bureau of Justice, in 2016 there were 1,298,159 prisoners in state prisons, with 15.2% of those prisoners charged with drug offenses.<sup>18</sup> In federal prisons there were 172,554 prisoners, with 47.5% of that population charged with drug offenses.<sup>19</sup> An individual's demographics play an important role in their risk of incarceration.<sup>20</sup> The Executive Office of the President of the United States has summarized the disproportional concentration of incarcerated individuals with substance abuse and mental health issues.<sup>21</sup> This report states that over one-third of the United States' incarcerated population had received public aid at some point in their lives, roughly 15% had spent time in the foster system, and 10% have experienced homelessness in the year prior to their arrest and entrance into prison.<sup>22</sup> It was found that over 50% of the incarcerated population experienced mental health issues.<sup>23</sup> Of this group, over 70% of prisoners self-reported regular drug use and 65% reported alcohol abuse prior to their incarceration.<sup>24</sup>

Further, substance-involved individuals are more likely to recidivate than others who are not struggling with substance abuse.<sup>25</sup> Over 52.2% of substance involved inmates have at least one previous incarceration,

---

17. McLellan, *supra* note 9, at 119.

18. Chelsea Davis, *The Iconic Impact of Substance Use and High Recidivism Rates*, S. Ill. Univ. Carbondale, 1, 4 (2018) (citing statistical data released by the U.S. Bureau of Justice after surveying federal and state prisoners).

19. *See id.* at 4.

20. *Id.*

21. *See id.* at 5 (clarifying that demographics have an important role in an individuals' risk of incarceration, for example this report further found that African American and Hispanic individuals comprise over 50% of the incarcerated population while making up only 30% of the general population).

22. *Id.*

23. *Id.*

24. *Id.*

25. The National Center on Addiction and Substance Abuse at Columbia University, *Behind Bars II: Substance Abuse in America's Prison Population*, i, 3 (Feb. 2010).

compared to the roughly 31% of inmates who are not substance involved.<sup>26</sup> Although over half of all inmates in the United States meet the medical criteria to be diagnosed with a substance abuse disorder, rarely do these incarcerated individuals receive treatment.<sup>27</sup> Addiction remains a highly stigmatized disease, and treatment is not constitutionally guaranteed, unlike the mandated treatment of other medical conditions.<sup>28</sup> Because substance-involved offenders are more than twice as likely to recidivate, this suggests that many returning inmates are rearrested because of their inability to refrain from substance abuse after reentering their communities.

#### HABITUAL CRIMINAL OFFENDER ACTS TARGET SUBSTANCE-INVOLVED INDIVIDUALS UNFAIRLY

Around the 1990's, roughly twenty-five states and the federal government passed laws requiring violent offenders convicted of a third felony to be sentenced to twenty-five years to life in prison without parole.<sup>29</sup> The federal system paved the way for state legislatures to create mandatory sentencing schemes with the passing of the federal Anti-Drug Abuse Act of 1986, and the federal Anti-Drug Abuse Act of 1988.<sup>30</sup> These laws created severe mandatory minimum sentencing requirements for drug offenses.<sup>31</sup> These sentencing mandates prevented judges from using their discretion to consider the wide range of mitigating factors in a case pertaining to an individual and the offense that would otherwise be an important part of the sentencing process.<sup>32</sup> Further, these mandates resulted in rapidly increasing incarcerated

---

26. *Id.* at 5.

27. Davis, *supra* note 16 at 8.

28. Davis, *supra* note 16 at 8.

29. V. Dion Haynes, *States Rethink 3-Strikes Laws*, THE CHICAGO TRIBUNE (Mar. 25, 2002), <http://www.chicagotribune.com/news/et-xpm-2002-03-25-0203250180-story/html>.

30. Marc Mauer, et al., THE SENTENCING PROJECT, A 25-YEAR QUAGMIRE: THE WAR ON DRUGS AND ITS IMPACT ON AMERICAN SOCIETY 7 (2007).

31. *See id.*

32. *Id.*



populations and costs associated with maintaining over-crowded facilities.<sup>33</sup> The expansion of mandatory minimum sentences and the abolition of parole opportunities have resulted in individuals serving longer sentences for drug offenses than before.<sup>34</sup>

While the amount of time served in prison has continued to increase, the severity of the charged conduct has not increased at the same rate.<sup>35</sup> The primary rationale for the federal mandatory sentencing structure was to “create the appropriate incentives for the Department of Justice to direct its most intense focus on major traffickers, and serious traffickers.”<sup>36</sup> These laws were intended to target high-level individuals who were operating a drug manufacturing or distribution network, and use the federal government’s ample resources on sophisticated drug selling enterprises.<sup>37</sup> However, in both state and federal prisons, a majority of prisoners have a criminal history including only drug or non-violent offenses, and were mainly low-level street dealers.<sup>38</sup> These individuals are appropriate candidates for diversion programs out of the traditional incarcerated setting.<sup>39</sup>

California famously had the nation’s toughest three-strikes law requiring that offenders receive their first and second strikes for serious and violent crimes, such as armed robbery or assault.<sup>40</sup> After an individual’s third offense, the mandatory sentence of twenty-five years to life in prison would

---

33. Haynes, *supra* note 29.

34. Mauer, *supra* note 30, at 8.

35. Mauer, *supra* note 30, at 8 (reporting that as a result of minimum sentencing laws, defendants convicted of a drug offense who were sentenced to prison increased from 79% to 93% between 1988 and 2004).

36. Mauer, *supra* note 30, at 12.

37. Mauer, *supra* note 30, at 12.

38. Mauer, *supra* note 30, at 12.

39. Mauer, *supra* note 30, at 13 (reporting a 2002 report found that the criminal history of three-quarters of drug offenders in state prisons consist of drug or non-violent offenses, and 58% of those individuals have no history of violence or high-level drug selling activity).

40. Haynes, *supra* note 29.

be triggered and applied to any felony, including petty theft.<sup>41</sup> This scheme was unlike other three-strikes laws around the country, which usually limited life sentences to violent felonies.<sup>42</sup> Under California's sentencing structure, offenders were punished with controversially long sentences. Defendants in California have been given sentences of twenty-five years to life in prison for crimes such as shoplifting golf clubs, videotapes, and pizza.<sup>43</sup> However, facing major budgetary constraints, and a federal appellate court ruling that deemed California's twenty-five years to life sentencing mandate for felons who had committed petty crimes cruel and unusual,<sup>44</sup> California is changing sentencing structures to more properly fit the crime.<sup>45</sup> In 2012, California modified elements of its three-strikes law including only imposing life sentences when the new felony conviction is "serious and violent," and authorizing re-sentencing for individuals currently serving life sentences for a non-violent third strike.<sup>46</sup> Under this state amendment, approximately 3,000 incarcerated individuals are eligible to petition for a resentencing hearing, saving the state between \$150 million and \$200 million per year.<sup>47</sup>

The modern, rehabilitation focused changes to California's mandated sentencing structure stand as a stark contrast to Illinois' outdated three-strikes

---

41. Haynes, *supra* note 29.

42. Haynes, *supra* note 29.

43. Anthony Nagorski, *Arguments Against the Use of Recidivist Statutes That Contain Mandatory Minimums*, 5 U. St. Thomas J. L. & Pub. Pol' 214, 215 (2010-2011); *see also* *Ewing v. California*, 538 U.S. 11, 18 (2002) (holding that the Eighth Amendment does not bar against the "three-strikes" sentencing structure, where a defendant whose criminal history consisted of two counts of misdemeanor theft, was sentenced to life in prison after stealing golf clubs).

44. Haynes, *supra* note 29, *see also* *Andrade v. Attorney General of California*, 270 F.3d 743, 746 (9th Cir. 2001) (holding a defendant charged with shoplifting merchandise worth \$153.54 was a non-violent recidivist, and applying the "three strikes" sentencing structure would be cruel and unusual).

45. *California Proposition 36, Changes in the "Three Strikes" Law*, BALLOTPEdia (last visited Oct. 21, 2019), [http://ballotpedia.org/California\\_Proposition\\_36\\_Changes\\_in\\_the\\_Three\\_Strikes\\_Law\\_\(2012\)](http://ballotpedia.org/California_Proposition_36_Changes_in_the_Three_Strikes_Law_(2012)).

46. *Id.*; *see also* CAL. PENAL CODE § 667 (West 2019).

47. *California Proposition 36, Changes in the "Three Strikes" Law*, *supra* note 43.

law. Rather, Illinois' Act requires every person who has been convicted of a Class X felony twice before to be classified as a "habitual criminal."<sup>48</sup> Individuals who are then convicted of a third Class X felony receive a mandated sentence of life in prison.<sup>49</sup> The prescribed list of Class X felonies include violent crimes such as armed robbery, aggravated arson, and aggravated battery with a firearm.<sup>50</sup> The only non-violent Class X felony included in the Act is possession of a controlled substance with the intent to deliver.<sup>51</sup> In a separate state statute, "substance use disorder" is defined as "a spectrum of persistent and reoccurring problematic behavior" which encompasses ten classes of drugs, namely alcohol, caffeine, hallucinogens, inhalants, opioids, stimulants, and sedatives.<sup>52</sup> Adding insult to injury, the State of Illinois bars individuals convicted of felony drug offenses from accessing state substance treatment programs.<sup>53</sup> These programs are only available to offenders convicted of misdemeanor offenses.<sup>54</sup>

Recidivist statutes, like the Illinois' Act, with mandatory minimum punishments are unfair to defendants who are abusing substances. For example, in *Fernandez*, a defendant, who was previously employed as a construction and maintenance worker, sold approximately two pounds of cocaine to an undercover officer.<sup>55</sup> Because of the defendant's prior drug-related offenses more than twenty years earlier, and his status as a "habitual offender" under the Act, the mandated punishment was life in prison.<sup>56</sup> The

---

48. 730 ILL. COMP. STAT. ANN. 5/5-4.5-95 (2019).

49. 730 ILL. COMP. STAT. ANN. 5/5-4.5-95 (2019).

50. 730 ILL. COMP. STAT. ANN. 5/5-4.5-95 (2019).

51. 730 ILL. COMP. STAT. ANN. 5/5-4.5-95 (2019); *see also* 720 ILL. COMP. STAT. ANN. 570/401.

52. 20 ILL. COMP. STAT. ANN. 301/1-10 (2019).

53. 20 ILL. COMP. STAT. ANN. 301/40-5 (2019).

54. 20 ILL. COMP. STAT. ANN. 301/40-5 (2019).

55. *People v. Fernandez*, 16 N.E.3d 151, 153 (Ill. App. Ct. 2014) (holding a defendant who plead guilty to two prior non-violent drug offenses more than twenty years prior was sentenced to life in prison under the Act).

56. *Id.* at 156.

court noted that these drug-related offenses were the only convictions in this defendant's background, and none of his convictions involved the use of or threat of violence.<sup>57</sup> In fact, both the trial court and the appellate court noted on the record that had the court not been mandated by state law to sentence the defendant to life in prison, it is unlikely they would have done so.<sup>58</sup> Instead, both courts were favoring a lighter sentence and including mandatory substance abuse treatment.<sup>59</sup> This case illustrates the distorting effect mandatory life sentences have on courts. The Act requires courts to impose the harshest available penalty, while simultaneously blocking the court from taking into account any of the defendant's mitigating characteristics or circumstances.

Recent neurobiological, genetic, and psychological science suggest that substance use disorder is more like an acquired chronic illness than a poor lifestyle choice; something that can be managed but not yet cured.<sup>60</sup> Moreover, what constitutes "recovery" from a substance use disorder lacks a clear definition and is highly individualized with significantly varied reported outcomes.<sup>61</sup> Among mental health professionals, "recovery" has four distinct categories including, recovery as a lived experience among individuals and families, recovery as a connection within a larger community of individuals working toward recovery, recovery as a measurable outcome, and recovery as a goal and a benchmark for accountability for an individual.<sup>62</sup>

The term "recovery" connotes a return to health following a trauma or an illness, and for individuals struggling with a substance use disorder or

---

57. *Id.* at 165.

58. *Id.*

59. *Id.*

60. McLellan, *supra* note 9, at 114.

61. William L. White, *Addiction Recovery: Its Definition and Conceptual Boundaries*, 33 J OF SUBSTANCE ABUSE TREATMENT 33, 229, 229-30 (2007).

62. *Id.* at 230.

addiction, the substance use can act as their trauma or illness. In a majority of situations, an individual working towards recovering from a substance abuse problem will abstain from using the substance as a method of recovery. Abstaining from the use of a substance allows the individual to overcome their physical and psychological dependence on a substance.<sup>63</sup> This focus can be seen in substance recovery groups like Alcoholics Anonymous (AA) who celebrate “sobriety birthdays” and centralize sobriety as a way to mutually aid group members as they work toward recovery.<sup>64</sup>

However, recovery from a substance use disorder is not an easy undertaking. Addiction relapse is so common, studies suggest that approximately half of all individuals who try to get sober return to heavy substance use, with 90% of individuals experiencing at least one mild to moderate slip in their sobriety.<sup>65</sup> Addicts who return to substance use nearly always do so in response to drug-related cues in their environments.<sup>66</sup>

For an individual returning to their community after a period of incarceration, they may be susceptible to psychosocial stressors such as seeing drug paraphernalia or visiting places where they once scored drugs.<sup>67</sup> Neuroimaging studies support the existence of these triggers, finding that brain imaging shows drug use alters the connections between the brain’s reward center and memory hubs.<sup>68</sup> For recovering addicts, the triggers to use substances become hardwired as part of the collateral brain damage of addiction.<sup>69</sup> Because of this, recovery programs consistently recommend

---

63. *Id.* at 231.

64. *Id.* at 231.

65. David Sack, *Why Relapse isn’t a Sign of Failure*, Psychology Today (Oct. 19, 2012), <http://www.psychologytoday.com/us/blog/where-science-meets-the-steps/201210/why-relapse-isnt-sign-failure>.

66. Sack, *supra* note 65.

67. Sack, *supra* note 65; *see also* Davis, *supra* note 18 at 6.

68. Sack, *supra* note 65.

69. Sack, *supra* note 65.

avoiding people, places, and things from the addict's using past.<sup>70</sup> The Illinois legal system fails to recognize that an individual's path to recovery is not a straight line by barring individuals from state funded treatment programs, and classifying repeat offenders as "habitual criminals" without taking into consideration the medical and mental health aspects of substance use disorder.

#### AN EFFECTIVE FOCUS: THE REHABILITATION APPROACH

The answer to combating substance abuse and lowering rates of recidivism is not found in a jail cell or a traditional court room. Since the "War on Drugs" began in the 1980's the United States has treated drug-related offenses as a moral and criminal failure.<sup>71</sup> The national experiment of punishing people with substance use disorders, and mental health disorders is ineffective, expensive, and inequitable in its application.<sup>72</sup> Clearly, problematic substance use is widespread,<sup>73</sup> and the traditionally used tools – police, courtrooms, and prisons – are not equipped to make things better. Instead, Illinois should modify the systems in place, to better help non-violent individuals with substance use issues. Using Washington state's King County as a model<sup>74</sup>, Illinois could implement similar changes and dramatically lower drug-related crime and state costs.

For instance, non-traditional therapeutic courts, such as mental health courts and drug courts, work toward embracing an individuals' lifestyle goals, rather than punitive objectives within the judicial system.<sup>75</sup> An example being Washington's King County Drug Diversion Court which

---

70. Sack, *supra* note 65.

71. Dan Satterberg & Lisa Daugaard, *Connections Not Convictions*, 3(1) UCLA CRIMINAL JUSTICE L REV., 137, 139 (2019).

72. *See id.*; *see also* Davis, *supra* note 18, at 5.

73. The National Center on Substance Abuse and Addiction, *supra* note 25, at 3.

74. Satterberg & Daugaard, *supra* note 71, at 137.

75. Satterberg & Daugaard, *supra* note 71, at 140.

provides structured treatment programs for those struggling with addiction, most of whom are facing prison for drug-related crimes.<sup>76</sup> Drug diversion courts serve as a reentry point for individuals charged with non-violent drug-related crimes who are struggling with substance use.<sup>77</sup> Typically, these courts will provide case management services, and substance abuse treatment services to offenders under judicial supervision.<sup>78</sup> Given the obstacles released prisoner face reintegrating into their communities, offenders recovering from a substance disorder require a reentry plan that addresses the availability of supportive resources in coordination with supervision.<sup>79</sup>

The King County drug diversion court system has been in operation successfully for over twenty years, and has the capacity to help up to 350 people in their treatment programs at one time.<sup>80</sup> However, there are limitations to an approach which requires individuals to be charged with a crime as a precondition to obtaining help.<sup>81</sup> This method is inherently costly, because of the attorney costs on both sides, and necessary court fees.<sup>82</sup> Therapeutic courts should be reserved for specific cases and individuals that are not well-suited to intervention outside the court system,<sup>83</sup> such as an offender who has previously been convicted of multiple drug-related crimes. While life in prison seems absurdly cruel, a mandated treatment program works to rehabilitate the individual and prevent recidivism.

Indeed, Illinois needs to stop prosecuting individuals where it is counterproductive. Similar to the legalization of recreational and medical

---

76. Satterferg & Daugaard, *supra* note 71, at 140.

77. Davis, *supra* note 18, at 11.

78. *Id.*

79. *Id.*

80. Satterferg & Daugaard, *supra* note 71, at 140.

81. Satterferg & Daugaard, *supra* note 71, at 141.

82. Satterferg & Daugaard, *supra* note 71, at 141.

83. Satterferg & Daugaard, *supra* note 71, at 141.

marijuana<sup>84</sup>, Illinois legislature could change the state standard and determine that prosecutors should no longer file charges in cases of drug possession regardless of a perceived intent to deliver under a certain amount. This kind of policy would allow the state to focus resources for first responders, like police and EMTs, and train them to address violations of the law because of an individuals' substance use issues without the overuse of jail or prosecution.<sup>85</sup> In this system, an individual who breaks the law because of an underlying behavioral health issue or a substance use problem can be referred by law enforcement and first responders to community-based treatment programs.<sup>86</sup> In King County, Washington where a similar program is in place, officials have found that participants in this treatment program commit fewer new crimes than similarly situated nonparticipants.<sup>87</sup> Further, community members are encouraged to refer others to the community-based treatment program, rather than calling law enforcement or filing complaints with local government.<sup>88</sup> Because of this program, communities receive help and guidance, rather than simply removing individuals only for them to return after incarceration.<sup>89</sup>

Illinois should stop pushing individuals into the cycle of punishment and stigma associated with substance use disorders. As evidenced by the high rates of recidivism for substance-involved offenders, this cycle is not effective. Using prosecution as an exceptional circumstance, and instead mobilizing resources to create community responses to an individuals' substance use disorder are responses that are based in research, and employ

---

84. Austin Berg, *What You Need To Know About Marijuana Legalization In Illinois*, ILLINOIS POLICY (June 1, 2019), <http://www.illinoispolicy.org/what-you-need-to-know-about-marijuana-legalization-in-illinois/>.

85. Satterberg & Daugaard, *supra* note 71, 143.

86. Satterberg & Daugaard, *supra* note 71, 145.

87. Satterberg & Daugaard, *supra* note 71, 147.

88. Satterberg & Daugaard, *supra* note 71, 148.

89. Satterberg & Daugaard, *supra* note 71, 148.



an understanding of mental health rather than blocking people from access to resources and help.

# Evaluating the Effectiveness of Diversion Programs for Justice-Involved People with Mental Illnesses

*Nicole Harris*

Individuals with mental illness are vastly overrepresented in the United States justice system.<sup>1</sup> There are three times as many men and twice as many women suffering from mental illness in the justice system than in the general population.<sup>2</sup> Furthermore, parolees with mental illnesses are significantly more likely to have their parole revoked, and thus, return to prison.<sup>3</sup> Many blame deinstitutionalization, the well-intentioned, but poorly planned social change that emptied mental institutions.<sup>4</sup> Deinstitutionalization was a massive reform undertaken to reshape mental health services from institutionalization to community mental health services.<sup>5</sup> This led to a dramatic decrease in the population of mental hospitals in favor of community-based services.<sup>6</sup> Around the same time, tough-on-crime laws and longer sentencing practices led to a sweeping increase in incarceration in the U.S.<sup>7</sup> As a result, the U.S. became the undisputed leader of imprisonment in the world.<sup>8</sup> All of these major policy changes helped contribute to the

---

1. Jennifer L. Skeem, *Correctional Policy for Offenders with Mental Illness: Creating a New Paradigm for Recidivism Reduction*, 35 *LAW. HUM. BEHAV.* 110, 110 (2011).

2. *Id.*

3. *Id.*

4. E. Fuller Torrey et al., *More Mentally Ill Persons are in Jails and Prisons Than Hospitals: Survey of the States 2* (2010).

5. Ellen L. Bassuck, *Deinstitutionalization and Mental Health Services*, 238 *SCI. AM.* 2, 46 (1978).

6. *Id.*

7. Marc Mauer, *Long-term Sentences: Time to Reconsider the Scale of Punishment*, 87 *UMKC L. REV.* 113, 113-14 (2018).

8. David Cole, *Turning the Corner on Mass Incarceration*, 9 *OHIO ST. J. CRIM. L.* 27, 28 (2011).

“criminalization of mental illness,” and led to the aforementioned statistics.<sup>9</sup> America’s jails and prisons have become, de facto, the nation’s largest psychiatric hospitals.<sup>10</sup> This situation rightfully attracted a lot of attention from policymakers and experts.<sup>11</sup> One of the policy changes that was introduced to remedy the number of incarcerated people with mental health illness are diversion programs.<sup>12</sup>

Diversion programs are “specific programs that screen specific groups of detainees for the presence of a mental disorder.”<sup>13</sup> After screening, diversion programs use mental health professionals or police officers to evaluate the detainees and negotiate with prosecutors, defense attorneys and community-based mental health providers.<sup>14</sup> Together they produce a program for the duration of an individual’s prosecution or as a condition for a reduction in charges.<sup>15</sup> Lastly, they link the detained individual directly to community-based services.<sup>16</sup> Diversion programs have the potential to decrease recidivism rates and be used as an alternative to criminal charges.<sup>17</sup> However, diversion programs have many flaws and are not nearly as effective as they should be at reducing recidivism rates.<sup>18</sup>

Diversion programs were created in response to the disproportionate amounts of people suffering from mental illness imprisoned in U.S. jails.<sup>19</sup>

---

9. Skeem, *supra* note 1, at 111.

10. Torrey et al., *supra* note 4, at 6.

11. Skeem, *supra* note 1, at 111.

12. Skeem, *supra* note 1, at 112.

13. Henry J. Steadman et al., *The Diversion of Mentally Ill Persons from Jails to Community-Based Services: A Profile of Programs*, 85 AM. J. PUB. HEALTH. 1630, 1630 (1995).

14. *Id.*

15. *Id.*

16. *Id.* at 1631.

17. Frisman et al., *Outcomes of Court-Based Jail Diversion Programs for People with Co-Occurring Disorders*, 2 J. DUAL DIAGNOSIS 5, 22 (2006).

18. Skeem, *supra* note 1, at 119.

19. Torrey et al., *supra* note 4, at 6.

However, diversion programs are not achieving their goals of keeping people suffering from mental illness out of jails.<sup>20</sup> While diversion programs do increase time in the community, the lack of follow up supervision is often cited as the reason they have little effect on recidivism rates.<sup>21</sup> One way to decrease recidivism rates and improve the effectiveness of diversion programs is a balance of supervision after release, accountability, and community treatment. Releasing individuals back into the situation in which they found themselves in trouble with the law does little to prevent them from offending again. Follow-up monitoring is necessary to help justice involved populations build upon and solidify the foundation created by diversion programs.

This article will examine the effectiveness of current diversion programs, present case studies of successful programs, and provide suggestions for increased effectiveness. Part I of this article provides background on pre-booking diversion models and post-booking diversion models and discusses the roadblocks in current models. Part II discusses the Worcester case study and the development of an integrated program and the issues associated with creating such a program. Part II examines one of the most effective diversion programs in the United States and how they have succeeded in increasing effectiveness and reducing recidivism rates. Finally, Part IV presents some recommendations for increased effectiveness.

#### DIVERSION MODELS

There are two main types of diversion initiatives: pre- and post-booking models.<sup>22</sup> Pre- and post-booking diversion programs have been used in many

---

20. Skeem, *supra* note 1, at 119.

21. Skeem, *supra* note 1, at 114.

22. See Frank Sirotych, *The Criminal Justice Outcomes of Jail Diversion Programs for Persons with Mental Illness: A Review of Evidence*, 37 J. AM. ACAD. PSYCH. L. 461, 462 (2009).

jurisdictions to decrease the numbers of individuals with mental health issues in jail and deliver treatment.<sup>23</sup>

*Pre-booking Diversion Models*

In pre-booking diversion models, the police determine whether an arrest or diversion is appropriate in the situation.<sup>24</sup> One major problem with this model is that it relies so heavily on police discretion.<sup>25</sup> Further, studies have shown that officers rely more on the demands of the situation than the degree of symptomology.<sup>26</sup> For example, police officers often base their decision to arrest someone on the availability of hospital beds, the reluctance of hospitals to accept intoxicated persons, and whether the officer believed that the person was likely to cause more problems if he or she were not arrested.<sup>27</sup>

One major roadblock in pre-booking diversion programs is the communication and coordination between police and mental health services within the community.<sup>28</sup> Police officers have become the gate keepers of the criminal justice and mental health systems.<sup>29</sup> However, in the absence of convenient and accessible non-jail placement options, police officers may use informal means to dispose of these cases.<sup>30</sup> For example, “police initiated trans-jurisdictional transport of troublesome persons,” or dumping, is a commonly used practice where police officers transport or arrange transport of troublesome persons—in many cases, people with mental illnesses—to a

---

23. Risdon N. Slate, *Deinstitutionalization, Criminalization of Mental Illness, and the Principle of Therapeutic Jurisprudence*, 26 S. CAL. INTERDISC. L. J. 341, 354 (2017).

24. Sirocich, *supra* note 22, at 462.

25. Sirocich, *supra* note 22, at 462.

26. Linda A. Teplin, *Police Discretion and Mentally Ill Persons*, NAT'L INST. JUST J. 8, 10 (2000).

27. Sirocich, *supra* note 18, at 462.

28. *Id.* at 493.

29. See William Wells & Joseph A. Schafer, *Officer Perceptions of Police Responses to Persons with a Mental Illness*, 29 POLICING: INT'L J. POLICE STRAT. & MGMT. 578, 579 (2006).

30. *Id.* at 580.

location outside of the officer's jurisdiction.<sup>31</sup> In this case, the troublesome person is not dropped off at an appropriate institution or with a competent and capable person.<sup>32</sup> Instead, he or she is taken to another location so they are no longer that police officer's problem.<sup>33</sup> Another practice called "diesel therapy" involves placing a troublesome person with mental illness onto a bus destined for a different jurisdiction.<sup>34</sup>

If an officer recognizes someone is displaying symptoms of mental illness and concludes it would be more appropriate to divert the person to community mental health programs, they often find community resources insufficient, complicated, or completely absent.<sup>35</sup> Research shows that most police agencies do very little to collaborate with mental health service providers.<sup>36</sup>

Due to these challenges, arrest is often the most convenient option.<sup>37</sup> Even when officers recognize that arrest may not be in the best interest of the person, it may be chosen because it is the most efficient.<sup>38</sup> Many studies found that people with mental illness frequently experience arrest during their encounters with police.<sup>39</sup> However, there have been steps toward greater integration and partnerships between mental health service providers and the

---

31. *Id.*

32. *Id.*

33. *Id.*

34. *Id.*

35. *Id.* at 581.

36. Husted et al., *California Law Enforcement Agencies and the Mentally Ill Offender*, 23 BULL. AM. ACAD. PSYCHIATRY L. 315, 326 (1995).

37. *Id.*

38. Wells et al., *supra* note 29, at 581.

39. Randy Borum et al., *Substance Abuse, Violent Behavior and Police Encounters Among Persons with Severe Mental Disorder*, 13 J. CONTEMP. CRIM. JUST. 236, 237 (1997); H. Richard Lamb et al., *Outcome for psychiatric emergency patients seen by an outreach police-mental health team*, 46 PSYCHIATRIC SERV. 67, 67 (1995); Mark R. Pogrebin, *Police Responses for Mental Health Assistance*, 58 PSYCHIATRIC QUARTERLY 66, 66 (1986-87); H.J. Steadman et al., *Explaining the increased arrest rates among mental patients: the changing clientele of hospitals*, 13 AM. J. OF PSYCHIATRY 816, 820 (1978).

police in an effort to make diversion programs more successful.<sup>40</sup>

Diversion programs were more successful when police were trained on mental health.<sup>41</sup> Interventions and training that teach police to rapidly identify and serve people with mental illness promise to be the most useful in serving the needs of individuals who find themselves in the justice system.<sup>42</sup> Many officers understand both the importance and the value presented by an opportunity to learn how to recognize mental health status.<sup>43</sup> However, officers often receive inadequate training despite their psychiatric triage role.<sup>44</sup>

Some police departments have instituted specialized training programs.<sup>45</sup> One of the most common training programs is CIT or Crisis Intervention Team.<sup>46</sup> CITs are teams specifically dedicated to handling interventions with people with mental illness.<sup>47</sup> Officers spend forty hours training with mental health representatives.<sup>48</sup> Part of this training is learning how to talk to people with mental illnesses and studying the effects of various medications.<sup>49</sup> A study conducted by Strauss, a psychiatrist who teaches CIT Training and his team, evaluated the effectiveness of CIT training by assessing whether there was a difference in the profile and disposition of patients brought in by CIT

---

40. Wells et al., *supra* note 29, at 582.

41. Michael T. Compton et al., *A Potential New Form of Jail Diversion and Reconnection to Mental Health Services: Demonstration of Feasibility*, 35 BEHAV. SCI. L. 492, 493 (2017).

42. Jeffrey Draine et al., *The Impact of Mental Illness Status on the Length of Jail Detention and the Legal Mechanism of Jail Release*, 61 PSYCHIATRIC SERV. 458, 458 (2010).

43. Compton et al., *supra* note 41, at 493.

44. *Id.*

45. Sirotych, *supra* note 22, at 462.

46. *Id.*

47. Sarah E. Abbott, *Evaluating the Impact of a Jail Diversion Program on Police Officers' Attitudes Toward the Mentally Ill*, 16 (Ar. 2011) (unpublished dissertation, Northeastern University).

48. *Id.*

49. *Id.*

officers and non-CIT trained officers.<sup>50</sup> They also identified whether CIT officers made the right decisions when they identified their referrals.<sup>51</sup> The research showed that while the disposition of patients referred did not significantly differ from non-CIT referred patients, CIT officers could more accurately identify people in psychiatric crises and make appropriate referrals.<sup>52</sup> The study concluded that CIT training was successful in its goal of training officers to accurately identify and refer people in psychiatric crisis for evaluation and treatment.<sup>53</sup> However, while pre-booking diversion programs usually increase time in the community because they divert individuals from incarceration, studies have shown that they may not decrease recidivism rates.<sup>54</sup> Even pre-booking jail diversion programs with specially-trained officers face many challenges when attempting to confront recidivism rates.

#### *Post-booking Diversion Models*

Post-booking diversion programs occur after individuals have been arrested and booked into jail or charged with a criminal offense.<sup>55</sup> There are three main types of post-booking diversion models: jail-based diversion, court-based diversion, and specialized mental health courts.<sup>56</sup> Jail-based post-booking programs are operated by jail personnel who can identify, assess and divert detainees from custody to community health programs; however, they first need the consent of the prosecutor, the judge and a defense lawyer.<sup>57</sup> Court-based post-booking diversion programs use specially-trained court

---

50. Gordon Strauss et al., *Psychiatric Disposition of Patients Brought in by Crisis Intervention Team Police Officers*, 41 CMTY. MENTAL HEALTH J. 2, 223, 225 (2005).

51. *Id.*

52. *Id.* at 227.

53. *Id.*

54. Skeem, *supra* note 1, at 114.

55. Sirolich, *supra* note 22, at 463.

56. *Id.* at 462.

57. *Id.*



staff and mental health clinicians that are employed by the state and work in the courthouse.<sup>58</sup> Clinicians screen the arraignment list for clients and receive additional referrals from the staff.<sup>59</sup> Then, they assess the clients and negotiate with prosecutors, judges, and defense attorneys to devise treatment plans and help with the bail and release of the accused person.<sup>60</sup> In specialized mental health courts the judge, prosecutors, defense attorneys and other court staff are specifically trained to work with people with mental illness.<sup>61</sup> These courts make supervised community-based mental health treatment and specialized parole mandatory although enrollment in the mental health court is voluntary.<sup>62</sup>

While both types of diversion programs successfully increased time within the community for people with mental illness, they do relatively little for recidivism rates, but while post-booking diversion programs have fewer issues with police bias or problems like dumping, they also have shown little promise for reducing recidivism.<sup>63</sup>

Specialized law enforcement and post-booking diversion are valuable to identify individuals with mental illness eligible for diversion programs.<sup>64</sup> However, the long-term effectiveness has received mixed reviews.<sup>65</sup> Diverted people continue to be arrested at the same rate as non-diverted people.<sup>66</sup> So far there has been little empirical research done on the obstacles standing in

---

58. Frisman et al., *supra* note 17, at 7.

59. Sirotych, *supra* note 22, at 462.

60. *Id.*

61. Frisman et al., *supra* note 17, at 7.

62. Sirotych, *supra* note 22, at 462.

63. *Id.*

64. David DeMatteo et al., *Community-based alternatives for justice involved individuals with severe mental illness: Diversion, problem-solving courts, and reentry*, 41 J. CRIM. JUST. 64, 67 (2013).

65. Joseph R. Morrissey & Gary S. Cuddeback, *Jail Diversion*, CLINICAL HANDBOOK OF SCHIZOPHRENIA 524, (Kim T. Mueser & Dilip V. Jeste eds., 1<sup>st</sup> ed. 2008).

66. Frisman et al., *supra* note 17, at 22.

the way of increased effectiveness.<sup>67</sup> However, most research suggests that the most effective way to increase the success of diversion programs is to increase coordination between service delivery systems and the police as well as integrating treatment modalities into the integrated system.<sup>68</sup>

#### WORCESTER SERVICE INTEGRATION INITIATIVE AND THEIR CHALLENGES

There have been promising case studies that have identified barriers and are working toward improvements to increase success in diversion programs. One of these case studies is the Worcester Service Integration Initiative.<sup>69</sup>

The Worcester Police Department (WPD) officers were not interested in developing a specialty police force, but identified two situations which bothered the police officers the most.<sup>70</sup> The first situation was when an individual is brought to an emergency setting by a police officer who was expected to remain with the individual until they were seen and evaluated; this takes the officer away from his regular patrol duties.<sup>71</sup> The second situation occurred when an individual was taken to an emergency site, seen, evaluated, not admitted and put back on the street only to be arrested again.<sup>72</sup>

In Worcester, Massachusetts, the local government worked on a program called the Massachusetts Mental Health Diversion and Integration Program (MMHDIP).<sup>73</sup> This program encourages local law enforcement to work with service providers, client advocates, and research professionals.<sup>74</sup> The professionals in the program then work together to identify strengths and

---

67. Steve Ryan et al., *Toward Successful Postbooking Diversion: What are the Next Steps?*, 61 PSYCHIATRIC SERV. 469, 469 (2010).

68. Albert J. Grudzinskas et al., *Integrating the Criminal Justice System into Mental Health Service Delivery: The Worcester Diversion Experience*, 23 BEHAV. SCI. & L. 277, 287-88 (2005).

69. *Id.*

70. *Id.* at 289.

71. *Id.* at 288.

72. *Id.*

73. *Id.*

74. *Id.*

weaknesses in delivering effective services to justice involved populations struggling with mental illness.<sup>75</sup>

In order to combat the two situations mentioned above, the WPD began working with MMHDIP team to enhance the capacity of local health care and mental health services organizations to effectively receive and handle cases involving people with mental illness.<sup>76</sup> The researchers used network analysis to discover the main barriers to care and service.<sup>77</sup> They then addressed these barriers with different organizations, reached out to new organizations, and held monthly meetings to overcome these issues.<sup>78</sup> The effectiveness of Worcester's system has yet to be analyzed, but is a promising step toward further integration and communication between social service providers and the justice system.

There are quite a few major barriers to the effectiveness of diversion programs identified in the literature discussed above.<sup>79</sup> There is a lack of funding for the development of integrated, community-based services necessary to permit safe transition of persons with mental illness from inpatient treatment to community-based settings.<sup>80</sup> There is also a lack of police knowledge on symptoms of mental illness which leads to bias.<sup>81</sup> Community mental health programs for offenders are undeveloped, underfunded, and ineffective.<sup>82</sup> There is a lack of coordination and communication between mental health services and the criminal justice systems.<sup>83</sup> Finally, there is a lack of follow up procedures for diverted

---

75. *Id.*

76. *Id.*

77. *Id.*

78. *Id.* at 290.

79. *Id.*

80. *Id.*

81. Kathleen Hartford et al., *Pre-arrest Diversion of People with Mental Illness: Literature Review and International Survey*, 24 BEHAV. SCI. L. 845, 849 (2006).

82. Skeem, *supra* note 1, at 114.

83. Compton et al., *supra* note 41, at 497.

detainees.<sup>84</sup>

The most consistent of the problems brought up by the limited literature on diversion programs is lack of follow up supervision and successful treatment options.<sup>85</sup> One study by Steadman, a scholar in the sociology of mental health and criminal justice, noted that discharge planning and follow up is almost always seen as critical to the success of diversion problems.<sup>86</sup> One program in Miami Dade County has been able to overcome barriers to successful follow up supervision and treatment options and has succeed in increasing the effectiveness of their diversion programs and decreasing recidivism rates in their county.<sup>87</sup>

#### MIAMI DADE COUNTY MENTAL HEALTH PROJECT AND HOW THEY SUCCESSFULLY DECREASED RECIDIVISM

In a different study done by Heiss titled, “Coordinating Access to Services for Justice Involved Populations,” Heiss and his team discussed promising diversion programs.<sup>88</sup> One Miami program drastically reduced the number of arrests and recidivism rates associated with individuals with mental illness.<sup>89</sup> The Miami Dade County Mental Health Project (MDCMHP) has successfully decreased recidivism rates for people initially booked for misdemeanors by more than half.<sup>90</sup> Most notably, they have even achieved a less than 6% recidivism rate among individuals who have completed their diversion program.

---

84. Steadman et al., *supra* note 13, at 1634.

85. Abbott, *supra* note 41, at 14; Cole, *supra* note 8, at 31; DeMatteo et al., *supra* note 58, at 69; Skeem, *supra* note 1, at 110.

86. Steadman et al., *supra* note 13, at 1634.

87. Stephen Eide, *Keeping the Mentally Ill Out of Jail: An Innovative Miami Dade Program Shows the Way*, CITY JOURNAL (Autumn, 2018), <https://www.city-journal.org/miami-dade-criminal-mental-health-project>.

88. Christian Heiss et al., *Coordinating Access to Services for Justice-Involved Populations* 1, 13 (2016).

89. *Id.*

90. *Id.*

The MDCMHP has succeeded where many other diversion programs have failed: reducing recidivism.<sup>91</sup> They have achieved these outcomes by focusing first on police training for pre-booking diversion and escalation.<sup>92</sup> Since not every mental health crisis can be solved without arrest, the MDCMHP also has a comprehensive system of post-booking diversion programs.<sup>93</sup> They have three separate jail diversion initiatives, but more importantly, their programs have a comprehensive follow up and supervision program.<sup>94</sup> Once the individual has been screened the staff puts together a treatment plan.<sup>95</sup> This treatment plan includes housing arrangements and access to appropriate service providers.<sup>96</sup> Involvement with the individuals does not stop with their treatment plan: close oversight is exercised to make sure they are closely following their plans.<sup>97</sup> The staff makes sure that the patients attend their prescribed therapy, actively participate in group, stay sober, take all of their prescribed medicine, and monitor their relationships to make sure the individuals are becoming healthier.<sup>98</sup>

Much of the literature discussed above posits policy changes and revamping of the entire system. However, Miami Dade's successful program demonstrates that rebuilding the entire mental health system is not necessary.<sup>99</sup> MDCMHP funds and builds upon existing programs and agencies in order to build a successful diversion program that many districts have yet to achieve.<sup>100</sup> MDCMHP administration insists that close

---

91. Stephen Eide, *Keeping the Mentally Ill Out of Jail: An Innovative Miami Dade Program Shows the Way*, CITY JOURNAL (Autumn, 2018), <https://www.city-journal.org/miami-dade-criminal-mental-health-project>.

92. *Id.*

93. *Id.*

94. *Id.*

95. *Id.*

96. *Id.*

97. *Id.*

98. *Id.*

99. *Id.*

100. *Id.*

partnerships with the community are essential to their success.<sup>101</sup>

#### RECOMMENDATIONS FOR INCREASED EFFECTIVENESS

Most of the limited research that has been done on jail diversion programs is both positive and negative.<sup>102</sup> On one hand, individuals with mental health issues are spending less time in jail and more time in their communities.<sup>103</sup> Diversion programs are also successful in their attempts to decrease the population of people with mental illnesses who are currently in jail.<sup>104</sup> However, major policy changes and steps need to be taken to further improve these programs.<sup>105</sup> Issues with police bias, lack of training, and practices such as dumping reduce the effectiveness of diversion programs. Post-booking diversion programs include more intense supervision and individuals are more likely to be linked with people who are trained in handling and screening those with mental illnesses.<sup>106</sup> However, neither one of these programs do much, if anything, to reduce recidivism.

Increased supervision like those modeled in some post-booking diversion programs have been shown to increase favorable outcomes.<sup>107</sup> One study showed that subjects who were diverted to receive judicially monitored treatment had better outcomes than subjects who were not mandated to receive monitored treatment.<sup>108</sup> Further, those with mandated supervision had much better outcomes than subjects who were referred for treatment without

---

101. *Id.*

102. Sirolich, *supra* note 22, at 469.

103. Abbott, *supra* note 47, at 21.

104. Sirolich, *supra* note 22, at 469.

105. CENTER FOR HEALTH AND JUSTICE, A NATIONAL SURVEY OF CRIMINAL JUSTICE DIVERSION 30 (2013).

106. Pamela K. Lattimore et al., *A Comparison of Pre-booking and Post-booking Diversion Programs for Mentally Ill Substance-Using Individuals with Justice Involvement*, 19 J. OF CONTEMP. CRIM. JUST. 30, 58 (2003).

107. Henry J. Steadman et al., *A SAMHSA Research Initiative Assessing the Effectiveness of Jail Diversion Programs for Mentally Ill Persons*, 50 PSYCHIATRIC SERV. 1620, 1621 (1999).

108. *Id.*

monitoring.<sup>109</sup> Mandated treatment within diversion programs results in a higher probability of successful completion of treatment and therefore more favorable outcomes.<sup>110</sup> The most effective response to individuals with mental health issues is often a balance of supervision, accountability and community treatment.<sup>111</sup> Follow-up monitoring may help justice involved populations solidify or build upon the foundation created in diversion programs.<sup>112</sup>

Pre-booking diversion programs would benefit from mental health training. In order to combat damaging police practices such as dumping, police officers need to be more familiar with mental illness. CIT training has the potential to change the nature of interactions between police officers and people with mental illness.<sup>113</sup> Not only are CIT programs more beneficial for people with mental illness, but they also have demonstrated effectiveness in reducing officer injuries.<sup>114</sup> Other findings suggest that specialized police training reduces reliance on jails to house people with mental illness.<sup>115</sup>

For both pre-booking and post-booking diversion, research and successful programs such as the MDMHP have shown that by simply increasing coordination and linkage systems between people in the justice system and mental health service providers, there could be a successful decrease in the rates of individuals with mental illness in correctional facilities and drastic decrease recidivism.<sup>116</sup> One study by Steadman showed that trained interdisciplinary teams increased the likelihood that the mentally ill persons

---

109. *Id* at 1622.

110. Ryan et al., *supra* note 67, at 474.

111. CENTER FOR HEALTH AND JUSTICE, *supra* note 95, at 2.

112. Ryan et al., *supra* note 61, at 474.

113. Wells & Shafer, *supra* note 29, at 596.

114. CENTER FOR HEALTH AND JUSTICE, *supra* note 105, at 12.

115. *Id*.

116. Compton et al., *supra* note 41, at 499.

would have access to mental health services.<sup>117</sup> Lawyers, service providers, judges and health care providers must work together to create an integrated system that provides for the needs of individuals with mental illness within the community.<sup>118</sup>

Increased linkage and coordination are a very important obstacle to overcome for both pre and post booking diversion programs.<sup>119</sup> In Hartford's study, one of the four key elements associated with successful programs was coordination between mental health and criminal justice agencies when creating the program.<sup>120</sup> Another key element recognized in the study was appointing a liaison whose only job is to coordinate efforts among agencies.<sup>121</sup> Further, while there are many types of programs that exist across the country, there are no overarching standards for publishing data or common sets of measures.<sup>122</sup> Many programs are collecting the data, but there are no means of sharing the data across diversion programs.<sup>123</sup> Most officers want linkages with mental health systems because of how frequently and how much of their work involves interacting with people suffering from mental illness.<sup>124</sup> Specifically, for treatment rather than arrests to occur in pre-booking diversion programs officers need to be provided with linkages to mental health services that allow for direct referrals with no refusal policies.<sup>125</sup> CIT-trained officers are more likely to link people to mental health services; however, service availability can still remain an issue.<sup>126</sup> In

---

117. See Steadman et al., *supra* note 13, at 1632.

118. *Id.*

119. See Compton et al., *supra* note 41, at 499.

120. Hartford et al., *supra* note 81, at 854.

121. *Id.*

122. CENTER FOR HEALTH AND JUSTICE, *supra* note 105, at 28.

123. *Id.*

124. Compton et al., *supra* note 41, at 493.

125. Carolyn S. Dewa et al., *Evidence for the effectiveness of police-based pre-booking diversion programs in decriminalizing mental illness: A systematic literature review*, PLOS ONE, 1, 2 (2018).; See also Hartford et al., *supra* note 81, at 854.

126. *Id.*



order for there to be linkages to mental health services, those mental health programs need to exist in the community to begin with.<sup>127</sup> Policymakers first need to expand budgets for community mental health services in order to make access to them more readily available and to ensure justice involved populations access treatment.<sup>128</sup>

#### CONCLUSION

Increased criminal behavior is only directly linked to individuals suffering from mental illness in a very small sub-group of offenders; thus, the disproportionate number of individuals with mental illnesses currently in jail is more attributable to the criminalization of mental illness than mental illness itself.<sup>129</sup> Recidivism rates among those with mental illnesses are highly attributable to technical errors and violations that end with having their community terms and parole suspended and revoked.<sup>130</sup> Studies show that revocation of parole in many cases is inappropriately used as a response to parolees in emotional crisis.<sup>131</sup> Revocation of parole is also inappropriately used in many occasions if an individual is deemed to be non-compliant with treatment.<sup>132</sup> When this information is taken together, the “findings are consistent with the notion that supervision failures reflect the criminalization of mental illness rather than new crime.”<sup>133</sup>

The criminalization of mental illness is a problem which will persist without appropriate supervision and coordination efforts.<sup>134</sup> The success of

---

127. Henry J. Steadman & David Morrisette, *Police Responses to Persons with Mental Illness: Going Beyond CIT Training*, 67 *PSYCHIATRIC SERV.* 1054, 1054 (2016).

128. Kelly L. Coffman & Grayson Norquist, *Recommendations to Avoid Criminalizing Individuals with Severe Mental Illness and Substance Abuse* 13–14 (Stan Jones et al. eds., 2017).

129. Skeem, *supra* note 1, at 118.

130. *Id.*

131. *Id.*

132. *Id.*

133. *Id.*

134. *See generally* Coffman, *supra* note 128.

Miami Dade in combating this problem shows that community based social services and diversion programs can be an effective solution to the over-representation of individuals with mental illness in correctional facilities. However, current models are not working because supervision, or consistent monitoring of diverted individuals, tends to stop after diversion. Ensuring individuals with mental illnesses have access to appropriate housing, therapies, affordable health care, and other social services are the key to the successful and prolonged success of diversion programs.



# Recidivism in Former Mentally Ill Prisoners Connected to Lower Funded Mental Health Programs in Prisons

*Michael Manganelli*

## INTRODUCTION

The epidemic of psychiatric disorders in the U.S. prison system represents a national public health crisis.<sup>1</sup> Beginning in the 1960s, scholars argued that moving patients into community-based outpatient settings would be more humane than into overcrowded and understaffed institutions.<sup>2</sup> However, as a result of the war on drugs, health insurers restricting mental health coverage, and private hospitals limiting enrollment of psychotic patients, there was an increase in the proportion of individuals with psychiatric disorders being put in prison rather than proper institutions, which continues to be prevalent today.<sup>3</sup> According to the World Health Organization (“WHO”), “an estimated 450 million people worldwide suffer from mental or behavioral disorders.”<sup>4</sup> Addressing mental health needs will improve not only the health and quality of life for prisoners with mental health disorders, but the prison population as a whole.<sup>5</sup> Many believe that improving access to mental health services for those with mental disorders, including substance abuse, should be part of health services all prisoners are afforded.<sup>6</sup> To accomplish this,

---

1. Jacques Baillargeon et al., *Psychiatric Disorders and Repeat Incarcerations: The Revolving Prison Door*, 166 AM. J. PSYCHIATRY 103, 103 (2009).

2. *Id.*

3. *Id.*

4. WORLD HEALTH ORG., INFORMATION SHEET, MENTAL HEALTH AND PRISONS 1.

5. *Id.* at 2.

6. *Id.* at 3 (“...access to assessment, treatment, and (when necessary) referral of people with mental disorders, including substance abuse, should be an integral part of general health

states should improve access to mental health resources for incarcerated individuals. In addition, states should create a targeted re-entry program catered to the prisoners needs in order to re-integrate them back into society. This process, as noted later within this article, can be done in a cost-effective and efficient manner.

The National Alliance on Mental Illness (“NAMI”) posted a study conducted by the U.S. Department of Justice’s Bureau of Justice Statistics showing that sixty-four percent of local or county jail inmates, fifty-six percent of state prisoners, and forty-five percent of federal prisoners have symptoms of serious mental illness.<sup>7</sup> The study showed that the mental health problem within prisons is much worse than people have imagined.<sup>8</sup>

When incarcerations end, many mentally ill, including drug addicted prisoners, are sent back into the world without basic tools they need to succeed, such as ready access to medication, addiction counseling, or adequate support and oversight.<sup>9</sup> The Harvard-led Boston Reentry Study found that in 2014, the inmates with a mix of mental illness and addiction are significantly less likely than others to find stable housing, work income, and family support in the time following release, leaving these former prisoners insecure, isolated and at risk for falling back into diminished mental health, drug use, and recidivism.<sup>10</sup> The United States has three times more individuals with severe mental illness in prison than in psychiatric hospitals, thus, it appears the majority of persons with mental illness are landing in the

---

services available to all prisoners.”).

7. NAT’L ALL. ON MENTAL ILLNESS, DEPT. OF JUSTICE STUDY: MENTAL ILLNESS IN PRISON INMATES WORSE THAN PAST ESTIMATES 1 (2006).

8. *Id.* (“[t]he study reveals that the problem is two to three times greater than anyone imagined”).

9. Jenna Russel & Maria Cramer, *There May Be No Worse Place For Mentally Ill People To Receive Treatment Than Prisons*, THE BOSTON GLOBE (Nov. 25, 2016), [apps.bostonglobe.com/spotlight/the-desperate-and-the-dead/series/prisons/?p1=Spotlight\\_MI\\_Story\\_Explore](https://apps.bostonglobe.com/spotlight/the-desperate-and-the-dead/series/prisons/?p1=Spotlight_MI_Story_Explore).

10. *Id.*

criminal justice system rather than the mental health system.<sup>11</sup>

Many mentally ill prisoners receive poor treatment. According to a Department of Corrections analysis of 2012 prisoner releases, thirty-seven percent of mentally ill former prisoners return to prison.<sup>12</sup> In comparison, only thirty percent of non-mentally ill former prisoners return to the prison system.<sup>13</sup> This disparity is likely attributed to the current funding structure for Illinois mental health programs within prisons. Increased funding for mental health services within prisons does not automatically equate to low recidivism rates, as will be discussed later in the article by comparing Illinois to Virginia.<sup>14</sup> Virginia's Re-Entry model, or at a minimum parts of Virginia's policies, should be implemented in Illinois because the state has proven that the use of an efficient and carefully planned program, regardless of funding, is more effective in rehabilitation and reintegrating mentally ill prisoners back into society rather than the current program Illinois has in place.<sup>15</sup>

This article will consider the effects of recidivism in former mentally ill prisoners in two different states. First, the article will examine Illinois through the lens of Cook County, as Illinois spends the eighth most on total mental health funding and Cook County is the most densely populated area within the state yet serves as one of the largest mental health care providers in the country.<sup>16</sup> This article will also analyze Virginia, which spends the fifteenth most on mental health.<sup>17</sup> These states were selected not only due to

---

11. Robert Morgan et al., *Treating Offenders With Mental Illness: A Research Synthesis*, 36 L. & HUM. BEHAV. 37, 37 (2012).

12. Russel, *supra* note 9.

13. *Id.*

14. See generally *Mental Health Spending: State Agency Totals*, GOVERNING (2010), [www.governing.com/gov-data/health/mental-health-spending-by-state.html](http://www.governing.com/gov-data/health/mental-health-spending-by-state.html) (showing state mental health agency total expenditures); see *infra* Part II and Part III.

15. *Infra* pp. 4, 8.

16. *Mental Health Spending*, *supra* note 14; Samantha Michaels, *Chicago's Jail Is one of the Countries Biggest Mental Health Care Providers*, MOTHERJONES (January 8, 2019), [www.motherjones.com/crime-justice/2019/01/chicagos-jail-is-the-one-of-the-countys-biggest-mental-health-care-providers-heres-a-look-inside/](http://www.motherjones.com/crime-justice/2019/01/chicagos-jail-is-the-one-of-the-countys-biggest-mental-health-care-providers-heres-a-look-inside/).

17. *Mental Health Spending*, *supra* note 14.

their funding differences, but also because Virginia has the lowest recidivism rates within the nation, and could possess the blueprint to an effective prison system.<sup>18</sup>

After cutting much of the funding towards mental health treatment in prisons, Illinois appears to be reversing this trend.<sup>19</sup> Illinois has plans to build a \$150 million mental health institution.<sup>20</sup> This facility will be a hospital that will provide 250 beds to “meet the most critical needs of the state’s mentally ill inmates.”<sup>21</sup> However, this might not be enough. In 2014, amid mounting criticism and legal pressure, the Federal Bureau of Prisons (“BOP”) imposed a new policy promising better care and oversight for inmates with mental health issues.<sup>22</sup> However, as of February 2018, the BOP classified just three percent of inmates as having a mental illness serious enough to require regular treatment.<sup>23</sup> When examining Illinois, the Illinois Department of Corrections has identified mental health disorders in approximately thirty-one percent of its current population.<sup>24</sup>

#### EXAMINING ILLINOIS’ PRISON SYSTEM

On July 22, 1969, Governor Richard B. Ogilvie created the Task Force on Corrections and named Peter B. Bensinger as its chairman.<sup>25</sup> In presenting his message outlining the creation of the new Department of Corrections,

---

18. VA. DEP’T OF CORR., STATE RECIDIVISM COMPARISON 1 (Nov. 2017).

19. Phil Kadner, *Report: Mental Health Care in Crisis In Illinois*, CHI. TRIB. (May 28, 2015), [www.chicagotribune.com/suburbs/daily-southtown/opinion/ct-sta-kadner-mental-st-0529-20150528-story.html](http://www.chicagotribune.com/suburbs/daily-southtown/opinion/ct-sta-kadner-mental-st-0529-20150528-story.html).

20. Alicia Fabbre, *Officials Break Ground On \$150M Inmate Hospital In Joliet*, CHI. TRIB. (Mar. 18, 2019), [www.chicagotribune.com/suburbs/daily-southtown/ct-sta-new-joliet-health-facility-st-0319-story.html](http://www.chicagotribune.com/suburbs/daily-southtown/ct-sta-new-joliet-health-facility-st-0319-story.html).

21. *Id.*

22. Christine Thompson, *Treatment Denied: Mental Health Crisis In Federal Prisons*, THE MARSHALL PROJECT (Nov. 21, 2018), [www.themarshallproject.org/2018/11/21/treatment-denied-the-mental-health-crisis-in-federal-prisons](http://www.themarshallproject.org/2018/11/21/treatment-denied-the-mental-health-crisis-in-federal-prisons).

23. *Id.*

24. ILL. DEP’T OF CORRS., FISCAL YEAR 2018 ANNUAL REPORT 18, (2018).

25. ILL. DEP’T OF CORRS., A SHORT HISTORY OF ILLINOIS CORRECTIONS (1970).

Governor Ogilvie said, “In Illinois, we keep our adult felons incarcerated for periods longer than forty-five other states, yet our rate of recidivism is one of the highest.”<sup>26</sup> The Governor concluded his message with a plea to the Task Force designed to put Illinois back on track in regards to rehabilitating prisoners into functioning members of society.<sup>27</sup> This statement was made in 1969, but still resonates today as Illinois is currently ranked eighth among the states in total mental health funding and maintains a high recidivism rate.<sup>28</sup>

Chicago’s Cook County jail is the largest single-site corrections facility in the United States.<sup>29</sup> It is also one of the largest mental health care providers in the country.<sup>30</sup> However, between 2009 and 2012, Illinois cut \$113.7 million from its budget for mental health services, causing at least two state-operated inpatient facilities and six Chicago clinics to close their doors.<sup>31</sup> As a result of limited facilities capable to house these individuals, roughly 2 million people with mental illness admitted into jails each year.<sup>32</sup>

To combat this issue, the Illinois Department of Corrections (“IDOC”) is building a new inpatient mental health facility that is expected to be open in Fall of 2021.<sup>33</sup> This facility will have 200 mental health beds and 50 medical beds, which will serve to deliver specialty care for patients requiring higher levels of service from throughout the state.<sup>34</sup> IDOC has identified mental health disorders in approximately thirty-one percent of its current population.<sup>35</sup> To help them reenter society, the prisoners will be offered case

---

26. *Id.*

27. *Id.* (“[t]he threat . . . must be met with all the skills, the tools, the financial backing and the dedication we can summon to the task”).

28. *Mental Health Spending*, *supra* note 14

29. Michaels, *supra* note 16.

30. *Id.*

31. *Id.*

32. *Id.*

33. ILL. DEP’T OF CORR., *supra* note 24.

34. *Id.*

35. *Id.*



management services and aid with housing, employment, and medical services which will include mental health services.<sup>36</sup> This program is designed to help mitigate the issues identified in the Harvard-led Boston Reentry Study.<sup>37</sup> In fact, from 2013 to 2018, Illinois recidivism rates have decreased from fifty-one to thirty-nine percent.<sup>38</sup> In order to continue to lower this rate, Illinois aims to bridge the gap between incarcerated offenders, community service providers, employers, policy experts and government agencies by providing opportunity, jobs, continued care, and stability to newly released prisoners.<sup>39</sup>

One program implemented in the Hill Correctional Center, called the Graduated Re-Entry Initiative, releases offenders from full confinement into a program-provided housing with tightly controlled conditions, allowing the prisoner to earn increased freedoms while gaining employment, training, or educational opportunities prior to full release.<sup>40</sup> This program has identified “four static areas and eight dynamic areas that contribute to recidivism.”<sup>41</sup> The static areas include mental/medical health, criminal history, response to supervision, and sexual offenses, while the dynamic areas include aggression, substance use, social network, family, employment/education, attitudes, adaptive skills, and stability.<sup>42</sup> A successful mental health program should aim to touch on these areas in order to decrease recidivism rates within populations of prisoners with mental health disorders.<sup>43</sup> The goal of the Graduated Re-entry Initiative at Hill Correctional Center is to assist offenders with successful re-entry leading to decreased recidivism, resulting in a lesser

---

36. *Id.* at 33, 35.

37. Russel, *supra* note 9.

38. ILL. DEP’T OF CORRS., *supra* note 33, at 2.

39. *Id.* at 26.

40. ILL. DEP’T OF CORRS., *supra* note 33, at 35.

41. *Id.*

42. *Id.*

43. *Id.*

cost to taxpayers.<sup>44</sup>

The success of the Hill Correctional Center Graduated Re-Entry Initiative, in conjunction with claims of preventable deaths and substandard medical care, Illinois state officials have agreed, in early 2019, to a sweeping overhaul of the health care system in prisons across the state.<sup>45</sup> This is in part due to a class action lawsuit filed about eight years ago alleging denial of adequate medical and dental care, putting prisoners at substantial risk of serious harm.<sup>46</sup> According to the Financial Impact Statement for 2017, Illinois spent approximately \$26,000 per prisoner during fiscal year 2016.<sup>47</sup> Illinois has a financial incentive to lower recidivism rates because a ten percent reduction in total state recidivism would generate more than \$301 million in taxpayer savings, which could then open these funds towards other services such as education.<sup>48</sup>

To that point, the 2020 Fiscal Year report indicates plans to continue funding mental health facilities at \$46.2 million in order to come into compliance with *Rasho v. Baldwin* settlement agreements.<sup>49</sup> In *Rasho*, the plaintiffs, who were prisoners of various institutions in Illinois, alleged that the IDOC punishes prisoners with mental illness, rather than treating them, and any treatment IDOC did provide was grossly inadequate.<sup>50</sup> In May 2016, IDOC agreed to completely revamp the way people with serious mental illness are treated within Illinois prisons.<sup>51</sup> However, in May 2017, a federal

---

44. *Id.*

45. Angie Leventis Lourgou, *Illinois Agrees to Health Care Reforms At All Prisons*, J STAR (Jan 4, 2019), [www.pjstar.com/news/20190104/illinois-agrees-to-health-care-reforms-at-all-prisons](http://www.pjstar.com/news/20190104/illinois-agrees-to-health-care-reforms-at-all-prisons).

46. *Id.*

47. ILL. DEP'T. OF CORR., FINANCIAL IMPACT STATEMENT 1 (2017).

48. Vincent Caruso, *Report: Recidivism to Cost Illinois More Than \$13B Over Next 5 Years*, ILL. POL. (Aug 3, 2018), [www.illinoispolicy.org/report-recidivism-to-cost-illinois-more-than-13b-over-next-5-years/](http://www.illinoispolicy.org/report-recidivism-to-cost-illinois-more-than-13b-over-next-5-years/).

49. JB PRITZKER, ILLINOIS STATE BUDGET FISCAL YEAR 2020, 26 (2019).

50. *Rasho v. Baldwin*, UPTOWN PEOPLE'S LAW CENTER, [www.uplcchicago.org/what-we-do/prison/rasho-v-baldwin.html](http://www.uplcchicago.org/what-we-do/prison/rasho-v-baldwin.html) (Last visited Dec. 3, 2019).

51. *Id.*

court monitor found that the IDOC failed to comply with the guidelines within the settlement agreement.<sup>52</sup> Some of the complaints included: insufficient number of psychiatric staff, problems with the continuation of medication, failure to monitor effects of psychiatric medications, backlogs in psychiatric evaluations, and deterioration of mental health for prisoners in solitary confinement.<sup>53</sup> Complying with the *Rasho* settlement agreement would go a long way to remedying the treatment of mental health prisoners, and while also positively impacting the recidivism rates within that specific prisoner population.<sup>54</sup>

In addition to the *Rasho* settlement agreement, the fiscal year 2020 budget also makes plans to meet the terms of the *Lippert* consent decree by allocating additional funding for “comprehensive medical and mental health contract.”<sup>55</sup> As part of the agreement in *Lippert v. Baldwin*, the State of Illinois has agreed to an overhaul of the system that provides health care to 40,000 state prisoners.<sup>56</sup> In *Lippert*, the Court found that the inmates who suffered from various illnesses were being provided insufficient medical care on a systematic basis that jeopardized their well-being, as well as the well-being of other prisoners within IDOC who also suffered from serious medical needs.<sup>57</sup> The *Rasho* and *Lippert* agreements, if followed, are steps in the right direction for adequate mental and physical health in prisoners.

While there is still much work to be done within Illinois prisons, the rates of recidivism have dropped and there are active plans to update and improve access to adequate health care for all prisoners within the state.<sup>58</sup> Hopefully,

---

52. *Id.*

53. *Id.*

54. *Id.*

55. PRITZKER, *supra* note 49, at 41.

56. ACLU of Ill., *Major Agreement Reached to Overhaul Inadequate Health Care in Illinois Prisons*, ACLU OF ILLINOIS (Jan 3, 2019), [www.aclu-il.org/en/press-releases/major-agreement-reached-overhaul-inadequate-health-care-illinois-prisons](http://www.aclu-il.org/en/press-releases/major-agreement-reached-overhaul-inadequate-health-care-illinois-prisons).

57. *Lippert v. Baldwin*, 2017 WL 1545672, 1, 9 (N.D. Ill. 2017).

58. Caruso, *supra* note 48.

these plans become reality, but until then, there remains an issue that mental health prisoners are being mistreated, poorly medicated, and released back into society without the tools to be successful.<sup>59</sup>

EXAMINING THE VIRGINIA DEPARTMENT OF CORRECTIONS RE-ENTRY  
MODEL

At 22.4%, Virginia has the lowest recidivism rate among forty-five states that report three-year re-incarceration rates.<sup>60</sup> Virginia attributes its success to its effective treatment while incarcerated, Re-Entry Programming, treatment offered by the Virginia Department of Corrections (VADOC), and its effective supervision in the community after release.<sup>61</sup> According to a November 2017 state recidivism comparison, VADOC tailors its programming and supervision to address each offender's criminogenic risks.<sup>62</sup>

According to a 2007 study by the National Conference of State Legislatures, correctional programs show increases in recidivism unless offenders who were higher risk for crimes and recidivism were targeted and provided more services for a longer period of time.<sup>63</sup> The goal of targeting programming is to increase public safety, risk reduction, efficiency, and deterrence of future crimes.<sup>64</sup> Criminogenic risk factors can be categorized into the "Big Four" and the "Central Eight".<sup>65</sup> History of antisocial behavior, antisocial personality pattern, antisocial cognition, antisocial associates, family and/or marital, school and/or work, leisure, and substance abuse all

---

59. *Id.*

60. VA. DEP'T OF CORR. *supra* note 18.

61. *Id.*

62. *Id.*

63. ROSEMARY KOOY, NCSL: DESIGNING & MEASURING CORRECTIONS & SENTENCING POLICY OPTIONS 3 (September 2007).

64. *Id.* at 4.

65. *Id.* at 6.

make up the major criminogenic risk factors.<sup>66</sup> The re-entry program, which is financed by a state appropriation and administered by the Department of Criminal Justice Services (“DCJS”), supports pre-release and post-incarceration professional services and guidance that increase the opportunity for, and the likelihood of, successful reintegration of adults upon release from prisons and jails into local communities.<sup>67</sup>

The creation of pre-release services is intended to prepare offenders for transition back into the community.<sup>68</sup> Jail pre-release services may include assessment, reentry and transition planning, training, counseling, mentoring, tutoring, information and referral.<sup>69</sup> Training programs, for example, focus on job readiness and employment skills, budgeting, consumer skills, family relationships, transition expectations, and related areas of value to offenders soon to be released.<sup>70</sup> When looking at the pre-release services, the pre-release services offered appear to implement the Boston Studies suggestions.<sup>71</sup> Post-incarceration services are provided to clients that have been recently released from incarceration and are intended to address specific needs in individual offenders to support successful integration into the community and sustain a crime-free life.<sup>72</sup> Some of these programs include assisting clients in obtaining stabilization and emergency services such as locating food, clothing, transportation, and shelter.<sup>73</sup>

Even with all the success, Virginia is not without its problems. In November of 2013, Virginia state senator Creigh Deeds’ son, Gus, who

---

66. *Id.*

67. Va. Dep’t of Criminal Justice Servs., *PAPIS: Virginia Prisoner Reentry Program*, VA. DEP’T OF CRIMINAL JUSTICE SERVS., [www.dcjs.virginia.gov/correctional-services/grants/papis-virginia-prisoner-reentry-program](http://www.dcjs.virginia.gov/correctional-services/grants/papis-virginia-prisoner-reentry-program). (Last visited Dec. 3, 2019)

68. *Id.*

69. *Id.*

70. *Id.*

71. *Id.*; see Russel *supra* note 9.

72. Va. Dep’t of Criminal Justice Servs. *supra* note 67.

73. *Id.*

suffered from mental illness, repeatedly stabbed Deeds.<sup>74</sup> Gus Deeds suffered from bipolar disorder and crippling paranoia.<sup>75</sup> As a result of this tragedy, Creigh Deeds, who survived the attack, urged his colleagues in Richmond to reform mental health laws within the state.<sup>76</sup> Turing to Illinois, and more specifically Cook County, at least a third of the inmates in Cook County Jail are mentally ill, overwhelming the staff.<sup>77</sup> Budget cuts throughout the state have left mentally ill patients in the community without access to medication and services, resulting in more mentally ill patients turning to jail to receive aid.<sup>78</sup> This problem is rampant throughout the United States; Dr. E. Fuller Torrey, founder of the Treatment Advocacy Center, estimated that there are three times more mentally ill people in jail and prisons than there are in hospitals.<sup>79</sup> Virginia's Re-Entry Program has proven to be a vital tactic to slow the rate of readmission of mentally ill, former prisoners.

VADOC and the Department of Behavioral Health and Development Services ("DBHDS") still seek ways to improve the development of criminal justice programs for individuals with serious mental illness.<sup>80</sup> DBHDS, with the help of criminal justice professionals, behavioral health professionals, advocates, and other stakeholders, has identified thirteen standards as essential and must be available to all individuals incarcerated as well as an additional standard as important, but not essential (Suicide Prevention Program).<sup>81</sup> Virginia's programs must provide the following:

---

74. Lauren Kirchner, *Jails and Emergency Rooms Are Our De Facto Mental Health Clinics*, PACIFIC STANDARD (Feb. 4, 2014), [www.psmag.com/navigation/health-and-behavior/jails-emergency-rooms-de-facto-mental-health-clinics-73948/](http://www.psmag.com/navigation/health-and-behavior/jails-emergency-rooms-de-facto-mental-health-clinics-73948/).

75. *Id.*

76. *Id.*

77. *Id.*

78. *Id.*

79. *Id.*

80. *Mental Health Standards for Jails*, VA. DEP'T OF BEHAV. HEALTH & DEV. SERVS., [www.dbhds.virginia.gov/forensic-services/mh-standards](http://www.dbhds.virginia.gov/forensic-services/mh-standards).

81. *Id.*

- 1) Access to Care;
- 2) Policies and Procedures defined in a manual;
- 3) Communicate Patient Needs;
- 4) Mental Health Training for Correctional Officers;
- 5) Mental Health Liaison designated with coordinating care with health care professionals;
- 6) Medication Services;
- 7) Proper Mental Health Screening;
- 8) Mental Health assessments;
- 9) Emergency Services;
- 10) Restrictive Housing to monitor mental health;
- 11) Continuity & Coordination of Health Care During Incarceration;
- 12) Discharge Planning;
- 13) Basic Mental Health Services for all inmates; and
- 14) Suicide Prevention Programs.<sup>82</sup>

The group identified compliance indicators, explored the degree to which jails were already meeting these standards, barriers to implementation, and what, if any, resources would be required.<sup>83</sup> With the thirteen essential standards, Virginia has been able to formulate its re-entry program to cater to the prisoners' needs once they leave.

#### CONCLUSION

While Virginia's model program may seem adequate and efficient, there is no one correct way to create a mental health program in prison that effectively reduces recidivism rates within mentally ill prisoners. That said,

---

82. *Id.*

83. *Id.*

there are some programs, such as the current Illinois programs, that are just plain ineffective. Illinois, via the court's ruling in *Rasho* and *Lippert*, aimed to update its plans, which may result in a decrease in recidivism rates. Virginia, on the other hand, has crafted a program designed for each incarcerated individual.<sup>84</sup> This individual-specific approach has resulted in incredibly low recidivism rates across the board within the Commonwealth of Virginia.<sup>85</sup> For Illinois, it must improve on two fronts. First, it must create an effective and efficient program pre-release. Specifically, Illinois should aim to follow or implement some of the standards used by the VADOC model for pre-release programs. This would provide incarcerated people an opportunity to get acclimated to life beyond the confines of the prison prior to being released. Not stopping there, Illinois should revamp its current mental health care within prisons in order to reflect Virginia's fourteen-point essential standard.<sup>86</sup> These points are vital in providing effective mental health care to individual prisoners.

Virginia has proven that more money does not necessarily result in success. They have been able to craft an effective re-entry program catered to their incarcerated people's needs, providing them with the tools necessary to re-enter society and stay there.<sup>87</sup> Illinois has yet to figure this out. However, using money more efficiently, in conjunction with a proper re-entry program, could help mitigate the problem before it begins. More comprehensive and easy to access mental health services could alleviate much of the burden placed upon prisons systems within Illinois.

---

84. VA. DEP'T OF CORR. *supra* note 18.

85. *Id.*

86. VA. DEP'T OF BEHAV. HEALTH & DEV. SERVS, *supra* note 80.

87. *Id.*





# Female Inmates and Access to Feminine Hygiene Products

Milea Moya

## INTRODUCTION

Female prisoners are the fastest growing demographic within the United States' incarcerated population "as it has risen by 700% since 1980."<sup>1</sup> The rapid growth in the female population brought challenges that do not exist within male incarcerated populations, such as access to feminine hygiene products. Courts have previously acknowledged that there are different grooming requirements for male and female inmates,<sup>2</sup> yet with this acknowledgment there have been issues with female inmates accessing adequate supplies of feminine sanitary supplies.<sup>3</sup> Considering that many of the incarcerated women are of reproductive age,<sup>4</sup> there is room for improvement within state and federal legislation to correct this issue.<sup>5</sup>

The Federal Bureau of Prisons ("BOP") review of correctional facilities revealed that female inmates' access to the necessary quantity of sanitary napkins varied by institution.<sup>6</sup> This review focused on the availability and

---

1. See Amanda Robert, *Feminine Protection*, A.B.A. J., June 2019 (showing the growing population of female prisoners); Holly Seibold & Gianna Fienberg, *Free to Bleed: VA House Bill 83 and the Dignity of Menstruating Inmates*, 22 RICH. PUB. INT. L. REV. 69, 78 (2019).

2. *Harrison v. Kernan*, No. 16-cv-07103-NJV, 2017 U.S. Dist. LEXIS 133525, at \*11 (N.D. Cal. Aug. 21, 2017).

3. OFF. OF THE INSPECTOR GEN., U.S. DEP'T OF JUSTICE, REVIEW OF THE FED. BUREAU OF PRISON'S MANAGEMENT OF ITS FEMALE INMATE POPULATION, 29-31 (Sept. 2018).

4. See BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, NCJ 250229, PRISONERS IN 2015 (2016), at 13 (reporting that only 7% of female state and federal prisoners were over the age of 55).

5. Abigail Durkin, *Profitable Menstruation: How the Cost of Feminine Hygiene Products is a Battle Against Reproductive Justice*, 18 GEO. J. GENDER & L. 131, 154 (2017).

6. OFF. OF THE INSPECTOR GEN., *supra* note 3, at 29.

quantity of free sanitary napkins provided by prisons.<sup>7</sup> This review adds to the growing literature that indicates that female prisoners should be provided with adequate access to feminine sanitary supplies at no cost to them.

This paper argues that access to feminine hygiene products is a basic right that female inmates have historically been deprived of, and therefore, legislation needs to be enacted to ensure that female inmates have access to feminine sanitary supplies. This article will delve into the lack of access that female prisoners experience in accessing the quantity of menstrual supplies required for their basic hygienic needs, as well as, the lack of access to quality supplies and basic options in menstrual products that address biological differences. Next, the paper will examine some of the barriers that currently prevent women from accessing the needed supplies such as prohibitive pricing of menstrual products. This paper will then discuss some of the ways in which the health of incarcerated women has been negatively impacted by the lack of basic feminine hygiene products. Finally, I will discuss some of the legislative barriers that have prevented all 50 states from implementing laws at the state level to provide access.

#### PROHIBITIVE PRICING

Correctional facilities treat some hygiene products as luxurious options rather than basic necessities for human health. While sanitary napkins are provided in most facilities for free, inmates are often given an insufficient fixed quantity.<sup>8</sup> Inmates report that the napkin's poor quality and lack of absorbency can lead to embarrassing accidents that result in the inmates being "forced to wear soiled clothing for days at a time."<sup>9</sup> At many

---

7. OFF. OF THE INSPECTOR GEN, *supra* note 3, at 29-31.

8. Seibold & Fienberg, *supra* note 1, at 77.

9. Seibold & Fienberg, *supra* note 1, at 79; *See also*, Lauren Shaw, *Bloody Hell: How Insufficient Access to Menstruation Hygiene Products Creates Inhumane Conditions for Incarcerated Women*, 6 TX. AM. L. R. 475, 478 (2019) (explaining that the napkins provided were low absorbency and no wings to securely fasten the napkin to under garments).

correctional facilities inmates have the option of purchasing tampons as an alternative to the sanitary napkins, but this comes at an exorbitant cost.<sup>10</sup> One prison commissary in the state of Maryland has been documented as selling a box of eighteen tampons for over \$5, while the average inmate in prison earns less than \$5 monthly.<sup>11</sup> Inmates who do not have financial support from friends and family to assist with purchasing sanitary items are often forced to decide between purchasing the feminine hygiene products or purchasing other necessities such as soap or toothpaste.<sup>12</sup>

By treating feminine hygiene products as a luxury instead of the basic necessity prisons are violating female prisoners' basic human rights.<sup>13</sup> There are reports of female prisoners being made to perform certain acts or being made to shame themselves in front of male guards in order to access hygiene products.<sup>14</sup> Female prisoners have been told by prison guards that they were not allowed to bathe after having soiled their clothing or bedding and have also been denied access to clean laundry and bedding.<sup>15</sup> Female inmates have

---

10. Siebold & Fienberg, *supra* note 1, at 79; Anne E. Marimow, *A New Law Promised MD's Inmates Free Tampons. They're Still Paying*, WASH. POST, (June 5, 2019); *See, e.g.*, Kristina Marusic, *The Sickening Truth About What It's Like to Get Your Period in Prison*, WOMEN'S HEALTH, July 7, 2013 (describing the high costs for menstrual supplies in comparison to the low wages earned by prisoners).

11. Marimow, *supra* note 10.

12. Marimow, *supra* note 10.

13. *See generally* Kate Walsh, *Inadequate Access: Reforming Reproductive Health Care Policies for Women Incarcerated in New York State Correctional Facilities*, 50 COLUM. J.L. & SOC. PROBS. 45, 80 (2016) (quoting Mayor de Blasio stating new law recognizes that access to hygiene products is a fundamental necessity and not a luxury); *see also*, Siebold & Fienberg, *supra* note 1, at 86-88 (explaining that state legislation ensuring feminine hygiene products for inmates "stands for the idea that the incarcerated deserve to live with dignity, and it recognizes that menstrual products are a basic, hygienic need, not a luxury").

14. *See, e.g.*, Shaw, *supra* note 9, at 476 (explaining how often times distribution of menstrual hygiene products are at the discretion of correction officers and access can also be limited as a form of humiliation).

15. *See, e.g.*, *Docherty v. Cape May Cty.*, No. CV 15-8785 (RMB), 2017 WL 2819963 (D.N.J. June 29, 2017) (describing a case brought on behalf of female inmates who have been denied access to hygiene items and were also forced to wear dirty, and soiled clothing); *See also*, *Semelbauer v. Muskegon Cty.*, No. 1:14-CV-1245, 2015 WL 9906265 (W.D. Mich. Sept. 11, 2015) (providing an additional example of female inmates that were denied access or suffered delayed to feminine hygiene items and clean clothing).

also stated that they have missed out on visitation days with loved ones in order to avoid being seen in soiled clothing.<sup>16</sup>

#### HEALTH CONCERNS

The lack of access to basic feminine hygiene products has led some inmates to create their own sanitary products from other objects they can readily find such as socks, mattress stuffing, notebook paper, or toilet paper, placing their health at risk.<sup>17</sup> These makeshift menstrual products leave female inmates susceptible to bacterial infections, Toxic Shock Syndrome, sepsis, or even death.<sup>18</sup> Unsafe practices and overall poor menstrual hygiene can negatively impact the health of female inmates, leaving them at higher than average rates to suffer bacterial infections such as urinary tract infections, and bacterial vaginosis.<sup>19</sup> These conditions do not remedy themselves when left untreated and require attention from a healthcare provider.<sup>20</sup>

#### GLOBAL DIGNITY FOR INCARCERATED WOMEN

Some European countries have recognized the need to alter or in some instances create policies and laws that secure the basic rights of female

---

16. Samantha Laufer, *Reproductive Healthcare Rights for Incarcerated Women: From “Rights” to “Dignity”*, 56 AM. CRIM. L. REV. 1785, 1800 (2019).

17. See Bailey Laske, *Tampons, Pads Cost Money in Michigan’s Women’s Prison*, SPARTAN NEWSROOM (June 12, 2018), <https://news.jrn.msu.edu/2018/06/tampons-pads-cost-money-in-michigans-womens-prison> (addressing the heightened rate of infections); See also Austin Huguelet, *Free Tampons for Inmates? Missouri House Gives Initial Yes*, SPRINGFIELD NEWS-LEADER (Feb. 22, 2019, 5:57 PM), <https://www.news-leader.com/story/news/politics/2019/02/22/missouri-state-prisons-free-tampons-new-bill/2950458002/1>; OFF. OF THE INSPECTOR GEN, *supra* note 3; See also Marimow, *supra* note 10, at 4.

18. See, Erin Polka, *The Monthly Shaming of Women in State Prisons*, PUB. HEALTH POST (Sept. 4, 2018) <https://www.publichealthpost.org/news/sanitary-products-women-state-prisons/>.

19. See e.g., Shaw, *supra* note 9, at 481 (explaining that reused menstrual products can cause an abundance of infections), see also, Durkin, *supra* note 5 at 134 (explaining that tampons left in for too long cause infections).

20. See e.g., Durkin, *supra* note 5, at 164 (noting that infections directly impact health and can potentially lead to death).

inmates.<sup>21</sup> The United Nations, along with Thailand, authored and supported the enactment of the “Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders,” also known as the “Bangkok Rules” in 2010.<sup>22</sup> The Bangkok Rules were unanimously supported by 193 countries, and list roughly seventy requirements for the treatment of female prisoners.<sup>23</sup> Among the requirements contained in the Bangkok Rules are requirements for the provision of preventive health screenings, access to mental health, resources and treatment of substance abuse, and the prohibition of shackling female inmates in the labor and delivery process.<sup>24</sup> Most importantly, for the purposes of this article, the Bangkok Rules acknowledge that access to sanitary products is a basic human right.<sup>25</sup>

Similarly to the United Nation’s Bangkok Rules, is the creation of the Kiev Declaration on Women’s Health in Prison (“the Kiev Declaration”).<sup>26</sup> The Kiev Declaration was published with the assistance of the World Health Organization (WHO), and the Quaker’s offices at the United Nations in the United Nations and Brussels.<sup>27</sup> The Kiev Declaration provides recommendations for the healthcare of incarcerated women in support of their goal of correcting gender inequity in prison health.<sup>28</sup> The Kiev Declaration provides a checklist of recommendations that include mental health, care for pregnant and breast feeding women, and the provision of hygiene requirements such as sanitary towels, tampons, extra showers, and

---

21. See Patthara Limsira, *The United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders (Bangkok Rules)*, 4 J.E. ASIA & INT’L L. 241 (2011).

22. *Id.*

23. *Id.*

24. *Id.*

25. *Id.*

26. Brenda Van den Bergh & Alex Gatherer, *Women’s Health in Prison*, WHO REGIONAL OFFICE FOR EUROPE, [https://idhdp.com/mediaimport/7586/who\\_euro\\_unodc\\_women\\_s\\_health\\_in\\_prisons\\_check\\_list.pdf](https://idhdp.com/mediaimport/7586/who_euro_unodc_women_s_health_in_prisons_check_list.pdf) (2011).

27. *Id.*

28. *Id.*

soap.<sup>29</sup> The Kiev Declaration acknowledges that many facilities fail to cope with women's menstruation and specifies that acceptable sanitary products should be accessible to female prisoners.<sup>30</sup> The Kiev Declaration goes on to further state that females should have access to proper disposal methods for menstrual waste and access to frequent showers in bathing facilities that offer privacy.<sup>31</sup>

The provisions of the Kiev Declaration contain similar rules and recommendations as the Bangkok Rules, but goes a step further by directly addressing prison staff and administrators.<sup>32</sup> The Kiev Declaration suggests that prison staff undergo gender sensitivity training, and human rights training.<sup>33</sup> The Kiev Declaration discusses the importance of training staff members due to the fact that they routinely come into contact with the prisoners.<sup>34</sup> These ideas are in alignment with the provisions promoted within the Dignity Act, discussed below, which establishes that female prisoners are still human beings that should be treated with dignity.<sup>35</sup>

#### DIGNITY FOR INCARCERATED WOMEN IN AMERICA

The struggles female inmates face in securing adequate access to feminine hygiene products have caught the attention of politicians in the United States. In 2017, Senators Corey Booker, Elizabeth Warren, Kamala Harris, and Dick Durbin introduced the Dignity Act for Incarcerated Women ("Dignity Act") to Congress.<sup>36</sup> Along with female prisoners visitation rights with family members, the bill addresses pregnant inmates' ability to give birth without

---

29. *Id.*

30. *Id.*

31. *Id.*

32. *Id.*; see also Limsira, *supra* note 21 (noting the similarities between the Bangkok Rules and Kiev declaration).

33. Van den Bergh, *supra* note 26.

34. *Id.*

35. Dignity for Incarcerated Women Act of 2017, S.1524, 115th Cong. (*preamble*) (2017).

36. Dignity for Incarcerated Women Act of 2017, S.1524, 115th Cong. (2017).

being shackled, and having access to free feminine hygiene products paid for by the prisons.<sup>37</sup> However, the proposed bill did not make it past the senate judiciary.<sup>38</sup> In 2019, the Dignity Act was reintroduced by U.S. Representatives Pramilla Jaypal and Karen Bass.<sup>39</sup>

In August of 2017, the BOP released a memo (“the Memo”) providing guidance on the feminine hygiene products that were to be supplied to its female prisoners.<sup>40</sup> The Memo specifies that sanitary napkins and tampons will be provided in regular and super absorbencies, but did not specify exactly how they should be provided.<sup>41</sup> While the Memo is well intentioned, it leaves implementation up to the prisons. For example, the Memo does not specify whether the sanitary napkins and tampons should be issued, or if the inmate must make a request for the products.<sup>42</sup> The Memo also fails to address the issue of timeliness, when should the hygiene products be issued, or how long after the request has been made must the inmates wait to receive the products.<sup>43</sup> In addition to lack of guidance on implementation, the Memo also fails to provide support for enforcement, and there is concern women still have to pay for their feminine hygiene items in some federal prisons, women still have to pay for their feminine hygiene items. The Dignity Act is being used to appeal to lawmakers and convince them that female prisoners should be treated as humans.<sup>44</sup> The incarceration itself, is the punishment for the inmates, barring access to basic daily necessities is unnecessary.<sup>45</sup>

---

37. *Id.* at §2(c) (visitation rights), §2(j)(1) (healthcare products), §2(d) (prohibition on shackling pregnant prisoners).

38. Dignity for Incarcerated Women Act of 2017, S.1524, 115th Cong. (2017).

39. Dignity for Incarcerated Women Act of 2019, H.R. 2034, 116th Cong. (preamble) (2019).

40. FED. BUREAU OF PRISONS, U.S. DEP’T OF JUSTICE, OPERATIONS MEMORANDUM 001-2017, PROVISIONS OF FEMININE HYGIENE PRODUCTS (2017).

41. *Id.*

42. *Id.*

43. *Id.*

44. S.1524 *supra* note 35.

45. *See generally*, Shaw, *supra* note 9, at 489 (explaining how the lack of freedom is one punishment, combined with the lack of access to feminine supplies it creates an eighth



In addition to the Memo, the Office of the Inspector General (“OIG”) conducted a review of BOP’s capacity to address the need of female inmates.<sup>46</sup> The OIG made field visits to twenty-nine institutions that house female inmates and noted that the access to feminine hygiene products varied by institution.<sup>47</sup> The inconsistencies in implementation leaves the menstrual needs of some female prisoners unmet. On average, a period typically lasts between four to five days, and blood loss for a woman with normal menstrual flow is between 10 to 35 ml per cycle.<sup>48</sup> A soaked sanitary napkin or tampon has the capacity to hold 5 ml of blood.<sup>49</sup> These statistics apply for women with regular flow but blood flow varies from person to person and also changes with age as well as life changing events such as childbirth.<sup>50</sup> Those with heavy flows can lose more than 80 ml in a given menstrual cycle, this would require using between nine and twelve regular sized sanitary napkins or tampons.<sup>51</sup> Regardless of flow, it is still recommended that women change their menstrual products every four to eight hours to remain hygienic and prevent growth of bacteria.<sup>52</sup> Recommendations for the number of sanitary napkins or tampons to be used during a cycle range from ten to twenty.<sup>53</sup>

---

amendment violation).

46. OFF. OF THE INSPECTOR GEN, *supra* note 3, at 29.

47. OFF. OF THE INSPECTOR GEN, *supra* note 3, at 3 n. \*8, 29.

48. CTR FOR DISEASE CONTROL AND PREVENTION, *Bleeding Disorders in Women*, <https://www.cdc.gov/ncbddd/blooddisorders/women/menorrhagia.html> (December 20, 2017) (explaining the average length of a period); *See also*, Jerilynn Prior, *Very Heavy Menstrual Flow*, *the Centre for Menstrual Cycle and Ovulation Research*, <https://www.cemcor.ubc.ca/resources/very-heavy-menstrual-flow> (October 4, 2017) (explaining the average amount of blood loss during a menstrual cycle).

49. Prior, *supra* note 48 (describing normal menstrual flow); *See also*, CLEV. CLINIC, *Is My Period Normal? How Menstrual Cycles Change With Age*, <https://health.clevelandclinic.org/is-my-period-normal-how-your-menstrual-cycle-change-as-you-age/> (November 28, 2018) (explaining how menstrual cycles change with age).

50. Prior, *supra* note 48.

51. *Id.*

52. *See e.g.*, Tracee Cornforth, *How Often to Change Tampons or Pads During Your Period*, VERYWELL HEALTH, <https://www.verywellhealth.com/menstrual-hygiene-how-often-to-change-tampons-or-pads-3522511> (November 14, 2019) (verifying the general guidance of changing sanitary products every four to eight hours); *See also*, Laske, *supra* note 17.

53. *See generally*, Cornforth, *supra* note 52 (explaining that feminine products should be changed every four hours which supports that on average a woman will change feminine

Within the prison system, some facilities provide the recommended supply, while there are other facilities who issue less.<sup>54</sup> There are also reports in some facilities where it is alleged that favoritism of the correctional officers also effects the distributed supply.<sup>55</sup>

While the Memo and follow-on guidance addressed the concerns that women face regarding to access to feminine hygiene products in federal correctional facilities, the majority of incarcerated females are located in state and local jails and prisons.<sup>56</sup> This means that in order to have an impact on a larger scale that will be appreciated by the female incarcerated population, states will have to act independently on behalf of female prisoners and create legislation to support access to free feminine hygiene products.<sup>57</sup>

#### STATE LEVEL INVOLVEMENT

After the initial introduction of the Dignity Act, many states created their own versions of the Dignity Act, including New York, Illinois, Alabama, Louisiana, and Texas.<sup>58</sup> While the state level involvement is certainly a step in the right direction, there is room for improvement within the state enacted statutes. For example, while New York requires sanitary napkins be provided, it does not specify how many napkins, or when they should be

---

hygiene products approximately six times in a day if changed every four hours); *See also*, CTR FOR DISEASE CONTROL AND PREVENTION, *supra* note 48 (explaining the average length of a period).

54. *See e.g.*, OFF. OF THE INSPECTOR GEN, *supra* note 3, at 29-30, (explaining that access to feminine products in the institutions surveyed).

55. *See e.g.*, Shaw, *supra* note 9 (detailing how prison guards distribute sanitary supplies to individuals they favor).

56. *See* BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, NCJ 250229, PRISONERS IN 2015 (2016), at 5 (reporting that Federal correctional facilities housed 12,953 female inmates in 2015, while state correctional facilities housed 98,542 female inmates).

57. *See generally*, Aleks Kajstura, *Women's Mass Incarceration: The Whole Pie 2019*, Prison Policy Initiative, <https://www.prisonpolicy.org/reports/pic2019women.html> (October 29, 2019) (illustrating that the population of women incarcerated in state and local jails and prisons outweighs the number of women incarcerated in federal institutions. Supporting the need for state and local legislature to be created in order to benefit these women).

58. *See* 83 N.Y. Jur. 2d Penal and Correctional Institutions §238; *see also* 105 ILCS 5/10-20.63, AL ST § 14-3-44, LA R.S. 15:892.1.; *see also* Tx Gov't § 501.0675 (mandating feminine hygiene products for the states NY, IL, AL, LA, and TX).

provided.<sup>59</sup> In New York and Connecticut, inmates are given a fixed amount monthly, and if a woman requires more napkins, she must either bring a used sanitary napkin to the health services unit to receive more, or have the money to buy supplies from the commissary or obtain a medical permit for more, one prison, that is now closed, required the inmate to produce the napkin to receive more.<sup>60</sup>

Grassroots movements and advocacy groups are assisting incarcerated women and bringing attention to the cause.<sup>61</sup> These groups and activists continue to spread awareness of issues that affect incarcerated women and their families.<sup>62</sup> However, with the increased awareness on the issue of female inmates and their access to feminine hygiene products there are still a number of states that have not adopted legislation in support of free menstrual products for incarcerated women.<sup>63</sup>

States that have yet to adopt a version of the Dignity Act include Vermont, Nevada, Missouri, and Utah.<sup>64</sup> The failure to enact laws such as the Dignity Act impact not only the female prisoners that are being deprived of these basic necessities, they also adversely impact the families and loved ones of the incarcerated women.<sup>65</sup> For example, in Missouri state prisons, sanitary

---

59. Walsh, *supra* note 13, at 55; 83 N.Y. JUR. 2D PENAL AND CORRECTIONAL INSTITUTIONS §238.

60. Walsh, *supra* note 13, at 56 (explaining that New York inmates are given 24 napkins monthly, inmates need medical permission to receive more, and one, now closed prison, required inmates show the used napkin prior to receiving more); Seibold & Fienberg, *supra* note 1, at 78-79 (Connecticut inmates are given 10 sanitary napkins per cycle and can purchase more).

61. See generally Robert, *supra* note 1 (ABA Criminal Justice Section drafting a resolution in response to inmates not receiving necessary sanitary napkins); ACLU VERMONT, *New Prison Plan Undermines Criminal Justice Reforms*, <https://www.acluvt.org/en/news/new-prison-plan-undermines-criminal-justice-reforms> (April, 24 2019); #cut50, *Dignity for Incarcerated Women*, <https://www.cut50.org/dignity> (last updated 2019).

62. ACLU VERMONT, *supra* note 61.

63. *Id.*

64. See e.g., #cut50, *supra* note 61 (illustrating which states have signed Dignity Act legislation into law).

65. Brenda J. van den Bergh et al., WORLD HEALTH ORG, *Women's Health in Prison: Urgent Need For Improvement in Gender Equity and Social Justice*,

napkins are provided free to inmates, but not tampons.<sup>66</sup> In Salt Lake City is operating a pilot program that provides free sanitary napkins and tampons in the its public buildings, however this program does not extend to state jails and prisons.<sup>67</sup>

#### STATE LEGISLATIVE BARRIERS

Supplying free sanitary products to female inmates comes at a price.<sup>68</sup> However, the price of maintaining an adequate supply of sanitary products would arguably be less than the medical treatment for female inmates who are at risk of developing Toxic Shock Syndrome, or other related infections, from fashioning their own products, reusing products, or keeping items such as tampons inside their bodies for too long.<sup>69</sup> This raises the question, if other countries as well as other states within the U.S. can recognize that access to feminine hygiene is a basic human right, what is keeping states like Utah from doing the same? The legislative history of the states that lack the Dignity Act have simply not made the issue a priority.

Between January 2018 and March 21, 2019, there were over 1,400 grievances reported by inmates housed in Vermont's only female prison.<sup>70</sup>

---

<https://www.who.int/bulletin/volumes/87/6/09-066928/en/> (2019).

66. Lexi Churchill, *Inmates Have to Buy their Own Tampons, But Missouri Prisons Provide Pads for Free*, ST. LOUIS POST-DISPATCH, [https://www.stltoday.com/news/local/crime-and-courts/inmates-have-to-buy-their-own-tampons-but-missouri-prisons/article\\_34068ab4-378f-5c57-8e06-c1e5006a5c1e.html](https://www.stltoday.com/news/local/crime-and-courts/inmates-have-to-buy-their-own-tampons-but-missouri-prisons/article_34068ab4-378f-5c57-8e06-c1e5006a5c1e.html) April 29, 2019.

67. Carrie Gaykowski, Letter, *Dignity for Utah's Incarcerated Women*, SALT LAKE TRIB., <https://www.sltrib.com/opinion/letters/2019/10/02/letter-dignity-utahs/> October 2, 2019.

68. See e.g., Marimow, *supra* note 10 (detailing the proposed Baltimore, MD budget of \$81,000 to support the provision of free sanitary supplies for prisoners); See also, Jesse Paul, *Colorado's Prisons Offer Free Tampons to Inmates. The State's Jails Might Soon be Required to as Well*, THE COLORADO SUN, <https://coloradosun.com/2019/03/19/colorado-jails-tampons-house-bill-1224/> (March 19, 2019) (describing Colorado's 2017 amended budget to accommodate the provision of sanitary supplies to federal inmates).

69. Durkin, *supra* note 5, at 134.

70. Ellie French, *Critics: Vt. Women's Prison "The Worst"*, VTDIGGER, <https://vtdigger.org/2019/03/21/panelists-raise-issues-medical-care-complaint-process-womens-prison/> March 21, 2019.

Grievances include complaints of untimely medical care, as well as, lack of access to running water.<sup>71</sup> The executive director of the Vermont ACLU writes that Vermonters would favor alternatives to incarceration, such as halfway homes or step-down facilities, rather than an expensive replacement for the female facility.<sup>72</sup>

Perhaps the largest barrier between incarcerated women and access to hygiene products is the general bad attitude that some legislators have expressed towards the cause.<sup>73</sup> In February of 2018, a bill was introduced in the Arizona House that would provide unlimited and free feminine hygiene products to incarcerated females in state facilities, but Rep. T.J. Shope stated that he did not intend to hear the bill, effectively stalling its approval.<sup>74</sup> The bill eventually received necessary approval from an all-male committee, but not before the hashtag “#letitflow” was created on social media and women began sending sanitary napkins and tampons to the department of corrections in the care of Rep. Shope.<sup>75</sup>

As recently as March of 2019, Maine politician Rep. Richard Pickett was on record making the statement that providing free menstrual products to female inmates would make jails more like “country clubs”.<sup>76</sup> As a society,

---

71. *Id.*

72. James Lyall, Commentary, *New Prison Plan Undermines Criminal Justice Reforms*, VTDIGGER, <https://vtdigger.org/2019/04/11/james-lyall-new-prison-plan-undermines-criminal-justice-reforms/> April 11, 2019.

73. See Lauren McCauley, *Maine GOP Rep. Says Access to Menstrual Products Would Make Jail Like “Country Clubs”*, MAINE BEACON, <https://mainebeacon.com/maine-gop-rep-says-access-to-menstrual-products-would-make-jails-like-country-clubs/> (2019).

74. Kaila White, *Arizona Legislator Kills Bill that Would have Given Female Inmates Free Feminine Products*, REPUBLIC, <https://www.azcentral.com/story/news/politics/legislature/2018/02/12/mail-pads-tampons-arizona-rep-tj-shope-stall-bill-inmates-free-menstrual-products-rep-athena-salman/330496002/> Feb. 12, 2018; See also Amir Vera, *Why Women in Arizona are Sending a State Representative Pads and Tampons*, CNN: HEALTH (Feb. 13, 2018, 3:04 AM), <https://www.cnn.com/2018/02/13/health/women-pads-arizona-state-representative-trnd/index.html>.

75. White, *supra* note 74.

76. Lauren McCauley, *Maine GOP Rep. Says Access to Menstrual Products Would Make Jail like “Country Clubs”*, MAINE BEACON (Mar. 18, 2019), <https://mainebeacon.com/maine-gop-rep-says-access-to-menstrual-products-would-make->

we are now aware of the issue that exists, we also know of potential solutions to this issue, but the general bad attitudes encountered on the road to change have served as a hinderance. When those who are entrusted to advocate and create laws to protect their constituents make disparaging comments or refuse to hear bills, they are effectively saying that female inmates do not deserve to be treated with basic human dignity.

#### CONCLUSION

The United States is behind the curve when compared to other countries who have implemented policies in favor of providing female prisoners with consistent and adequate access to feminine hygiene products. Lack of legislature in certain states combined with vague language in current policies create gaps that allow for the needs of female prisoners to be unmet. While state level Dignity Acts are helpful to women in the prison system, incarcerated women are still vulnerable to the barriers that prevent the necessary access to feminine hygiene products. The Dignity Act has been helpful in bringing this issue to the forefront and giving women a voice. While changes have been made in certain areas, the vagueness in the language that creates some of these laws keeps any measurable improvements from being made. When the rules can be left up to the interpretation of those with the power to enforce said rules, there is little chance of uniformity from state to state or within the states themselves. Incarcerated women have been embarrassed, humiliated, and made to live their incarcerated lives in shame while on their periods. State and federal legislators need to enact the necessary legislature to allow female inmates access to feminine hygiene products at no cost and allow them to maintain their both their health and dignity.



# Using Nature to Improve and Challenge Solitary Confinement

Victoria (“Peggy”) Frazier

## I. INTRODUCTION

Solitary confinement (“solitary”) has a long and convoluted history in the U.S.<sup>1</sup> Initially, solitary started as a punishment for a crime, then it was deemed too harsh.<sup>2</sup> It fell out of favor as a penal punishment, but now has snuck back into use as a form of discipline in prisons.<sup>3</sup> Despite the growing literature indicating that solitary is not only detrimental to the individual,<sup>4</sup> but also fails to deter future disciplinary actions,<sup>5</sup> it remains widely used.<sup>6</sup> Further, courts have repeatedly ruled solitary as constitutional, unless a physical or objective violation occurred.<sup>7</sup>

Outside of the U.S., the use of solitary has been largely condemned and, depending on length of confinement, may be regarded as a form of torture.<sup>8</sup> However, the international community’s dislike for solitary has not been

---

1. Alexander A. Reinert, *Solitary Troubles*, 93 NOTRE DAME L. REV. 927, 937 (2018).

2. *Id.*

3. *Id.*

4. *Id.* at 929.

5. *Id.* at 972.

6. *Id.* at 937.

7. See Andrew Leon Hanna, *Series on Solitary Confinement & the Eighth Amendment: Article I of III*, 21 U. PA. J. CONST. L. ONLINE 1, 2 (“no federal court in America has held that solitary confinement is per se unconstitutional”); Maria A. Luise, *Solitary Confinement: Legal and Psychological Considerations*, 15 NEW ENG. J. CRIM. & CIV. CONFINEMENT 301, 302 (1989) (“solitary confinement has not been deemed unconstitutional per se”); Elizabeth Vasiliades, *Solitary Confinement and International Human Rights: Why the U.S. Prison System Fails Global Standards*, 21 AM. U. INT’L. REV. 71, 87 (2005) (“mental abuse or psychological harm . . . [are] unlikely to rise to a constitutional violation”).

8. Reinert, *supra* note 1, at 964; Anna Conley, *Torture in U.S. Jails and Prisons: An Analysis of Solitary Confinement Under International Law*, 7 VIENNA J. INT’L CONST. L. 415, 416 (2013).



enough to establish solitary as a violation of the Eighth Amendment.<sup>9</sup> In the U.S., solitary confinement cases have focused almost exclusively on the physical conditions of the prison cell and the physical health of the prisoner.<sup>10</sup> However, the Supreme Court has mentioned that what the public perceives as standard decency determines the extent of the Eighth Amendment.<sup>11</sup> Public perception related to solitary may be shifting, and as such, courts may soon be required to consider the psychological impact of solitary confinement.<sup>12</sup>

One way to help align prison policy with public perception is to allow prisoners in solitary access to nature, as nature has been shown to positively affect both the physical and mental well-being of individuals.<sup>13</sup> In today's society, access to nature is gaining recognition as a necessity for an individual's physical and mental health.<sup>14</sup> Thus, access to nature is becoming part of the standard of decency.<sup>15</sup> Therefore, courts faced with questions about solitary should be required to consider a prisoner's access to nature in determining if an Eighth Amendment violation occurred.<sup>16</sup> Simply put, courts

---

9. Luise, *supra* note 7.

10. See Luise, *supra* note 7, at 313 (“federal courts seem to focus on the physical needs of the prisoner as well as the physical conditions of the cell”); Peter Scharff Smith, *The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature*, 34 CRIME & JUST. 441, 444 (“while the courts feel confident in scrutinizing the physical conditions of imprisonment, they are hesitant to consider the psychological impact”) (internal quotations omitted).

11. *Trop v. Dulles*, 356 U.S. 86, 101 (1958).

12. See Luise, *supra* note 7, at 321 (“[t]he profound psychological effects resulting from this punishment, however, would appear to be unacceptable to contemporary society.”).

13. Matilda Annerstedt & Peter Währborg, *Nature-Assisted Therapy: Systematic Review of Controlled and Observational Studies*, 39 SCANDINAVIAN J. PUB. HEALTH, 371, 372 (2011) (summarizing literature that shows nature impacts three main health effects: “short-term recovery from stress or mental fatigue, faster physical recovery from illness, and long-term overall improvement on people’s health and well being”).

14. See, e.g., Richard G. Singer, *Confining Solitary Confinement: Constitutional Arguments for a New Penology*, 56 IOWA L. REV. 1251, 2164-72 (1971) (discussing various studies related to the psychological impacts of solitary); Brie A. Williams, *Older Prisoners and the Physical Health Effects of Solitary Confinement*, 106 AM. J. PUB. HEALTH 2126, 2126 (2016) (discussing the physical ailments associated with solitary).

15. See Yvonne Scannell, *A Right of Access to Nature*, 40 ENVTL. POL’Y. & L. 229, 229 (2010) (discussing access to nature being considered a human right).

16. See generally, Luise, *supra* note 7, at 302 (discussing that courts do not consider

should be forced to acknowledge that society's standard of decency has evolved and now includes having access to nature. Acknowledging that the standard of decency now includes access to nature would force courts to reconsider their stance on the constitutionality of solitary, and at a minimum would provide courts the ability to more strictly regulate solitary confinement.

This paper proposes that due to court precedent, solitary will not be ruled as an unconstitutional violation of the Eighth Amendment unless there is a physical or tangible violation of an inmate's rights.<sup>17</sup> However, a violation of the Eighth Amendment depends on society's evolving "standard of decency."<sup>18</sup> Society's standard of decency is evolving to include access to nature as a human right,<sup>19</sup> recognizing that access to nature has both physical and mental effects on an individual.<sup>20</sup> Thus, depriving an individual of access to nature will be viewed as a constitutional violation. Therefore, when deciding the constitutionality of solitary cases, courts should consider access to nature as a factor rather than limiting analyses to the physical conditions of the cell or the physical harms to the prisoner.<sup>21</sup> Furthermore, this paper recommends that prisons incorporate nature therapy into solitary confinement to reduce the harmful effects of solitary.<sup>22</sup>

This paper begins by providing an overview of what solitary confinement looks like in the U.S. and discusses the impact solitary has on an individual's physical and mental health. Next, the paper discusses how U.S. courts have ruled regarding the constitutionality of solitary, specifically with regards to

---

psychological impacts on a prisoner when conducting an Eighth Amendment analysis).

17. Smith, *supra* note 10, at 444.

18. Trop, 356 U.S. at 101.

19. Scannell, *supra* note 15.

20. *E.g.*, Williams, *supra* note 14, at 2126.

21. Luise, *supra* note 7, at 313.

22. Nalini M. Nadkarni et al., *Impacts of Nature Imagery on People in Severely Nature-Deprived Environments*, 15 FRONTIERS IN ECOLOGY & THE ENV'T 395, 398-400 (2017).

the Eighth Amendment. Then the paper addresses how access to nature is growing in recognition as a human right, both internationally and domestically. The paper then considers how this increased recognition could allow a court to regulate use of solitary and offers the possibility of incorporating nature therapy into solitary confinement as a possible method to minimize the harmful effects of solitary. Finally, the paper discusses how access to nature may pave the way for courts to reevaluate what factors should be considered when solitary is challenged as a violation of the Eighth Amendment.

## II. SOLITARY CONFINEMENT IN THE U.S.

Solitary refers to the practice in prisons of forcing an individual to remain separate from fellow inmates, usually as a discipline measure.<sup>23</sup> In practice, solitary looks like a bare cell, generally the size of a parking space, where inmates remain for close to twenty-three hours a day.<sup>24</sup> The inmates have around one hour of exercise during which they are still isolated from other people.<sup>25</sup> The individual may be separated for any length of time, from days to years.<sup>26</sup> According to a report by the Department of Justice, an average of twenty percent of the prison population has been forced into solitary for some length of time.<sup>27</sup> Furthermore, on any given day, approximately five percent of the prison population is held in solitary.<sup>28</sup> Although there is no established reporting method for determining how many people are in solitary at a time, the most recent estimate from 2016 puts the number at around 60,000 and

---

23. *E.g.*, Williams, *supra* note 14, at 2126.

24. *Id.*

25. *Id.*

26. *Id.*

27. Allen J. Beck, *Use of Restrictive Housing in U.S. Prisons and Jails, 2011-12*, BUREAU OF JUST. STAT. 1, 1 (2015).

28. Reinert, *supra* note 1, at 929.

70,000 individuals in solitary on any given day.<sup>29</sup>

The sheer volume of individuals experiencing solitary confinement is much more concerning when one realizes the detrimental effect solitary has on individuals.<sup>30</sup> In addition to increasing depression, anxiety, self-harm, and suicidal thoughts, solitary causes or exacerbates illnesses such as hypertension, diabetes, arthritis, and heart disease.<sup>31</sup> Furthermore, these effects can occur after only a few days in solitary.<sup>32</sup> In addition to these negative physical and mental effects, solitary confinement also fails to achieve basic criminal justice goals, such as deterrence or rehabilitation.<sup>33</sup> Thus, not only does solitary extract a high price on the individuals, it does so for no apparent reason.<sup>34</sup> Rather than deterring bad behavior, solitary increases the propensity of an inmate to use violence in the future, not only increasing the risk for the prison guards, but also making reentrance into society an undesirable affair.<sup>35</sup> Unfortunately, courts have been largely unwilling to look beyond the physical health of the individual and the physical site of confinement, the cell.<sup>36</sup> Therefore, despite the ever growing literature showing the negative effects of solitary on an individual's mental well-being, without an additional reason, courts will likely continue upholding solitary as complying with the Eighth Amendment unless a

---

29. Stephanie Wykstra, *The Case Against Solitary Confinement*, VOX (Apr. 17, 2019) <https://www.vox.com/future-perfect/2019/4/17/18305109/solitary-confinement-prison-criminal-justice-reform>; ASS'N OF ST. CORR. ADM'R & ARTHUR LIMAN PUB. INT. PROGRAM YALE L. SCH., *AIMING TO REDUCE TIME-IN-CELL: REPORTS FROM CORRECTIONAL SYSTEMS ON THE NUMBERS OF PRISONERS IN RESTRICTED HOUSING AND ON THE POTENTIAL OF POLICY CHANGES TO BRING ABOUT REFORMS*, 20-23 (2016).

30. Luise, *supra* note 7, at 302.

31. Williams, *supra* note 14.

32. See Reinert, *supra* note 1, at 972 & 931 (“[h]ealth effects can occur after only a few days of solitary confinement,” and international entities “condemn periods of extreme isolation longer than fifteen days”).

33. Reinert, *supra* note 1, at 972.

34. *Id.* at 972; Luise, *supra* note 7 at 320.

35. Luise, *supra* note 7 at 320.

36. *Id.* at 313.

grievous violation of rights is present.<sup>37</sup>

### III. CONSTITUTIONALITY OF SOLITARY CONFINEMENT IN THE U.S.

Within the U.S., the use of solitary is regulated under the Eighth Amendment's prohibition on cruel and unusual punishment.<sup>38</sup> Yet legislatures and courts have accepted that solitary confinement is usually not a violation of the Eighth Amendment.<sup>39</sup> The first U.S. case to mention solitary confinement was *In re Medley*, an 1890 Supreme Court case where a convicted murderer was subjected to solitary confinement for the weeks leading up to his execution.<sup>40</sup> According to the Court, the issue of solitary confinement "is not . . . a mere unimportant regulation."<sup>41</sup> The Court then discusses an article that listed some of the negative effects of solitary that were known at the time and how the article led to modifications of the prison system.<sup>42</sup> The Court finishes by pointing out that even after these modifications, the general public found "solitary confinement . . . too severe."<sup>43</sup>

After considering the use of solitary in the U.S., the Court looked back to England's law, which first established the use of solitary confinement as a punishment worse than death to deter the rising number of murders at the time.<sup>44</sup> However, as with the American law, public opinion found the punishment too severe, and the act was repealed.<sup>45</sup> The Court ultimately determined "solitary confinement . . . was an additional punishment of the

---

37. *Id.* at 316.

38. *Id.* at 301-02.

39. *Id.* at 302.

40. *In re Medley*, 134 U.S. 160, 161-62 (1890).

41. *Id.* at 167.

42. *See id.* at 168 ("[i]t became evident that some changes must be made in the system, and the separate system was originated by the Philadelphia Society for Ameliorating the Miseries of Public Prisons").

43. *Id.*

44. *Id.* at 170.

45. *Id.*

most important and painful character, and is, therefore, forbidden by this provision of the Constitution of the United States.”<sup>46</sup> As a result, of the negative public opinion and the Court’s decision, use of solitary plummeted.<sup>47</sup>

Despite the consensus that solitary was too severe to be a criminal punishment, it regained use as a method of keeping order within the prisons.<sup>48</sup> Once it started as a form of discipline, courts were generally unwilling to criticize the prison administrator’s decisions of maintaining order.<sup>49</sup> The Court in *Rhodes v. Chapman*, determined that: “[c]ourts must and do recognize the primacy of the legislative and executive authorities in the administration of prisons; however, if the prison authorities do not conform to constitutional minima, the courts are under an obligation to take steps to remedy the violations.”<sup>50</sup> Though what counts as “constitutional minima” is not clearly defined,<sup>51</sup> the U.S. Bureau of Prisons (BOP) and the American Correctional Association (ACA) have established their own minimum requirements.<sup>52</sup> These include the cell be “well ventilated, adequately lighted, appropriately heated, and sanitary.”<sup>53</sup>

Unfortunately, though the standards exist, they are not adhered to nearly enough.<sup>54</sup> While it is understandable for courts to give a great deal of

---

46. *Id.* at 171.

47. *See Reinert, supra* note 1, at 937 (“By the end of the nineteenth century, state legislatures had concluded that it [solitary confinement] was not an appropriate punishment for violations of criminal law”).

48. *See id.*, at 937 (“[solitary confinement] reemerged in force in the 1960s and 1970s as a disciplinary response to disorder within prison, and by the 1990s many states constructed facilities dedicated solely to solitary confinement”).

49. Luise, *supra* note 7, at 304; *Rhodes v. Chapman*, 452 U.S. 337, 362 (1981).

50. *Rhodes*, 452 U.S. at 362.

51. *Id.*

52. Singer, *supra* note 14, at 2154.

53. *Id.* at 1255.

54. *See id.* at 2155 (“[c]ases involving challenges to the constitutionality of solitary confinement, however, demonstrate that these standards are violated more frequently than they are observed and that numerous state prisons pay no attention to them at all”).

deference to prison administrators regarding what counts as appropriate punishment, failing to keep administrators to the bare minimum standards set by the BOP and ACA is not.<sup>55</sup> Since solitary has such detrimental and well known negative effects on individuals, courts should be more inclined to ensure that the individual's rights are not being violated through regulation of the practice of solitary confinement.

Yet, in recent times, there has been a serious lack of solitary confinement court cases that have made their way up to the Supreme Court.<sup>56</sup> The closest mention of solitary confinement occurred in 2015, in Justice Kennedy's concurrence in *Davis v. Ayala*, which he writes specifically to address the issue of solitary confinement.<sup>57</sup> The concurrence is relevant for two main purposes. The first purpose is his acknowledgement that the Court condemned solitary back in 1890.<sup>58</sup> The second is his recognition that lack of public knowledge and interest in solitary has not been "sufficient" to regulate it.<sup>59</sup> He further notes the disconnect surrounding correctional policies; the public assumes the lawyers and judges are ensuring the policies are legal, while the lawyers and judges assume it is the legislature's duty to ensure the correctional policies are sound.<sup>60</sup>

Regarding the Eighth Amendment as a whole, the Supreme Court in *Trop v. Dulles*, said that the "basic concept underlying the Eighth Amendment is nothing less than the dignity of man" and then goes on to say that the "words of the Amendment are not precise, and their scope is not static."<sup>61</sup> The Court

---

55. Luise, *supra* note 7, at 322-23.

56. Christopher Zoukis, *Solitary Confinement Reforms Sweeping the Nation but Still Not Enough*, PRISON LEGAL NEWS (Oct. 8, 2018) ("[t]he U.S. Supreme Court has not ruled on the constitutionality of 'administrative segregation,' a common form of solitary confinement").

57. *Davis v. Ayala*, 135 S. Ct. 2187, 2208-09 (2015).

58. *Id.* at 2209.

59. *Id.*

60. *Id.* at 2209-10.

61. *Trop v. Dulles*, 356 U.S. 86, 100-01 (1958).

also says “the Amendment must draw its meaning from the evolving standards of decency that mark the progress of a maturing society.”<sup>62</sup> Therefore, the Eighth Amendment “extends to more than just physical punishment . . . as society becomes wealthier, more comfortable . . . the constitutional minimum of decency in incarceration rises.”<sup>63</sup>

Focusing on the Court’s language of “evolving standards of decency” leads to the recognition that a number of actions that previously would have been considered a luxury are now considered a necessity.<sup>64</sup> For the purposes of this paper, one altered right is the right to access nature in the form of a healthy environment or “green spaces.”<sup>65</sup> As society becomes wealthier there is a greater and greater push to acknowledge that access to nature should be an internationally recognized human right.<sup>66</sup> With access to nature recognized as a human right, the deprivation of nature during solitary confinement should be viewed as a violation of the Eighth Amendment.

#### IV. ACCESS TO NATURE IN THE INTERNATIONAL AND DOMESTIC COMMUNITIES

Access to nature as a human right is gaining recognition both internationally and domestically as we, as a society, more fully acknowledge our inherent need for exposure to nature.<sup>67</sup> Internationally, over one hundred different countries have made access to a healthy environment a constitutionally protected right.<sup>68</sup> The United Nations has created a special

---

62. *Id.* at 101.

63. Luise, *supra* note 7, at 307.

64. Trop, 356 U.S. at 101.

65. Richard Mitchell & Frank Popham, *Effect of Exposure to Natural Environment on Health Inequalities: An Observational Population Study*, 372 THE LANCET 1655, 1655 (2008).

66. Scannell, *supra* note 15.

67. John H. Knox (Special Rapporteur on Human Rights and the Environment), Report of the Special Rapporteur on the issue of human rights obligations relating to the enjoyment of a safe, clean, healthy and sustainable environment, U.N. Doc. A/73/188 (July 19, 2018).

68. David R. Boyd (U.N. Special Rapporteur for Human Rights and the Environment),



department to evaluate the right to nature, and the special rapporteur has declared, “Human life, health, and wellbeing, and dignity depend on access to clean water, clean air, and a healthy environment.”<sup>69</sup> The legislation reflects society’s changing standard of decency, which recognizes that nature is a human need.<sup>70</sup>

The recognition of nature as a human need is seen across the world. One prominent example of this recognition is Sweden’s Freedom to Roam (Right of Public Access), which allows “all people the right to roam free in nature” and the only cost is having “respect for nature and the animals living there.”<sup>71</sup> This right to roam on public and private property, without permission of the owner, is enshrined in Sweden’s law.<sup>72</sup> Other European countries have similar principles with the understanding that people have a right to access nature.<sup>73</sup> Moving beyond Europe, in Melbourne, Australia, trees were given identification numbers and email addresses to allow citizens to report problems, but in addition to reporting problems people began sending “heartfelt” emails to the trees.<sup>74</sup> Again changing continents, Ecuador in 2008 revised its constitution and became the first country to recognize nature as a legal entity, granting “the ecosystem itself . . . [to be] named as the defendant.”<sup>75</sup> These examples show the widespread opinion that access to

---

Special Rapporteur on Human Rights and the Environment at the Seventy-Third Session of the G.A. (Oct. 25 2018),

[www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=23789&LangID=E](http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=23789&LangID=E).

69. *Id.*

70. *Trop v. Dulles*, 356 U.S. 86, 101 (1958); Scannell, *supra* note 15.

71. Freedom to Roam, Visit Sweden, <https://visitsweden.com/freedomtoroam/> (last visited Oct 20, 2019).

72. *Id.*

73. JEN SOTOLONAGO, THIS LAND IS OUR LAND: PLACES IN EUROPE WHERE ACCESS TO NATURE IS A BASIC HUMAN RIGHT, AFAR (May 9, 2019) <https://www.afar.com/magazine/this-land-is-our-land-places-in-europe-where-access-to-nature-is-a-basic-human>.

74. Shaun Ley, *The Melbourne Treemail Phenomenon*, BBC RADIO (July 16, 2015), <https://www.bbc.com/news/magazine-33560182>.

75. Rights of Nature *Ecuador Adopts Rights of Nature in Constitution*, GLOBAL ALLIANCE FOR THE RIGHTS OF NATURE, <https://therightsofnature.org/ecuador-rights/> (last

nature is a human right.

Domestically, though legislation such as the Green New Deal includes language of accessing nature, it has not yet been adopted.<sup>76</sup> However, our need for nature can be seen in the rise of nature based therapies for all types of people from “troubled teens”<sup>77</sup> to nursing home patients<sup>78</sup> and hospital patients.<sup>79</sup> The increase in nature-based therapies has resulted in more research showing the physical and mental benefits of nature. For example, being in nature can decrease “blood pressure and stress” as well as “circulatory disease.”<sup>80</sup> Research also suggests a connection with nature can decrease obesity, diabetes, and ADHD.<sup>81</sup> All of these examples show our growing acceptance that nature is a human need, something to which everyone is entitled. Yet “an estimated 5.3 million Americans live or work in nature-deprived venues such as prisons.”<sup>82</sup>

#### V. NATURE AND SOLITARY CONFINEMENT

Application of the right to access nature in prison may set the stage for solitary being considered unconstitutional as a violation of a human right. Nevertheless, in the U.S., that outcome is not likely, due to precedent

---

visited Oct. 20, 2019).

76. See 116 H. Res. 109, (2019) (introduced in the House, Feb. 7, 2019, but no further action has been taken towards passing the legislation).

77. See Tori DeAngelis, *Therapy Gone Wild*, 44 AM. PSYCHOL. ASS'N. 48, 48 (Sept. 2013) <https://www.apa.org/monitor/2013/09/therapy-wild> (describing a therapist who works with troubled teens uses nature as a background to therapy sessions).

78. See Michael C. LaFerney, *Patients and Nurses Need to Reconnect with Nature*, REFLECTIONS ON NURSING LEADERSHIP (Sept. 1, 2016) [https://www.reflectionsonnursingleadership.org/commentary/more-commentary/Vol42\\_3\\_patients-and-nurses-need-to-reconnect-with-nature](https://www.reflectionsonnursingleadership.org/commentary/more-commentary/Vol42_3_patients-and-nurses-need-to-reconnect-with-nature) (recommending exposing nursing home patients to some form of nature for their well-being).

79. See Jared Green, *In Boston's Leading Hospitals, Nature is Part of the Therapy*, THE DIRT (Dec. 14, 2017) <https://dirt.asla.org/2017/12/14/in-boston-leading-hospitals-heal-with-nature/> (nature is part of the healing process in Boston's largest hospital).

80. Mitchell & Popham, *supra* note 65, at 1655, 1658.

81. Lindsey Phillips, *Using Nature as a Therapeutic Partner*, COUNSELING TODAY (Apr. 26, 2018).

82. Nadkarni et al., *supra* note 22, at 399.

regarding solitary.<sup>83</sup> However, the recognition that access to nature is a human right<sup>84</sup> and the fact that there are physical health effects when deprived of nature<sup>85</sup> should encourage courts to take a firmer stance on regulating solitary.

One potential way for courts to regulate solitary, a far cry short of claiming solitary is per se unconstitutional, but a step in the right direction, is by requiring prisons to incorporate nature-based therapies within solitary. One novel experiment from 2017 by Nadkarni, *et al*, within a prison suggests that access to physical nature is not even required, simply seeing videos or photographs of natural scenery are enough to reduce the negative health effects of solitary confinement.<sup>86</sup> The study gave the experimental group of inmates the option to watch slides or videos with scenes of nature during their exercise period.<sup>87</sup> It then looked at self-reported emotions as well as incidents of violence compared to the control group of inmates, who did not have the option of the nature scenes.<sup>88</sup> Results of the study indicate that inmates with the option of seeing nature scenes had a twenty-six percent decrease in violent incidents compared with the inmates who did not have the option of nature scenes.<sup>89</sup> The study suggests that there are relatively easy and cheap methods that could be implemented by prison staff to make solitary confinement more civilized.<sup>90</sup>

Given the ease of implementing a nature based therapy program into solitary as well as society's changing view regarding access to nature as a

---

83. See Luise, *supra* note 7, at 313-14 (discussing cases where solitary has been deemed constitutional).

84. Scannell, *supra* note 15.

85. Williams, *supra* note 14, at 2126-27.

86. Nadkarni et al., *supra* note 22, at 399.

87. *Id.* at 397.

88. *Id.* 398-400.

89. *Id.* at 400.

90. See generally, *id.*, at 397 (using a projector to portray the images and videos).

human right, challenging solitary confinement under the Eighth Amendment to limit and regulate its use gains some traction.<sup>91</sup> However, a number of obstacles remain before courts can regulate how a prison is run.<sup>92</sup> One of the greatest obstacles is that while internationally the right to access nature is considered a human right,<sup>93</sup> within the U.S. the recognition is not quite as blatant.<sup>94</sup> Thus, due to the lack of domestic law and a lack of court precedent, U.S. judges may have little incentive to consider including access to nature.<sup>95</sup>

Due to the lack of precedent, an inmate bringing a suit that solitary is a violation of the Eighth Amendment should focus both on the public's changing perception that access to nature is a human right<sup>96</sup> and on the physical impacts lack of access to nature has on an individual, such as heart disease.<sup>97</sup> Focusing on both the "standards of decency"<sup>98</sup> and the physical ailments would allow courts to incorporate access to nature as an additional factor to consider for Eighth Amendment cases while still adhering to precedent which focuses on more tangible instances of violations, such as an unheated cell.<sup>99</sup> Including access to nature as a part of an Eighth Amendment analysis would begin to break down the barriers that currently prevent

---

91. See Amy Fettig & Margo Schlanger, *Eight Principles for Reforming Solitary Confinement*, AM. PROSPECT (Oct. 6, 2015) ("the reduction and amelioration of solitary [are] necessary steps to its eventual elimination . . . [and one] important reform is to give prisoners in solitary access to outdoor exercise and a window with a view of outside"); Center for Constitutional Rights, *Solitary Confinement: Torture in U.S. Prisons*, (Mar. 15, 2017) ("[a]cross the United States and the world, there is an emerging movement calling for the end of solitary confinement").

92. Luise, *supra* note 7.

93. Scannell, *supra* note 15.

94. See *generally*, 116 H. Res. 109, (2019) (introduced in the House, Feb. 7, 2019, but no further action towards passing the legislation).

95. See Luise, *supra* note 7, at 309 (discussing factors a court uses to evaluate public perception, including precedent).

96. Scannell, *supra* note 15.

97. Williams, *supra* note 14.

98. *Trop v. Dulles*, 356 U.S. 86, 101 (1958).

99. Singer, *supra* note 14, at 1255 (describing the *Loux v. Rhay* case where an inmate's cell did not have heat, but there was no cause of action found).

solitary from being ruled as unconstitutional.

A second significant obstacle, which Justice Kennedy identified, is that solitary confinement is “out of sight and out of mind.”<sup>100</sup> His point being that solitary confinement is not a topic that receives wide media coverage, specifically because it is so isolated. Due to the lack of information about and awareness of solitary confinement, it is not something that the general public thinks about, and thus not something often considered by legislators.<sup>101</sup> However, Kennedy goes on to state that awareness is growing in the eye of the public, which “will aid in the consideration of the many issues solitary confinement presents.”<sup>102</sup> Therefore, given enough time, this issue will resolve itself. For the sake of the thousands of people subjected to solitary on a daily basis,<sup>103</sup> education and awareness of solitary should be encouraged to help speed up the process.

#### VI. CONCLUSION

Overall, despite being deemed too severe in 1890,<sup>104</sup> the use of solitary confinement is unlikely to end in the U.S. until the public puts solitary confinement on the list of problems to fix or a court deems that society’s standard of decency has evolved<sup>105</sup> and condemns use of solitary. However, one evolution of society’s standard of decency is access to nature, which has become viewed as an international human right.<sup>106</sup> As a result of this change, courts should consider access to nature as a factor to consider when

---

100. *Davis v. Ayala*, 135 S. Ct. 2187, 2209 (2015).

101. Aldina Mesic, *Solitary Confinement Offends Basic Humanity*, B.U. SCH. PUB. HEALTH (Feb. 6, 2018) <https://www.theguardian.com/world/2016/apr/27/what-is-solitary-confinement> (the lack of legislatively mandated reporting on solitary confinement has allowed very limited data to be available).

102. *Davis*, 135 S. Ct. at 2210.

103. Wykstra, *supra* note 29.

104. *In re Medley*, 134 U.S. 160, 168 (1890).

105. *Trop v. Dulles*, 356 U.S. 86, 101 (1958).

106. Scannell, *supra* note 15.

evaluating a violation of the Eighth Amendment. Additionally, courts should take into account the physical impacts nature, or the lack thereof, has on an individual's health.<sup>107</sup> With the incorporation of access to nature as a factor, future cases may be successful in forcing courts to regulate solitary, if not deem it unconstitutional. One way to regulate solitary and decrease the negative effects of solitary is by incorporating nature therapy into solitary.<sup>108</sup>

---

107. Annerstedt & Währborg, *supra* note 13, at 372.

108. Nadkarni et al., *supra* note 22, at 400.



# The Need for a Universal Adoption of the Medicaid Expansion

Jessica Lubin

## INTRODUCTION

Historically, Medicaid eligibility was generally limited to certain low-income children, pregnant women, parents of dependent children, the elderly, and individuals with disabilities.<sup>1</sup> As a result of those categorical requirements, many justice-involved individuals were not eligible for Medicaid and were unable to obtain the health care services they needed upon release from correctional facilities.<sup>2</sup> Ironically, these same individuals have historically had higher rates of chronic and infectious diseases when compared with the general, non-incarcerated population.<sup>3</sup> Justice-involved populations are also several times more likely to suffer from mental health problems and have higher rates of substance use and dependence.<sup>4</sup> Despite having significant health care needs, many of these individuals often do not receive the necessary medical care and attention that they require while incarcerated.<sup>5</sup> Because the majority of individuals leaving jails and prisons<sup>6</sup>

---

1. ALISON MITCHELL, *THE ACA MEDICAID EXPANSION* 1 (2014).

2. LAURA TOBLER, *PROVIDING HEALTHCARE COVERAGE FOR FORMER INMATES* 22, at 1 (2014).

3. *Id.*

4. Katy Welter, Jennie Sutcliffe & Sarah Somers, *Unlocking the Affordable Care Act's Potential for Justice-Involved Individuals*, 2016 CLEARINGHOUSE REV. 1 (2016).

5. Catherine McKee, et al., *State Medicaid Eligibility Policies for Individuals Moving Into and Out of Incarceration*, THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, August 2015, at 3.

6. See MERRIAM-WEBSTER, <https://www.merriam-webster.com/words-at-play/jail-vs-prison-difference> (last visited Nov. 17, 2019). (defining jail as a place for those awaiting trial or held for minor crimes while prison describes a place for convicted criminals of serious crimes.)



do not have health insurance, they continue to lack access to adequate health care after release.<sup>7</sup>

However, with the passing of the Patient Protection and Affordable Care Act (ACA), states were offered the *option* to extend Medicaid coverage to most non-elderly, non-pregnant adults with income up to 133 percent of the federal poverty level.<sup>8</sup> The ACA offered a chance for states to cover more individuals involved with the criminal justice system, with additional federal support starting in January 2014.<sup>9</sup> Because the 2012 Supreme Court decision in *National Federation of Independent Business (NFIP) v. Sebelius* made the Medicaid expansion optional rather than mandatory,<sup>10</sup> much of the criminal justice-involved population still lack access to health care.<sup>11</sup> As of August 1, 2019, thirty-seven states, including Washington D.C., have adopted the Medicaid expansion while fourteen states have not adopted the Medicaid expansion.<sup>12</sup> Generally speaking, the states' adoption of the Medicaid expansion has resulted in positive change, most notably the increased equitable access to health care among justice involved populations.<sup>13</sup> Moreover, increased access to health care has provided opportunities for improved availability of higher quality care for patients.<sup>14</sup> Expansion states are finding that the vast majority of those incarcerated lack healthcare, despite being eligible for Medicaid prior to reentry, which has had a

---

7. *Id.*

8. MITCHELL *supra* note 1, at 1; NAT'L FED'N OF INDEP. BUS. V. SEBELIUS, 567 U.S. 519, 588 (2012).

9. THE PEW CHARITABLE TRUSTS 3 (2015) [Hereinafter Pew].

10. MITCHELL *supra* note 1, at 4; *See* Sebelius, 567 U.S. at 690.

11. *See* TOBLER *supra* note 2, at 1 (explaining that justice-involved individuals lacked coverage where states didn't expand Medicaid).

12. Status of State Action on the Medicaid Expansion Decision, HENRY J KAISER FAMILY FOUNDATION (Aug. 1, 2019), <https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>.

13. Dayna Bowen Matthew, *Next Steps in Health Reform: Hospitals, Medicaid Expansion, and Racial Equity*, 46 J. L., MED. ETHICS 906, 907 (2018).

14. *See Id.* (explaining that the Medicaid expansion improves quality of care which has reduced health disparities and increased equity beyond health care).

significant impact on justice-involved individuals after their release.<sup>15</sup>

All states should adopt the Medicaid expansion because enrolling eligible adults in Medicaid before exiting incarceration improves justice-involved individuals' prospects for reintegration and simultaneously benefits the public for three reasons, which I will discuss in turn. First, the Medicaid expansion ensures and facilitates timely and effective health coverage for many inmates after their release because it provides access that would otherwise not be available.<sup>16</sup> Second, enrolling inmates prior to their release results in overall financial savings for states because state Medicaid agencies are able to obtain federal reimbursements.<sup>17</sup> Third, enrolling individuals in Medicaid prior to release helps to offset high recidivism rates and improves overall public safety within communities because access to healthcare often correlates to improved well-being and life outcomes in justice-involved individuals.<sup>18</sup>

#### MEDICAID ENROLLMENT ENSURES TIMELY & EFFECTIVE HEALTH COVERAGE FOR INMATES AFTER RELEASE

First, the Medicaid expansion ensures and facilitates timely and effective health coverage for many inmates after their release because it provides access that would otherwise not be available.<sup>19</sup> Formerly incarcerated individuals are known to have physical and mental health problems at higher

---

15. Jocelyn Guyer et al., *State Strategies for Establishing Connections to Health Care for Justice-Involved Populations: The Central Role of Medicaid*, THE COMMONWEALTH FUND (January 11, 2019), [www.commonwealthfund.org/publications/issue-briefs/2019/jan/state-strategies-health-care-justice-involved-role-medicaid](http://www.commonwealthfund.org/publications/issue-briefs/2019/jan/state-strategies-health-care-justice-involved-role-medicaid).

16. See JENNIE SUTCLIFFE ET AL., MEDICAID AND CHIP (MAC) LEARNING COLLABORATIVES 1-39 (Feb. 19, 2015). (explaining that there are significant opportunities to provide Medicaid to justice-involved individuals in expansion states because non-disabled adults under 65 are now potentially eligible for Medicaid).

17. KIL HUH ET AL., THE PEW CHARITABLE TRUSTS 13 (Casey Ehrlich et al. eds., 2018).

18. JESSE JANETTA ET AL., BUREAU OF JUSTICE ASSISTANCE 2 (Jane Wishner eds. 2018).

19. See SUTCLIFFE *supra* note 16, at 5. (explaining that there are significant opportunities to provide Medicaid to justice-involved individuals in expansion states because non-disabled adults under 65 are now potentially eligible for Medicaid).

rates than the general population.<sup>20</sup> Research suggests that incarceration has a negative impact on individuals' health in addition to the negative impacts of social determinants of health.<sup>21</sup> Without access to health services immediately upon release, individuals are more susceptible to deteriorated physical and mental conditions and increased risk of death.<sup>22</sup> There are no federal statutes, regulations, or policies that prevent individuals from being enrolled in Medicaid while incarcerated, yet the majority of people released from jails and prisons still lack health care.<sup>23</sup>

Some expansion states, including Illinois, have implemented policies to combat the high numbers of unenrolled incarcerated individuals. For example, states like Illinois have increased Medicaid enrollment among these populations at every stage of their involvement in the criminal justice system.<sup>24</sup> Illinois has pursued several cross-agency initiatives to enroll justice-involved individuals in Medicaid.<sup>25</sup> In 2015, Department of Health, Department of Corrections, governor's office and other advocates participated in a joint workgroup and created a resource guide for criminal justice personnel with background information on the ACA rules and information on enrollment opportunities.<sup>26</sup> To facilitate enrollment efforts at larger jails, Illinois used navigator programs<sup>27</sup> and conducted extensive outreach to parole officers to integrate health care as one of the core topics

---

20. Elizabeth Marlow & Catherine Chesla, *Prison Experiences and the Reintegration of Male Parolees*, NAT'L INST. HEALTH, 1, 1 (2009).

21. *Id.* (Social determinants such as limited education and poverty); Guyer *supra* 14, at 8.

22. McKee, *supra* note 5, at 4.

23. *Id.* at 3, 4.

24. SUTCLIFFE *supra* note 16, at 32.

25. *Id.*

26. *Id.*

27. NATIONAL HEALTHY START ASSOCIATION, [http://www.nationalhealthystart.org/what\\_we\\_do/healthcare\\_navigator\\_program](http://www.nationalhealthystart.org/what_we_do/healthcare_navigator_program) (last visited Nov. 18, 2019).

discussed with discharged inmates.<sup>28</sup> In addition, using the Department of Corrections automatic messaging system, parole officers communicated with parolees regarding the availability of Medicaid coverage and enrollment opportunities.<sup>29</sup>

While some justice-involved individuals may be eligible for Medicaid based on categorical requirements—including age, disability, and pregnancy in non-expansion states—they are likely to remain uninsured and lack access to health care after release.<sup>30</sup> This lack of access is exacerbated because the ACA states that consumers are not eligible to enroll in a qualified health plan through the Health Insurance Marketplaces if they are incarcerated, unless they are pending the disposition of charges.<sup>31</sup> In Medicaid non-expansion states, eligibility remains restricted to those who both have severe financial need and qualify as aged, blind or disabled, pregnant, or are otherwise categorically eligible through programs like Temporary Assistance for Needy Families which requires having dependents.<sup>32</sup> As a result, millions of those with limited financial means and health problems fall within the Medicaid “gap” and are both unable to afford private insurance and do not qualify for Medicaid.<sup>33</sup> Therefore, the vast majority of justice-involved individuals falling within the coverage gap, this vulnerable population faces significant barriers to accessing public programs and limited access to other sources of coverage.<sup>34</sup> Most justice-involved individuals face an uphill battle in

---

28. SUTCLIFFE *supra* note 16, at 32.

29. *Id.*

30. McKee, *supra* note 5, at 3.

31. *Incarcerated and Recently Released Consumers*, HEALTH INS. MARKETPLACE 1,1 (2019), <https://marketplace.cms.gov/technical-assistance-resources/incarcerated-and-recently-released-consumers.pdf> [Hereinafter “Marketplace”].

32. Catherine A. Grodensky et al., *Medicaid Enrollment in a Non-Expansion State: Exploring Predisposing, Enabling, and Need Factors Related to Enrollment Pre-Incarceration and Post-Release* N.Y. Acad. Med. 455, 455 (2018).

33. *Id.*

34. *Id.*

accessing health care coverage, but in non-expansion states, they face significantly more challenges.<sup>35</sup> The Medicaid gap in non-expansion states ensures that justice-involved individuals lack access to health coverage and timely medical care.<sup>36</sup>

While more uncommon, some individuals enter jail or prison already enrolled in Medicaid, yet even they face obstacles at the close of their incarceration in both expansion and non-expansion states.<sup>37</sup> This is often the case because federal and state entitlements, including health insurance, are typically suspended or terminated if a person is incarcerated for more than one month.<sup>38</sup> Some states automatically facilitate the Medicaid application process for justice-involved individuals prior to release from incarceration, while others have policies to suspend, rather than terminate, a person's Medicaid coverage while incarcerated.<sup>39</sup> Termination or suspension of benefits has serious consequences for reentry planning because it can take up to six months for Medicaid to be reinstated after an inmate's release.<sup>40</sup>

#### JUSTICE-INVOLVED INDIVIDUAL'S MEDICAID ENROLLMENT RESULTS IN OVERALL STATE SAVINGS

Second, the enrollment of inmates prior to their release results in overall financial savings for states because state Medicaid agencies are able to obtain federal reimbursements.<sup>41</sup> States are constitutionally mandated to provide prison populations with necessary health care, which typically includes on-site primary care and basic outpatient services.<sup>42</sup> However, since so many

---

35. *Id.*

36. *Id.* at 460.

37. *Id.* at 454.

38. Nancy Wolff, *Community Reintegration of Prisoners with Mental Illness: A Social Investment Perspective*, 2013 NAT'L INST. HEALTH 1, 11.

39. Marketplace *supra* note 31, at 6.

40. Wolff, *supra* note 3738, at 12.

41. HUH *supra* note 17, at 13.

42. *Id.* at 2.

correctional systems' facilities and equipment are limited, states rely on hospitals for some specialist consultations, diagnostic tests, surgery, and other services.<sup>43</sup> States had never been precluded from enrolling incarcerated individuals in Medicaid, but until the passing of the ACA Medicaid expansion, most of these individuals were not enrolled.<sup>44</sup> Even now, states may not provide Medicaid coverage for health care services provided to incarcerated adults unless the care is delivered outside of correctional facilities and the eligible adult has been admitted for at least twenty-four hours.<sup>45</sup>

Historically, off-site care costs, such as hospitalization, have been a significant part of correctional facility health budgets.<sup>46</sup> But if an eligible incarcerated individual is hospitalized for a day or more, state Medicaid agencies are able to obtain federal reimbursement that covers at least half of the off-site inpatient costs.<sup>47</sup> Moreover, because a state's Medicaid program typically negotiates the lowest rates of any payer in the state, a corrections facility in an expansion state typically pays less for off-site services than corrections facilities in non-expansion states.<sup>48</sup> Since this change in policy, there has been a large shift of eligible in-patient costs from state corrections agencies to the Medicaid program; some officials in expansion states, namely Alaska and Ohio, have even reported millions of dollars in savings because most corrections hospitalizations have qualified for coverage.<sup>49</sup> Accordingly, states would find value in adopting the Medicaid expansion for both financial

---

43. *Id.*

44. *Id.* at 13 (explaining that the expansion has made many more incarcerated individuals eligible for Medicaid coverage, as income for nearly all of this population often falls below the threshold while they are in jail or prison).

45. *Id.* at 2.

46. *Id.* at 2. (Recent data showed that hospital care accounted for 23 percent of health spending in New York and 27 percent of health spending in Virginia.).

47. *Id.* at 13.

48. *Id.* at 12.

49. *Id.* at 13.

reasons and improved accessibility.<sup>50</sup>

While critics of the Medicaid expansion have maintained that the policy change resulted in financial harm to the states, often because some states underestimated the number of individuals who would enroll, the evidence tells a different story.<sup>51</sup> Many state and independent analyses have found that because the federal government was paying the full cost of expansion enrollees, a typical expectation of the Medicaid expansion, the expansion produced net savings for state budgets.<sup>52</sup> Since the initial growth of the expansion in 2014, Medicaid enrollment and costs have stabilized.<sup>53</sup> Expansion states could increase Medicaid enrollment again by promoting new, or bolstering already existing, cross-agency partnerships to connect justice-involved populations to Medicaid.<sup>54</sup>

#### ENROLLMENT OFFSETS HIGH RECIDIVISM RATES & IMPROVES PUBLIC SAFETY

Finally, Enrolling individuals in Medicaid prior to release often offsets high recidivism rates and improves overall public safety within communities because access to healthcare often correlates to improved well-being and life outcomes. Medicaid enrollment among justice-involved individuals prior to leaving incarceration is imperative to ensure access to quality health care, reduce recidivism rates, and improve overall public safety.<sup>55</sup> The periods of

---

50. *See Id.* at 13.

51. JESSE CROSS-CALL, CENTER ON BUDGET AND POLICY PRIORITIES 1 (2018); *See* Louise Norris, *Illinois and the ACA's Medicaid expansion*, HEALTH INSURANCE.ORG (December 3, 2018), [www.healthinsurance.org/illinois-medicaid/](http://www.healthinsurance.org/illinois-medicaid/) (noting that far more Illinois residents enrolled in expanded Medicaid than the state expected).

52. *Id.* at 2. In Michigan, the net savings from the expansion are projected to total more than \$1 billion from 2018-2021 due to increased tax revenue and savings on mental health programs while Arkansas projects the Medicaid expansion will produce net savings each year through fiscal year 2021, and \$444 million total from 2018-2021 as the state pays less to hospitals to cover uncompensated care costs, among other factors. *Id.*

53. *Id.* at 3.

54. SUTCLIFFE *supra* note 16, at 30.

55. JANETTA *supra* note 18, at 1.

incarceration and reentry into the community are key periods to implement interventions to reduce recidivism rates among justice-involved individuals, especially those with serious mental illness.<sup>56</sup> The Brookings Institution has found that for all offenders, the highest rate of recidivism occurs during the first year after release.<sup>57</sup> On average, approximately 96,000 prison inmates will reenter the community with acute to severe mental health problems.<sup>58</sup> For inmates reentering the community from prison, especially those who suffer from mental health problems, treatment is critical.<sup>59</sup> But when individuals are released from correctional institutions, they often face disruptions in medical care and treatment which often results in poor and costly health outcomes and/or drug use: the perfect conditions for relapse and recidivism.<sup>60</sup> Furthermore, there is ample evidence which shows that treating medical and behavioral health conditions improves the probability of successful reintegration into the community.<sup>61</sup> The best defense against relapse is active and continuous health treatment.<sup>62</sup>

Shortly after the passing of the ACA, Acting Associate Attorney General Tony West authored a post highlighting the important connections between public health and public safety.<sup>63</sup> With the backing of the Department of Justice, he cited the ACA, most specifically the Medicaid expansion, as being

---

56. U.S. Department of Justice, *Groundbreaking 50-State Report on Public Safety Updated with 2017 Data*, THE COUNCIL OF STATE GOVERNMENTS (October 15, 2018), <https://csgjusticecenter.org/jr/posts/new-report-combines-unprecedented-data-analyses-case-studies-to-help-states-reach-public-safety-goals/>.

57. The Hamilton Project, *Recidivism of Prisoners, by Prior Arrest History*, THE BROOKINGS INSTITUTION (2019), [www.hamiltonproject.org/charts/recidivism\\_of\\_prisoners\\_by\\_prior\\_arrest\\_history](http://www.hamiltonproject.org/charts/recidivism_of_prisoners_by_prior_arrest_history).

58. Wolff *supra* note 38, at 1.

59. *Id.*

60. JANETTA *supra* note 18, at 2.

61. Kavita Patel et al., *Integrating Correctional and Community Health Care for Formerly Incarcerated People Who Are Eligible for Medicaid*, 2014 HEALTH AFFAIRS 468, 471.

62. Wolff *supra* note 38, at 1.

63. TONY WEST, OFFICE OF PUBLIC AFFAIRS 1 (2014).



a key way to increase access to adequate health care coverage for justice-involved individuals.<sup>64</sup> The Medicaid expansion would prove beneficial to effectively treating the physical and mental health of incarcerated and formerly incarcerated individuals so as to improve the odds for successful reentry, reduce recidivism, improve overall public health, and make communities safer.<sup>65</sup> Data compiled by the Center for American Progress speaks to the public benefits in a concrete way.<sup>66</sup> Studies have linked the Medicaid expansion to improved cancer-related health outcomes<sup>67</sup> while critical prenatal and postnatal health care services have reduced infant mortality rates.<sup>68</sup> Moreover, providing preventative care and affordable treatments to the low-income, non-elderly adults, who were once denied Medicaid eligibility, dropped overall mortality rates in expansion states across the United States.<sup>69</sup> Data compiled by the Center for American Progress also speaks to the drastic effect the health care program expansion has had on overall public safety in expansion states.<sup>70</sup> Prior to the expansion, low-income working age adults, who are most affected by the criminal justice system, faced major barriers to re-entry, most notably a lack of access to health care.<sup>71</sup> Research has found, however, that the Medicaid expansion led to a drop in various types of criminal offenses,<sup>72</sup> which was consistent with previous research that found a correlation between medical/financial stability

---

64. *Id.*

65. *Id.*

66. *See generally* RACHEL WEST, CENTER FOR AMERICAN PROGRESS 3 (2018) (explaining, through data, that states that have not adopted the Medicaid expansion would save more than 14,000 lives per year).

67. *Id.* at 6.

68. *Id.* at 5.

69. *Id.* at 3.

70. *See generally* WEST *supra* note 66, at 12 (explaining, through data, that states that have adopted the Medicaid expansion have enhanced public safety).

71. WEST *supra* note 66, at 12.

72. *Id.*

and greater public safety.<sup>73</sup> States that have not adopted the expansion have lost the opportunity for various benefits, which would include, but not be limited to, health, financial, and safety measures.<sup>74</sup>

If the Medicaid expansion were adopted in the remaining non-expansion states, many of the justice-involved individuals would qualify for Medicaid, better preparing them to reenter their communities permanently.<sup>75</sup> While some critics believe that health insurance alone is often insufficient to effectively link all individuals released from incarceration to holistic community care, coverage is an important precondition.<sup>76</sup> The health care that the prison population receives is a critical component of states' public health strategies.<sup>77</sup>

#### CONCLUSION

Non-expansion states should adopt the Medicaid expansion to provide timely and effective health care coverage so that more justice-involved individuals have access to medical care because the policy change has been shown to result in net savings and improve overall public safety in communities across the United States. Medicaid enrollment provides immediate access to health services for inmates upon release, making individuals less susceptible to deteriorated physical and mental conditions and increased risk of death. The Medicaid expansion proves beneficial to effectively treating the health of justice-involved individuals so as to improve their odds for successful reentry, reduce recidivism, improve overall public health, and make communities safer. Finally, many states have found that

---

73. *Id.*

74. *Id.* at 14.

75. *See* Grodensky *supra* note 32, at 462.

76. Patel *supra* note 61, at 471.

77. Matt McKillop, *To Strengthen Public Health, Look to Prisons*, THE PEW CHARITABLE TRUSTS, (November 30, 2017), [www.pewtrusts.org/en/research-and-analysis/articles/2017/11/30/to-strengthen-public-health-look-to-prisons](http://www.pewtrusts.org/en/research-and-analysis/articles/2017/11/30/to-strengthen-public-health-look-to-prisons).

because the federal government has paid the costs of expansion enrollees, a typical expectation of the Medicaid expansion, the expansion has produced savings for state budgets and families alike.

## A Case Against Medicaid Work Requirements for Prisoners Re-entering Society

*Raminta Kizyte*

When Medicaid was signed into law it was designed to be a joint federal-state program to help lower income individuals obtain affordable medical coverage.<sup>1</sup> States have significant flexibility in a way they design their Medicaid programs.<sup>2</sup> For example, by using Section 1115 Demonstration Waivers, states can create “experimental, pilot, or demonstration project[s]” that are “likely to assist in promoting the objectives of the Medicaid Program.”<sup>3</sup> On January 11, 2018, Centers for Medicare and Medicaid Services (“CMS”) sent guidance to state Medicaid directors titled “Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries” (hereinafter “work requirements”) that states were encouraged to implement through Section 1115 Waivers.<sup>4</sup> The express primary objective of these work requirements is to “promote better mental, physical, and emotional health,” and second, “to help individuals and families rise out of poverty and attain independence.”<sup>5</sup>

While work requirements may be designed to improve health and

---

1. *Program History*, CTR’S. FOR MEDICAID & MEDICARE SERV’S. (last visited Nov. 21, 2019), [www.medicaid.gov/about-us/program-history/index.html](http://www.medicaid.gov/about-us/program-history/index.html).

2. *About Section 1115 Demonstrations*, MEDICAID.GOV (last visited Nov. 21, 2019), [www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html](http://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html).

3. *Id.*

4. Letter from Brian Neale, Dir, Ctr for Medicaid & CHIP, to State Medicaid Directors, 1, 1-9 (Jan. 11, 2018) (available at [www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf](http://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf)) [hereinafter *Work Requirements*] (States have options to designate activities that promote health and wellness besides employment. “These activities include, but are not limited to, community service, caregiving, education, job training, and substance use disorder treatment”).

5. *Id.* at 1.

wellbeing, they are likely going to have the opposite effect because they directly conflict with Medicaid's primary goal of providing affordable medical coverage.<sup>6</sup> Overall, work requirements are likely to decrease coverage, worsen health outcomes, and in turn, make it more difficult for people rise out of poverty.<sup>7</sup> In states that expanded Medicaid coverage to individuals who earn 133% of the federal poverty level, many prisoners re-entering society would qualify for Medicaid coverage and this article will explore how prisoners re-entering society will likely struggle to obtain employment, medical coverage, and experience worse health outcomes if work requirements were instituted.<sup>8</sup> First, this article will provide relevant background. Then, it will address ongoing litigation that work requirements are subject to. Next, the article will showcase particular challenges that formerly incarcerated individuals re-entering society face. Finally, the article will analyze why Medicaid work requirements don't work and should be abandoned as a failed Section 1115 experiment.

#### BACKGROUND

Work requirements generally demand that Medicaid enrollees work about eighty hours each month, engage in job searching, volunteer work, or be exempt because of medical conditions, pregnancy, or a period of parenthood.<sup>9</sup>

---

6. *Program History*, *supra* note 1.

7. See generally J. Michael McWilliams, *Health Consequences of Uninsurance Among Adults in the United States: Recent Evidence and Implications*, 87 MILBANK Q. 443, 443 (2009) (studies have found consistently positive and often significant effects of health insurance on health across a range of outcomes); see also INSTITUTE OF MED. (US) COMMITTEE ON THE CONSEQUENCES OF UNINSURANCE, CARE WITHOUT COVERAGE: TOO LITTLE, TOO LATE 48 (National Academy of Sciences, 1st ed. 2002) ([www.ncbi.nlm.nih.gov/books/NBK220639/?report=reader](http://www.ncbi.nlm.nih.gov/books/NBK220639/?report=reader)) (Uninsured adults are less likely than adults with any kind of health coverage to receive preventive and screening services and less likely to receive these services on a timely basis. Health insurance that provides more extensive coverage of preventive and screening services is likely to result in greater and more appropriate use of these services).

8. *Eligibility*, CTR'S. FOR MEDICAID & MEDICARE SERV'S. (last visited Nov. 21, 2019), [www.medicaid.gov/medicaid/eligibility/index.html](http://www.medicaid.gov/medicaid/eligibility/index.html).

9. *Work Requirements*, *supra* note 4, at 1.

CMS, encourages states to enforce work requirements and evaluate whether sustained employment, or other approved community engagements, will lead to improved health outcomes and well-being.<sup>10</sup> Section 1115 projects must be “budget neutral” to the Federal government, meaning that project funds have to come out of states’ own Medicaid expenditures.<sup>11</sup>

#### WORK REQUIREMENTS CHALLENGE IN COURTS

In light of ongoing litigation in several states, the status of states approving work requirements is rapidly changing.<sup>12</sup> While work requirements were approved without legal challenges in Michigan, Ohio, Utah, and Wisconsin, they are still pending in nine states and are stalled due to litigation brought on by Medicaid enrollees in five more states.<sup>13</sup> Four states will exclude previously incarcerated individuals from complying for six to twelve months, but a majority of other states will require previously incarcerated individuals to comply with work requirements without exceptions.<sup>14</sup>

In Kentucky and Arkansas, courts struck down work requirements for not aligning with Medicaid Act’s primary objective of providing affordable health coverage.<sup>15</sup> In the Kentucky suit, the judge noted that where Congress expresses a clear purpose of a program, agencies are bound to meet it by appropriate and prescribed means.<sup>16</sup> The Federal judge used the Supreme Court’s “broccoli horrible” example and noted that if the Secretary of Health

---

10. *Work Requirements*, *supra* note 4, at 3.

11. *About Section 1115 Demonstrations*, *supra* note 2.

12. *A Snapshot of State Proposals to Implement Medicaid Work Requirements Nationwide*, NAT’L. ACAD. FOR ST. HEALTH POL’Y. (Sep., 19, 2019), [www.nashp.org/state-proposals-for-medicaid-work-and-community-engagement-requirements/](http://www.nashp.org/state-proposals-for-medicaid-work-and-community-engagement-requirements/) [hereinafter *Work Requirements Snapshot*].

13. *Id.*

14. *Id.*

15. Michelle Hackman, *Federal Judge Blocks Medicaid Work Requirements*, WSJ (Mar. 27, 2019), [www.wsj.com/articles/federal-judge-scrap-medicaid-work-requirements-11553724923](http://www.wsj.com/articles/federal-judge-scrap-medicaid-work-requirements-11553724923).

16. *Stewart v. Azar*, 313 F. Supp. 3d 237, 266 (D.D.C. 2019).

and Human Services wanted to improve health, “nothing could stop him from conditioning Medicaid coverage on consuming more broccoli.”<sup>17</sup> Promoting health would do nothing to promote health care coverage, as intended by Congress when designing Medicaid.<sup>18</sup> In the end, the judge remanded the case back to CMS, observing that the Secretary never considered whether the work requirements will actually help provide coverage.<sup>19</sup>

It is unlikely that the Secretary will be able to show that work requirements will help furnish coverage, as it is estimated that 86,000 to 136,000 Kentuckians would have lost coverage if work requirements would have been instituted, with a loss of overall coverage in United States estimated around 600,000 to 800,000 adults.<sup>20</sup> In Arkansas, where work requirements were active for just three months, 18,000 people lost coverage.<sup>21</sup> While CMS expected that loss of Medicaid coverage would be attributed to coverage obtained through employers, many Medicaid enrollees work for employers that do not provide health care benefits.<sup>22</sup> Additionally, vast majority of Medicaid enrollees already work, and those who do not, have substantial barriers in obtaining full-time employment with health care benefits.<sup>23</sup>

---

17. *Id.* at 267-68.

18. *Id.* at 268.

19. *Id.* at 243.

20. Leighton Ku & Erin Brantley, *Medicaid Work Requirements in Nine States Could Cause 600,000 to 800,000 Adults to Lose Medicaid Coverage*, COMMONWEALTH FUND (June 21, 2019), [www.commonwealthfund.org/blog/2019/medicaid-work-requirements-nine-states-could-cause-600000-800000-adults-lose-coverage](http://www.commonwealthfund.org/blog/2019/medicaid-work-requirements-nine-states-could-cause-600000-800000-adults-lose-coverage).

21. Rachel Garfield et al., *Understanding the Intersection of Medicaid and Work: What Does the Data Say*, KAISER FAM. FOUND. (Aug. 8, 2019), [www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-what-does-the-data-say/](http://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-what-does-the-data-say/) [hereinafter *Medicaid and Work*].

22. *Id.* (explaining that many Medicaid adults who work are employed by small firms and in industries that have low employer-sponsored insurance (ESI) offer rates).

23. *Id.* (Illness or disability was a primary reason for not working among (. . . ) Medicaid adults. Caregiving responsibilities or school attendance were other leading reasons reported for not working. The remaining seven percent of Medicaid adults report that they are retired, unable to find work, or not working for another reason).

Prisoners re-entering society face additional restrictions in obtaining coverage because of their former incarceration status.

#### HEALTH IS A RIGHT IN PRISON

Incarcerated individuals receive free health care while in prison since the Supreme Court held in *Estelle v. Gamble* that, “deliberate indifference to serious medical needs of prisoners constitutes the unnecessary and wanton infliction of pain proscribed by U.S. Const. amend. VIII.”<sup>24</sup> Inmate healthcare costs are not covered by Medicaid, except for when they are patients at an inpatient medical institution for over 24 hours.<sup>25</sup> States have the option to terminate coverage upon entry to prison, suspend it for a short amount of time, or suspend for full duration of incarceration.<sup>26</sup> States have an incentive to suspend coverage because it improves continuity of care when prisoners re-enter society, reducing hospitalizations, reliance on emergency rooms, overdoses, and recidivism.<sup>27</sup> Continuity of care would be negatively affected if prisoners re-entering society would be required to find employment as a condition for reactivating coverage.

Additionally, suspension as opposed to termination of Medicaid leads to a significant reduction in cost when prisoners have to receive care outside of the prison.<sup>28</sup> External care presents a substantial part of correctional

---

24. *Estelle v. Gamble*, 429 U.S. 97, 105 (1976).

25. *Medicaid and the Criminal Justice System*, MACPAC (July, 2018) (explaining that this includes individuals admitted to a hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility on an inpatient basis, as long as they remain Medicaid eligible).

26. *Id.*

27. *Emerging Strategies for Connecting Justice-Involved Populations to Medicaid Coverage and Care*, STATE HEALTH & VALUE STRATEGIES (June 18, 2019), <https://vimeo.com/343437802>.

28. *Medicaid and the Criminal Justice System*, *supra* note 25 (explaining that New Jersey attributed a twenty percent reduction in the department of correction’s hospitalization costs due to its efforts to enroll individuals in Medicaid. Ohio saw a more dramatic decline, reducing hospital costs by more than half, and attributed the availability of Medicaid to the reduction in prison health spending).



departments' health expenses.<sup>29</sup> But, if prisoners will be required to comply with work requirements while incarcerated, many of them are going to lose coverage because of the limiting nature of employment in prisons. Moreover, requiring prisoners to work in order to finance their health care may run into potential *Estelle v. Gamble* challenges.

#### HEALTH NEEDS OF JUSTICE-INVOLVED POPULATIONS REQUIRE COVERAGE

Work requirements would be particularly detrimental to justice-involved populations because the imprisoned population is significantly less healthy than the general population, presenting unique challenges for health care inside and outside the prison system.<sup>30</sup> Justice-involved have higher rates of HIV/AIDS, STIs, and hepatitis B and C than the general population.<sup>31</sup> They also have higher prevalence of chronic conditions such as, “asthma, diabetes, and hypertension, as well as behavioral health disorders.”<sup>32</sup> Prisons have become mental health centers, housing more mentally ill individuals than hospitals.<sup>33</sup> About sixty-five percent of inmates meet the criteria for alcohol or other drug dependence or abuse.<sup>34</sup>

---

29. *State Prisons and the Delivery of Hospital Care*, in PEW CHARITABLE TRUSTS 1, 1 (July 2018) (explaining that hospital care accounted for about twenty percent of health spending in ten states between 2007 and 2011. More recent data from two additional states, New York (twenty-three percent) and Virginia (twenty-seven percent), showed the proportion may now be greater).

30. Michael Massoglia, *Incarceration, Health, and Racial Disparities in Health*, 42 L. SOC. REV. 275, 276 (June 2008).

31. *Medicaid and the Criminal Justice System*, *supra* note 25 (including individuals admitted to a hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility on an inpatient basis, as long as they remain Medicaid eligible).

32. *Id.*

33. See E. Fuller Torrey et al., *More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States*, MENTAL ILLNESS POL'Y ORG (May 2010), [www.mentalillnesspolicy.org/ngri/jails-vs-hospitals.html](http://www.mentalillnesspolicy.org/ngri/jails-vs-hospitals.html) (In the United States there are now more than three times more seriously mentally ill persons in jails and prisons than in hospitals. Looked at by individual states, in North Dakota there are approximately an equal number of mentally ill persons in jails and prisons compared to hospitals. By contrast, Arizona and Nevada have almost ten times more mentally ill persons in jails and prisons than in hospitals).

34. *Incarceration and Health: A Family Medicine Perspective (Position Paper)*, AM.

Some inmates' short-term health outcomes improve when they enter prison because they are provided housing, meals, restrictions on alcohol and substance abuse, and health care.<sup>35</sup> Additionally, because incarcerated individuals cannot self-treat by taking over the counter medications for simple things like headaches or colds, prison medical staff is involved in every medical decision.<sup>36</sup> This may lead to positive outcomes for some prisoners because their care is managed. However, incarceration does not usually lead to better health outcomes in the long run because ninety-five percent of inmates are eventually released back into their communities where they have to apply for their own health coverage.<sup>37</sup>

#### BARRIERS TO OBTAINING HEALTH CARE COVERAGE

People returning back to their communities face significant barriers in accessing health care.<sup>38</sup> Most inmates are released with a \$15 to \$40 allowance and a list of resources to help them find work, housing, food, and health care.<sup>39</sup> Majority of inmates re-entering society, eight in ten men and nine in ten women, have health conditions that require treatment or supervision.<sup>40</sup> Inmates with health issues are usually given about a two-week

---

ACAD. FAMILY PHYSICIANS ON INCARCERATION & HEALTH (June 12, 2017), <https://aafp.org/about/policies/all/incarcerationandhealth.html>. [hereinafter *Physician Position Paper*].

35. *Id.*

36. William Rold, *Thirty Years After Estelle v. Gamble: A Legal Retrospective*, 14 J. CORRECTIONAL HEALTHCARE 11,15 (Jan. 2008).

37. David Redemske, *Providing Healthcare in the Prison Environment*, HDR 1,17 (Oct. 2018).

38. NAT'L CONF. STATE LEGISLATURES, RETURNING HOME ACCESS TO HEALTH CARE AFTER PRISON (July 2019)

("These populations also frequently are adversely affected by socioeconomic risk factors for poor health, including lower educational attainment and higher rates of poverty. Given this risk, such populations are in clear need of significant health services. Particularly upon release from an institution or correctional facility, former inmates may require substantial assistance in securing health care benefits and access").

39. Chad Kinsella, *Corrections Health Care Costs*, COUNCIL ST. GOVT'S. 1,3 (Jan. 2004).

40. Kamala Mallik-Kane & Christy Visser, *Health and Prisoner Reentry: How*

supply of critical medications to manage their health, but no follow-up appointments scheduled for continuance of care.<sup>41</sup>

Because returning inmates are sicker than the general population, they have to continue using health services.<sup>42</sup> This puts a significant burden on community health systems as emergency rooms absorb the costs of treating the severely-ill.<sup>43</sup> Hospitals and taxpayers end up making up the cost for emergency room treatment of conditions that could have been dealt with earlier with proper health coverage.<sup>44</sup> Additionally, because inmates tend to have higher prevalence of communicable diseases, without proper continuance of care, there is a risk of a spread of infection to their communities when inmates are released.<sup>45</sup> Thus, requiring former inmates to comply with work requirements before they get health coverage will raise health care costs and will likely affect the health of communities to which they reintegrate back to.

Returning inmates also have a more difficult time obtaining continuous employment than the general population because they are frequently

---

*Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration*, URB. INST. JUST. POL'Y. CTR. 1, 13 (Feb. 2018).

41. Josiah Rich et al., *Medicine and the Epidemic of Incarceration in the United States*, 364 N. ENGL. J. MED. 1, (Aug. 11, 2011).

42. *Incarceration, Health, and Racial Disparities in Health*, *supra* note 30, at 277.

43. See Jason Schnittker et al., *The Institutional Effects of Incarceration: Spillovers From Criminal Justice to Health Care*, 93 MILBANK Q. 516, 517 (Sept. 2015) (explaining that higher numbers of people released from prisons correspond with increased numbers of uninsured emergency room visits. Former inmates with health conditions tend to be heavy consumers of health services, and they often utilize health care in cost-intensive ways. For example, many use emergency rooms for care, sometimes more frequently than using regular health care providers).

44. Rae Ellen Bichell, *Helping Ex-Inmates Stay Out Of The ER Brings Multiple Benefits*, NPR (Dec. 5, 2016), [www.npr.org/sections/health-shots/2016/12/05/499775644/helping-ex-inmates-stay-out-of-the-er-brings-multiple-benefits?utm\\_content=buffer99c54&utm\\_medium=social&utm\\_source=twitter.com&utm\\_campaign=buffer](http://www.npr.org/sections/health-shots/2016/12/05/499775644/helping-ex-inmates-stay-out-of-the-er-brings-multiple-benefits?utm_content=buffer99c54&utm_medium=social&utm_source=twitter.com&utm_campaign=buffer).

45. Steven Ross Johnson, *Prison health systems need better integration into the community*, MODERN HEALTHCARE (Oct. 11, 2018), [www.modernhealthcare.com/article/20181011/NEWS/181019963/prison-health-systems-need-better-integration-into-the-community](http://www.modernhealthcare.com/article/20181011/NEWS/181019963/prison-health-systems-need-better-integration-into-the-community) (conditions such as tuberculosis, HIV and hepatitis C).

discriminated against by employers.<sup>46</sup> Justice-involved populations are less educated<sup>47</sup> and have less work experience, making it more challenging for them to find stable employment.<sup>48</sup> Job searching is made more difficult in states that have already approved work requirements because none of them mandate the removal of previous imprisonment history from job applications for private employers.<sup>49</sup> Additionally, former felons are less likely to be hired if the employer knows about their conviction.<sup>50</sup> Employers themselves may face challenges in hiring former inmates for specific jobs.<sup>51</sup> Comparing privately insured adults with Medicaid enrollees, a study found that 82.9% of nonexempt Medicaid enrollees shared that they had at least one characteristic that would pose a barrier to employment (“compared with 53.2 percent of privately insured adults”).<sup>52</sup> Employment barriers affecting former inmates re-entering society will make it more likely that they will struggle to fulfill work requirements and will lose or be ineligible for coverage.<sup>53</sup>

---

46. Christy Visser, *Employment After Prison: A Longitudinal Study of Former Prisoners*, JUST. Q. 699, 699 (Dec. 2010) [hereinafter *Employment After Prison*].

47. Eric Westervelt, *Measuring the Power of a Prison Education*, NPR (July 31, 2015), [www.npr.org/sections/ed/2015/07/31/427741914/measuring-the-power-of-a-prison-education](http://www.npr.org/sections/ed/2015/07/31/427741914/measuring-the-power-of-a-prison-education) (explaining that forty percent of incarcerated adults do not have a high school education).

48. *Employment After Prison*, *supra* note 46, at 700.

49. BETH AVERY, BAN THE BOX, NATL. EMP. L. PROJECT, 1,1 (July 2019).

50. Binyamin Appelbaum, *Out of Trouble, but Criminal Records Keep Men Out of Work*, N.Y. TIMES (Feb. 28, 2015), [www.nytimes.com/2015/03/01/business/out-of-trouble-but-criminal-records-keep-men-out-of-work.html](http://www.nytimes.com/2015/03/01/business/out-of-trouble-but-criminal-records-keep-men-out-of-work.html).

51. See *Employment After Prison*, *supra* note 46, at 700. (Employers may face direct barriers to hiring formerly incarcerated individuals, including state laws and occupational licensing requirements that exclude persons with criminal records from holding specific jobs).

52. Michael Karpman, *Many Adults Targeted by Medicaid Work Requirements Face Barriers to Sustained Employment*, URBAN INST. (May 2019) (Employment barriers evaluated include: skill barriers such as lack of high school diploma or limited English proficiency; Health barriers such as activity or functional limitation, multiple chronic conditions, ever diagnosed with a mental health condition; search/participation barriers such as lack of household internet access, limited access to transportation; and hiring barriers such as criminal records, former incarceration, or being black or Hispanic).

53. Tracy Jan et al., *After prison, more punishment*, WASHINGTON POST (Sept. 3, 2019), [www.washingtonpost.com/graphics/2019/business/jobs-after-prison-rhode-island-recently-occupational-licensing/](http://www.washingtonpost.com/graphics/2019/business/jobs-after-prison-rhode-island-recently-occupational-licensing/) (explaining that across the country, more than 10,000 regulations

Coverage will also be harder to obtain because of administrative requirements that pose a substantial burden, even when former inmates do obtain employment.<sup>54</sup> Determining which requirements are acceptable, collecting approval signatures, and logging everything monthly on a computer present a significant challenge.<sup>55</sup> Lack of proposed funding for Section 1115 Waivers may contribute to effective roll out of work requirements. For example, in Arkansas, the reporting website would shut down between the hours of nine in the evening and seven in the morning.<sup>56</sup> Although logging work requirements requires access to a computer and the internet, those wishing to obtain or retain their coverage were subject to an additional hurdle of logging into the reporting website on time.<sup>57</sup> This may seem like a minor inconvenience to some, but to prisoners re-entering society it presents a special challenge because they are more likely to lack access to a computer as well as the skills necessary to use it.<sup>58</sup>

Communication and implementation challenges are other aspects that significantly impact the Medicaid population.<sup>59</sup> The problem is compounded by the fact that states did not submit their waivers with anticipated program expenses, thus implementing and communicating about work requirements will end up costing an unanticipated 400 million dollars every one to three

---

restrict people with criminal records from obtaining occupational licenses).

54. Philip Rocco, *Why Work Requirements Will Not Improve Medicaid*, SCHOLARS STRATEGY NETWORK (Apr. 19, 2018).

55. Bryce Covert, *How Does Losing Medicaid Help You Get a Job*, THE NATION (Mar. 7, 2019), [www.thenation.com/article/arkansas-medicaid-work-requirement-healthcare/](http://www.thenation.com/article/arkansas-medicaid-work-requirement-healthcare/).

56. Catherine Rampell et al, *With new work requirement, thousands lose Medicaid coverage in Arkansas*, PBS NEWS HOUR (Nov. 19, 2018), [www.pbs.org/newshour/show/with-new-work-requirement-thousands-lose-medicaid-coverage-in-arkansas](http://www.pbs.org/newshour/show/with-new-work-requirement-thousands-lose-medicaid-coverage-in-arkansas).

57. *Id.*

58. *Medicaid and Work*, *supra* note 21 (noting that 26% of Medicaid adults report that they never use a computer, 25% do not use the internet, 20 and 40% do not use email, which may pose a barrier to both gaining a job and complying with reporting).

59. *Medicaid Work Requirements and Coverage Losses*, N.H. FISCAL POL'Y INST. (May 20, 2019), [www.nhfpi.org/research/health-policy/medicaid-work-requirements-and-coverage-losses.html#\\_edn24](http://www.nhfpi.org/research/health-policy/medicaid-work-requirements-and-coverage-losses.html#_edn24).

years.<sup>60</sup> Even those who are aware of these requirements may be confused by how to comply with them.<sup>61</sup> Many former inmates do not have a permanent address to use for correspondence.<sup>62</sup> The multiplicity of burdens to log work requirements will result in loss of coverage for people who need it the most.<sup>63</sup> The Medicaid-eligible population is already living complex lives, made more difficult by lower income, and work requirements are unlikely to make them healthier.<sup>64</sup> Not having coverage means that former inmates will lack treatment options, and those who need follow-up treatment after incarceration, especially those with substance abuse disorders, will likely resort to recidivism.<sup>65</sup> Health coverage that is not restricted by work requirements has the potential to make former inmates healthier, improve community health and reduce recidivism.<sup>66</sup>

#### MEDICAID WORK REQUIREMENTS DON'T WORK

The work requirement guidance sent to all states cites several studies showing that employed people are happier and healthier.<sup>67</sup> Although

---

60. ACTIONS NEEDED TO ADDRESS WEAKNESSES IN OVERSIGHT OF COSTS TO ADMINISTER WORK REQUIREMENTS, GOVT. ACCOUNTABILITY OFF. (Oct. 2019).

61. Kim Krisberg, *Thousands lose coverage from Medicaid work requirements: New procedures causing confusion*, NATION'S HEALTH (Feb/Mar. 2019), [www.thenationshealth.aphapublications.org/content/49/1/1.3](http://www.thenationshealth.aphapublications.org/content/49/1/1.3).

62. Rae Ellen Bichell, *supra* note 44.

63. See Harrison Neuert et al., *Work Requirements Don't Work*, IDEAS 42, 1,11 (Mar. 2019) (Work requirements don't work because they, "dramatically increase cognitive costs of participating in a program, remove slack from the already complex lives of people living with low incomes, and create program-level interactions that are disempowering").

64. *Id.*

65. See Steven Belenko et al., *Treating Substance Use Disorders in the Criminal Justice System*, 15 CURR. PSYCHIATRY REP. 1, 2 (Nov. 1, 2014) (explaining that illegal drug use increases the likelihood of continued involvement in criminal activity, with high rates of relapse and recidivism found among drug-involved offenders; 68% of drug offenders are rearrested within three years of release from prison. Because there are effective treatment models for offenders, expanding access to these is likely to help break the links between drug use and crime).

66. Josiah Rich et al., *How Health Care Reform Can Transform the Health of Criminal Justice-Involved Individuals*, 33 HEALTH AFF'S, 462, 465 (Mar. 2014).

67. *Work Requirements*, *supra* note 4.

employment generally may make people healthier,<sup>68</sup> work requirements for prisoners re-entering society present a significant burden that will make their health and health coverage worse off.<sup>69</sup> Major physician associations have issued statements opposing work requirements because even a brief loss of access to medications or treatment could have serious health consequences.<sup>70</sup>

Section 1115 Waivers allow states to create experimental projects that promote objectives of the Medicaid Program and, “focus on evidence-based interventions that drive better health outcomes and quality of life improvements.”<sup>71</sup> However, studies overwhelmingly show that work requirements do more harm than good, thus there is no need for states to experiment.<sup>72</sup> Denying people health coverage will not make people healthier, facilitate employment, or help them rise out of poverty. States would be better off improving the health of their citizens by allocating resources to initiatives that have been evidence-based to improve health.

---

68. *Work Requirements*, *supra* note 4.

69. Ladonna Pavetti, *TANF Studies Show Work Requirement Proposals for Other Programs Would Harm Millions, Do Little to Increase Work*, CTR BUDGET & POL’Y PRIORITIES, 1, 4 (Nov. 13, 2018).

70. *Trump Administration’s Harmful Changes to Medicaid*, CTR. BUDGET & POL’Y PRIORITIES (June 12, 2019), [www.cbpp.org/research/health/trump-administrations-harmful-changes-to-medicaid](http://www.cbpp.org/research/health/trump-administrations-harmful-changes-to-medicaid) (describing how physician societies opposing work requirements include the American Medical Association, American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, American Osteopathic Association, and American Psychiatric Association — as well as the AARP, Catholic Health Association, Consortium for Citizens with Disabilities, and many organizations representing patients, including the American Heart Association, American Cancer Society Cancer Action Network, and American Diabetes Association).

71. *About Section 1115 Demonstrations*, *supra* note 2.

72. Ladonna Pavetti, *supra* note 69, at 1.

# Advocating for Access: How the Eighth Amendment and the Americans with Disabilities Act Open a Pathway for Opioid-Addicted Inmates to Receive Medication-Assisted Treatment

*Emily Mann*

## INTRODUCTION

In 2017, the U.S. Department of Health and Human Services (“HHS”) declared a public health crisis due to the drastic rise in opioid addiction and overdose deaths since 1999.<sup>1</sup> HHS reports that an estimated 130 people or more die every day from opioid drug overdoses in the United States and more than 11.4 million Americans misuse prescription opioids.<sup>2</sup> Even those who were originally prescribed opioids for pain management can become addicted, and may turn to illegally manufactured Fentanyl or heroin to get their fix.<sup>3</sup>

Medication-assisted treatment (“MAT”) has been proven to be one of the most effective interventions for opioid detoxification and treatment for opioid dependency.<sup>4</sup> This is a comprehensive approach that combines the use of medication and behavioral therapies.<sup>5</sup> Certain medications, including methadone, buprenorphine, and naltrexone, have been approved by the Food

---

1. *What Is The U.S. Opioid Epidemic?*, U.S. DEP’T OF HEALTH & HUMAN SERVS., [www.hhs.gov/opioids/about-the-epidemic/index.html](http://www.hhs.gov/opioids/about-the-epidemic/index.html) (last visited Sept. 23, 2019).

2. *Id.*

3. *Opioid Basics*, CTRS. FOR DISEASE CONTROL & PREVENTION, [www.cdc.gov/drugoverdose/opioids/index.html](http://www.cdc.gov/drugoverdose/opioids/index.html) (last updated Dec. 19, 2018).

4. Ariel S. Ludwig & Roger H. Peters, *Medication-Assisted Treatment for Opioid Use Disorders in Correctional Settings: An Ethics Review*, 25 INT’L J. DRUG POL’Y 1041, 1041 (2014).

5. *Id.*



and Drug Administration (“FDA”) for use in MAT.<sup>6</sup> Without proper medication, opioid addicts have less than a thirty percent chance of staying sober.<sup>7</sup>

Several medications can be used in treating opioid addiction. Methadone and buprenorphine target the neurotransmitters involved in the physical dependence on opioids.<sup>8</sup> These medications help reduce symptoms of withdrawal and cravings.<sup>9</sup> Naltrexone, on the other hand, works by blocking the effects of opioids and is used to help prevent relapse.<sup>10</sup> This medication can stay in the body for up to a month, providing protection from opioid overdose and hindering drug cravings.<sup>11</sup>

Today’s opioid crisis has hit prison populations particularly hard, with approximately 300,000 of America’s adult inmates having a history of heroin addiction.<sup>12</sup> Despite recommendations by major medical and correctional experts, the vast majority of jails and prisons in the United States continue to refuse to offer MAT for opioid dependency during incarceration.<sup>13</sup> Instead, correctional facilities favor a “cold turkey”<sup>14</sup> approach that lacks an evidence-based foundation and only prolongs prisoners’ needless suffering of extreme

---

6. Michael S. Gordon et al., *A Randomized Clinical Trial of Buprenorphine for Prisoners: Findings at 12 Months Post-Release*, 172 DRUG & ALCOHOL DEPENDENCE 34, 35 (2017).

7. Sandra E. Garcia, *Kansas Inmate Will Be Allowed Opioid Addiction Drugs*, N.Y. Times, Sept. 11, 2019, [www.nytimes.com/2019/09/11/us/kansas-aclu-inmate-opioids.html](http://www.nytimes.com/2019/09/11/us/kansas-aclu-inmate-opioids.html).

8. Ludwig, *supra* note 4, at 1042.

9. *Id.*

10. Cerner Multum, *Naltrexone*, DRUGS.COM (Aug. 26, 2019), <https://www.drugs.com/mtm/naltrexone.html>.

11. Gordon, *supra* note 6, at 35.

12. Megan McLemore, *Prisons Are Making America’s Drug Problem Worse*, POLITICO, Mar. 11, 2015, <https://www.politico.com/magazine/story/2015/03/federal-bureau-of-prisons-medication-assisted-therapy-115998> (assessing that roughly 15 percent of all inmates in the U.S. have a history of heroin addiction).

13. *Id.*

14. A “cold turkey” detox involves abrupt cessation of the drug without medication support for withdrawal symptoms.

withdrawal symptoms.<sup>15</sup>

In the weeks following release from jail or prison, the risk of opioid relapse and overdose is extremely high.<sup>16</sup> Death from drug overdoses is the leading cause of death for inmates post-release.<sup>17</sup> During the first two weeks after release, prisoners are 129 times more likely to die of an overdose as compared to the general population.<sup>18</sup> With no access to their drugs of choice while behind bars, addicted inmates develop a lower tolerance and an increase of cravings.<sup>19</sup> Pilot programs in states like Rhode Island and New York have proven that access to MAT while in jail or prison can greatly reduce overdose deaths for the recently incarcerated.<sup>20</sup> In the first two years of the Rhode Island study, they were able to reduce overdose deaths by more than sixty percent.<sup>21</sup> Thus, the importance of access to MAT while incarcerated cannot be understated as an important factor in decreasing overdose deaths following release.

The holding in *Pesce v. Coppinger* (2018) provides support for inmates wishing to sue for access to medicines to combat their opioid addictions through the combination of the Americans with Disabilities Act<sup>22</sup> and the

---

15. See, e.g., Shannon Gwin Mitchell et al., *Incarceration and Opioid Withdrawal: The Experiences of Methadone Patients and Out-of-Treatment Heroin Users*, 41(2) J. PSYCHOACTIVE DRUGS 145, 145 (2009).

16. Byron Alex et al., *Death After Jail Release: Matching to Improve Care Delivery*, 23 J. CORRECTIONAL HEALTH CARE 83, 83 (2017).

17. *Id.* at 86.

18. Beth Schwartzapfel, *When Going to Jail Means Giving Up the Meds That Saved Your Life: How the Americans with Disabilities Act Could Change the Way the Nation's Jails and Prisons Treat Addiction*, THE MARSHALL PROJECT, Jan. 29, 2019, [www.themarshallproject.org/2019/01/29/when-going-to-jail-means-giving-up-the-meds-that-saved-your-life..](http://www.themarshallproject.org/2019/01/29/when-going-to-jail-means-giving-up-the-meds-that-saved-your-life..)

19. *Id.*

20. Erick Trickey, *How the Smallest State Is Defeating America's Biggest Addiction Crisis*, POLITICO, Aug. 25, 2018, [www.politico.com/magazine/story/2018/08/25/rhode-island-opioids-inmates-219594](http://www.politico.com/magazine/story/2018/08/25/rhode-island-opioids-inmates-219594); Alex, *supra* note 16, at 83.

21. *Id.*

22. Penn. Dep't of Corr. v. Yeskey, 524 U.S. 206, 208 (1998).

Eighth Amendment<sup>23</sup> prohibition against cruel and unusual punishment. Based on the ruling in *Pesce*, access to MAT could and should be granted to inmates in jails and prisons nationwide.

Widespread change is needed to expand access to these treatments for inmates in correctional facilities around the country. Though the cases reviewed by courts so far have been narrowly applied to individual petitioners, every win makes it more difficult for jail and prison administrators to claim that offering such treatment is “impossible.”<sup>24</sup> This article will advocate for a broad interpretation of these protections, aiming to provide MAT for any inmate who wishes to recover from an opioid addiction. Additionally, this article will analyze arguments often used by correctional agencies in opposition of providing MAT and other similar treatment. Lastly, this article will offer workable solutions to deliver greater access to MAT for incarcerated populations.

#### LEGAL FRAMEWORK

The Eighth Amendment, the Americans with Disabilities Act (“ADA”), and current legal precedent all provide the legal framework for inmates to assert their rights to MAT for opioid dependency.

#### *Eighth Amendment*

*Estelle v. Gamble* established that correctional facilities have an Eighth Amendment obligation to provide health care that meets the standard of care in the outside community.<sup>25</sup><sup>26</sup> In *Estelle*, the Court found that “deliberate

---

23. *Estelle v. Gamble*, 429 U.S. 97, 104 (1976).

24. Beth Schwartzapfel, *How the Americans with Disabilities Act Could Change the Way the Nation’s Jails and Prisons Treat Addiction*, THE MARSHALL PROJECT, Feb. 8, 2019, [www.abajournal.com/news/article/how\\_the\\_ada\\_could\\_change\\_jails\\_prisons\\_addiction\\_treatment](http://www.abajournal.com/news/article/how_the_ada_could_change_jails_prisons_addiction_treatment).

25. Ludwig, *supra* note 4, at 1043 (finding that often care in the outside community would include the option for MAT).

26. *Estelle*, 429 U.S. at 104.

indifference” toward a prisoner’s serious medical needs constitutes “unnecessary and wanton infliction of pain,” as defined under the prohibition against cruel and unusual punishment.<sup>27</sup> These protections were later expanded to include pre-adjudication settings, including jails, which applied to the states through the Fourteenth Amendment.<sup>28</sup>

This duty to provide access to proper care has been continuously interpreted by U.S. courts to include an obligation to alleviate suffering, including from the symptoms of drug and alcohol withdrawal.<sup>29</sup> However, this is often understood as a requirement to provide supportive treatment for specific withdrawal symptoms, rather than addressing the causes of withdrawal directly.<sup>30</sup> Supportive treatment may include, for instance, “Ibuprofen for pain, Bentyl for stomach cramps, Imodium for diarrhea, Zofran for nausea, Maalox for indigestions and Clonidine for anxiety and/or elevated blood pressure,” but does not get to the root cause of withdrawal symptoms.<sup>31</sup>

When correctional facilities agree to provide MAT, this is often only offered in limited circumstances, such as in the case of pregnant inmates or those who are prescribed the medications for purposes other than to aid recovery, such as pain relief.<sup>32</sup> In circumstances where inmates are receiving MAT in their communities prior to incarceration, they often denied the opportunity to continue that treatment once in prison.<sup>33</sup> This interruption in care may result in withdrawal symptoms from the therapeutic medications.<sup>34</sup>

---

27. *Id.*

28. *Bell v. Wolfish*, 441 U.S. 520, 531 (1979).

29. *Schaub v. VonWald*, 638 F.3d 905, 914 (8th Cir. 2011); *Greeno v. Daley*, 414 F.3d 645, 653 (7th Cir. 2005); *Boretti v. Wiscomb*, 930 F.2d 1150, 1153 (6th Cir. 1991).

30. Ludwig, *supra* note 4, at 1042 (i.e., providing anti-nausea medication).

31. *Pesce v. Coppinger*, 355 F. Supp. 3d 35, 42 (D. Mass. 2018).

32. Ludwig, *supra* note 4, at 1042.

33. *Id.*

34. *Id.*

Based on current interpretations, the Eighth Amendment alone is not enough to ensure that jails and prisons are required to provide access to MAT for recovering opioid addicts.

*Americans with Disabilities Act*

The ADA was passed in 1990 to provide protection against discrimination toward people with disabilities.<sup>35</sup> When it was passed, the law included a provision to protect those suffering from alcohol and drug addiction.<sup>36</sup> In 1998, the Supreme Court held that the ADA applies to people in prison.<sup>37</sup> Under Title II of the ADA, a “public entity” includes “any department, agency, . . . or other instrumentality of a State or . . . local government.”<sup>38</sup> While the ADA does not apply to federal executive branch agencies like the Bureau of Prisons, such agencies are governed by section 504 of the Rehabilitation Act, which provides similar protection against disability discrimination.<sup>39</sup>

To prove a violation under Title II of the ADA, a plaintiff is required to show that (1) he is “a qualified individual with a disability;” (2) he “was either excluded from participation in or denied the benefits of some public entities’ services;” and (3) “such exclusion, denial of benefits, or discrimination was by reason of the plaintiff’s disability.”<sup>40</sup> Under this test, medical care provided at correctional facilities constitutes a “service” that must be provided indiscriminately under the ADA.<sup>41</sup> Medical decisions that

---

35. Americans with Disabilities Act of 1990, 42 U.S.C. § 12132.

36. *The ADA, Addiction and Recovery*, ADA NATIONAL NETWORK, <https://adata.org/factsheet/ada-addiction-and-recovery> (last visited Sept. 23, 2019).

37. *Pennsylvania DOC v. Yeskey*, 524 U.S. 206, 206 (1998).

38. 42 U.S.C. § 12131(1)(B).

39. Rehabilitation Act, 29 U.S.C. § 794(a) (“No . . . qualified individual with a disability in the United States shall be excluded from, denied the benefits of, or be subjected to discrimination under any program or activity . . . conducted by any Executive agency.”).

40. *Parker v. Universidad de P.R.*, 225 F.3d 1, 5 (1st Cir. 2000).

41. *Penn. Dep’t of Corr. v. Yeskey*, 524 U.S. 206, 210 (1998).

are based on stereotypes about certain disabilities instead of “an individualized inquiry into the patient’s condition” can be considered discriminatory in violation of the ADA.<sup>42</sup>

However, a few questions have yet to be answered by the courts. The ADA does not apply to someone using drugs illegally. Rather, it only applies to people in recovery.<sup>43</sup> Conversely, the ADA also says current drug users cannot be denied health care.<sup>44</sup> It is uncertain if someone with a prescription for methadone or buprenorphine who continues to abuse opioids would qualify under the ADA.<sup>45</sup> Additionally, it is uncertain if someone with no prescription can begin MAT while he or she is incarcerated.<sup>46</sup>

*Pesce v. Coppinger*

The case of *Pesce v. Coppinger* illustrates how individuals have brought successful lawsuits against correctional facilities for access to MAT through the combination of the Eighth Amendment and the ADA.

Geoffrey Pesce’s life was turned upside down by his addiction to heroin and oxycodone.<sup>47</sup> Wanting to turn his life around, he visited a methadone clinic daily to receive his dose of medication that helped him to keep from relapsing.<sup>48</sup> He had lost his driver’s license as a result of his addiction, so he relied on his parents to transport him back and forth from the clinic, until one day when they were unavailable.<sup>49</sup> Not wanting to risk his sobriety, Pesce decided to drive himself.<sup>50</sup> While in route to the clinic, he was pulled over for

---

42. *Pesce v. Coppinger*, 355 F. Supp. 3d 35, 46 (D. Mass. 2018) (quoting *Kiman v. N.H. Dep’t of Corr.*, 451 F.3d 274, 285 (1st Cir. 2006)).

43. *The ADA, Addiction and Recovery*, *supra* note 36.

44. Schwartzapfel, *supra* note 18.

45. *Id.*

46. *Id.*

47. *Id.*

48. *Pesce v. Coppinger*, 355 F. Supp. 3d 35, 40 (D. Mass. 2018).

49. Schwartzapfel, *supra* note 18.

50. *Id.*

speeding and was charged with driving with a suspended or revoked license, which carries a sentence of at least 60 days in jail.<sup>51</sup> The rules of the county jail in Massachusetts mandated that he stop taking his methadone.<sup>52</sup>

Fearing his inability to turn down black market opioids behind bars without the support of methadone to stave his cravings, Pesce sued the county sheriff.<sup>53</sup> In his court filings, he said, “I am terrified that if I am unable to remain on my medication . . . I will lose control of my addiction, and I will relapse, overdose and die.”<sup>54</sup> In his lawsuit he claimed that denial of his medication amounted to disability discrimination under the ADA, as well as cruel and unusual punishment under the Eighth amendment.<sup>55</sup> This argument proved successful, as the federal judge sided with Pesce and ordered the jail to provide the treatment.<sup>56</sup> Specifically, the court found that defendants failed to take Pesce’s medical history into consideration when attempting to force him into their standard opioid treatment program (the same types of programs that failed to help Pesce maintain his sobriety for over five years before he began MAT).<sup>57</sup> Further, while “concerns over prison security may be legitimate non-discriminatory grounds for limiting access to a jail program,” the court found that the concerns presented by administrators in this case were not applicable because Pesce was receiving a liquid methadone prescription.<sup>58</sup>

Pesce’s lawsuit is not the only case out there that reached this result. In

---

51. *Pesce*, 355 F. Supp. 3d at 41.

52. *Id.*

53. *Id.* at 39.

54. Schwartzapfel, *supra* note 18.

55. *Pesce*, 355 F. Supp. 3d at 39.

56. *Id.* at 49.

57. *Id.* at 45 (“In lieu of conducting an individualized assessment of Pesce’s medical needs or his physician’s recommendation, [the defendants] would require Pesce to participate in a treatment program that bares a strong resemblance to the methods that failed Pesce for five years.”).

58. *Id.* at 46 (quoting *Kogut v. Ashe*, 602 F. Supp. 2d 251, 253 (D. Mass. 2009)).

April 2019, the First Circuit decided a case where a petitioner requested to continue her twice daily dose of buprenorphine while serving her jail term. The Court affirmed the lower court's granting of a preliminary injunction to force the jail to provide her medication under the ADA.<sup>59</sup> Similarly, federal suits filed in Kansas, Maine, and Washington state also held in favor of petitioners, allowing them to continue their MAT while incarcerated. These cases were all decided on the same grounds as *Pesce*.<sup>60</sup>

In reflecting on the *Pesce* decision, Sally Friedman, of the Legal Action Center, an organization that advocates for access to addiction medication in the criminal justice system, said, “[t]his judge is basically saying that the vast majority of jails and prisons in this country are likely violating federal law.”<sup>61</sup> Already, federal prosecutors are starting to investigate correctional facilities for denying access to methadone and buprenorphine to prisoners with a valid prescription.<sup>62</sup>

As individual petitioners continue to advocate for access to MAT, the case law precedent will be reinforced. It is hoped that in response to these lawsuits and investigations, more correctional facilities will voluntarily change their policies to address MAT for opioid-addicted inmates.

#### INTERNAL CONCERNS ARE INSUFFICIENT FOR DENYING TREATMENT

Based on the results of these current cases, MAT could and should be

---

59. *Smith v. Aroostook County*, 922 F.3d 41, 42 (1st Cir. 2019).

60. *Crews v. Sawyer*, 19-cv-02541 (D. Kan. 2019) (allowing inmate with 14 months of sobriety continued access to buprenorphine while incarcerated); *DiPierro v. Hurwitz*, 19-cv-10496-WGY (D. Mass. 2019) (granting inmate access to methadone); *Kortlever et al. v. Whatcom County*, 18-cv-00823 (W.D. Wash. 2019) (agreeing to provide access to MAT to all prisoners who need it, not just pregnant women). *See also* *Godsey v. Sawyer*, 19-cv-01498 (W.D. Wash. 2019) (case pending).

61. *Schwartzapfel*, *supra* note 18 (“In October [2018], Andrew Lelling, the U.S. Attorney in Massachusetts, sent Copping and another county sheriff letters informing them that their offices were under investigation for potential ADA violations for not allowing access to buprenorphine and methadone to addicts with a valid prescription. Lelling had previously alerted the state’s Department of Corrections that it was under investigation.”).

62. *Id.*





medical resources) in correctional facilities.<sup>70</sup>

One of the reasons correctional facilities favor drug free detox is due to a perception that MAT “just substitute[s] one addiction for another.”<sup>71</sup> But many medical professions find this to be a misconception. According to Dr. Josiah Rich, the Director of the Center for Prisoner Health and Human Rights, “What these treatments do is allow people to have the breathing room to move in the direction of recovery.”<sup>72</sup>

Some of the safety and security concerns raised in connection with medication diversion are legitimate. Opioids are frequently smuggled into correctional facilities to be sold or traded amongst inmates.<sup>73</sup> Better medication monitoring efforts can decrease the likelihood that these prescriptions make it to the black market inside prisons.<sup>74</sup> Additionally, requiring more health care or security staff, efforts like “mouth checks” can help to quell these concerns.<sup>75</sup> A common practice in the United States for the oral administration of methadone prescriptions involves having the inmate drink a glass of water and then talk to the nurse, which ensures they have ingested their dose.<sup>76</sup> Lastly, by increasing accessibility to these treatments, the need to acquire these medications through illicit means diminishes.<sup>77</sup>

Corrections officers also continue to question the efficacy of MAT for opioid addiction, despite evidence that all three medications approved by the

---

70. *Id.* at 1042.

71. *Id.*

72. Silber, *supra* note 65.

73. Schwartzapfel, *supra* note 18.

74. *Id.*

75. *Id.* (“Other facilities have . . . required inmates to place their hands on a desk for several minutes, eat crackers and drink water after they take their dose, with a nurse or correctional officer watching.”).

76. *Pesce v. Coppinger*, 355 F. Supp. 3d 35, 46 (D. Mass. 2018).

77. *Id.*

FDA for this purpose have shown effectiveness in the prison context.<sup>78</sup> Various clinical trials have exhibited success with starting methadone treatment prior to release, showing an increase in engaging with follow up treatment in the community and a reduction in illegal drug use after release.<sup>79</sup> However, methadone must be administered under the supervision of a physician at a federally licensed methadone clinic, which creates an obstacle for administration in a jail or prison setting.<sup>80</sup> Since the medication needs to be administered daily, it may be easier for correctional facilities to establish an on-site clinic rather than arrange for individual transport back and forth to an outside clinic.<sup>81</sup>

Buprenorphine has the potential to be even more successful in correctional facilities, due to a number of advantages over methadone.<sup>82</sup> As a lower strength opioid, buprenorphine has a lower risk for overdose and requires less oversight, thus it is able to be used outside of specially regulated treatment programs.<sup>83</sup> This also makes it more widely available for patients after release, allowing them to receive less-stigmatized care within their communities.<sup>84</sup> Another benefit of buprenorphine is that it can be administered every other day, making it more efficient and reducing the burden on health care workers within the facility.<sup>85</sup>

Furthermore, a pilot study in a New York City jail showed promise for the administration of extended-release naltrexone just prior to release in reducing

---

78. Gordon, *supra* note 6, at 35.

79. *Id.*

80. *Methadone*, SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN., Aug. 1, 2019, [www.samhsa.gov/medication-assisted-treatment/treatment/methadone](http://www.samhsa.gov/medication-assisted-treatment/treatment/methadone).

81. Schwartzapfel, *supra* note 18. In Pesce's case, the sheriff is arranging for him to have individual trips while the jail investigates alternative options for scaling up to accommodate more inmates seeking MAT. *Id.*

82. Gordon, *supra* note 6, at 35.

83. *Id.*

84. *Id.*

85. *Id.*

post-release relapse and overdose.<sup>86</sup> Like buprenorphine, naltrexone does not have to be administered in a specialty clinic.<sup>87</sup> Moreover, it can last up to a month, which may minimize the strain on prison healthcare workers. Lastly, it is available in an injectable form, which removes concerns over medication diversion.<sup>88</sup>

#### CONCLUSION

With the support of the Eighth Amendment and the ADA, inmates like Geoffrey Pesce can now expect access to MAT while incarcerated.<sup>89</sup> Though implementation of these treatment programs may be costly, research shows that these improvements in addiction care will lessen expenses for health care and incarceration in the future.<sup>90</sup> The prevalence of opioid dependency within correctional facilities offers a unique opportunity to combat the opioid epidemic in a controlled environment where medication compliance can be closely monitored.<sup>91</sup> The research showing the success of MAT in treating opioid addiction continues to grow. Additionally, federal prosecutors continue to take a stronger stance against sheriffs and other prison officials who deny access to it. The hope is that the ADA protections continue to be construed and expanded in favor of inclusivity, granting access to addiction treatment for any inmate who desires to start on the road to recovery.

---

86. *Id.*

87. *Naltrexone*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., May 7, 2019, [www.samhsa.gov/medication-assisted-treatment/treatment/naltrexone](http://www.samhsa.gov/medication-assisted-treatment/treatment/naltrexone); *An Introduction to Extended-Release Injectable Naltrexone for the Treatment of People with Opioid Dependence*, SAMHSA, [www.integration.samhsa.gov/Intro\\_To\\_Injectable\\_Naltrexone.pdf](http://www.integration.samhsa.gov/Intro_To_Injectable_Naltrexone.pdf) (last visited Oct. 21, 2019).

88. *Id.*

89. *Pesce v. Coppinger*, 355 F. Supp. 3d 35, 49 (D. Mass. 2018).

90. *Vestal*, *supra* note 63.

91. *Id.*